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Engaging with clinical supervision in a community midwifery setting: an action research study

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CHAPTER ONE

Introduction

> *…one of us is very emotional at the moment…I remember coming in…I'd been to a home birth and I was hoping I could just hand over and go to bed…I just wanted to say "here have the work" and then go to bed…and she was in pieces…so then it was a question of looking at the work…I took visits…I said "I've got to go home and get some sleep now" – so I had a few hours in the morning and then did eight visits in the afternoon…I got her clinic covered…I was out of my brains…I keep saying to myself "I'm eating, drinking, sleeping so I can't be that bad"…and I just keep pushing myself…I find I'm going from one crisis to the next…I spent three days of my holidays doing booking letters…sorting out my cards…I'm just not organised… I think a lot of it is to do with the fact that I spend too much time in the homes and I end up chatting and talking…*
> (Rachel)

Rachel's poignant words above reflect life as a community-based midwife in a NHS maternity service that was trying to respond to strategic planning and policy making directives (DOH, 1993a) without giving due regard to long standing and deeply entrenched cultural and organisational barriers to achieving this (Kirkham, 1999; Hughes, Deery & Lovatt, 2002). These contradictions have resulted in a midwifery workforce that is struggling with the pace and nature of change. Midwives have reported feeling stressed (Sandall, 1998) and unsupported (Kirkham & Stapleton, 2000) as they have juggled, trying to meet competing organisational and client demands within a culture that is resisting change.

In this chapter I set the scene and explain the need for my study. I consider how many years experience as a midwife, often without purposeful support, led me to explore the support needs of midwives further. The study has highlighted a contradiction that runs throughout this thesis; that is, midwives are being asked to engage in meaningful, supportive relationships with clients when they themselves have impoverished support and are not adequately prepared for the supportive

aspect of their role. I also introduce key theoretical issues as well as an overview of the NHS Trust[1] in which the research took place.

The need for the study

I have been a midwife for 26 years. During this time, I have birthed three of my own children, practised in all areas of midwifery, taught midwifery and been part of a profession that has been, and still is, undergoing tremendous change. Parallel to this has been my own personal and professional development which has been profound. This has involved the transition from an 'accepting' midwife practising in a hierarchical and medically dominated hospital setting, to practising as a 'feminist' midwife and challenging that setting. The energy, which has carried me through this research and the writing of the thesis, has derived from my commitment to, and feminist[2] values of, women supporting women.

It was during my time spent in what I perceived to be highly stressful areas (for example, labour and community midwifery), that I first felt the need to mobilise some sort of support mechanism for myself. Using myself as a therapeutic resource for clients during childbirth often left me feeling drained and 'uncared for' and I used to describe feeling emotionally exhausted (Butterworth, Carson, White, Jeacock, Clements & Bishop, 1997) or 'psychologically drained' to my peers. Thomas (1994) states that these feelings can eventually lead to emotional burnout and furthermore, Williams, Michie & Pattani (1998) in a review of the literature, have found that psychological illness is the main cause of ill health in NHS staff. This could, in part, account for the recruitment and retention difficulties that the midwifery profession is currently experiencing (Ball, Curtis & Kirkham, 2002).

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[1] During the late 1980s a funding crisis within the NHS prompted a review of services with the subsequent publication of the document "Working for Patients" (DOH, 1989). As a result the Government effected organisational change within the NHS by allowing all those providing health care ('providers') to manage themselves and to apply to become NHS Trusts (Jenkins, 1995a). An internal market was created whereby a system for contracting services was put into place. The contract between purchaser (e.g. fundholding General Practitioners) and provider became "central to successful competition…powered by the price mechanism" (Bradshaw, 1995, p. 977).
[2] My feminist principles are addressed later in this chapter.

As my career as a midwife changed to focus on education as a senior lecturer in midwifery, and I visited maternity units in this capacity, I began to observe and hear midwives relating this same feeling of emotional exhaustion. My work as a bank midwife[3] at the same time also found me working alongside midwives who shared with me that they often felt emotionally exhausted. I became conscious of some midwives keeping their emotions "under wraps" (Bond & Holland, 1998, p.62) and often becoming stressed as a result. I also observed midwives who had appeared to become hardened and almost uncaring. I began to question that, if this happened, healthy, helping relationships with other midwives and their clients would not develop. As stated by Bond & Holland (1998) this "can mean that practitioners keep their own emotional lids on tight, and in so doing ensure that the client's needs for appropriate emotional expression are not encouraged" (p.65).

These early questions and observation of midwives in clinical practice led to my undertaking this research study. My feminist values and a move within midwifery towards a more woman-centred approach (DOH, 1993a) meant that I wanted to carry out research collaboratively with midwives in order that we could explore clinical practice and attempt to bring about practice changes.

Aims of the study

This research aimed to:

1. Explore midwives' views and experiences of the support they currently receive in practice.

2. Identify how midwives would wish to receive support.

3. Facilitate the teaching of midwives in order to help them draw up plans to introduce appropriate change. This would include the provision of information from the literature which midwives have identified they need.

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[3] Bank midwives are those practising midwives who are held on a register in the Trust and called upon by midwifery managers to support core staff and cover shifts in the case of sickness and absence. Bank midwives are remunerated for their work but are under no obligation to work the shifts they are offered.

4. Use an action research approach to plan programmes of action and introduce change in order to enhance the support available to midwives.

5. Plan a model of clinical supervision with the midwives for utilisation in midwifery practice.

6. Implement, test and develop the proposed model of clinical supervision with the participating midwives.

7. Evaluate in an on-going and frequently reviewed manner, at all stages of the research, and also to evaluate the impact that the new model of clinical supervision has on midwifery work.

<u>Setting the scene</u>

The scope of this research is limited to a work team of eight NHS community-based midwives[4] (Glendale Team)[5], their working relationships and also their ways of working in the local maternity service and the NHS. The research is also a story about my aspirations to work with the midwives in order to help them acknowledge and address their support needs at work. The research took an action research approach in order to generate data that I hoped would help to plan programmes of action and introduce change that might enhance the support available to midwives. Figure 1, on page 5, signposts the phases and progress of the study. In the early planning stages I thought that an action research approach would help the midwives to make a positive impact within their working relationships. However, as the research story unfolds the reader will be drawn into an "emotional minefield" (Flint, 1986, p.1) that exposes the nature of the way the midwives worked when they were offered and received support. The way in which the midwives reacted and coped when their work team[6] was challenged will also be scrutinised. The study also examines working relationships in midwifery and how wider organisational and cultural issues affect these.

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[4] Community-based midwives practice midwifery in a community setting and usually provide care for women before and after the birth of their baby. Some community-based midwives update their skills in helping women to birth their babies by working on the delivery suite for one week or more every few months.
[5] A description of each midwife is provided in Appendix 1.
[6] In order to facilitate reading of the thesis I refer to the team in which the midwives worked on a daily basis as "the work team". As will be seen in Chapter 10, "the group" is that in which the midwives experienced their planned support mechanism. The membership of these 'groups' was the same, except for new members to the work team, who the participating midwives chose to exclude from their planned support mechanism.

FIGURE 1: FLOW CHART SIGNPOSTING PHASES AND PROGRESS OF THE STUDY

Phase One: Gaining access and recruitment to the study

March 1997, Ethical approval granted → Meeting with Head of Midwifery → Meeting with supervisors of midwives → April 1997, Meeting with community midwifery manager

September 1997 – March 1998, preliminary individual interviews held with midwives. ← March – September 1997, several meetings with midwives in Health Centre. ← Pilot interviews held

Phase Two: Preparing for, and negotiating, clinical supervision

Meeting with midwifery manager ← November 1998, second focus group ← Educational input about clinical supervision from Dawn ← April 1998, first focus group held.

Meeting with new Head of Midwifery → January 1999, Meeting with prospective clinical supervisor, Joss → Funding awarded from West Yorkshire Workforce Development Confederation → April 1999, further meeting between myself and clinical supervisor

Phase Three: Undertaking clinical supervision and evaluation

Contract setting meeting with midwives and clinical supervisor → May – October 1999, midwives participated in clinical supervision → December – April 2000, final individual interviews → February 2000, individual interview with Joss

Data analysis

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The research is also a reflexive account of my personal and professional development. As will be seen throughout the thesis, I incorporate and examine my "historically situated self" (DeVault, 1999, p.5) in order to locate myself[7] in relation to the research that I was undertaking with the midwives. As a feminist I feel that it is important not "to adopt a disinterested 'objective' voice" (Jackson, 1998, p.47) but to make it clear where I am speaking from. I therefore felt that if I did not understand myself it was likely that I might misconstrue the experience of the midwives taking part in the study.

Key theoretical issues

Feminist theory

In the past, feminist writers and researchers have expressed concern that women were seen as invisible in a social world dominated by men and that social science theorising neglected or ignored important parts of their lives (Arksey & Knight, 1999). They resolved to correct this invisibility by hearing women's voices (Oakley, 1993a; Belenky, Clinchy, Goldberger & Tarule, 1986) and enabling them to articulate their experiences in order to help bring about change and free them from their perceived subordination and subservience (Belenky et al. 1986; Jackson, 1998; Maguire, 2001).

As a feminist I value women and the concerns they express about their lives and I hope to constantly strive to improve women's status and their ways of working. As Marjorie DeVault (1999) has stated:

> "'Feminism' is a movement, and a set of beliefs,
> that problematize gender inequality. Feminists
> believe that women have been subordinated
> through men's greater power, variously
> expressed in different arenas."
> (DeVault, 1999, p.27)

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[7] I discuss the use of personal history in research more fully in Chapter 6.

However, there are many different feminisms (Reinharz, 1992) although most feminists would agree that they are united by a desire and "accountability" (DeVault, 1999, p.28) to consider the different experiences and interpretations of women's lives. Likewise, there are many different approaches to feminist research (Reinharz, 1992). One of these approaches involves exploring the different perspectives of women through the use of research strategies that help to find 'voices' (Burt & Code, 1995). Although not specifically taking a feminist standpoint in this thesis, I drew on the principle of "research on women, by women, for women" (Stacey, 1991, p.111) and therefore sought an approach to research that would value midwives, eventually leading to change or further understanding of a situation that would benefit the participating midwives.

Humanistic psychology

When I was studying for my diploma and during degree studies in the early 1990s I became influenced by humanism and at times I have drawn on this further during my own personal growth on this research journey. Reflecting on the way humanism has influenced me prior to, and during this research has helped me to understand and come to terms with many of the difficult situations and contradictions within the research.

Humanistic psychology, particularly that relating to person-centredness (Rogers, 1967), has helped to reinforce my belief that midwives are capable of growing and developing through effective 'helping relationships'. Rogers (1967) uses counselling, psychotherapy and group work to achieve what he refers to as the "fully functioning person". He emphasises the importance of empathy, warmth and genuineness. Rowan (1998) on the other hand, reminds us that humanistic psychology is also concerned with human diminution and the way in which different social roles and situations can diminish people. This is particularly pertinent within this study where working relationships have been exposed and scrutinised.

I found Rogers' (1967) theory uncomplicated and practical and his therapeutic application of humanistic psychology helped me to apply his ideas to my clinical and educational practice. His theory also helped me to understand the everyday experience of midwives' working lives and their relationships with each other and their clients. Its application has helped me in my role as an educationalist in a university setting. Long before the research began, and probably as far back as the late 1970s, I had realised that there appeared to be a culture pervading midwifery that prevented midwives from experiencing midwifery positively.

An awareness of the importance of valuing each other and their clients seemed lacking. This distressed me, as I have been a midwife for a long time and would have expected to see some growth and development in this area. Thus, at the start of the study, I hoped that gaining an empathetic understanding of each other's worlds would provide midwives with the confidence to explore their perceptions of themselves and then aid amelioration.

Counselling theory

Some years later and linked to humanistic psychology, counselling theory became very important to me and was therefore a key theoretical influence within the study. Personal experience of Re-evaluation Counselling (RC) at an important and stressful time in my life has helped me to understand how potential complexities that exist within people's lives may affect both their thinking and the way they deal with different situations that they are faced with.

Jackins (1965) describes Re-evaluation Counselling as that which takes the stance of emotions clouding a person's thinking. By the time I attended counselling I could recollect many distressing events during my life. These recollections had become unresolved issues and often meant I felt despondent when feelings in relation to my historical self manifested themselves. As Jackins (1965) states:

> "Very early in life the first time, and repeatedly
> after that, we meet experiences of distress.
> When we meet one – whether the distress is
> physical…or whether it is emotional distress… -
> a particular effect takes place. While hurting,
> physically or emotionally, our flexible human
> intelligence stops functioning."
> (Jackins, 1965, p.29)

At the time I experienced these feelings I was not able to express them, probably because of a lack of insight, and I "buried" them. My counsellor used to talk about "getting those feelings down that I had stored away on the top shelf, out of reach". She would deliberately provoke some of these feelings in order that I could relive them in a safe environment.

Clearly, personal and professional development during my career as a midwife triggered some of these "buried" emotions and provoked reactions in me that needed addressing. As the research unfolded, some of the encounters I had with the participants and midwifery managers kindled previously unresolved issues and associated emotions. Re-evaluation Counselling helped me to examine those emotions constructively before putting them back "on the top shelf". Unfortunately placing an increasing emphasis on self-awareness is still not viewed as being legitimate or intrinsic within the culture of midwifery (Deery & Corby, 1996; Kirkham, 1999; Deery, 1999a). I was hoping that this research would begin to address this situation.

Group work theory

As my research story unfolded further I began to realise that working with groups was an immensely complex process and furthermore, I knew very little about this process. I reflected on my years as a hospital-based midwife and then as a community-based midwife and how I had always been part of a 'group'. I had never received any educational input or guidance about the development and

processes within groups and yet I felt that this was crucial to my work as a midwife. I was informed of a therapeutic group work course at a nearby University that was attended by people who were currently working with groups. I applied and was offered a place on the course. I hoped that this would help me to understand more about how the midwives worked together and formed relationships. Not only did my knowledge about groups grow enormously but I also experienced first hand some of the intense, often painful, interpersonal dynamics that can often happen within groups.

The members of the course comprised psychologists, counsellors, mental health nurses, social workers and occupational therapists. I was the only midwife. The course included lectures and had time set aside in order for group members to share their experiences and to examine various episodes of practice. A therapeutic experiential group was also part of the course and it was through this aspect that I learnt so much about the functioning of groups. The group I was part of enabled me to relive several decades previously by reincarnating my family and my life as a child. Old memories and feelings were evoked that remain painful to this day although I am now able to deal with these more constructively and work with them positively.

Psychotherapeutic theory

The group work course introduced me to many psychotherapeutic concepts that were unfamiliar but nevertheless connected in one way or another to midwifery and the research I was undertaking. By becoming more psychologically aware I learnt that there are not always black-and-white answers to everything and I began to become more comfortable with anxiety provoking feelings of uncertainty[8], particularly in relation to midwifery. This thesis therefore draws on some of these concepts and how they can help to understand how groups of people work

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[8] The concept of uncertainty is addressed more fully in Chapter 4.

together, especially midwives. To date this is a body of knowledge that has been largely ignored in midwifery but one which can make an important contribution to midwifery work. Raphael-Leff (2000) has stated that incorporating psychodynamic understanding into midwifery work can help to "enhance emotional support in the clinical relationship between the midwife and her client" (p.686) although she is also clear that this understanding does not include psychotherapeutic intervention. Being able to differentiate between "ordinary emotional turbulence…and either unbearable distress or denied disturbance" (Raphael-Leff, 2000, p.688) will help midwives identify those clients who may be in need of further help.

The psychotherapeutic concepts highlighted in this research offer a new way of thinking about relationships in midwifery and how current ways of working often replicate 'old ways' that are detrimental to midwives and their clients. As Jackins (1965) states "when we are confronted by a new experience that is similar enough to the recorded distress experience we are compulsively forced to meet it with an attempted re-enactment of the old distress experience" (p.45). Although Jackins is referring to distressing episodes in a person's life the same principles can be applied to current and old ways of working within midwifery.

Sociological theory

This research has also uncovered the ways in which some midwives manage their emotions at work. I have already described on page 2 how I attempted to manage my own emotions at work as a midwife and how I observed other midwives doing the same. I realised, fortuitously, during the course of the research, and especially during data analysis, that I would have to further explore the ways in which midwives managed their emotions at work.

Billie Hunter (2002) insightfully develops and focuses on the emotional aspects of midwives' experiences of their work. The midwives' accounts I present in Chapter

8 support her work and explore sources of emotion in midwifery work and the strategies that midwives use to manage their emotions. I draw on the work of Erving Goffman (1974, 1990) in order to demonstrate how midwives appear to control their emotions in order to create a 'performance' in accordance with societal expectations (Goffman, 1990). The work of Arlie Russell Hochschild (1983) is also addressed and how she has described the ways in which workers manage and control their emotions as 'emotional labour' or 'emotion work'.

I also draw on the work of Michael Lipsky (1980) who compares the work of different public service workers so that their work practices and the way these are managed can be identified. Lipsky (1980) investigated the work of welfare departments, police departments, schools and court and legal services and described these as "street-level bureaucracies" (pxi). These 'bureaucracies' became the organisational setting within which the workers experienced a combination of increasing caseloads, inadequate resources, the unpredictability of clients and uncertainty about the best way to approach their work with clients. As a result service workers were often not able to meet their full potential. Developing my understanding of Lipsky's work has helped me to contextualise how the participating midwives behaved and coped when challenged with the prospect of further change promised within this research.

Transforming the local maternity services

Prior to this study being undertaken a reconfiguration of the maternity services in the area had taken place and the two maternity hospitals in the city merged to provide services on one site in an effort to address cost effectiveness and ever decreasing resources. As will be seen in Chapter 7, this created major upheaval and stress for many of the midwives, on both sites, in terms of changed working relationships and a changed work environment.

Unusually, both traditional community-based midwifery and team midwifery[9] had been practised in the area where the research was undertaken. Funding had been granted by the Department of Health (DOH) to enable team midwifery to be piloted across a large area of the city. The midwives were encouraged to participate in this change on the grounds that team midwifery would be beneficial for them, their clients and the maternity service as a whole. As will be seen, when team midwifery was disbanded some two years later, the midwives claimed that this approach to midwifery had not lived up to their expectations and that relationships with their midwifery managers and peers had been compromised. Although the midwives taking part in this study remained part of traditional community midwifery they claimed that team midwifery and its associated working patterns had brought extra burden to their working lives. Their perceptions seemed to be that team midwifery had created a two tier midwifery service, had been understaffed and under resourced, and as a result they had often found themselves having to 'help out' their colleagues who were practising team midwifery.

Almost 6,000 births take place per year in the maternity unit where this research was undertaken. There is a high concentration of births in the inner city and high unemployment and associated socio-economic deprivation. As well as the sheer volume of women using the maternity services, there had been an increasing move for clients to be transferred home early from hospital following the birth of their babies and also for the initial antenatal interview to be undertaken in the client's home.

This change of working practices had imposed extra work for community midwives, many of whom already perceived that there was inequity in community midwives' workloads across the city. This, plus a mounting workload and a constant cycle of

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[9] The team midwifery model was suggested by the Winterton Report (1992) and the DOH (1993a) as a way in which the maternity services could be organised to enhance continuity of care through sensitive, flexible and woman centred ways of working. There is no single accepted definition of team midwifery although the principles are that a small team of midwives take responsibility for the majority of care of individual women before, during and after the birth of the baby (Seccombe & Stock, 1995).

change being imposed, meant there was a quick turnover of midwives[10] and high sickness levels both within the hospital and community. As will be seen, the midwives blamed the high sickness levels on job-related stress.

Glendale work team

Community midwifery as practised by the Glendale Team at the NHS Trust was unique in that the midwives were geographically based according to certain locations in the city. The Glendale Team was also unique in that it covered both inner city and rural areas. Some of the work team had a caseload that comprised almost 100 per cent ethnic minority clients, for many of whom English was not their first language. Other members of the work team had caseloads that comprised mainly white, middle class clients who brought a different perspective to their midwifery work.

The users of the maternity service viewed the geographical basing of the midwives as advantageous for them in that they attended health centres or clinics near to where they lived for their appointments. However, the midwives viewed this as disadvantageous as those midwives who worked in the inner city had much larger caseloads than those midwives working in the rural areas. Those midwives working in the inner city had caseloads that comprised mainly ethnic minority clients, many of whom did not speak English as their first language and who often presented with high risk pregnancies. This perceived inequity had posed problems for the midwifery managers for many years.

At the time of the first round of individual interviews in 1997 team midwifery had been disbanded because of a lack of funding and community-based midwives were

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[10] The difficulties in recruiting and retaining midwives in the maternity unit were further exacerbated by a national shortage of midwives at the time (UKCC, 2001).

being asked to move towards being General Practitioner (GP) attached[11] rather than geographically based. This was anxiety provoking for some of the midwives who claimed that some GPs had much larger caseloads than others, especially those who had practices in the inner city area. Thus a perceived inequity in terms of workload was raised once again by community midwives. Understandably, the merging of two maternity units, each with its own unique culture, the imposition of team midwifery and then GP attachment appeared to have contributed to creating a sense of instability and anxiety within the midwives.

Dawn's influence on my study

After I had undertaken my Advanced Diploma in Midwifery in 1990 I was fortunate enough to be sponsored by the then, English National Board (ENB)[12], to study for my first degree at a local university. This coincided with the need for more graduate midwifery teachers, as there was a push towards an all graduate profession (Alexander, 1995). During my undergraduate studies I met a community psychiatric nurse (Dawn) who had an interest in clinical supervision. She introduced me to clinical supervision as a supportive intervention for health practitioners and from then on my interest grew. Little did I know when I met her that our mutual interest in clinical supervision would eventually lead to my undertaking this research.

The concept of clinical supervision was very new for me and challenged my usual way of thinking about 'supervision'. I could see the positive implications for midwives, clinical practice and ultimately, the clients. Dawn put me in contact with many people who were experts in this field and my knowledge and networks grew immensely. I found out from the literature that there appeared to be little or no

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[11] Becoming GP attached meant that maternity care would be offered to women that involved GPs and midwives working collaboratively. Care under these circumstances takes place in the GP's practice, and postnatally in the woman's home.
[12] The English National Board (ENB) was responsible for ensuring that standards of clinical practice were met and were also responsible for providing educational courses for midwives as well as courses of preparation for supervisors of midwives. The Board was superseded by the Nurses and Midwives Council (NMC) in April 2002.

acknowledgement of the subsequent effects of 'caring' on midwives' emotional well being and that clinical supervision offered an opportunity to explore and reflect on clinical practice in a safe, supportive, relaxed and open environment. Dawn has continued to play a key role in this research. As will be seen in Chapter 9, prior to the midwives devising their own framework for support, Dawn spent two days with them, providing educational input to assist the midwives in their future planning within the study.

Joss' influence on my study

I met Joss through Dawn. She was one of the key people that Dawn had directed me to in order that I could explore clinical supervision further. Joss also had vast experience of working with women's groups and was influenced, as I was, by humanistic psychology and feminism and subsequent insights into the helping relationship. She was based in a psychotherapy department. She had undertaken the same group work course as I had and seemed to possess the necessary qualifications and experience for this work. As will be seen in Chapter 4, Joss had also developed her own personal model of clinical supervision that she used and shared with the midwives participating in this study.

The organisation of the thesis

In Chapter 2 historical, cultural, social and political perspectives of midwifery are reviewed as well as factors that might have affected the way midwives work. This chapter is intended to provide the reader with insight into the many changes that have taken place in the maternity services both at local and national level in the United Kingdom. Chapter 3 is divided into two parts. Part 1 examines the substance of the literature surrounding change and culture in the NHS and how the two concepts are inextricably linked. I address how current Government policy proposes working towards organisational and cultural shift but does not appear to

acknowledge the barriers that exist to prevent this. Part 2 examines the literature surrounding caring, the midwife-mother relationship and emotion work and argues that this is a body of knowledge that until recently has been largely ignored within the midwifery profession. Chapter 4 examines the literature surrounding clinical supervision. Its origins, history and development are traced and some clinical supervision frameworks are explored more closely. Also in this chapter I discuss the supportive framework used within the study and also make a comparison between midwifery supervision and clinical supervision.

Chapter 5 justifies and explores action research as my chosen approach to the study. I demonstrate how action research is a useful approach in midwifery in order to generate data to help plan programmes of action and introduce change. Parallels are drawn between the complexity of action research and clinical practice. I acknowledge that action research is fraught with complex challenges but that it was well suited for the aims of this study. Chapter 6 reports the methods used in each phase of the study in order to gather data. I explore the use of in-depth interviews, focus groups, personal history, contributions from Dawn and Joss, data analysis and interpretation and issues of ethics and rigour in the study.

The study findings are set out in Chapters 7 to 10. Chapter 7 presents the findings of preliminary individual interviews I held with the community midwives during phase one of the study. Chapter 8 goes on to examine this data in more detail, exploring how the midwives experience their work and the way in which emotion work has impacted on their 'performances' as community-based midwives. Chapter 9 presents findings from two different focus groups held with the midwives during phase two of the study. Educational input to the study is also discussed as well as meetings that were held with midwifery managers following the focus groups. Chapter 10, the third phase, presents the findings of the final individual interviews where the midwives were asked to describe their experiences of clinical supervision and participation in the study. Finally Chapter 11 recalls and discusses

the key findings from the study. The conclusions of the study are drawn as well as the utility of the findings and an action research approach. Recommendations and implications for midwifery practice, midwifery education and further research are also made.

CHAPTER TWO

Voices and Issues from past and present midwifery

> My dream is to run
> from the past
> into the future
> carrying with me
> tightly wrapped
> the tattered garments
> of what was
> so that they
> can be woven
> into what
> may yet be

From Miller Mair, 1989

This chapter provides an overview of some of the changes that have occurred within midwifery since 1902. When I entered the NHS in 1972, nursing and midwifery work was task-based and health practitioners were not encouraged to 'get close' or build relationships with their patients/clients. Likewise, clients were expected to be compliant and not make their voices heard unless they wanted to be labelled as 'unpopular' or 'difficult' (Kelly & May, 1982). When I trained to be a midwife in 1976 a woman would not be seen on the labour ward unless she had been subjected to a pubic shave, an enema and a bath in the admission room. The 'delivery rooms' smelled of disinfectant, theatre lights glaringly lit the rooms and stainless steel troughs for hand-washing were omnipresent on the walls of the 'delivery rooms'. At that time, questioning admission procedures or the décor of the maternity unit where I trained would have been more than my life was worth. Three decades have since passed and massive change has, and still is occurring, within the NHS. Indeed, in all this time, I have never experienced such large-scale change as is currently happening within the NHS. This chapter therefore, explores relevant historical, cultural, social and political factors that may have affected the way midwives work in order to place current ways of working into context.

The move from 'disordered' to 'ordered' practice

Prior to the Midwives Act in 1902, midwifery practice was considered disordered (Heagerty, 1996) mainly because of the self-employed handywomen who attended births at this time. Leap & Hunter (1993) provide an interesting historical account that relates both positive and negative images of these women. Negative images of drunken, slovenly 'old gamps' are set against positive images of conscientious, clean and caring women (Leap & Hunter, 1993; Kent, 2000). According to Heagerty (1997, p.70), midwifery at this time "was an integral part of the network of economic and social relationships which comprised working-class life and culture".

Midwifery was practised mainly within the community setting with working class lay midwives[13] having a shrewd awareness of the needs of the women they cared for. However, the perceived disorderliness of practising in this way was taken up as "a cause for social reform" (Heagerty, 1996, p.13) by the members of the Midwives Institute. This "socially well placed" (ibid, p.13) group of women from middle, upper and aristocratic backgrounds believed that working class women had to conform to the "values and behaviours considered appropriate" (ibid, p.13) for them by this group. This had implications for childbearing women at that time because women were mainly cared for by the working class lay midwives otherwise known as handywomen. Needless to say, the image of a midwife who would obey and serve in an appropriate manner was the one favoured by the Midwives Institute. Their opinion was that these midwives forged healthy relationships with women and were particularly aware of the implications that economic deprivation brought for their clients[14]. However, pregnant working class women and poor women were more

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[13] Lay midwives were working class midwives who attended working class childbearing women. Their lack of formal training meant that midwifery reformers felt they were unfit to attend women in childbirth. According to (Heagerty, 1996) it was "lay midwives, working in every village, neighbourhood and town, who attended the majority of births at the turn of the century as safely…as the average general practitioner at the time and under certain conditions even more so" (p.15).
[14] Currently there is a resurgence of interest in the public health role of the midwife. 'New public health' (Harlem Brundtland, 1999) encompasses the old concept of public health involving health hazards in the environment with current thinking around lifestyle and behaviour change. There is a much greater emphasis on the socio-economic environment and the impact of poverty and health inequalities (Kaufmann, 2002). Sure Start midwives (DOH, 1999a) are now working in areas of deprivation across the country to provide midwifery care for disadvantaged or isolated mothers and their families.

likely to approach lay midwives, not doctors, because their services were affordable (Leap & Hunter, 1993) and middle class women were more likely to opt for expensive medical care believing this to be the better option.

The Midwives Institute formed to regulate the training and practice of midwives and in 1902, the first Midwives' Act for England and Wales was passed. This also established the Central Midwives' Board, which governed the training and practice of midwives and made practising as a midwife illegal for any unqualified person. However, the Act also made specific provision for lay midwives to be able to continue in practice as there were so few trained midwives at that time (Heagerty, 1997).

Achieving professional status or a means to control practice?

The Midwives' Act was seen as the starting point for midwifery achieving professional status (Cowell & Wainwright, 1981) and the anticipated equality and autonomy with other professions that this also brought. The Act was also seen as providing the power to reform the practice of midwifery, to change the relationship between the mother and the midwife and to "create and sustain a powerful apparatus of enforcement" (Heagerty, 1997, p.70). The Act therefore "created a powerful instrument for the control of midwives' practice" (Heagerty, 1996, p.13) and rather than enabling and recognising the scope of their practice, midwives became disempowered and professional relationships with doctors began to be "defined and codified" (Kent, 2000, p.51). The control of midwives' practice through the medicalisation of childbirth has remained a thorny, much debated, issue to this day.

Dominant doctors and 'disabled' midwives

Doctors, who comprised the majority members of the Central Midwives Board (CMB), did not want midwives to become autonomous practitioners (Flint, 1993a). In fact, the Midwives Act was only passed on the proviso that doctors outnumbered midwives on the CMB and that they could continue to oversee the profession (Flint, 1993a). There was therefore, never a midwifery majority on the CMB, but always a medical majority placing midwives "in a subordinate position, both in terms of knowledge and practice" (Lay, 2000, p.59). Doctors agreed that midwives could be trained under their supervision and control and they took over the childbirth process through obstetrics (Colliere, 1986).

This desire to oversee the profession of midwifery by doctors is closely linked to obstetrics becoming a recognised profession in the nineteenth century. There was concern amongst medical 'men' that there would be a blurring of boundaries between the role of the midwife and doctors and that this should be clearly demarcated (Kent, 2000). Some of the doctors sought to use their power to "protect their sphere of practice and their income" (Kent, 2000, p.49) by attempting to incorporate all aspects of midwifery work into their own as well as forbidding independent midwife practitioners. However a de-skilling strategy (Witz, 1992) was favoured that allowed for independent midwife practitioners but only because "the demand for midwifery services could not be satisfied by medical men" (Kent, 2000, p.51). This exertion of the dominant status of doctors, coupled with midwives' acceptance of their limitations on practice, has persisted since the Midwives Act of 1902 and medical control of childbirth has continued to disempower women as mothers and women as midwives (Heagerty, 1996; Kent, 2000).

Statutory compliance; 'supervising' or 'policing' midwifery work?

Supervision of midwives was also introduced with the Midwives Act in 1902 to ensure statutory compliance amongst those midwives who were at that time almost wholly self-employed and seen as isolated (Jenkins, 1995b). Since then supervision of midwives has operated within a statutory framework that has existed for 100 years during which time midwives have moved from being self-employed handywomen to employees in a large NHS organisation.

The Act established a public watchdog function and from then on many midwives were of the impression that supervisors of midwives were policing their practice (Flint, 1993a; ARM, 1995; Deery & Corby, 1996; Stapleton, Duerden & Kirkham, 1998). However, over recent years the supervisor of midwives role has developed to include counselling, support, friendship and guidance as well as the statutory conditions necessary for the role. For some midwives this has caused unacceptable contradictions within the role (Kirkham, 1996; Deery & Corby, 1996). A working party, set up by the Association of Radical Midwives (ARM) in 1993, attempted to address and clarify ideas for the future provision of midwifery supervision in the hope that a more acceptable model of supervision could be developed (ARM, 1995).

The deliberations of this working party probably provided the impetus for the United Kingdom Central Council (UKCC)[15] to suggest radical change to the education of supervisors of midwives who are now required to have completed appropriate education before they take on the role (UKCC, 1994). As will be seen in Chapter 4, the idea that a supervisor can be a friend and counsellor one day and investigate a midwife's practice the next day remains contentious (Stapleton et al. 1998, Deery,

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[15] The United Kingdom Central Council for Nursing and Midwifery (UKCC) was set up in 1983 and replaced the General Nursing Council and Central Midwives Board. The UKCC claimed to represent and regulate midwifery although Tew (1998) argued that subsuming midwifery with nursing made midwifery a subsection of a much larger nursing profession exchanging control by doctors for control by nurses (Sargent, 2002).

1999a, Deery, 1999b) as both concepts militate against each other (Kirkham, 1996).

Medicalisation of childbirth

The medical model of childbirth insists on childbirth as a pathological event that is full of risks and dangers and therefore necessitates a "medical expert to oversee the event" (Murphy-Lawless, 1998, p.22). The disempowerment experienced by women and midwives as a result of medical intervention and oppression has, argues Oakley (1980), led to a prevailing view that women are victims of their own 'out of control' reproductive systems. This view fosters a sense of helplessness in midwives and women and is onerous and complex to escape from in a masculine world (Murphy-Lawless, 1998; Oakley, 1993b). As a result women as midwives have struggled to define themselves as the experts on childbirth (Oakley, 1989; Campbell & Garcia, 1997; Heagerty, 1997). They have been forced to concentrate on the pathological risks of pregnancy and childbirth thereby ignoring the family, relationships and the environment. This has resulted in the knowledge possessed by doctors being perceived as superior to that of midwives (Campbell & Garcia, 1997; Murphy-Lawless, 1998; Oakley, 2000).

Who knows?

Belenky et al. (1986) write about how knowledge is understood and then internalised by women and they have grouped women's perspectives on knowing into five epistemological categories; silence (knowing in action), received knowing, subjective knowing, procedural knowing and constructed knowing. These authors believe that engaging in collaborative, participative forums where everyone concerned is involved in questioning and expanding ideas best achieves the acquisition of knowledge for women[16].

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[16] As will be seen in Chapter 5 there are comparisons here with an action research approach.

Belenky et al. (1986) undertook in-depth interviews with 135 women and explored how women's self concepts and ways of knowing are linked together and how women often struggle to "claim the power of their own minds" (p.3). *Silence* is when women experience themselves as "mindless and voiceless and subject to the whims of external authority" (Belenky et al. 1986, p.15). *Received knowledge* is when women realise that they are "capable of receiving, even reproducing, knowledge from the all-knowing external authorities" (ibid, p.15) but they still do not see themselves as being able to create knowledge on their own. *Subjective knowledge* is viewed by Belenky et al. (1986) as a stance from which "truth and knowledge are conceived as personal, private, and subjectively known or intuited" (ibid, p.15) for women whereas *procedural knowledge* means that women are able to "engage in conscious, deliberate, systematic analysis" (ibid, p.93). The women taking part in Belenky et al's study who used procedural knowledge:

> "…learned that truth is not immediately accessible, that you cannot "just know." Things are not always what they seem to be. Truth lies hidden beneath the surface, and you must ferret it out. Knowing requires careful observation and analysis. You must "really look" and "listen hard.""
> (Belenky et al. 1986, p.93-94)

At the position of *constructed knowledge* women are in "the process of sorting out the pieces of the self and of searching for a unique and authentic voice" (ibid, p.137) and they "reveal an appreciation for complexity" (p.139) and are "not troubled by ambiguity and are enticed by complexity" (p.139). As Belenky et al. (1986) state "these women contribute[s] to the empowerment and improvement in the quality of life of others" (p.152).

In writing about women's knowledge, Belenky et al. (1986) acknowledge that similar categories may be found in men's thinking although they deliberately chose not to include men as they thought that:

"The male experience has been so powerfully
articulated that we believed we would hear the
pattern in women's voices more clearly if we held
at bay the powerful templates men have etched
in the literature and in our minds."
(Belenky et al., 1986, p.9)

However, Deborah Tannen (1990) has analysed everyday conversation and gendered language and customs. She states that men approach conversational interactions as negotiation for status and independence where they "try to achieve and maintain the upper hand…[l]ife is a contest, a struggle to preserve independence and avoid failure" (p.24-25). Women on the other hand, as well as being focused on achieving status and avoiding failure, tend to approach conversation as a "connection" in which people "negotiate for closeness…[and] try to seek and give confirmation and support" (p.24-25). This connectedness has many similarities with the procedural knowing category as described by Mary Belenky and colleagues (1986).

However, Belenky et al. (1986) claim that despite the progress of feminist thinking, many women still feel silenced by what they refer to as 'two institutions', the family and the schools, and claim that both can hinder and help women's development. In the context of this study, schools can be likened to NHS hospitals as institutions that mute women and disregard midwives' knowledge in a system that relies on risk management (Murphy-Lawless, 1998; Oakley, 1993b; Oakley, 2000).

Hospitals are hierarchically organised places of employment and there are systems in place that are divisive and management led (Kirkham, 1999). Although recent changes have led to a flattening of management structures (Bradshaw, 1995) there still remains a need for some midwifery managers to control midwives and their practice (Kirkham, 2000). This controlling of their practice has led to some midwives developing coping strategies that internalise "the values of the power-holders" (Kirkham, 2000, p.233). However, many of these "power-holders" are

women in management posts who have internalised and adopted male styles of relating that depend on control and dominance (Belenky et al. 1986). In this case, the way in which knowledge is internalised by midwives becomes complicated because the values of midwifery managers do not then appear to be congruent with the values held by the midwives. As Lipsky (1980) states, workers are:

> "…affected by the extent to which managers' orders are considered legitimate. Street-level bureaucrats may consider legitimate the right of managers to provide directives, but they may consider their managers' policy objectives illegitimate."
> (Lipsky, 1980, p.18)

The quandaries surrounding different ways of internalising knowledge are likely to have affected working relationships with doctors. As a result, midwives have persistently found themselves defending the view that they are passive victims, in constant struggle and conflict with doctors whilst trying to seek control over childbirth which essentially is "a conflict about who knows best" (Kent, 2000, p.13). This struggle for who knows best is reiterated by Jordan who states that "[t]he power of authoritative knowledge is not that it is correct but that it counts" (p.58). Rather than viewing midwifery knowledge as "equally legitimate parallel knowledge" (Jordan, 1997, p.56) a valuing of obstetric knowledge has occurred which has resulted in this form of knowledge becoming the dominant epistemology.

McNiff (2000) has stated that "the epistemologies we use reflect our social commitments" (p.96). Although McNiff is referring to action research and methodological concerns about valuing one form of research methodology above another, there are close comparisons to be made with epistemological debates surrounding midwifery and obstetric knowledge. Doctors appear more located in a 'science' epistemology whereas many women would prefer to see midwifery located in a more 'relational' epistemology (Gilligan, 1985; Belenky et al. 1986; Murphy-Lawless, 1998; Oakley, 2000) that is grounded in experiential and intuitive

practice. These opposing viewpoints have resulted in differing opinions about the legitimacy and value of such forms of knowledge, and expose the debate concerned with "the legitimacy and the use value of those epistemologies…and what right one person has to explore an issue from within one set of values rather than another"(McNiff, 2000, p.96).

These issues, McNiff (2000) goes on to say, are linked to identity and worth and in this context relate to midwives having the right to pursue and believe in their own midwifery knowledge rather than believing in a knowledge system that devalues and even dismisses all other forms of knowledge, including that which women bring to their own birthing experience. This devaluing of what Jordan (1997) refers to as "nonauthoritative knowledge systems" (p.56) has resulted from a hierarchical knowledge system that is paralleled in the way midwives work and interact with each other and clients. As Taylor (2001) states, obstetrics has become a powerful dominant discourse "allied with powerful technological and profit making interests" (p.6).

The subjugation of midwifery knowledge

Kirkham (2000, p.246) reminds us of Foucault and "subjugated knowledge". The traditional, often experiential knowledge of midwifery is subjugated by the authoritative knowledge of obstetricians but on the other hand the experiential knowledge of childbearing women is subjugated by midwives as professionals[17] (Kirkham, 2000). Hunt & Symonds (1995) ethnographic study of midwives highlights how they often belittle women, asserting their professional knowledge and insisting that they know best. Therefore midwives can both experience subjugation and subjugate others (Kirkham, 2000). As will be seen in Chapter 10, the midwives in this study experience subjugation on a much more intimate level within their own work team.

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[17] To a lesser extent comparisons also exist in the way research is viewed and conducted within the health care professions (Deery & Kirkham, 2000).

The acceptance of authoritative knowledge (sometimes in the form of evidence-based practice) and the resulting increased intervention and technological surveillance of childbirth has met with resistance from some midwives (ARM, 1986), clients (Cartwright, 1979; Oakley, 1993a; Kitzinger & Davies, 1991) and obstetricians (Savage, 1986). As Oakley (2000) states this is because "it was apparent at this time…that women having babies were increasingly being subjected to forms of health care practice…which might not be in their or their babies' best interests" (p.17). Dissatisfaction has also been expressed by feminists and women's groups regarding the ensuing fragmentation of care that this brings as well as the de-valuing of midwifery and women's experiential knowledge (Oakley, 1993b; Murphy-Lawless, 1998).

Invisible midwifery expertise and invisible women

The valuing of one epistemological knowledge base over another has also led to a division of labour between midwives and doctors. As both professions have developed a sexual division of work has occurred[18]. The widespread illusion that "doctors know what they are doing" (Oakley, 2000, p.17) became apparent and midwives were taught what doctors thought was useful or necessary for their practice even though doctors did not always carry out themselves what they prescribed for midwives' practice[19]. Midwifery work became task-orientated and the midwife's own cultural background and experience as a woman was seen as irrelevant (Murphy-Lawless, 1998).

The professional expertise that midwives were accumulating as they practised was not taken into account and according to Colliere (1986) was often "despised or condemned to silence" (p.103). As a result of this socialisation, midwifery work that deals with caring for[20] women appears to have not been recognised as part of the

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[18] As will be seen in the following chapter, page 69, this has resulted in the gendering of work, especially caring work being viewed as women's work.
[19] The proverb "do as I say not as I do" comes to mind here.
[20] I analyse the concept of caring more fully in the following chapter.

midwife's role, or as a specific activity, and has thus become invisible (Davies, 1995). Whilst some of the technological aspects of midwifery are necessary, the midwife's work also involves relational aspects including listening to women, expressing feelings and building relationships with women and their families (Hunt & Symonds, 1995; Leap, 2000; Taylor, 2001).

Technological surveillance and intervention

Midwifery continued to be practised mainly in the community until the late 1960s when managerial reform swept through the UK health service with the intention of greater efficiency and economy (Jenkins, 1995a; Savage, 2000). The Peel Report (SMMAC, 1970) and the Short Report (1980) advocated 100 per cent hospital births thus reinforcing compliance with a medical model of care. Moving birthing women into hospital also warranted an increase in hospital midwives and a move away from community-based midwifery practice.

The move towards greater efficiency and economy in the NHS also brought an increasing trend towards intervention and technological surveillance in obstetrics (Tew, 1998). Women were led to believe, through the dominant discourse of obstetrics, that interventions and technology would save their lives, as well as the lives of their babies. Monitoring childbirth in this way meant that "every birth became subject to its gaze" (Arney, 1982, p.100), not just those that were considered abnormal or high risk. This represented "a change in the deployment of obstetrical power and a new mode of social control over childbirth" (Arney, 1982, p.100). Taylor (2001) believes that continuous electronic fetal monitoring has been shown:

> "…to be counterproductive to the wellbeing of
> mother and child, but it has the advantage for
> some of being very profitable and for others of
> keeping women compliant and still. The political
> implications of this are vast and are seldom
> articulated because they are taken for granted."
> (Taylor, 2001, p.4)

Monitoring therefore became a "new order of obstetrical control" (Arney, 1982, p.100) where surveillance of the fetus "provided obstetricians an entrée through which they could invest pregnancy with yet newer meanings that would give them once again positive reasons for medical control of the birth process" (Arney, 1982, p.136).

Tew (1998) also draws attention to the fact that the safety of childbirth is more related to the health of women and their standard of living rather than the safety of the hospital setting. Since Tew wrote in 1998 there have been increasing calls for midwives to protect and promote healthy, uncomplicated childbirth (Page, 1995, 2000; Gould, 2000; Davis-Floyd, 2000; Downe, 2001; Anderson, 2002). However, rather than return to 'uncomplicated' ways of working midwives have not challenged unfounded assumptions around obstetric discourses that appear to "silence certain practitioners or negate practices and knowledge systems" (Lay, 2000, p.18) and they have become powerless. As a result, they do not practise in ways that reflect their midwifery values and work philosophy and "politically and technologically based norms then become unthinkingly internalised" (Taylor, 2001, p.4). As will be seen in Chapters 7 and 8 this confusion as to the nature of their work has resulted in some midwives distancing themselves from their clients.

Adapting to, and changing ways of working

Since the early 1980s maternity services in the UK have continued to undergo major reform and have had to adapt to complex and rapidly changing patterns of care as a result. Also during this time the midwifery profession has been under increasing scrutiny by the users of the service, the profession itself and government to improve cost-effectiveness and provide evaluation of care (Oakley, 1984; Brooks, 2000). There has also been an increasing focus on the management of risk (Brooks, 2000) with ensuing protocols and guidelines dictating the type and quality of care given by midwives. As well as meeting the demands of

a large organisation such as the NHS, midwives have also had to meet the demands of clients. Lipsky (1980) agrees, stating that "[s]treet-level bureaucrats characteristically work in jobs with conflicting and ambiguous goals…that make them difficult to achieve and confusing and complicated to approach" (p.40).

In response to government policy reforms (DOH, 1993a; DOH, 1999a), a more community-based approach (as in earlier days), with an emphasis on providing improved continuity of care was promoted in midwifery. This was based on work undertaken by Flint, Poulengeris & Grant (1989). The approach to care set out in the "Vision" (ARM, 1986) and Caroline Flint's work (Flint et al. 1989) appear to have influenced many team midwifery schemes that were set up regionally in the UK.

In 1992, the Winterton Report recommended that a move towards a woman-centred approach to maternity care might better meet the needs of women. The report recommended continuity of care, choice of care and place of delivery and women's right to control their bodies at all stages of pregnancy and childbirth (House of Commons, 1992). The Government response was "Changing Childbirth" (DOH, 1993a). As a result of these reports much debate was generated within the midwifery profession about what constitutes 'knowing' the midwife (Jackson, 1994) and continuity of care and carer (Currell, 1990; Sandall, 1995a).

"Changing Childbirth" (DOH, 1993a) promoted midwifery and the normality of childbirth and challenged long held assumptions about childbirth as a pathological event and the dominance of medical expertise. However, "Changing Childbirth" also reinforced previous policy within the maternity services in that there was "a prioritization of professional concerns and input" (Brooks, 2000, p.42). As a result the model of woman-centred care promoted through "Changing Childbirth" has been challenged as merely paying lip-service to the needs of women using the maternity services (Kirkham & Stapleton, 2001; Brooks, 2000).

Other policy initiatives such as "The Named Midwife" (DOH, 1992), "The Patient's Charter" (DOH, 1994) and a report "Mapping Team Midwifery" (Wraight, Ball & Secombe, 1993) also influenced the way midwifery was organised and midwives found themselves under increasing pressure to adapt and change their ways of working. NHS providers were given a five year target by the Government to demonstrate a move towards a more community based service (Brooks, 2000) although interestingly the maternity services never initiated the achievement of these targets. More recently a number of health service documents, the "NHS Plan" (DOH, 2000), "Clinical Governance" (NHS Executive, 1999) and "Making a Difference" (DOH, 1999b) suggest a need to educate health practitioners to meet women's needs and to improve the quality of midwifery care delivered.

The effects of changing approaches to care

Clearly, midwives have found themselves being urged, from several directions, to practise in ways that demanded the utilisation of wide ranging skills and opportunities. Some of the above policy initiatives (DOH, 1992; DOH, 1993a) and the report by Wraight et al. (1993) have greatly influenced the maternity services and as a consequence fundamental changes to the way in which midwives work have come about. Nationally and regionally midwives found themselves working towards a model of care called team midwifery (Flint et al. 1989). Page (2000, p.xi) refers to a "new midwifery [that] holds dear the central values of midwifery, of being 'with the woman' and respecting normal birth". And so, as approaches to care gradually changed so too did women's views around childbirth and subsequently some women became more able to voice their needs (Deery, 1999a).

Giving a greater voice to the users of the health service had become a priority for the NHS (DOH, 1996a; DOH, 2000) especially as involving clients in their own care has also been shown to improve health care outcomes and increase client satisfaction (Farrell & Gilbert, 1996). For some women having their voices heard

as a result of these government initiatives meant that they experienced increased autonomy and they became increasingly active in their care, particularly in terms of their involvement with the monitoring and planning of maternity services (Deery, 1999a; Harcombe, 1999; Mander & Reid, 2002). Consequently midwives were encouraged to plan care for women and their families on the basis of needs identified through collaboration or partnership[21] with their clients.

The impact of changing work patterns on the midwifery workforce

More recently, the Government has set some difficult challenges in the NHS Plan (DOH, 2000) in order to achieve change. Some of these challenges have provided midwives with the opportunity to extend their role to "Modern Matron" and "Consultant Midwife" whilst others have taken on more responsibility for various aspects of the junior doctor's role when they saw a reduction in their working hours (DOH, 2000). Midwives have seen clients given new powers and more influence over the way the NHS works whilst at the same time they are being asked to increase and improve care given to clients in deprived areas, to introduce screening programmes for women and children as well as provide smoking cessation services (DOH, 2000).

The priority that is now given to delivering high quality services means that midwives are often working in complex and sometimes difficult circumstances. The climate of continual change brought about by varying policy directives has become a potential health hazard for midwives in terms of stress related disease (Mackin & Sinclair, 1998; Sandall, 1997, 1998, 1999). This is further complicated by the fact that midwifery as an occupation involves direct contact with women and their families which in turn makes midwives susceptible to a particular type of occupational stress known as 'burnout syndrome'[22] (Sandall, 1995b, 1997).

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[21] As will be seen in Chapter 4, I argue how action research is one way of encouraging collaboration and partnership with clients, peers and managers.
[22] The concept of burnout is addressed further in Chapter 8.

New working patterns have meant that a large number of midwives are now working longer hours than previously which can result in emotional exhaustion (Royal College of Midwives, 1997; Sandall, 1999). Indeed Ball et al. (2002) have now provided evidence that there is widespread dissatisfaction with the maternity services amongst those midwives who leave the profession. This study involved all those UK midwives who notified their intention to practise in 1999 but not in 2000. Strategies that provide effective support were cited by these ex-midwives as being important to effective recruitment and retention of midwives. My study is the first action research study of its kind to move beyond acknowledging that midwives need support and the existence of stress and burnout by devising and mobilising a support mechanism for midwives in clinical practice.

In this chapter I have attempted to explore past and present issues in midwifery and how these have impacted on the midwifery workforce. An understanding of the historical aspects of midwifery helps to place the 'new midwifery' (Page, 2000) in context. Wider political issues have also impacted midwifery and subsequently affected the way midwifery work is performed. Indeed there have been many attempts to incorporate differing perspectives into the practice of midwifery and this has often resulted in contradictions and conflicting values becoming apparent amongst the workforce. In the next chapter, which is divided into two parts, I begin to address these difficulties as I introduce the literature relating to culture and change, caring and the midwife-mother relationship.

CHAPTER THREE

Change, culture, 'caring' and relationships

This chapter is divided into two parts. Part 1 examines the culture of the NHS and midwifery and how the process of change[23] and culture within these organisations, particularly the maternity services, are linked. Part 2 is linked to Part 1 but specifically examines literature relating to midwives and caring and the midwife-mother relationship. Subsequent 'emotional labour' or 'emotion work' (Hochschild, 1979, 1983), and the effects of this on the participating midwives are addressed more fully in Chapter 8. I am aware throughout this chapter that the areas I address overlap.

Part 1: Culture and change in the NHS

The culture of midwifery in the NHS

Most midwives practise in the UK within the NHS. Since the NHS Re-organisation Act (1974) that brought together hospital and community midwifery services, even those midwives who practised within a community setting were subjected to the influences, and affected by, the organisational and cultural pressures within the NHS even though they did not work in an institution (Kirkham, 1999). Since then, the culture of midwifery has remained mostly unchanged and unchallenged despite the NHS as an organisation and provider of health care being subject to continuous, unprecedented change. Hospitals have continued to remain hierarchically organised places of employment whereby midwives have been required to practise in a culture that is dominated by the medicalised model of

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[23] As will be seen in Chapter 5, change is also considered central to action research (Winter & Munn-Giddings, 2001) and an understanding of how it takes place, is therefore crucial.

childbirth rather than a social model of childbirth (Kirkham, 1999; Walsh & Newburn, 2002).

As a primarily female profession midwives have been culturally excluded from "the exercising of authority" (Hunt & Symonds, 1995, p.35) which restricted its influence to the masculinised, public world of health service management (Hughes et al. 2002). The medical impetus to dominate midwifery within this hierarchical system has made it problematic for midwives to exercise their power and authority outside of the smaller and more private spheres of their daily work (Hunt & Symonds, 1995; Kirkham, 1999; Hughes et al. 2002). As was seen in the previous chapter, issues of power and control are linked to 'ways of knowing' (Belenky et al. 1986; Hugman, 1991) and the subjugation of midwifery knowledge to that of doctors has meant that obstetric knowledge has become authoritative, thus seeming to discredit midwifery knowledge. Likewise, within this hierarchy of knowledge, the client's knowledge has occupied an even lower status. As Kirkham (2000) has stated the above factors "have contributed to a culture of midwifery within organisations in which power lies with the professionals, relationships are not valued, and midwives feel under-valued as both women and carers" (p.233).

As there have been attempts to improve the maternity services and professional relationships, "efforts to humanise [the] service [often] reach midwives as orders though a hierarchical system" (ibid. p.235) and even though midwives may want to change, midwifery managers rarely respond (Kirkham, 2000). The forces outlined above are further complicated by a prevailing culture of 'protocolisation'[24] that appears to police midwifery practice in the guise of attempting to evaluate the quality of the care provided by the maternity services (Walsh, 2002). However this culture of 'protocolisation' reinforces the dominant, obstetric model of childbirth and facilitates task-based care for midwives which is not congruent with the aims of

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[24] I first heard Denis Walsh, a midwife, use the term 'protocolisation gone mad' at a "Birthing and Bureaucracy: the history of childbirth and midwifery" Conference at the University of Sheffield in 2002. He was commenting on the increasing use of evidence-based practice and national and local clinical guidelines that all appear to cause extra pressure on midwives in an attempt to "render practice uniform" (Kirkham, 2000a, p.235).

woman-centred care (DOH, 1993a) nor a social model of childbirth (Walsh &
Newburn, 2002).

Lipsky (1980) provides important insights into the occupational culture described
above. As a result of their inability to carry out their work as they would like, street-
level bureaucrats adopted several coping strategies. Rationing or routinisation of
work helped to decrease the demands placed on them by their clients. Street-level
bureaucrats also changed their own expectations of their work as well as altering
their attitudes to their clients often by "succumb[ing] to a private assessment of the
status quo" (Lipsky, 1980, p.xiii) within their employing organisation:

> "Ideally, and by training, street-level bureaucrats
> respond to the individual needs or characteristics
> of the people they serve or confront. In practice,
> they must deal with clients on a mass basis,
> since work requirements prohibit individualized
> service….At best, street level bureaucrats invent
> benign modes of mass processing that more or
> less permit them to deal with the public fairly,
> appropriately, and successfully. At worst, they
> give in to favouritism, stereotyping, and
> routinizing – all of which serve private or agency
> purposes."
> (Lipsky, 1980, p.xii)

Furthermore, Lipsky (1980) discovered that public service workers gave adaptation
to the realities of their work considerable forethought by adopting the coping
strategies described above. Lipsky argues that it is the reality of the decisions
made by the public service workers at "the coalface" (Hawkins & Shohet, 1989)
that define the service rather than policy development and planning processes
made by policy makers. However NHS strategic planning has rarely been informed
by the formal contributions of community-based midwives for a wide variety of
historical and organisational reasons. This means that there is a lack of expertise
regarding strategic planning of maternity policies amongst a skilled midwifery
workforce and that the lived experience and practical understanding and insight of
that workforce has been underused as a resource at a strategic level (Hughes et al.

2002). The rhetoric and reality within such an occupational culture then becomes visible and two sorts of "policy" become apparent with the reality of maternity policy being forged on the shop floor by midwives and the rhetoric appearing in health policy initiatives.

"The New NHS: Modern, Dependable" (DOH, 1997), for example, made it clear that the Department of Health (DOH) wished to see much greater involvement of frontline midwifery and nursing staff in policy development and planning processes. The publication of "Making a Difference" (DOH, 1999b) outlines how and why the government proposes to achieve this cultural and organisational shift but does not appear to give due recognition to the long standing and deeply entrenched cultural and organisational barriers to achieving this (Kirkham, 1999; Hughes et al. 2002).

Lipsky (1980) goes on further to argue that if public service workers are not able to adapt their behaviour in ways that make their work practices easier (for example, coping strategies to achieve distance[25] with clients) then they are likely to suffer from stress or burnout causing them to leave their job. Therefore those midwives wanting to aspire to their true values in clinical practice might well find that there is no place for such strongly held values in public service work (Lipsky, 1980). As Hunter (2002) points out, this is strange because "it is the desire to participate in socially useful work that appears to be the initial motivating force in recruitment" (p.17).

The context of change in the NHS

Much of the change that has taken place in the NHS has been influenced by the interplay of political, social and economic factors (Brooks & Brown, 2002). The structure and management of the NHS was radically changed by the Conservative government during the 1980s with the Griffiths Report (DHSS, 1983) proposing the

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[25] As will be seen later in this chapter health care practitioners use different types of detachment as coping strategies in their work.

development of management thinking within the NHS. A new breed of non-clinical, professional NHS managers emerged (Brooks & Brown, 2002). The ensuing management driven approach and the introduction of the NHS and Community Care Act (1990) encouraged the establishment of NHS Trusts. The 1990s saw the development of the internal market in an attempt to contain costs within the NHS and a business culture developed believing that the health service is no different from any other consumer organisation (Bradshaw, 1995). By the end of the 1990s most NHS providers had gained Trust status.

Parallel to the reorganisation of the NHS during the 1990s there have been numerous policy initiatives in nursing and midwifery with an emphasis on primary and community care (DOH, 1994; DOH, 1998; DOH, 2000). In the past where there had been clearly defined boundaries between health practitioners the NHS Plan (DOH, 2000) now encouraged working in partnership and collaboration with other health care practitioners as well as consulting the users of the service regarding their care (DOH, 1996a; DOH, 2000). The role of the midwife had become even more complex and much more was being expected of them (Deery, 1999a). These changes to the way in which midwives were being encouraged to practice meant that the ability to manage change became an additional, as well as an essential skill for midwives and midwifery managers to grapple with. The challenge of changing childbirth and the way their work was organised for clients has meant that midwives have been faced with ongoing change (Hunt, 1995) that has often only been initiated "at a point of crisis" (Menzies, 1979, p.22). This has resulted in uncertainty and fear surrounding midwifery work (Stapleton, 1997) as well as the role of the midwife being under constant scrutiny from the users of the service (Pratten, 1990).

Differing approaches to change

Change has been addressed by a number of change theorists but Lewin appears to have been the first person to have described the change process (Lewin, 1951). He identified three phases to the process of change; unfreezing, moving and refreezing. Lewin's argument was that any organisation, individual or group that intended to change had to be unfrozen from their comfort zone, changed and then refrozen. Lewin believed that once this process of change had occurred then no further change would be required. He therefore appeared to believe that change was a linear process and that once refreezing had occurred the desired change had also taken place. Lewin does not seem to address the scope for flexibility or working towards further change following refreezing.

Marris (1986) and Mead & Bryar (1992) make an important comparison between change and bereavement. These authors state that loss and change disrupt a person's ability to understand what they are experiencing and that it is during periods of recovery that attempts are made to give meaning to the present. Hunt (1997) draws a comparison between midwives facing relentless change on a large scale and the symptoms of grief, stating that midwives are likely to experience feelings of grief for the loss of old ways of working (see Chapter 7, page 222). Emotions experienced following death such as shock, denial, anger, bargaining, depression and later acceptance (Kubler-Ross, 1984) can be compared to the emotions experienced by some midwives as change is brought about (Hunter, 2002).

There are other change theorists (e.g. Rogers, 1962; Bennis, Benne & Corey, 1976) that have contributed to the literature surrounding change. Bennis et al. (1976) describe a power-coercive approach (top-down) that attempts to impose change by edict and a normative-re-educative approach (bottom-up) which describes helping people to recognise the need for change and including them in

the change process. The same authors also include a rational empirical strategy which Binnie & Titchen (2002) used to reinforce the normative-re-educative approach in their action research study facilitating the development of patient-centred nursing. These approaches to change have been described as using a 'bottom up' or a 'top down' approach depending on where the initiative for change derives from (e.g. clinically-based midwives or midwifery managers).

Beer (1980) states that both top-down and bottom-up approaches are likely to be limited in terms of achieving internalised change and long lasting results because of a lack of 'shared responsibility'. As will be seen in Chapter 5, this 'shared responsibility' or collaboration is crucial to the change process because there must be "continual interaction between top and bottom levels and a process of mutual influence" (Beer, 1980, p.55). Although Beer argues that this 'shared responsibility' approach to change takes time, it is likely to cause less anxiety for those participating in the change process because a genuine and lasting change is achieved.

Binnie & Titchen (2002) compare Beer's (1980) 'shared responsibility' approach to change to their own 'collaborative change strategy' (p.33) that they used to "initiate, to support and broadly…steer a major change, while at the same time involving staff – responding to their ideas, stimulating their creativity and embracing their contributions" (Binnie & Titchen, 2002, p.224).

These authors state that this approach facilitated a process of mutual influence that enabled them to share responsibility with the nurses in their action research study. Parallel processes also occurred in the supportive approach taken by senior nursing managers to the researchers and also in the nurses participating in the project as they abandoned their hierarchical relationships with patients and shared responsibility with them for decisions about their care (Binnie & Titchen, 2002).

Sowing the seeds of change

Binnie & Titchen (2002) describe their 'horticultural model' of change (p.225) and state how this approach to change fits well with a collaborative approach and unstable, unpredictable organisational conditions. The authors state that both these scenarios "mirror life in a garden" (p.225); the creation of the garden is a collaborative venture between the gardener and nature and the gardener is confronted by unpredictable weather conditions. Parallel processes between the change process and horticultural terms occurred as the researchers worked with the participants e.g. "sowing ideas" and "nurturing staff" (p.225).

Comparing change to the metaphor of a garden helped Binnie & Titchen (2002) to take a living, dynamic approach to change within their action research project and to avoid being too mechanistic in their handling of change. Rather than forcing change, the researchers tried to be sensitive to prevailing conditions on the ward and focussed on "tending and nurturing…encouraging the nurses' practice to grow and blossom" (p.225). Managing change through the horticultural model provided a creative and sensitive approach for the researchers that they had found to be missing in orthodox organisational change theories.

Clearly then, as pointed out by Bate (1998), change is a very complex phenomenon that is difficult to understand. Binnie & Titchen's (2002) horticultural model of change reinforces that change is not linear in nature and as such becomes almost impossible to facilitate systematically. As was seen in Chapter 2 midwifery practice is complex and subject to continuous change. Therefore, applying a systematic approach to change within their practice would seem inappropriate for midwives.

Culture as a key influence on change

Coming to terms with, and adapting to change has not been easy for midwives as the NHS is a large, extremely complex organisation with a strong, well-developed culture (Walter, 2001) that appears to have changed very little over the years. Only in recent years have researchers dared to challenge some of the deeply entrenched cultural codes and routinised practices (Davies, 1995) within the NHS and suggest how changes in practice and working relationships can create real benefits for NHS hospitals and midwives (Stapleton et al. 1998; Kirkham, 1999; Kirkham & Stapleton, 2000; Hughes et al. 2002; Brooks & Brown, 2002; Ball et al. 2002).

Savage (2000) has stated that 'culture' is a powerful entity and that cultural change has been promoted as key to the successful implementation of the new NHS (DOH, 1998). Such change would involve frontline midwifery and nursing staff having much greater involvement in policy development and planning processes (Savage, 2000; Hughes et al. 2002). However as I have already discussed on page 38, "Making a Difference" (DOH, 1999b) minimised such cultural and organisational barriers to effecting these proposals by not consulting with clinically based staff to influence and participate in strategic planning and policy making. Such rhetoric does not appear to bode well for facilitating cultural shift within midwifery and supporting midwives as they face the challenge of change (Hughes et al. 2002).

Schein (1992) has defined culture as:

> "…a pattern of shared basic assumptions that the group has learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems".
> (p.12)

Although not specifically a definition about health culture, the 'basic assumptions' which are referred to by Schein (1992) are defined as unconsciously taken for granted beliefs, perceptions, thoughts and feelings which then become the values and ways of working within organisational culture. Eldridge & Crombie (1974) defined organisational culture as the unique configuration of norms, values, attitudes, beliefs and behaviours which characterise the interaction of groups and individuals as they try to achieve the goals of the organisation. Langton (1991) also refers to occupational ideology which shares many of the characteristics described by Eldridge & Crombie (1974).

Within an organisation these shared meanings and values (language, myths, rituals and ideologies) operate unconsciously and "define an organisation's (unchallenged) view of itself, its environment and its mission" (Walter, 2001, p.199). As the organisation's view of itself has been unchallenged the basic assumptions within the organisational culture then become difficult to change (Walter, 2001) because as Schein (1992) states these underlying assumptions held by the workforce become so valued that change on any level is difficult. Thus, culture as a concept that provides a state of stability and predictability for workers becomes wholly dependent on individual workers sharing the same set of values and assumptions as those collectively held by the organisation (Walter, 2001). As will be seen in later chapters, conflicting values was at the root of much of the participating midwives experience of their midwifery work.

Midwives as obedient technicians

Until recently there has been little literature that has specifically addressed or explored the culture of midwifery. This is probably due to the complex nature of culture but also because the culture in the NHS is constantly required to change. Therefore cultural change becomes a two-edged sword where the greatest

challenge to implementing and sustaining change lies in bringing about a change in culture (Scott, 2001).

Recently however, there has been a growing body of research that deals with certain aspects of NHS culture, for example the significance of ritual and ceremony (Brooks & Brown, 2002) and gender in nursing (Davies, 1995). Kirkham (1999) found when interviewing midwives across five NHS trust sites in England that a culture of 'service' and 'sacrifice' existed within the NHS. Midwives in this study lacked the rights as women which they were then expected to foster within the women they attended. They felt pressurised to conform to organisational needs and there was a lack of support and effective role models available for them. As will be seen, such contradictions lie at the heart of this thesis.

In the 1950s, Menzies carried out a classic study of hospital nursing that provided an extraordinary picture of traditional ways of working within hospitals (Menzies, 1979). The system Menzies sees functions as an organisational defence against stress and anxiety. Work that was task-orientated seemed to protect nurses from close contact with their patients and depersonalisation and categorisation of patients meant that relationships were kept unemotional and distant. The strict routines and standard procedures that seemed to pervade the whole of nursing practice also minimised responsibility and decision making for nurses thus protecting them from associated stresses (Menzies, 1979). This observation by Menzies is reminiscent of Lipsky (1980) who also sees detachment as a means of self-protection:

> "Some bureaucracies so routinize their processing of clients that significant psychological interactions are minimal…[midwives] may adhere to interview formats that exclude personal elements and reduce the likelihood of decision making on the basis of inter-personal interactions."
> (Lipsky, 1980, p.69)

Menzies acknowledged that there was no immediate or simple solution to the existing problems within nursing and stated that any change would take time.

Interestingly, when offering a rationale for research-based professionalism, Dadds (2002) refers to individuals working in an "overloaded, 'hurry-along' context, where time has to be used wisely" (p.11). Such conditions, she states, tend to create "obedient technical deliverers of others' political initiatives" (ibid, p.11) that spend much of their time figuring out how best to fit into the organisation in order to conform and survive. As will be seen in later chapters, this compliance results in task-orientated work where workers unconsciously collude within a 'performance culture' (Bradshaw, 1995) and then appear to resist change as values and assumptions conflict.

Change managing midwives

Raphael-Leff (1991) draws on the work of Menzies stating that the strategies that have been developed by nurses to help minimise the stressful effects of emotional relationships between clients and staff can also be applied to midwifery work. She specifically addresses three defensive techniques used by midwives and the organisation in which they work; splitting up of the nurse-patient relationship, denial and detachment of feelings and redistribution of responsibility. The splitting of the mother-midwife relationship is illustrated by using an example from the antenatal clinic:

> "…where a woman may be seen by as many as
> 30 'interchangeable' hospital professionals in the
> course of one pregnancy and little attempt is
> made to acknowledge her as a special individual
> either before, during or after birth."
> (Raphael-Leff, 1991, p.225)

Raphael-Leff (1991) describes how task-orientated care and no continuity of carer are used to protect midwives from anxiety provoking situations that might involve them building relationships with clients. Thus, protection from anxiety is achieved through breaking a client's care down into tasks, minimising contact for the client with a midwife and "reinforcing the myth" (p.225) that all midwives are the same with interchangeable skills. The use of technological aids such as fetal monitors and scanning machines also seemed to minimise contact with clients.

Raphael-Leff (1991) believed that a certain amount of detachment and denial of feelings were necessary within the midwife-mother relationship in order that personal feelings could be controlled and over-involvement in the developing relationship was avoided. This is reinforced by Carmack (1997) in a study investigating how caregivers balance engagement with detachment to cope with cumulative demands and losses, and where it was identified, that practitioners need "a certain amount of numbing if they are to function effectively" (Carmack, 1997, p.140).

However, as will be seen in Chapter 8, in times of heightened anxiety, emotion or stressful situations, detachment such as this can become excessive to the point that midwives are no longer able to empathise with clients and their work becomes routine, ritualised and depersonalised (see Table 5 on page 285). This mechanistic approach to work is reminiscent of a technical rational model (Fish & Coles, 2000) where midwives work with clients through a "pre-determined set of clear-cut routines and behaviours" (ibid, p.291). Such an approach to work can be likened to the role of ceremony in organisational change whereby routine and ritualised care become concerned with "promoting and preserving" (Brooks & Brown, 2002, p.344) that which already exists. Menzies (1979) also argued that nurses avoided change by "cling[ing] to the familiar even when the familiar had obviously ceased to be appropriate or relevant" (p.22).

Detachment as a monitoring process

Thus, two sorts of detachment become apparent that may operate as safety valves or defence mechanisms for midwives helping them to "make conscious choices based on their emotional needs and on their understanding of what they can handle at a particular time" (Carmack, 1997, p.141). Technical detachment (that is, breaking a client's care down into manageable tasks) is used by midwives to keep a balance in terms of their clinical decision-making and might involve feeling a need to control the client's birth experience. Emotional detachment is used to protect the worker from over-involvement with clients as well as helping them to control their emotions. This type of detachment is able to benefit the midwife on a short term basis and usually only in times of heightened anxiety. An over reliance on this type of detachment could lead to a routine and depersonalised approach to midwifery work.

Raphael-Leff (1991) also refers to the redistribution of responsibility and how midwives can become so over anxious that they are unable to make "a final committing decision" (p.225) regarding work related issues. The participants in Carmack's (1997) study learned that they did not have to take on the problems of clients. Instead they came to accept "the limits of what they could do and to focus on the things they could change or control" (Carmack, 1997, p.141). However, as Raphael-Leff (1991) points out, there are hierarchical divisions between obstetricians and midwives and conflicting philosophies and ways of working with the same clients, by different practitioners can cause "horizontal antagonism" (p.225). This concept is reminiscent of horizontal violence which manifests itself as scapegoating, in-fighting, backstabbing and sabotage (Leap, 1997) amongst midwives.

'Militating organisational imperatives'

In a study that explored informed choice, Kirkham & Stapleton (2001) found that the maternity services are characterised by 'cultural inertia'. A mixed method approach was taken to address whether informed choice leaflets[26] were effective in promoting informed choice. The study was conducted in two phases; the first phase was an ethnographic study of three maternity units which had purchased and been using the informed choice leaflets. The results of the first phase of the research informed the second phase where a cluster randomised controlled trial, involving thirteen maternity units (grouped into ten clusters) was undertaken in conjunction with some qualitative fieldwork. Five maternity units were randomised to receive the intervention and five were randomised to act as controls. A postal questionnaire was sent to clients who were 28 weeks pregnant and at eight weeks post delivery, both before and after the intervention had commenced (Kirkham & Stapleton, 2001).

As well as highlighting the complexity of the environment in which the intervention was applied, this study found that clients wanted and needed more information than they were given by health practitioners even though midwives were committed to giving information. However opportunities for sharing and giving information to clients were not maximised by the midwives and "organisational imperatives" (p.ii) were cited as mitigating against helping relationships developing between midwives and women. Working under considerable pressure, the pressure of time and fear of litigation contributed towards a culture of informed compliance rather than informed choice, (Kirkham & Stapleton, 2001) where a commitment to the organisation rather than to the individual woman was evident.

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[26] These informed choice leaflets are produced by the Midwives Information and Resource Service (MIDIRS), together with the NHS Centre for Reviews and Dissemination. The leaflets summarise ten discrete topics on which decisions are made in pregnancy. The leaflets are produced in pairs with the woman's version summarising the research evidence and the health professional's version detailing the research evidence in greater depth with full referencing. The leaflets were intended to provide research based information to inform choice in accordance with women's individual needs. The leaflets are usually purchased from MIDIRS (Kirkham & Stapleton, 2001)

In research that I undertook in 1999, (Hughes et al. 2002), with the aim of improving and understanding local midwifery morale and enhancing midwifery involvement in strategic planning, a culture of 'avoidance' and 'compliance' at a local level was found. Focus groups were used to help midwives voice their concerns although they avoided articulating a vision for the future provision of their maternity service. Through collective action they retreated to their comfort zones and carried on with routine behaviour. As a result of their reluctance to voice their concerns the midwives appeared to have no choice but to comply with the changes imposed by midwifery managers whom they saw as more powerful than themselves. They appeared unable to vision a future for themselves and persisted in criticising others for their increasing workloads, low morale and staff shortages (Hughes et al. 2002).

Key points emerging:

The NHS has been subject to continuous, unprecedented change over the last two decades. However the culture of midwifery has remained largely unchanged or unchallenged until recently. This contradiction reflects a midwifery workforce that is struggling to voice its concerns over the future of the maternity services and that prefers to foster a culture where responsibility is devolved and everyone else is seen as more powerful. The values of managers are often not congruent with the values of the workers on the shop floor. A number of change theorists have contributed to the growing body of knowledge surrounding change in an effort to address this deficit. Lipsky (1980) also provides useful insights into the way in which street-level bureaucrats cope with large caseloads and limited resources. However, the greatest challenge to implementing and sustaining change for midwives appears to lie in bringing about a change in culture. This cultural change has become increasingly difficult for midwives who work in hierarchically organised institutions where their practice appears dominated by the medical model of childbirth and obstetric knowledge is viewed as superior to midwifery knowledge.

Part 2: The midwife-mother relationship

As one of the aims of this study was to examine and explore working relationships between midwives, and how midwives saw their relationships with their clients, I decided to explore the literature surrounding the midwife-mother relationship. This led me to attachment theory[27], theories of caring and emotion work. In this section of the literature review I explore how knowledge of attachment theory can help midwives understand their working relationships.   I also explore caring as a concept and the way 'caring' is used by health practitioners in a way that fails to unpack the assumptions and generalisations that are embedded within the word. Emotion work is dealt with separately in Chapter 8 although I am aware that aspects of Part 2 of this chapter and Chapter 8 overlap.

Midwives continue to be the main health practitioners that attend the majority of births in the UK (DOH, 1998). They have also been recognised as the experts in normal childbirth (RCM, 2000).   Within a variety of settings[28], midwives are expected to provide physical and emotional support for clients and their families, as well as manage the feelings that arise within these relationships and within themselves. There is much research evidence to support the importance clients place on the contribution of the midwife to the quality of their childbirth experience (Niven, 1994; Oakley, 1994; Kennedy, 1995; Kirkham, 2000).   It is surprising therefore to find little or no acknowledgement of the effects of managing feelings in such relationships within the midwifery literature. This is despite the fact that midwives work in "an emotional minefield" (Flint, 1986, p.1).

Encouraging midwives to get to know their clients is not a new phenomenon and has been fervently advocated over the last two decades (Flint et al. 1989; Flint, 1993b; Page, Jones & Bentley, 1994; Page, 1995; Page, Cooke & Percival, 2000).

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[27] The importance of attachment theory, and implications for those working in groups, was also brought to my attention during the Group Work Course that I undertook.
[28] Midwives working in the NHS can be hospital or community-based. Some NHS Trusts have now instigated midwife-led units and birth centres. Some midwives also practise independently.

During this time there have also been messages from clients about the importance of the quality of the relationship with their midwife. In 1986, Caroline Flint commented that:

> "Mothers and midwives are intertwined…whatever happens to midwives affects women and whatever happens to women affects midwives. Midwives need to be strong and loving and sensitive to the needs of women… sharing their travail and their suffering, their joys and their delights."
> (Flint, 1986, p.viii:1)

Cronk & Flint (1989) further state that to be a midwife means to be "with woman" in order for "that special relationship…on which so much depends" (p.9) to develop. More recently, midwives have been urged to develop and strengthen their roles by developing further that "special relationship" and relating to clients in a way that involves more than performing caring actions or task-orientated care (Deery, 1999b; Kirkham, 2000). Recent government policy (DOH, 1996a; DOH, 1999b) has drawn attention to the midwife-mother relationship and changes to midwives' patterns of working and more collaborative relationships between clients and midwives have been encouraged.

Some studies have drawn attention to the emotion work involved in midwifery (Murphy-Lawless, 1991; Niven, 1994; Deery, Hughes, Lovatt & Topping, 1999; Walsh, 1999) but as yet, there is little research, with the notable exception of Hunter (2002), that addresses the effects of such emotion work on the midwife or ways of addressing this deficit. Neither could I find any literature within midwifery that made links between attachment theory and midwives' ways of working and developing relationships.

First relationship crucial to subsequent relationships

Zagier Roberts (1994) has stated that a person's decision about which profession to train for, the client group concerned and the work setting for that professional group are "all profoundly influenced by our need to come to terms with unresolved issues from our past" (p.110). Knowledge of attachment could therefore become useful when working in or with groups, as insight into the lives of individual group members can be gained and can help to understand the way some group members behave and cope in certain circumstances. However, whilst making reference to Bowlby's work I am aware that this body of literature appears to place the responsibility for the welfare of children firmly with women. In today's society, women are not solely responsible for the upbringing of children and many men raise children. My point is, that the first relationship a child develops is probably crucial to the development of subsequent relationships, and although hypothetical, this first relationship may have a bearing on the way in which midwives develop future relationships[29].

Bowlby (1988) and Yalom (1995) have stated that the need to be closely related to someone is a basic biological need and is equally necessary for survival in view of the period of helpless infancy that is experienced by individuals. The role of the relationship between the infant and others in forming the personality, and how this can go wrong, has been explored within psychoanalysis (Yalom, 1995). The importance of a nurturing relationship between the infant and its carers means that early problems may become manifest in a person's subsequent relationships with others (Barnes, Ernst & Hyde, 1999). These authors go on further to state that developmental theories associated with mother-child relationships can inform those working in groups whereby "the origins of difficulties in relationships can be explored" (p.19). Both personally (for some) and professionally, midwives are part of the mother-child relationship and feelings may be aroused within these

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[29]Raphael-Leff (2000) also explores this from the pregnant woman's perspective. Early relationships that have been experienced by pregnant women as less secure may "impede...optimal adjustment to pregnancy, birth or parenthood" (p.686).

relationships that do not become articulated (Taylor, 2001). If midwives are not able to recognise or understand that feelings can be aroused within the relationship the effect on both personal and working relationships may be detrimental (Taylor, 1996; Raphael-Leff, 2000; Taylor, 2001).

Providing a holding environment

Winnicott (1964) emphasised the importance of the environment for the developing infant and the way in which this can facilitate future development. He believed babies come into the world seeking a relationship and that consistency and empathy on the part of the mother (or other) are crucial as it provides a "holding" environment for the baby. The baby can then develop a "sense of…continuity" (Barnes et al. 1999, p.19) but if this "holding" environment is not secure the baby will experience "itself as annihilated" (p.19) and develop a false instead of a true self.

As the baby grows, strength and dependency are tested out within the environment with the discovery that the baby can exist separately from, but still relate to the mother (Barnes et al. 1999). As knowledge and confidence grow within the infant, the ability to imagine develops and the baby becomes "capable psychologically of tolerating separation" (Taylor, 2001, p.7). Winnicott (1960) refers to this as "play" stating that many people who come to therapy are unable to "play" because they still feel a need to live in a fantasy world where they prefer to exist as a baby. Barnes et al. (1999) state that such people are dominated by "a need to please and comply rather than to live" (p.20). Thus, the terms "holding" and "playing" (Winnicott, 1960) are often used by group analysts when trying to understand the life stories that individual members bring to a group setting. Likewise, in midwifery, individual midwives bring their own "psychological constellation" (Raphael-Leff, 2000, p.687) to the professional setting and in the case of this study, to the work team setting as well.

Providing a secure base

Bowlby (1969, 1973, 1980) theorises further about attachment suggesting that it is an intrinsic biological human need with "the aim of being close to a mother figure" (Barnes et al. 1999, p.21). The relationship formed with the mother during infancy therefore has implications for adult life in terms of psychological development and whether a "secure-enough base" (ibid. p.21) has been formed. If basic needs such as security and consistency are not met a "poor sense of self" may form (Bond & Holland, 1998, p.58) leading to insecure and ineffectual relationships with others.

Therefore, the quality of developing relationships with others appear to become internalised meaning that when an individual "connects" with another, that person is compared to an existing model of self or a parent (Barnes et al. 1999). The person will behave according to the models that have been internalised or learned from experience. Therefore midwives who may have been exposed to relationships with a lack of emotional expression in early life may find themselves continuing to behave in a similar way in adult life.

It is important to realise though that new ways of relating can be learned. However, some midwives have become socialised into new ways of working and relating that actually hinder, or are detrimental, to their midwifery work and thus they know much more about "deploying resources than about affecting working relations" (Lipsky, 1980, p.187). For example, midwives have learned to behave and cope by internalising the values of others' (Kirkham, 1999) rather than challenging these opposing values. Therefore developing an awareness and understanding of the complexities within human relationships can help midwives learn to deal with sensitive issues rather than appearing to resist them or becoming so engulfed by them that they find difficulty coping with, or challenging their peers.

Community-based work as a refuge

The isolation of community-based midwifery might provide a refuge for those midwives who find working in a group or closer working relationships with their colleagues difficult. Bond & Holland (1998) support this stating that "those with a history of pre-dominantly insecure avoidant attachment may avoid close contact with others and even choose a specialty which allows for maximum independence" (Bond & Holland, 1998, p.60). As Bond & Holland (1998) were specifically addressing the nursing profession I have made the assumption that they are referring to nurses who prefer to work in areas such as the intensive care unit where patients are mainly unconscious and not expected (unless recovering) to engage in any interaction with nurses. Typically, (and in this study), community midwives meet at a base room prior to the day's work in order to organise their work. It is possible that this is the only contact a community-based midwife would have with another midwife for the rest of the day unless antenatal clinics are held in the afternoon, although increasingly antenatal clinics are held by only one midwife. If work team dynamics were tense or interpersonal relationships difficult, less contact with each other might seem like an easy option for some community-based midwives.

Traditionally community midwifery has been an area where individualised care has been practised by midwives and they have been able to facilitate and develop more meaningful relationships with clients (Flint et al. 1989; Cronk & Flint, 1989; Page et al. 1994, 1995; Green, Curtis, Price & Renfrew, 1998; Wilkins, 2000; Hunter, 2002). In a longitudinal research study addressing the mother-community midwife relationship from a sociological perspective, Wilkins (2000) found that midwives highlighted many contradictions in relation to their conceptualisations of midwifery practice. Midwives in this study found their work in the community "more personal, relaxed and humane, less clinical, medicalised, bureaucratic and rushed" (Wilkins,

2000, p.46). Thus, community midwifery might also provide a refuge for midwives from the bureaucracy of their jobs.

The slipperiness of 'care'…..

Caring has been considered synonymous with the development of nursing (Davies, 1995) and as such has seen a change in focus from physical aspects "that 'submerged' caring in a sea of tasks, rituals and other mechanical practices" (Barker, Reynolds & Ward, 1995, p.387) to an increased awareness of the psychosocial and therapeutic aspects within "new caring" (Barker et al. 1995, p.388). The concept and role of 'caring' has also been closely linked to midwifery work, probably because of its historical links with nursing, suggesting that the change in focus from physical tasks to more psychosocial and therapeutic aspects also applies to midwives. This has meant midwives facilitating and building close relationships with clients, as well as meeting their physical needs. However, there is a multiplicity of meanings attached to 'care' leaving what appears to be a linguistic mess in the literature (Hall, 1990).

Mason (2000) in her book "Incurably Human" states that:

> "The term 'carer' applied to a professional relationship, has no place in the social model of disability. It simply confuses to use a word that implies an emotional relationship instead of one that is practical. It gives the impression that needs are being met which are not being met, and could never be met, by a paid worker. Carers are the people who care about us, our friends, family, colleagues at work, not the people who deliver our meals-on-wheels. (Some people do cross the line and become part of our social circle, but this is an *additional relationship*, independent of the role)."
> (Mason, 2000, p.67-68)

Although not specifically discussing midwifery, Mason (2000) draws further attention to a caring rhetoric that I have also found within the literature. As I have attempted to deconstruct the concept of care and wade my way through this rhetorical complexity, I have been left with the feeling that the word 'care' is used to describe aspects of midwifery work that do not even have relevance to 'care'. Phrases such as 'under the care of' and 'care taken over by' serve to reinforce notions of professional power and surveillance and bear no resemblance to the provision of caring for clients. This blurring of meanings further complicates 'emotion work' and the way nurses manage their feelings and as a result the emotion work of midwives and nurses appears to have become submerged into theories of caring complicating conceptual clarity.

…makes caring complex

Nursing literature relating to caring has grown rapidly leading to the development of significant but varied theories of caring in nursing (Hall, 1990; Davies, 1995) that variously describe the "core, essence, or central focus of nursing" (Barker et al. 1995). Leininger (1988) for example, uses an anthropological approach to address the transcultural context of care in relation to human growth, knowledge and practice. Watson (1985) takes a theological approach to caring stressing the importance of transpersonal relationships and the existentialist view of human worth. The focus of existentialism is the nature of human existence which is seen as a process of 'becoming' rather than a fixed state of being (Binnie & Titchen, 2002). As I suggested on page 56 this implies that midwives can learn new ways of relating to each other and their clients. However, as will be seen, this is dependent upon midwives being exposed to healthy, helping relationships in the first instance. Mayeroff (1971) suggests that all caring relationships share common characteristics and highlights concepts such as devotion, knowledge, patience, honesty, trust and hope as being inherent.

The fact that caring as a concept still remains "frustratingly diffuse, [and] hard to capture" (Davies, 1995, p.140) is further complicated by the fact that the term is used metaphorically to justify nursing (Morrison & Cowley, 1999). Indeed, Barker et al. (1995) state that nursing appears to "possess some kind of metaphorical heart" (p.389). Graham (1983) and Himmelweit (1999) suggest that one of the reasons for the confusion around caring is that it has a double meaning; 'caring for' and 'caring about' another person. Within midwifery for example, 'caring for' might involve acts relating to meeting a client's physical needs (caring actions) whilst 'caring about' would entail *a desire on the midwife's part* for the client's well being which might mean becoming emotionally involved (caring feelings).

The balancing act….becoming emotionally involved

The notion of becoming 'emotionally involved' can be likened to a midwife being committed to the interpersonal challenges within the midwife-mother relationship *and* the outcome of childbirth. These midwives might combine caring feelings and caring actions during their interactions with clients although some aspects of midwifery do not demand this in every encounter with clients. Fish & Coles (2000) have also referred to the combination of 'caring actions' and 'caring feelings' as professional artistry. They state that:

> "…professional activity is more akin to artistry,
> where only the principles can be predetermined
> and practitioners may in practice and for good
> reason need to choose to go beyond them, just
> as…good artists often go beyond or break
> artistic conventions in order to achieve an
> important effect."
> (Fish & Coles, 2000, p.292)

This implies that the activities of the midwife could not be pre-specified, rather they are socially constructed, and midwives would have to be truly autonomous, making clinical decisions about their actions and using their professional judgement in every clinical situation. Some midwives however appear more committed to the

outcome of childbirth rather than the dynamics within the midwife-mother relationship (Kirkham, 1989; Kirkham & Stapleton, 2000). This approach to midwifery work accords with a technical rational model (Fish & Coles, 2000) and would involve midwives only administering caring actions during their interactions with clients, indicating that they may have become entrenched in "techno-care" (Barker et al. 1995). Working in this manner means that cultural codes and values (Davies, 1995) underpinning the medico-technical surveillance of pregnancy and childbirth are reinforced (Arney, 1982; Jordan, 1997; Murphy-Lawless, 1998) objectivising aspects of midwifery and only making easy options available to midwives (for example, pharmacological methods of pain relief and electronic fetal monitoring). This approach to caring would appear not to take account of all the attributes necessary for the development of midwifery as a human, helping profession that incorporates the personal, emotional and biographical experiences of the client (Wilkins, 2000).

Staying connected despite differences

Meutzel (1988) explains that the ideal nurse-patient relationship is viewed as one of mutuality or reciprocity and refers to therapeutic relationships. Meutzel (1988) believes the components of therapeutic relationships are partnership, reciprocity, intimacy and support making them also subject to numerous social and psychological influences. In their work with women, Orbach & Eichenbaum (1987) explore such relationships and the emotional and psychological processes that are at play when women communicate with each other. They believe that differentiating between engagement and detachment within therapeutic relationships is an art although one that is achievable by women.

In one of their conscious-raising groups Orbach & Eichenbaum (1987) found that women were able to remain "separate, individuated people" (p.171) as well as

having different values[30] to other women in the group. The women could remain supportive, empathetic and connected without any differences between the women affecting the connection between them. Watson (1989) supports this stating that when caring for someone it is not enough just to want to help a person. The midwife for example would have to "comprehend the subjective individual's life-world" and be "touched by human suffering" (Watson, 1989, p.126). This psychotherapeutic approach also links to the pioneering work of Abraham Maslow and Carl Rogers (Rogers, 1967; Maslow, 1970).

Reciprocity: mutual aims and aspirations

Valerie Fleming (1998), in a study that used grounded theory methodology, found that midwives do not act in isolation from external influences. Fleming's model of interdependence highlights six categories that emerged from the data and that arose at different points in the relationship between midwives and clients. These categories were attending, presencing, supplementing, complementing, reflection and reflexivity. The women taking part in the study were also asked what they believed were important concepts to the practice of midwifery. The concepts raised by the women were: beliefs, colleagues, culture, experience, expertise, education, environment, friends, families, intuition, knowledge and professionalism. Fleming acknowledges that the responses of the women may reflect the two different countries (New Zealand and the UK) in which the research was undertaken.

Fleming (1998) highlights reciprocity as "the essence of all successful midwife-client relationships" (p.142). Reciprocity was discussed in terms of compromise between the woman and the midwife and was also highlighted in terms of "bringing together aims and aspirations to create the reality" (p.142). Fleming (1998) concludes by stating that as long as midwives practice in such a way that they

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[30] As will be seen in Chapter 4, being accepting of each others' different values is important in the work setting.

acknowledge what each woman knows about her own body, then reciprocity within the relationship will occur. However reciprocity also implies a respect for each others' knowledge which is difficult when "professional knowledge is exclusive, formal, discrete and cerebral" (Wilkins, 2000, p.30) and applied in an "object-orientated relationship of domination and control" (ibid, p.30) where midwives seek and express a need for expert status (Kirkham, 2000).

As was seen in Chapter 2, and will be seen again in Chapter 5, evidence-based practice, especially the use of RCTs (Chalmers, Enkin & Keirse, 1989; NHS Executive, 1996) highlights a contradiction between 'knowledge' and 'experience' (Wilkins, 2000; Deery & Kirkham, 2000). Health practitioners have been encouraged to base their clinical practice on the results of scientific evaluation (Chalmers et al. 1989) reinforcing the "putative superiority of scientific over other kinds of knowledge" (Wilkins, 2000, p.35) even though "many things that really count cannot be counted" (Enkin & Chalmers, 1982, p.285). Midwifery research has therefore become profoundly influenced by evidence-based practice to the point that subjectivity has become separated from the client's childbearing experience:

> "…[scientific evaluation] denies the possibility of learning through identification with the client because it asserts an epistemic distinction between lay and professional knowledge corresponding to 'objective' and 'subjective' states (knowledge and experience respectively)."
> (Wilkins, 2000, p.36)

Furthermore, clients experience the maternity services as institutionalised and bureaucratic (Kirkham & Stapleton, 2001) and as "cold, impersonal and clinical" (Wilkins, 2000, p.46) where there is an increased need to meet organisational demands rather than the needs of the client and where "mothers and midwives are dissociated, care is stripped of its emotional aspect, and women become tongue tied, anxious and angry…stripped of personal identity….redefined as a 'patient';

sanitised, passive and helpless" (Wilkins, 2000, p.46). Reciprocity therefore becomes difficult within developing relationships when faced with the dilemmas highlighted above and denies the development of a personally energising relationship for both the client and the midwife. Drawing attention to these aspects of the "professional paradigm" (Wilkins, 2000) is crucial if midwives want to challenge the medical model of childbirth and develop reciprocal relationships or partnerships with clients.

Mediating between 'connectedness' and 'detachment'

Himmelweit (1999) believes that an important aspect of a developing relationship, and crucial to its success, is that there is motivation towards "genuine concern" (p.29). Although Himmelweit is not referring specifically to midwives, this "genuine concern" could be construed as the ability to mediate between connectedness and detachment within a relationship, even though the midwife may have a different interpretation of life or values than the client. Likewise, if there is a lack of "genuine concern" on the part of the client towards the midwife, this too could have a detrimental effect on establishing rapport between the midwife and the client.

Berg, Lundgren, Hermansson & Wahlberg (1996) in a phenomenological study describing women's experience of the encounter with the midwife during childbirth found that "care giver behaviour that was warm and nurturing produced feelings of comfort, strength and relaxation" (p.14) and that when this did not occur some women felt that midwives were "absently present" (p.13). Hunter (2002) refers to "balanced exchanges", "rejected exchanges", "unbalanced exchanges" and "unsustainable exchanges" (p.256). If there is no motivation towards "genuine concern" on the part of the midwife or client or the midwife is "absently present" this might suggest a "rejected" or "unbalanced" exchange and thus disruption to the developing relationship.

Kirkham (2000) has stated that at its best, the midwife-mother relationship is based on trust which must rest on shared values. Although not all midwives and clients will share the same values, through negotiation within the midwife-mother relationship, a reciprocal understanding of the childbearing process can be reached. Engaging with clients in this manner places the personal relationship between the midwife and the woman at the heart of midwifery. Also, this ability to be able to move and mediate in a sensitive manner between closeness and detachment, or remain permanently in one or the other area, lies at the heart of the relationships that midwives build with clients. The ability to move and mediate suggests that midwives can engage in constant "rebalancing" (Carmack, 1997, p.141) acknowledging that relationships can change and that midwives can learn through experience. However, the balance of the midwife-mother relationship could be disrupted if the midwife remains permanently anchored in either engagement or detachment. It is also important to note that all of the above (Berg et al. 1996; Himmelweit, 1999; Kirkham, 2000; Hunter, 2002) assume that the client is the focus of the midwife's work and not the organisation (see Table 5 on page 285).

Picking the right balance

Levy (1999) has found relationships that demand a degree of connectedness or detachment are immensely threatening to the well-being of midwives because they also have to balance and develop many other professional relationships. She refers to 'protective steering' in her grounded theory study which examines the processes by which midwives facilitate informed choices for clients. Protective steering was seen as a highly complex activity that involved midwives drawing on personal sensitivity as well as their professional skills and knowledge and "when facilitating informed choice midwives 'walked a tightrope' in attempting to meet the wishes of women, steering their way through several dilemmas" (Levy, 1999, p.105).

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Dilemmas such as the desire to give clients unbiased information clashed with midwives' personal feelings regarding certain issues. For example, screening tests for fetal abnormalities posed a particular challenge in that midwives had to "strike a balance" (ibid, p.105) between giving enough information in order for the client to make an informed choice whilst at the same time not giving too much information and intimidating the client (Levy, 1999). Such dilemmas highlight the necessity for midwives to meet organisational demands to the detriment of their relationships with clients and their colleagues. Just as Goffman (1967) refers to "a 'line'; that is, a pattern of verbal and nonverbal acts by which he expresses his view of the situation" (p.5) so too, Levy (1999) found that if midwives did not pick the "right line" (ibid, p.106) during decision making processes with clients, their safety, as well as the client's safety and well being, could be compromised and the balance of the relationship could be disrupted.

Different levels of engagement

In suggesting that midwives need to pick the right balance within the developing relationship (Levy, 1999) there is an implication that different levels of balance exist and furthermore, midwives must engage with clients at different levels within the developing relationship[31]. As Stapleton, Kirkham, Curtis & Thomas (2002a) state:

> "…there appears to be a continuum of engagement between woman and health professionals. At one extreme the professional is entirely engaged with their own predetermined agenda and words addressed to the woman are largely instructional. Further along the continuum, the professional is still engaged with their agenda but shares with the woman, to a lesser or greater extent, the information gained during the consultation. Beyond this, the agenda is shared and the professional embraces a more egalitarian approach and consciously use strategies whereby women are enabled to voice their concerns."
> (Stapleton et al. 2002a, p.395)

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[31] This is reminiscent of Hunter's (2002, p.256) model of role relations in midwifery as highlighted on page 64.

The level of engagement will depend on time and other organisational constraints, the amount of work to be got through, the interpersonal and communication skills of the midwife, the client, language barriers, whether the client has birthed her baby or not and the level of emotion work involved and how the management of feelings is impacting on the midwife. This balancing of engagement with detachment is important in midwifery because as Carmack (1997) states "one focuses on the here and now, recognizes limits, and does not attempt to over-control outcomes" (p.142).

> "People who successfully balance engagement with detachment know what they can and cannot change or control. They are sensitive to their own emotional needs. They choose their level of engagement based on what they know they can handle at a particular time. People who successfully balance engagement and detachment understand the importance of self-care."
> (Carmack, 1997, p.142)

Unfortunately developing an awareness of midwives' emotional needs is not yet regarded as a fundamental part of midwifery work (Deery, 1999a; Kirkham & Stapleton, 2000). Neither does there seem to be mechanisms in place in order that midwives can begin to take care of themselves (Deery, 1999b; Kirkham & Stapleton, 2000; Hunter, 2001, 2002). However, there are ways to address this deficit as will be seen in the next chapter.

The process of balancing within relationships is therefore closely linked to the process of caring which "is itself the development of a relationship" according to Himmelweit (1999, p.29). This means that the care being provided for the client is inseparable from the relationship that is developing, suggesting that caring is the essence of midwifery. This therefore implies that midwifery should always involve 'caring' in some unique way. This is reiterated by Davies (1995) who states that:

"Caring does not involve specific tasks; instead it involves the creation of a sustained relationship with the other, an ability to reflect on the specifics of that person's history, and an ongoing process of dialogue through which assessments and interventions can be tried, monitored for relevance and adopted or adapted as necessary."
(Davies, 1995, p.141)

The 'ongoing process of dialogue' referred to by Davies (1995) is another important aspect of the developing midwife-mother relationship. Without this 'ongoing process of dialogue' (that is only possible with some degree of continuity of care) between the midwife and client or feedback from the client, midwives would find it impossible to evaluate the effectiveness of their work with clients (Stapleton et al. 2002a). For many midwives their work is such that the opportunity for the client to provide feedback to the midwife about her childbirth experience is not encouraged (Stapleton, Kirkham, Thomas & Curtis, 2002b). This lack of engagement on the midwife's part could be related to fear of feedback or the impossibility of acting upon it in the current climate of having to meet organisational demands (Kirkham, 1999).

The philosophy of woman-centred care (DOH, 1993a) that is encouraged in the NHS, fits with the quote from Davies (1995) above, even though the NHS does not appear to provide the context that Davies (1995) saw as fundamental to caring for clients. As was seen in Chapter 2, midwifery practised in a woman-centred way promotes informed choice, continuity of midwife and choice and control for clients (DOH, 1993a) and encourages midwives to develop relationships with clients according to their differing needs. Although it could be argued that most midwives tend to develop a pre-packaged set of skills that can be used with all clients they encounter in their working lives, this would be almost impossible to achieve. Whilst midwives need to be able to develop effective, helping relationships with clients, they will also utilise different skills on an individual basis with clients. As Himmelweit (1999) states, "it matters who is doing what for whom" (p.30). As was seen earlier this implies, and is dependent on, reciprocity being part of the

developing relationship thereby excluding those midwives who only choose to perform routinised actions or task-orientated care.

Women as 'natural carers'

According to Reverby (1987) caring work that is undertaken by women has become invisible and is not understood or valued in society. Furthermore, caring is expected to come naturally to women (Smith, 1992). This is reiterated by Orbach (1994) who has stated that "girls are raised with the social injunction to be caring, thoughtful and to put everyone else first" (Orbach, 1994, p.127). As a result of this socialisation and current gender thinking the skills associated with caring have become "resistant to recognition and reward" (Davies, 1995, p.141) when displayed by women. The wide array of tasks that are associated with caring do not appear to take account of "the emotional turmoils and moral debates about love, duty and guilt that the work of a carer can evoke" (Davies, 1995, p.141). Furthermore, midwifery has traditionally been seen as a gendered profession and most of its espoused caring qualities have been associated with society's ideal of femininity.

The gendered nature of caring is addressed further by James (1989) who refers to emotional labour in health care settings. She discusses the way in which caring work has become constructed as 'naturally female' and has therefore become devalued because of women's position and work within the family. This point is elaborated further by Rafael (1996) who refers to the androcentric values of Western society whereby a 'male-stream' ethics of beneficence and rights-based justice has capitalised on women's ability to care in the private and public domain. The demands of the organisation in terms of workload then outweigh and undermine the value that midwives themselves might place on the relationships they build with clients. This 'professional predicament' (Davies, 1995) can ultimately lead to burnout (Morrison & Cowley, 1999).

The sentimental order of midwifery

Glaser & Strauss (1968) first introduced the idea of the sentimental order of the ward. They define the sentimental order of the ward as "intangible but very real patterning of mood and sentiment that characteristically exists on each ward" (Glaser & Strauss, 1968, p.14). The sentimental order of the ward therefore appears to be related to control and supervision issues on the part of the health practitioner. Within midwifery this concept relates to keeping the labour ward quiet by giving women pethidine to keep them calm and quiet. However this also prevents the midwife from communicating with labouring women. Likewise, attaching clients to electronic cardiotocograph monitors means that they are unable to mobilise thus keeping the usual routine of the labour ward undisturbed. Professional power is thus much easier to exert for the midwife when clients are kept under surveillance and control in this manner (Kirkham, 1989; Kirkham & Stapleton, 2001). Clients who sense such power are unlikely to ask questions and thus behave obediently for fear of being labelled 'difficult' (Kelly & May, 1982).

Similarly, Strauss, Fagerhaugh, Suczek & Wiener (1982) have introduced the notion of 'sentimental work' implying a change in focus from physical aspects to an increased awareness of psychosocial needs thus acknowledging the significance of emotion work in health care. This work underpins the sentimental order of the ward (Glaser & Strauss, 1968). Strauss et al. (1982) compare sentimental work to tender loving care which is seen, not only as humanistic, but as an effective way of ensuring that the necessary work gets done. Seven categories of sentimental work were generated from data collected during field observations and interviews. The authors suggest that their typology is useful for specifying the nature of working psychologically with clients because sentimental work often changed according to the nature of the patient's illness or the ward ethos. There is also a sense here of the health practitioner controlling the timing of this psychological work as well as the feedback from the client.

The sentimental order of the ward is also applicable to midwifery in that community-based midwives might change the approach they take to their work according to the nature of their existing workloads and where they perceive a need to control timing during the course of the working day. As Lipsky states (1980) street-level bureaucrats "operate in an environment that conditions the way they perceive problems and frame solutions to them" (p.27). Thus, a community midwife who has numerous postnatal visits to undertake during the morning is unlikely to offer the level of psychological support to clients that she would prefer if she has a busy antenatal clinic to attend in the afternoon. There is likely to be reluctance on the part of the midwife to open up any interpersonal or psychological agenda concerning the woman's childbearing experience and questions such as "how are you?" or "how is your breastfeeding going?" will be out of bounds (Stapleton et al. 2002b). Neither is the client likely to be offered the opportunity to ask any questions about her childbirth experience or the health of her baby. As a result the midwife will receive no feedback because the client respects the business of the midwife and does not want to bother or interrupt her busy work schedule.

In a paper highlighting how clients perceive midwives as 'checking' but not listening, Kirkham, Stapleton, Thomas & Curtis (2002) state that "women's insights into the organisational constraints on service provision tended to lower their expectations of midwives" (p.447). Thus, acquiescence on the part of the client is related to the amount of time the midwife has to spend with her as well as power and who controls the agenda within the midwife-mother relationship. As Lipsky (1980) states:

> "Routines and simplifications that arise in street-level work [are] in response to job stresses…these routines and simplifications originate in the coping needs of individual workers…and they become the patterns of agency behavior with which clients and policy reformers must contend."
> (Lipsky, 1980, p.86)

The sentimental work of the midwife therefore becomes adapted to meet the needs of the organisation rather than the needs of the client and midwife concerned in the relationship.

Midwives' 'composure work' – a form of task orientated care

Composure work as identified by Strauss et al. (1982) involves helping those being cared for to maintain their composure although who defines appropriate composure is not addressed by the authors. This phenomenon is the same as caring actions which means that the health practitioner probably defines the task to be carried out and as a result also controls the timing of the task. As was seen earlier this fragmented approach to caring then limits the development of the relationship between the health practitioner and client. Strauss et al. (1982) state that during the course of providing care many procedures and tasks are undertaken that expose people to "painful or frightening" (p.262) procedures. Health practitioners can help their clients by providing "those reassuring or helpful gestures" that are necessary for the completion of tasks. In midwifery for example this might involve holding a client's hand during a clinical procedure or helping a client into the bath following the birth of her baby. If composure work is not demonstrated by the health practitioner then the client may "cry, scream, change bodily position, collapse in panic, [or] refuse to go on" (Strauss et al. 1982, p.262). Therefore composure work which is "probably the most usual and the most visible type of daily, run-of-the-mill sentimental work" (Strauss et al. 1982, p.262) makes task-orientated care possible.

Composure work is also carried out in order to maintain the 'composure of the ward'. 'Loss' of composure can be likened to a client birthing her baby on the labour ward who is making a lot of noise and which some midwives find unacceptable (Hunt & Symonds, 1995). Although normal, this 'loss' of composure on the part of the client can prompt some midwives to sedate them with pethidine

rather than 'connect' and 'be with them' during their labour (Kirkham, 1989). Thus, if composure is not maintained this is likely to impede the satisfactory progress of the day's work and upset the sentimental order of the labour ward.

The emotion work involved in avoiding showing personal feelings in helping relationships (Hochschild, 1983; Bolton, 2000, 2001; Hunter, 2002) can be harmful and detrimental to midwives. This is one aspect of developing relationships that midwives are not adequately prepared for (Deery & Corby, 1996; Taylor, 1996; Deery 1999a). However some midwives may also choose to ignore this aspect of helping relationships because they do not want to become involved with clients (Kirkham & Stapleton, 2002) or because they are not ready to deal with the associated uncomfortable feelings (Taylor, 1996).

Identity work – attending to nurturance, growth and healing

Identity work is more subtle than composure work and would involve working on matters relating to the "personal identity" (Strauss et al. 1982, p.263) of the client, or psychological issues. This type of work, the authors argue, can involve "spontaneous, situationally elicited efforts" (p.263) on the part of health practitioners engaging in helping relationships that can "merge into" their work. The authors give an example of a nurse spending many hours of conversation with a terminally ill patient helping to keep spirits high in order to facilitate a fulfilling end to their life. The complexity and invisibility of this type of psychological work is acknowledged by Strauss et al. (1982) although these authors do not appear to address what the terminally ill patient actually desires. The nurse may have been spending time with the terminally ill patient in order to maintain the composure of the ward as well as the nurse's own composure rather than working on the client's personal identity. This again relates to professional power and compliance and the health practitioner knowing best (Kirkham, 1989; Kirkham & Stapleton, 2001).

Nevertheless, Strauss et al. (1982) seem to be implying through identity work that for helping relationships to be achievable caring actions (composure work) and emotion work (identity work) on the part of the health practitioner go hand in hand. Davies (1995) supports this idea and provides a definition that attempts to integrate caring actions and caring feelings as "attending physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other" (Davies, 1995, p.18-19).

McCrea, Wright & Murphy-Black (1998), in a study examining the influence of midwives' approaches to the care given to clients for pain relief during labour, found that professional care depends not only on the expertise of midwifery practice but also the personal qualities of the midwife. These authors identify three different approaches to pain relief offered by midwives. The 'cold professional' did not get involved with women and only carried out task orientated care. All clients were treated alike and she did not invest any of herself in the relationship and preferred to rely on the use of technology rather than her own expertise as a clinical midwife. She kept her distance emotionally from clients and preferred to work alone rather than in partnership with the women:

> "This type of midwife gave information in an objective and informed way, and did not offer her own opinions or share her experience (personal)…Her approach was influenced by women's social class…she did not offer to sit with the women or hold their hands…Instead she was observed…checking 'machines and monitors'…"
> (McCrea et al. 1998, p.177)

The 'disorganised carer' showed little evidence of care that was evidence based. Although she was found to be caring she was not competent and "provided care in a haphazard way" (ibid, p.177). This midwife's approach to care was found to be inconsistent and lacking continuity and "she spent more time on 'social chat' rather than listening actively to the women" (ibid, p.177). Both the 'cold professional' and

the 'disorganised carer' lack the skills necessary for emotional involvement and therefore accord with the notion of "caring for" someone but not "caring about" them.

The third approach to care identified by McCrea et al. (1998) is that of a 'warm professional'. This midwife "provided care in a holistic way, caring for the body and the mind" (p.179):

> "…she gave the women the opportunity to ask questions and seek clarifications…[she] provided emotional support to the women: she sat near them, holding their hands or massaging their back, and speaking words of comfort and encouragement in a gentle tone of voice… She made the women 'feel special'…the warm professional was observed to work with the women to help them cope…"
> (McCrea et al. 1998, p.178)

This midwife "cares for" and "cares about" clients and is prepared to offer her expertise as a midwife as well as becoming emotionally involved. This midwife is clearly able to perform the necessary tasks her job demands but her orientation was also to the client indicating that she can incorporate emotion work into the developing relationship.

Therapeutic midwifery: being a 'skilled companion'

Cronk & Flint (1989), Flint (1986) and Leap (2000) describe relationships with clients that are based on commitment and emotional understanding on the part of the midwife. Such relationships may carry emotional consequences. Berg et al. (1996) use keywords such as "friendliness, openness, safety, interpersonal congruity, intuition and availability" (p.13) as concepts being important to clients in relationships they build with their midwife. Relationships based upon such conditions are therapeutic (Rogers, 1967; Rogers, 1983) and as such, create

favourable conditions for setting in motion trustworthiness, dependability, acceptance, sensitivity and consistency (Deery & Corby, 1996) which are concepts consistent with "therapeutic proficiency" (Wilkins, 1998, p.201). Emotional giving such as this can often leave midwives feeling "uncared for" and emotionally exhausted (Butterworth et al. 1997) and can also have consequences of "tip[ping] people back into strategies from early childhood" (Brechin, 2000, p.157). This aspect of care work can make a relationship based on sensitivity and trust (Page, 1993) hard to achieve for some midwives especially if they themselves are feeling "uncared for" or they have no experience of being facilitated themselves.

Midwives as 'gravy'

In the rhetoric of policy documents (DOH, 1993a; DOH, 1999b; DOH, 2000) the traditional relationship of dominant, expert midwife and passive client has been discouraged in favour of a relationship in which midwives can engage in equal, empowering relationships with clients. In practice, this approach to midwifery demands a relational style that offers support and practical expertise for the client whilst at the same time encouraging the woman to make her own decisions in order to be in control of her childbearing experience (Leap, 2000; Stapleton et al. 2002a). When discussing similar developments in nursing (McMahon & Pearson, 1991) refer to the influence of humanistic psychology and the subsequent development of therapeutic nursing. Likewise a midwife practises therapeutically if she is emotionally and physically present with a client during pregnancy and childbirth, accompanying her as a "skilled companion" (Campbell, 1984) throughout the experience. She is also able to manage her own emotional wellbeing and will be aware of her defence mechanisms.

Some of those midwives who have successfully achieved a move from a task-orientated to a woman-centred approach (DOH, 1993a) may find themselves used

as therapeutic resources by clients[32]. Those midwives who practise a high degree of 'connectedness' with clients on a regular basis may find themselves being used in this way. Also, facilitating relationships with clients or being aware of the need to involve birth partners or relatives as and when necessary is encouraged as the preferred way of working within 'connectedness'. This then facilitates the development of "a sense of independence and responsibility" (Leap, 2000, p.7) within the client. At times this might mean that midwives are "gravy" (Lay, 2000, p.17) not necessarily doing anything but having a "calm presence" (Berg et al. 1996, p.14). Such midwives recognise that "the mother decide[s] on the setting for her birth, the people who would witness it, and the degree to which they would assist her. It is the mother's birth experience; she own[s] it" (Lay, 2000, p.17). Leap (2000) goes on further to state that "at every stage of our interactions with childbearing women…we should be adopting behaviours, ensuring that women can take up the power that will enable them to lead fulfilling lives as individuals and mothers" (p.3).

The consequences of partnership….devolving power

The term 'partnership' has also appeared in discourses around childbirth with the relationship between the midwife and the woman being increasingly described as a partnership (Fleming, 2000; Pairman, 2000). According to Hicks (1993), the move towards a less paternalistic approach within the mother-midwife relationship has meant that midwives should be able to recognise the influences that operate within a relationship as well as the emerging dynamics. This suggests that the specific way in which the midwife and the client interact, or the partnership that they develop, is "actualised" (Gallant, Beaulieu & Carnevale, 2002, p. 153) through the relationship.

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[32] There are parallels here with the interviewing process that I discuss in Chapter 5.

Gallant et al. (2002) suggest that power-sharing and negotiation are key factors to the "actualisation" of the relationship. However power has to be "conceptualised in a way that is congruent with the sharing nature and enablement focus of the partnership" (Gallant et al. 2002, p.154). As was seen in Chapter 2, concepts of power and knowledge in midwifery have manifested themselves in different ways often resulting in midwives exerting their professional power or control over clients. According to Starhawk's (1987) feminist, three-dimensional theory of power, this can be by power-from-within, power-with and power-over.

Power-from-within is personal power and comprises characteristics such as energy and self-awareness "that arise[s] from our sense of connection, our bonding with other human beings, and with the environment" (Starhawk, 1987, p.10). As seen earlier in this chapter, these are qualities that are not fostered and valued within the culture of midwifery (Kirkham, 1999). Power-with is "dependent on personal responsibility, on our own creativity and daring, and on the willingness of others to respond" (Starhawk, 1987, p.11). As seen earlier, this energising and challenging ambience created when two people are prepared to learn from each other is difficult for midwives working in the NHS. As Gallant et al. (2002) note, "control is shared between partners in this 'togetherness'" (p.154). However, as was seen in Chapter 2, the rhetoric of current government policy (DOH, 1993a) encourages a power-with framework but reality means that the patriarchal ideology of power associated with the medicalisation of childbirth and organisational demands within the NHS far outweigh the enablement of partnership with clients. Therefore, even though midwives might be willing to share their power with clients, they could find themselves buried in bureaucratic and administrative barriers to this power shift (Lipsky, 1980).

Starhawk (1987) states that "power-over shapes every institution of our society" (p.9). As such power-over is linked to domination and control and "enables one individual or group to make the decisions that affect others, and to enforce control"

(Starhawk, 1987, p.9). Gallant et al. (2002) suggest that power-over represents "the patriarchal use of dominance, exploitation and coercion in interpersonal relationships, to control the behaviour of another, possibly resulting in oppression or feelings of powerlessness in others" (p.154). A number of midwifery researchers have found that clients and midwives appear to be manipulated in this manner to serve the interests of obstetric and midwifery views and practices (Kirkham, 1989; Curtis, 1991; Hunt & Symonds, 1995; Leap, 1997; Stapleton et al. 1998; Kirkham & Stapleton, 2001).

Clearly, the transition to a more meaningful or therapeutic relationship involving more dynamic dialogue between the client and the midwife has remained difficult for some midwives even though it is central to the developing relationship. The organisation of work within the NHS is such that midwives mainly work in a medically and managerially dominated culture where clear hierarchical divisions still persist between all levels of staff. Midwives also have well developed defence mechanisms and the role of ceremony in promoting and preserving an existing task-orientated approach to work within the NHS continues to dominate. Nevertheless working in partnership with clients could help to maintain a balance between "personal involvement and objectivity" (Bond & Holland, 1998, p.43).

Key points emerging:

Healthy working relationships between midwives and clients and midwives themselves are crucial to positive childbearing experiences for clients and midwives. An understanding of attachment theory may help midwives to understand and change their ways of relating to each other and clients. The emphasis placed on the way midwifery care is delivered today and increasing pressure from midwifery managers to conform to organisational demands appear to have neglected the effects of the changing nature of the midwife-mother relationship on midwives. Community-based midwives are best placed to provide a

more woman-centred approach although this has meant that some midwives are investing more of their time and energy into a therapeutic approach to midwifery. Reciprocal relationships or partnerships demand a degree of emotional engagement that can often leave midwives having to "pick the right balance" (Levy, 1999) or engage with clients on different levels in order to cope with organisational demands and their increasing workloads. Technical and emotional detachment is used by midwives to help them cope with the reality of their work situation where the rhetoric of policy documents, caring and woman-centred care has become clearly evident. However technical and emotional detachment limits and fragments the development of relationships as midwives try to fit their clients into the bureaucracy of the organisation or maternity service.

In the next chapter I address the literature surrounding clinical supervision and explore how this may be one approach that midwives could use in order to help them to cope with the uncertainty and challenge of change within their practice. As well as comparing midwifery and clinical supervision, I explore some of the available clinical supervision 'models'.

CHAPTER FOUR

Clinical supervision – a potential source of support

> My task is not to carry across
> one old bit of culture
> to weave through
> some new bit
> both somehow separate from me
> but by inhabiting
> both worlds in myself
> to speak from where I am
> to where I am

from Miller Mair 1989

In this chapter I explore what is known about clinical supervision as "a formal process of professional support and learning" (DOH, 1993b) that has been described as having commonalities that include a "process orientated, interrelational and reflective approach" (Lindahl & Norberg, 2002, p.809) to working with, and supporting, health care practitioners. Much of the literature dealing with the theory and practice of clinical supervision is derived from professions other than midwifery (Hawkins & Shohet, 1989; Casement, 1985; Butterworth & Faugier, 1998) hence the literature I use is derived mainly from the nursing profession. Different frameworks (often referred to as 'models' in the literature) and ways of 'doing' clinical supervision are examined as well as the framework of clinical supervision adapted and used by the midwives within this study. I also explore midwifery supervision and compare this with clinical supervision.

Since the early 1990s there has been a growing interest around clinical supervision within the health professions and this has rapidly gained momentum within the NHS especially since the publication of "A Vision for the Future" (DOH, 1993b), Faugier & Butterworth's Position Paper (1993) and the emergence of clinical governance. This interest has been further fuelled by political and organisational interest (DOH, 1993b; UKCC, 1995; UKCC, 1996) which has encouraged NHS

employers and health practitioners to explore the concept of clinical supervision further. Nursing and other health professions, with the exception of midwifery, are now seen to be taking on board the perceived benefits that clinical supervision may offer (Farrington, 1995; Butterworth et al. 1997; Bishop, 1998) although Butterworth (1998) acknowledges that "there are tensions which have yet to be resolved, not least of which is the very title 'clinical supervision'" (p.1).

Strengthening or 'policing' clinical practice?

The Government document "A First Class Service: Quality in the new NHS" (DOH, 1998) followed from "The New NHS: Modern, Dependable" (DOH, 1997) and placed clinical governance high on the agenda in a modernisation strategy that was focusing on quality. NHS Chief Executives became responsible for assuring the quality of services in their trusts and comprehensive programmes of quality improvement activities became evident. These included clinical audit, evidence-based practice and risk management (DOH, 1998) and initiatives such as critical incident reporting and complaints procedures were put into place by managers so that they could monitor and act on what was reported to be poor performance. The midwifery profession claimed to already have a number of quality strategies in place which embraced the notion of clinical governance (for example, statutory supervision and confidential enquiry into maternal deaths and also into stillbirths and deaths in infancy) (RCM, 1998). At this time, other health professions, especially nursing, were generating interest in clinical supervision as a framework that could also contribute to quality service provision.

Rather than strengthening professional autonomy the quality improvement initiatives described above have been viewed by some midwives as further control over their clinical practice (Walsh, 2002). Spence, Cantrell, Christie & Samet (2002) have identified the organisational culture in which clinical supervision takes place as an important consideration because "not all cultures suit all purposes or

people" (Handy, 1993, p.183). Therefore, a controlling culture where "autocracy, macho management and management by directive" (Northcott, 1998, p.115) exists is unlikely to see "the need for, or to value, clinical supervision" (Spence et al. 2002, p.69).

However I was especially interested in clinical supervision as a supportive framework for health practitioners because as a process it did not appear to have as its focus monitoring or investigation[33] of clinical practice (Lawton & Samociuk, 1997; Faugier, 1998). Instead it has been described as supportive and enabling (Faugier, 1998), concerned with professional development (Hawkins & Shohet, 1989; Faugier, 1998; Cutcliffe & Epling, 1997), client-centred (Morris, 1995) and an investment in staff (Butterworth et al. 1996; Dudley & Butterworth, 1994; Hallberg & Norberg, 1993). However, Rolfe, Freshwater & Jasper (2001) point out that clinical supervision has still not become a reality in nursing practice and where it has become implemented resistance is evident amongst practitioners.

It is appropriate at this point to examine some of the earlier developments of supervision within counselling, psychotherapy and social work, as clinical supervision has its roots in these professions (Bond & Holland, 1998). The cultural contexts in which these professions have developed may help in deciding whether frameworks for clinical supervision might be usefully developed on similar lines in other health care professions.

Learning lessons from other professions

The term 'clinical supervision' originates from the training and practice of psychotherapy and counselling and, according to Bond & Holland (1998) supervision in this context:

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[33] The investigatory nature of midwifery supervision has been discussed elsewhere in this thesis (see Chapter 2, page 23). I also acknowledge that some nurses suggest that clinical supervision is used as a monitoring tool although the literature agrees that this is not the focus of clinical supervision (Bishop, 1998; Butterworth, 1998).

> "…focuses on the 'inner' and 'outer' world of the client and on clinical techniques within the therapeutic relationship, but also on the conscious and unconscious processes of the practitioner, their prejudices, blind spots and inner difficulties".
> (Bond & Holland, 1998, p.24)

There are two regulatory bodies; British Association for Counselling (BAC) and United Kingdom Council for Psychotherapy (UKCP). Membership of these bodies is voluntary although BAC provides a code of ethics and practice to which all members must adhere (Taylor, 1996). Trainees in both counselling and psychotherapy are expected to attend weekly supervision and, when qualified having their practice supervised on a weekly basis is encouraged (Taylor, 1996; Bond & Holland, 1998).

There are some important parallels between supervision in this context and how clinical supervision could help midwives. In counselling and psychotherapy clinical supervision is seen as a supportive structure for the therapist/counsellor to help them "work with the unknown" and cope with "not knowing" (Casement, 1985). These are important concepts in midwifery as most midwives face uncertainty everyday of their working lives by not knowing what the outcomes of childbirth are going to be for women (Taylor, 1996; Stapleton, 1997). As Peter Wilkins (1998) so eloquently states when writing about community psychiatric nursing and clinical supervision:

> "…there are many dark, shadowy moments when we lose direction and cannot see what needs to be done. Yet looking where the light shines does not necessarily mean that you will find what you are looking for. In clinical supervision, we need someone to guide us back to the casework moment, as only then can our retrospective darkness be illuminated by the light of insight".
> (Wilkins, 1998, p.189)

Therefore stepping backwards and becoming more self aware in our interactions with clients and other midwives is important although, as was seen in Chapter 2, midwives work in an organisational system that trains them to clinically manage and measure aspects of their work rather than providing "space to reflect upon and develop...practice" (Wilkins, 1998, p.190).

As midwifery is essentially about human relationships the development of interpersonal skills and ways of managing emotions at work are essential to help midwives cope with the often stressful nature of their work. However, it is important to stress that clinical supervision is not counselling because clinical supervision does not have as its prime focus the promotion of healing (Rogers, 1983), although some healing may take place (Deery & Corby, 1996). Some of the skills (for example, listening and empathy) required in counselling and psychotherapy can be transferred into midwifery work through clinical supervision but this would be with much less intensity and depth. However there is the opportunity for addressing the complexity of interpersonal relationships through a medium such as clinical supervision similar to that used in counselling and psychotherapy (Deery & Corby, 1996).

Social work – 'discussing cases' or 'anxious caseload management'

The fact that there was a lack of importance attributed to supervision in social work was commented on by Seebohm as far back as 1968 (Seebohm, 1968). Since then clinical supervision has developed in social work in order to provide a forum for social workers to discuss 'cases' although Woodhouse & Pengelly (1991) disagree, stating that "it is common place to find that this has either lapsed altogether or become an arena for anxious case management rather than for reflective understanding" (Woodhouse & Pengelly, 1991, p.236). Developments since 1968 have seen increased numbers of social workers being trained and entering the profession, some of whom, it has been argued, have received

inadequate supervision for their caseload (Faugier, 1998). This has then often come to light with the publicity of cases that have been seriously mismanaged.

Westheimer (1977) views the supervisor as someone who ensures that scarce human and material resources are used to best advantage and thus sees the supervisory process as a management tool. As such, identification of a role for supervisors in raising the standards of social work is highlighted. This probably led Hill (1989) to make the point that supervision in social work acts as a buffer between management and the social workers who provide a service for their clients. Butterworth (1998) has suggested that this might be a useful strategy for nursing, as they work within a similar management structure. However there is always the risk that supervisees will not discuss or highlight pertinent issues for fear of reprisal or disciplinary action from managers. Under such circumstances clinical supervision is likely to be resisted by the supervisee.

The concept of 'supervisor' – confusion and 'definition quagmire'

Clinical supervision is a much misunderstood and confusing concept, particularly in the field of midwifery (Deery & Corby, 1996). Within the health professions, especially midwifery, this confusion relates to a lack of knowledge about clinical supervision and also the term 'supervisor'. Indeed, health practitioners other than midwives assume that the supervisor of midwives provides clinical supervision (Bishop, 1994; Fowler, 1995; Morcom & Hughes 1996) with Rolfe et al. (2001) stating that "clinical supervision has been an important part of midwifery practice for many years" (p.76). There is a danger here that supervisors of midwives may believe they are providing clinical supervision and those midwives they supervise believe they are receiving clinical supervision, when in reality they are not (Deery & Corby, 1996).

One of the main causes of confusion around the development of clinical supervision and its understanding within the professions appears to be related to the use of the term 'supervisor'. It is therefore important to clarify issues around the term 'supervisor', before examining the development of clinical supervision because as the UKCC (1995) has stated the term is both misleading and unhelpful. The traditional view of a supervisor overseeing the work of a subordinate to make sure that they do not make mistakes stems from the industrial model and nursing has traditionally followed this model with senior nurses directing junior nurses. An alternative viewpoint, synonymous with preceptorship, is that supervision is intended for junior, inexperienced members of staff, who over time will outgrow the need for supervision (Lawton & Samociuk, 1997).

In midwifery, supervision has been viewed by some as an imposition on a previously egalitarian and self-regulating profession (Heagerty, 1996). Only since 1936 when many midwives became employees of the local authorities did supervision follow the industrial model and midwives began to feel that their practice was being overseen. Indeed, the Midwives Rules of 1993 stated that the supervisor of midwives was appointed to be 'over' the midwife rather than 'with' the midwife (UKCC, 1993, rule 44, p.22). Although the wording has since been changed (UKCC, 1998) for some midwives supervision remains hierarchical. This confusion is further compounded by the abundance of terms with which supervision is associated e.g. assessor, preceptor, mentor and clinical educator. These terms are often used interchangeably and without any consistent understanding being demonstrated by the users. Hagerty (1986) addresses this confusion as "definition quagmire" and suggests standardisation of terms is necessary to avoid individuals developing their own constructs. If there is no consensus around definitions within the literature, an assumption cannot be made that health practitioners are talking about the same concept. It is not surprising therefore to find that clinical supervision is resisted in areas of nursing and midwifery because of its associations as just another management monitoring tool (Rolfe et al. 2001).

'Big sister is watching you': supervision of midwives

At the same time that there has been debate about the development of clinical supervision in nursing and other health professions, debate about the development of midwifery supervision has also been taking place. As the supervisory role has evolved there has been very little rigorous research undertaken which explores midwives' and supervisors' views of their roles. Work undertaken by Stapleton et al. (1998) indicates that the majority of midwives want to retain supervision and gain support; however this research also demonstrates that midwives are unclear about the concept of midwifery supervision and that the support they require is not always available for them. On site 2 in an NHS trust in this important research, midwives received both statutory and clinical supervision and were enthusiastic about the clinical supervision they received. Likewise, Heptinstall (1998), in her small scale study examining clinical supervision, concludes that midwifery supervision may inhibit midwives' autonomy and that a system of clinical supervision needs to be set up entirely independently of midwifery supervision.

Duerden (1995) carried out an audit of supervision in the North West Health Region and found that there were some inconsistencies in midwifery supervision. A lack of clarification of supervision and its function and purpose, the education needs of some supervisors of midwives and the need for a structured programme of supervision for midwife teachers were some of the identified inconsistencies. Duerden (1995) states that where these inconsistencies exist they are being addressed although she does not state exactly how this is being achieved. It is only in later work (e.g. Duerden, 1996; Duerden & Halksworth, 2000) that developments are discussed and recommendations made.

Some of these developments include, clarification of supervision, improved liaison between supervisors of midwives across maternity services and high priority being given to the education and development of existing supervisors of midwives.

Therefore, in order for midwifery supervision to have a true enabling role there remains a need to further clarify the concept. In previous work I have suggested that this might involve a re-definition of the role of the supervisor of midwives (Deery, 1999b) with midwifery managers dealing with aspects of clinical practice that require investigation. This would leave the supervisor of midwives able to further develop and concentrate on the interpersonal, supportive nature of their role.

The two hats – contradictions in midwifery supervision

Over the years supporting midwives has become an accepted, although not always undertaken, part of the role of the supervisor of midwives. This lack of clarity and confusion over the way in which the role is facilitated has posed tensions and dilemmas for some midwives and they have articulated feeling unable to seek support from someone who could one day be their professional friend and counsellor (Isherwood, 1988; Flint, 1993a) and the next day a manager who could investigate their practice as midwives (Kirkham, 1996; Deery & Corby, 1996; Stapleton et al. 1998). As Taylor (1996) states tensions between management and supervision have evolved with supervisors being asked to "both police and support their supervisees, often within a context where the roles of supervisor and manager are combined. This seems inevitably to evoke confusion" (p.216).

The incorporation of managerial aspects into midwifery supervision is a thorny issue that needs to be acknowledged and explored further. Confusion is often aroused where the role of the supervisor and manager are combined and while supervisors of midwives may feel that they can fulfil the separate functions, it is unlikely that the midwives they supervise feel the same. This is supported by research undertaken by Parkinson (1992) in which the effectiveness of combined supervision was examined. In this study, nurse managers reported no difficulties in separating their managerial role from their advice and support role but admitted

that some members of staff had difficulty in responding to the latter. This is supported in further research by Stapleton et al. (1998).

As was seen in the previous chapter, the culture of the NHS has changed to one of depicting a corporate image (Bradshaw, 1995) and as a result management appears to have increased its concern with controlling and monitoring the work of midwives (see page 79). As supervisors of midwives were usually midwifery managers, supervision of midwives was perceived by some midwives as a management monitoring tool (Flint, 1993a; ARM, 1995). This probably led Kirkham (1996) to state that supervision of midwives exists to prevent bad practice and promote good practice but that clearly, different skills are needed for these two aspects of the role:

> "Different skills are required for these two functions and the vigilance which was traditionally applied to root out bad practice is very different from the support skills needed to foster the confidence in the face of uncertainty which is needed for innovation."
> (Kirkham, 1996, p.2)

These 'different skills' may cause a blurring of role boundaries thus creating confusion for midwives. The confusion is also likely to place "unfair and unforeseen demands and dilemmas" (Deery & Corby, 1996, p.207) upon the supervisors. Hence midwifery supervision is often viewed as being linked to organisational and managerial aspects and, as such, is seen by some midwives as more of a management tool for appraisal and investigation of their clinical practice.

Challenging midwifery supervision

Debates around midwifery supervision continue to this day. It is being challenged both within (ARM, 1995; Stapleton et al. 1998; Deery, 1999b) and outside the profession (Health Visitor's Association (HVA), 1994; UKCC, 1996). Bond &

Holland (1998) warn other professions against following midwifery's approach to supervision. The Health Visitor's Association (1994), in their briefing document on clinical supervision, is unrestrained in its criticism of the midwifery model:

> "The role however has not developed into one of
> empowerment or professional development;
> rather one of guidance and direction to ensure
> practice is correct. It is also used to discipline
> when practice goes wrong. One would not wish
> to see clinical supervision within nursing and
> health visiting, developing in this way."
> (HVA, 1994)

During the progress of this study I have challenged the current model of midwifery supervision in favour of clinical supervision (Deery & Corby, 1996; Deery, 1998; Deery 1999b). I have been invited by LSA Responsible Officers for midwifery supervision[34] to talk with supervisors of midwives about clinical supervision on many occasions. I have been received with both hostility and support on these occasions. Whilst I have not advocated the demise of midwifery supervision I have encouraged professional debate on management and leadership models within a profession that claims autonomy. I have also pointed out to midwives that supervisors of midwives manage the supervisory process and that this is different to clinical supervision where the process is collaborative and seen as working in partnership (Deery, 1998).

The nature and range of clinical supervision

The nature and purpose of supervision of midwives has been described by Winship (1996) as a tool to:

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[34] When the Health Authorities Act of 1995 was implemented, the health regions devolved much of their responsibilities to the health authorities and this included the statutory responsibility for the supervision of midwives. Each health authority then became a Local Supervising Authority (LSA) with LSAs increasing dramatically from 8 to 100 (Duerden, 2000). As there was such a large number of LSAs a consortia had to be formed with a responsible midwifery officer being appointed to each consortia. All LSA Responsible Officers are reportedly practising midwives (Duerden, 2000) and provide support for supervisors of midwives and midwives in their LSA.

> "…protect the public by actively promoting a safe standard of midwifery practice…standards are agreed by midwives for midwives in the Midwives Rules and Code of Practice…It is about quality, about caring and preventing poor practice…It is about enabling midwives to practice with competence and confidence in a properly resourced work environment."
> (Winship, 1996, p.44)

This definition encompasses supervision of midwives as part of a much larger context and concentrates on the overall practice of midwifery, its rules and the environment in which midwifery work takes place. The purpose of clinical supervision on the other hand has been described by Bond & Holland (1998) as:

> "…regular, protected time for facilitated, in-depth reflection on clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part she plays as an individual in the complexities of the events and the quality of her practice. This reflection is facilitated by one or more experienced colleagues who have expertise in facilitation and the frequent, ongoing sessions are led by the supervisee's agenda."
> (Bond & Holland, 1998, p.12)

The focus in the definition provided by Bond & Holland (1998) is much more on reflection and clinical practice and how practitioners engage with clients for the benefit of clients. The emphasis is also on the personal and professional development of the supervisee, which also incorporates reflection on clinical practice. The value of supporting the supervisee is emphasised as well as learning from the experience of clinical supervision. The concept appears to be much more supervisee led and does not suggest compulsory attendance. The relationship between the supervisor and the supervisee can be terminated at any time by the supervisee whereas in midwifery supervision this would not be possible unless the supervisee nominated or was allocated another supervisor of midwives. Other definitions of clinical supervision (e.g. Bishop, 1998) contain elements of the purpose of clinical supervision as identified in the "Position Statement on Clinical

Supervision" (UKCC, 1996) and emphasise quality of care, standards of care, patient safety and protection:

> "Clinical supervision is a designated interaction
> between two or more practitioners, within a
> safe/supportive environment which enables a
> continuum of reflective, critical analysis of care,
> to ensure quality patient services."
> (Bishop, 1998, p.8)

As midwives and nurses have sought to define the theoretical base of their professions, models of care have been developed on the premise that they are fostering a partnership approach to planning care between the midwife and the client. I remain sceptical however about the word "models" and their use in midwifery and clinical supervision. Models of care offer a reductionist approach in the way that they define entities and relationships and they can imply a rigid way of functioning or working and can actually be restrictive in their implementation[35]. I have therefore chosen to refer to 'frameworks' of clinical supervision which I think better reflects my desire to collaborate with the midwives in developing a different way of working rather than implementing a "model of supervision".

'Doing' clinical supervision

Before presenting the different frameworks of clinical supervision it is appropriate at this point to address ways of 'doing' clinical supervision. The way of 'doing' refers to the way of operationalising the process and whether clinical supervision is going to be individual, group, peer or managerial. As will be seen in Chapter 9 the participating midwives chose to undertake group clinical supervision and their reasons for doing this are discussed in Chapter 10.

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[35] As will be seen in the following chapter, there is a parallel here with my early confusion around action research models (see page 142).

Individual supervision

Rolfe et al. (2001) state that individual supervision is often the preferred mode for those supervisees who are just starting to undertake clinical supervision or for those who find working in groups threatening. Individual supervision also has the advantage of giving the supervisee more time and provides the opportunity for the supervisor and the supervisee to develop the continuity and intimacy within their relationship which may then enhance the professional development of the supervisee and parallel similar relationships with their clients. The style of the supervisor will have to be clear for the supervisee at the outset because the process of supervision and feedback provided by the supervisor will be based on their theoretical influences and preferences. This needs to be congruent with the supervisee's preferred way of working with clients. Feedback is also limited to the supervisor with the risk of bias always being present for the supervisee (Rolfe et al. 2001). The supervisee also misses out on the opportunity for peer feedback. However less experienced practitioners may feel that they do not have enough experience upon which to draw in clinical supervision and may find this mode threatening.

Group supervision

In terms of insufficient time, a lack of resources and there not being enough supervisors, group supervision offers an attractive alternative to individual supervision for managers. Apart from the opportunity for peer support and peer feedback, group supervision also provides an opportunity to explore and learn more about group dynamics and group processes. Hawkins & Shohet (1989) point out that it is important that group supervision is the choice of those practitioners concerned and that as an experience it has not been forced on them. These authors also point out some of the limitations of group supervision. Mainly these are that as a process it is less likely to mirror the individual work of the participants

and how they engage with their clients. There is also the possibility of a preoccupation with group dynamics and less time allocated to each member of the group than in individual supervision. Hawkins & Shohet (1989) highlight an important difference between group supervision and team supervision. Group supervision is described as that where the group has come together solely for the purpose of group supervision. Team supervision on the other hand involves the supervisor working with a group of supervisees who work together outside of the group. Team supervision was undertaken by the midwives participating in this study.

Peer supervision

Peer supervision is defined by Hawkins & Shohet (1989) as that which is undertaken by a group of supervisees where there is no identified group facilitator. On a positive note this mode of supervision encourages reciprocity amongst equals through collaboration and also acts as a resource for ongoing professional development (Rolfe et al. 2001). However, there is a danger within this mode that members of the group will be unaware of some of the group dynamics that are at play. As 'games' take place in most groups there is the potential that damaging group dynamics may occur and individual supervisees will not gain a positive experience because they lack the knowledge and skill associated with peer supervision. Bond & Holland (1998) state that a possible way round this is for individual supervisees within the group to take on the facilitation role in turns. However there is also a danger that supervisees may be restricted by a lack of facilitation skills. Rolfe et al. (2001) are reluctant to recommend this mode of clinical supervision to other professional groups.

Frameworks for clinical supervision

There are a number of different approaches to clinical supervision highlighted within the literature although Yegdich & Cushing (1998) point out that there is:

> "…a lack of consensus among nurse scholars
> about definitions, models and modes of
> utilization, in spite of its endorsement from the
> United Kingdom Department of Health (DoH)
> and the United Kingdom Central Council for
> Nurses, Midwives and Health Visitors (UKCC)."
> (Yegdich & Cushing, 1998, p.4)

Interestingly these authors also point out that frameworks of "formalized clinical supervision" have been developed "in a discipline that had not established such a system from its inception" (Yegdich & Cushing, 1998, p.3). Consequently models have been developed and modified to match the differing needs of nurses and health visitors and have usually depended on the philosophical approach of that health profession (see Table 1, page 98).

The focus of clinical supervision

The differences in focus and delivery of clinical supervision present a confusing picture when deciding upon which model to employ in practice, particularly as some models utilise the theoretical base of psychotherapy and some the theoretical base of teaching. Yegdich & Cushing (1998) argue that this is because nursing has neglected to examine the early debates around clinical supervision and "consequently, has confused the teaching aspects of clinical supervision with the treating aspects of psychotherapy and, unnecessarily, misconceived the intention of formalized clinical supervision" (Yegdich & Cushing, 1998, p.5).

Yegdich & Cushing (1998) have argued that alternative approaches (see Table 2, page 99-100) to clinical supervision have developed according to the differing

needs of nurses and health visitors. This would seem appropriate where there is a diversity of clinical needs to be found in nursing (Butterworth et al. 1996). However, this same argument cannot be applied to midwifery as agreement has not yet been reached on a shared philosophy of care according to the needs of midwives and clients. Indeed, as will be seen in Chapter 10, the midwives participating in this study did not have a shared work team philosophy. Even before this point is reached though, debate would be useful within the profession to articulate and demonstrate how midwives have been influenced by the schools shown in Table 1 (Deery, 1998; Deery, 1999a, 1999b). For example, the humanistic model of supervision has much to offer midwifery practice. However, there are a number of tensions and limitations because the model places emphasis on the collaborative nature of the supervisory relationship and the utilisation of a non-judgemental approach. Although some midwives purport to be practising collaboratively and building relationships with clients and their peers, this is often rhetoric and not reality (Kirkham & Stapleton, 2000). The application of a humanistic model of supervision might therefore pose tensions and dilemmas within midwifery.

Rolfe et al. (2001) also state that it is crucial that the supervisor is not hierarchically linked to the supervisee within a humanistic model of supervision. Within midwifery many of the supervisors of midwives that are allocated to midwives are hierarchically linked. The supervisor that works within a humanistic model is also expected to challenge and to "be genuine" (Rogers, 1967) towards the supervisee. These are skills that as yet are not inherent within midwifery practice (Kirkham, 2000) and being willing and able to challenge is 'a challenge in itself' that not all supervisors of midwives would be able to facilitate or accept. Yet, and as was seen in the previous chapter, midwives are expected to develop relationships with clients and their peers in a complex, changing environment that demands effective management of their emotions. Also, there is a "requirement for the needs of the organization to be balanced with the needs of the supervisee and the effect of the

organization on the supervisee" (Todd & Freshwater, 1999) to be considered, although as yet, this remains within the rhetoric of policy documentation.

TABLE 1: SCHOOLS OF PSYCHOTHERAPY OR COUNSELLING AS APPLIED TO CLINICAL SUPERVISION
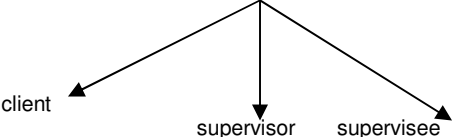
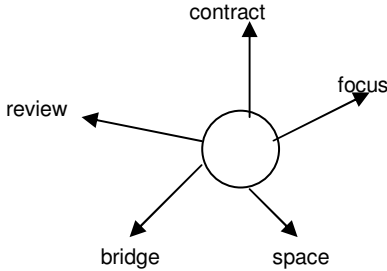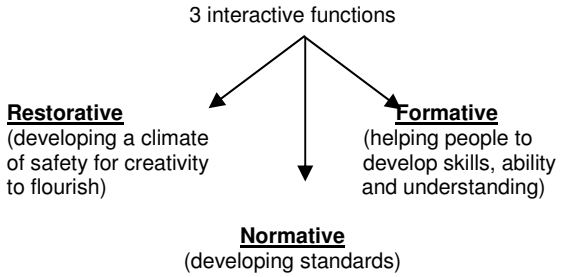| SCHOOL	GUIDING PRINCIPLES	FEATURES
Humanistic	Has its roots in person-centredness or humanistic psychology (Rogers, 1967). Concentrates on the supervisee's self-understanding, self-awareness and emotional growth.	Time allowed to discuss 'cases' and the feelings of the client and supervisee. Core conditions of empathy, genuineness and respect are necessary.
Psychoanalytic	Emphasises the importance of transference and counter-transference and an understanding of the parallel process in supervision.	Built on the assumption that human beings use each other for unconscious purposes. It provides an opportunity for understanding the affective component of the supervisory relationship as well as clear contract setting.
Behavioural	Time is spent helping supervisees to develop standards within a safe environment.	Primarily concerned with the development of the supervisee's professional skills.

Clearly then, clinical supervision is not a singular concept and the 'model' initially chosen by the supervisor will depend on the school of counselling or psychotherapy to which the supervisor subscribes (Farrington, 1995). Whilst this is an important area within clinical supervision, Farrington (1995) does not suggest the role of the supervisee in this decision making process is equally important. As the supervisor's experience and competence grows and clinical supervision becomes more of an everyday concept, it is anticipated that supervisors and supervisees will develop their own 'working', personalised models or ways of

working although the models presented in Table 2 are often the ones currently employed in practice.

Nevertheless, what most definitions of clinical supervision have in common is that they acknowledge the shared, dynamic nature of the interaction between the supervisor and the supervisee. Some further develop this by adding desired environmental characteristics (e.g. place, safety and support) (Butterworth et al. 1997; Faugier, 1998) whilst Rolfe et al. (2001) relate clinical supervision to reflection. All definitions appear to embrace "therapeutic proficiency" (Wilkins, 1998, p.201), the development of professional skills, support and the acquisition of knowledge (Sloan, 1999). Gilmore (1999) is probably correct to state that models of clinical supervision "generally encapsulate a supportive, educational and quality assurance function. The general consensus is that a bottom up approach occurs in clinical supervision where ownership of the process belongs to the practitioner" (p.4).

TABLE 2: MODELS OF CLINICAL SUPERVISION

MODEL	FEATURES
Hunt (1986)	Supervision styles are divided into 3 types; Case-centred approach which involves a discussion of the case 'out there'. Therapist centred approach that focuses on the behaviour, feelings and processes of the therapist. Interactive approach which focuses on the interaction in the therapy relationship and the interaction in the supervisory relationship.
Triadic model (Milne, 1986)	3 way interaction; client supervisor supervisee
Double matrix model (Hawkins & Shohet, 1989)	6 methods of supervision within one model (See Figure 2, p.101)

Cyclical Model of Counsellor Supervision (Page & Wosket, 1994)	
Growth and Support Model (Faugier, 1998)	Provides characteristics of the supervisory relationship that are seen as essential to good clinical supervision practice.
Interactive model (Proctor, 1991)	
Guided reflection (Johns, 1993, 1995)	Challenges, supports and helps the practitioner to unpack their practice. It differs from Proctor's model in that the emphasis is on enabling the practitioner to be 'caring' as a pre-requisite to achieving 'desirable work'
Six-category intervention analysis[36] (Heron, 1991)	6 styles of intervention (prescriptive, informative, confrontative, facilitative, cathartic, catalytic and supportive) are divided into 2 key areas; **Authoritative** and **Facilitative**.
Problem-orientated supervision (Rogers & Topping-Morris, 1997)	Addresses two main areas: 1. problems the supervisee is having with the nurse-client relationship 2. organisational difficulties. The main tools used are problem-solving strategies, for example defining the problem and brainstorming solutions.
Practice-centred, six-stage supervision cycle (Nicklin, 1997)	1. Objective practice analysis 2. Problem identification 3. Setting 4. Planning 5. Implementation 6. Evaluation

---

[36] Six Category Intervention Analysis (Heron, 1991) is not generally considered to be a 'model', rather an analysis framework. I have included it in this table for ease of presentation.

FIGURE 2: HAWKINS & SHOHET'S (1989) DOUBLE MATRIX MODEL OF SUPERVISION
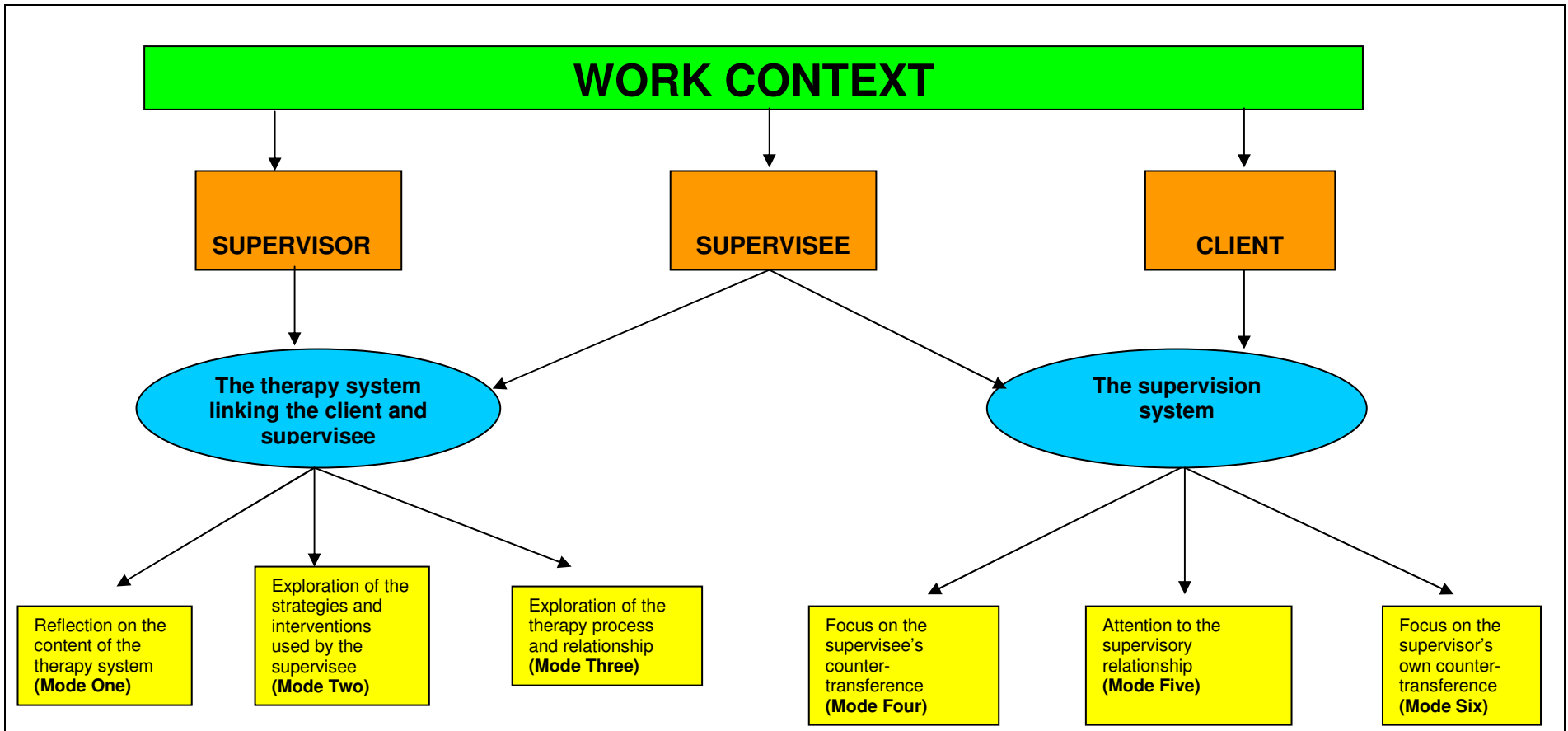
Derived from: Hawkins, P. & Shohet, R. (1989) *Supervision in the Helping Professions*, Open University Press, Buckingham.

Hunt's three approaches to supervision

Hunt (1986) in her article on supervising marriage guidance counsellors suggests three types of supervision styles as depicted in Table 2, page 99-100. She also stresses the importance of utilising the three approaches together during a supervision session. Hunt (1986) states that if the case centred approach is used consistently then the supervision session will focus mainly on the client, not enabling the supervisee to reflect on practice and develop self awareness.

Hawkins & Shohet (1989) compare Hunt's model to their own and refer to this as the "fudge-factor" (p.72) whereby the supervisee hides information or clinical material from the supervisor for fear of reprisal or judgement. Hawkins & Shohet (1989) compare the case centred approach to Mode One of their own model (see Figure 2). Interestingly, the midwifery model of supervision tends to focus on a case-centred approach (usually in an investigatory way) which I have argued ignores the self development of the midwife and thus creates a blurring of boundaries for midwives (Deery & Corby, 1996; Kirkham, 1996; Deery, 1999a) which can be likened to the "fudge-factor".

The therapist centred approach (Hunt, 1986) focuses on the behaviour, feelings and processes of the supervisor. Hawkins & Shohet (1989) compare the therapist centred approach to Modes Two and Four in their approach to supervision. However, if the therapist centred approach is concentrated on for most of a supervision session then there is the possibility that the supervision session will encroach into therapy and be found intrusive by the supervisee which is not the intention of clinical supervision.

The interactive approach (Hunt, 1986) focuses on the interaction in the supervisory relationship and the interaction in the supervision session. Hawkins & Shohet (1989) compare this approach to Modes Three and Five of their model of supervision. The

ability to be able to move about within Hunt's model and integrate all three approaches in a supervision session is a complex process and one which I feel midwives could not cope with yet. As Hawkins & Shohet (1989) point out, timing is an important skill in this model of supervision so that the different approaches are used on an individual basis and appropriately by clinical supervisors for their supervisees. Sufficient allocation of time would therefore be required in order for the supervisor to get to know their supervisee, as well as skilled judgement as to the timing of the appropriate use of the different approaches.

Double Matrix Model (see Figure 2, p.101)

Hawkins & Shohet (1989) argue that the choices and decisions that supervisors make about the focus of the tripartite relationship between the supervisor, supervisee and client influence different styles of clinical supervision. They view situations involving supervision as being divided into four main components; supervisor, supervisee, client and work context. Hawkins & Shohet (1989) then argue that the supervisory process can be further separated into two interlocking systems. These interlocking systems are *the therapy system* (links the client and supervisee through an agreed contract that may involve regular time together and shared tasks) and *the supervision system* (involves the supervisor and the supervisee spending regular time together and sharing tasks through an agreed contract).

These two systems for supervision can then be further sub-divided into three distinct categories or modes, which give six methods of supervision within one model (see Figure 2). The emphasis and focus of these methods of supervision could be:

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For the therapy system:

Mode 1:   Reflection on the content of therapy system.
Mode 2:   Exploration of the strategies and interventions used by the supervisee.
Mode 3:   Exploration of the therapy process and relationship.

For the supervision system:

Mode 4:   Focus on the supervisee's counter-transference.
Mode 5:   Attention to the supervisory relationship.
Mode 6:   Focus on the supervisor's own counter-transference

Farrington (1995) suggests that good supervision within this model would involve effective movement between modes and the adoption of several modes at one time. Similar parallel processes can occur within therapy to ones that occur within supervision. For example, a midwife may not be able to form an effective relationship with a client in the same way that she cannot develop an effective relationship with a supervisor and this could be explored further. However this implies, and is dependent upon, the development of relationships between midwives and the midwife-mother relationship being understood in considerable depth by midwives. There is also an implication that continuity of care exists and is being facilitated within midwifery and that midwives are practising as true autonomous practitioners. If this is not the case, then the processes inherent within the clinical supervision relationship to help the supervisee reflect on practice, and further develop their own self understanding will not take place, because midwives will not be able to reflect on contemporary practice.

Triadic model of supervision

The triadic model comprises a three way interaction between the supervisor, supervisee and client. Milne (1986) argues that therapists who are in clinical practice should be credible and triadic supervision offers a way to encourage this credibility through facilitation of each other's self development. The supervisor is seen as

providing the skills and knowledge necessary for the supervisory process which in turn has an important educational effect on the supervisee and thus upon the relationship with the client. This model of supervision implies an in-depth, ongoing relationship between midwives and clients and between midwives themselves, not the fragmented care that often seems apparent within midwifery work.

Six Category Intervention Analysis

Heron (1991) identifies six categories of intervention, which are useful tools for supervisor facilitation skills. The emphasis of each category of intervention is on intention, "that is, what the intended effect, point or purpose of the intervention is when used by the practitioner" (Page & Wosket, 1994, p.91).

The interventions are divided into 'Authoritative' and 'Facilitative' as follows;

Authoritative

1. Prescriptive – give advice or direct the behaviour of the supervisee. The supervisor makes suggestions or recommends behaviour.
2. Informative – give information or impart new knowledge.
3. Confronting – give direct feedback or challenges what the supervisee is saying. This may involve helping them to overcome prejudices or blind spots.

Facilitative

1. Cathartic – enable the supervisee to discharge feelings or release tension.
2. Catalytic – encourage reflection and problem-solving as well as self-directed learning in the supervisee.
3. Supportive – be approving, valuing and affirm the worth of the supervisee.
   (Heron, 1991)

Interestingly the authoritative and facilitative interventions identified by Heron (1991) mirror the dilemmas posed for midwives within their work in that almost all care given by midwives appears prescribed or medically defined by doctors. In terms of facilitating care for clients problems arise because midwives are required to use skills

that they have not had the opportunity to develop themselves (Kirkham, 2000). As was seen in Chapter 2, midwives also seem to prefer to prescribe care for clients through the development of hierarchical relationships and the use of professional power, although this way of working mirrors the relationships to which midwives have always been exposed as well as a task-based approach to care. However, the facilitative aspect of Heron's model could go some way towards addressing this deficit in midwifery as words such as 'cathartic', 'catalytic' and 'supportive' lend themselves well to engaging emotionally with clients. Facilitating an approach to clinical supervision such as this in midwifery would require time and patience on the part of the supervisor and supervisee.

Cyclical Model of Counsellor Supervision

Page & Wosket (1994) acknowledge that although their model of supervision has been deigned for use in counsellor supervision it can be used in a range of supervision situations. Their model attempts to address what they perceive as:

> "…a lack of an overarching framework for the supervision process, as applied to both novice and experienced practitioner, which can encompass process, function, aims and methodology. Such a framework is designed to complement rather than replace existing theories and models, and to provide a firm but flexible structure into which a range of different approaches can be incorporated".
> (Page & Wosket, 1994, p.34)

This supervision model has five stages; contract, focus, space, bridge and review and although Page & Wosket (1994) present them as a logical sequence they state that this is not meant to imply rigidity and that there is scope for flexibility within the model. The model can be entered at any stage and each of the five phases in this model offers guidance on how to conduct a supervision session, clearly emphasising the

necessary tasks. The guidelines provided by Page & Wosket (1994) enable the supervisor and the supervisee to develop within a dynamic supervision process rather than being static. Change is considered as fundamental both within the supervision process and within clinical practice. This model would be difficult to facilitate in midwifery because there is likely to be prolonged concentration on clinical material and self development which again some midwives have not been adequately prepared for. However the 'space' stage of this model might provide the time necessary to concentrate on these issues.

Growth and Support Model

Faugier (1998) has provided some useful guidelines to the characteristics of the supervisory relationship that she sees as essential to good practice. Faugier believes that the role of the supervisor is to facilitate growth both educationally and personally in the person being supervised, whilst at the same time providing essential support to the development of clinical autonomy for the supervisee. The supervisor must therefore be aware of the elements of the relationship for which they are responsible. Faugier (1998) views such elements as generosity, reward, openness, humanity, sensitivity, and trust.

Although Faugier (1998) states that nursing has recognised the importance of the supervisory relationship within clinical supervision outside of the traditional hierarchical roles within the NHS, there are still those that would argue clinical supervision is not understood or well developed within nursing (Yegdich & Cushing, 1998; Lawton & Samociuk, 1997). Nurses, like midwives, are still struggling with the concept of patient/woman-centred care in favour of task-based care which results in "impersonal interactions" (Binnie & Titchen, 2002) between clients and health practitioners. Faugier's model would therefore seem to be an ill fitting model for nursing which does

not depict the true path of clinical practice and only pays lip service to patient-centred nursing.

Guided reflection or 'professional narcissism'

This model of supervision encourages the supervisee to "unpack" (Gilmore, 1999) their practice through elements of support, learning and monitoring of their own clinical practice and draws on a model of guided reflection suggested by Johns (1993, 1995). Clinical supervision in this environment helps the supervisee to become an effective practitioner through critical reflection. This is achieved through the elements of support, learning and practitioner self-monitoring of their effectiveness. The cue questions that Johns provides in this model are grounded in systematic observations of actual guided reflective sessions.

He uses the epistemological basis from Carper's (1978) four patterns of knowing; aesthetics, personal, ethics and empirics, adding a further pattern called reflexive. In the reflexivity way of knowing Johns encourages supervisees to connect with previous experiences and to consider how these experiences might be handled differently in the future[37]. If the supervisee is discussing an experience that is still ongoing then this dimension provides the opportunity to explore how the situation could be taken further.

Gilmore (1999) supports this viewpoint stating that this model of structured reflection provides a guide for supervisees when they are preparing issues for discussion within supervision sessions. Rolfe et al. (2001) point out that clinical supervision should not be dominated by the use of a reflective model; rather clinical supervision involves critical reflection by the supervisee and the supervisor. Binnie & Titchen (1995) support this further by stating the tasks and functions of clinical supervision are

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[37] As will be seen in Chapter 6, there are parallels here with the importance I place on using my own personal history

inextricably linked to the development of critical reflection but stress that clinical supervision is a formalised structure in which reflection on clinical practice takes place. However, Fowler & Chevannes (1998) suggest that the use of reflection in clinical supervision is inappropriate for less experienced practitioners because they may feel that they have a lack of clinical experience and knowledge upon which to draw in order to make sense of complex clinical practice issues. This then implies that the clinical supervisor must be from the same professional background as the supervisee rather than possessing the necessary skills to reflect on clinical practice constructively.

Within midwifery, reflection has been emphasised as a way of turning information into knowledge and challenging the concepts and theories by which midwives try to make sense of that knowledge. As was seen in Chapter 2, midwifery knowledge has been suppressed by the dominant, medical model of childbirth so that midwives find it hard "to see through and beyond the accepted ways of seeing and thinking" (Kirkham, 1997, p.259). It is important therefore that reflection helps midwives to engage in honest interactions with each other and clients rather than resorting to "professional narcissism" (Kirkham, 1997, p.261) where reflection would become an easy option ignoring the theoretical base.

Interactive Model

The interactive model (Proctor, 1991) is one of the most widely used and referred to models for supervision. This model has three facets, namely the normative, formative and restorative functions. The normative aspect of the model is concerned with maintaining standards of practice and quality control. The supervisor would ensure that the needs of the client are being met within a clearly defined framework of ethical and professional practice (UKCC, 1998). However when midwifery work is clearly defined in this manner (usually by guidelines and protocols) midwives cannot "see

through and beyond the accepted ways of seeing and thinking" (Kirkham, 1997, p.259). As was seen in Chapter 2, and will be seen further in Chapter 5, midwifery work is complex and can be unpredictable involving "processes which are subtle and difficult to articulate" (Taylor, 2001, p.7). Therefore the normative aspect of Proctor's model creates a sense of "[s]upervision and control [that] provide guidance toward bureaucratic goals" (Lipsky, 1980, p.40).

The formative function of the model addresses the educational and professional development needs of the supervisee. This would probably be achieved through exploration and reflection on the supervisee's work with clients (Page & Wosket, 1994). However, reflection can often be superficial in midwifery meaning that the formative function of Proctor's model would "promote reflection but only promote seeing from one angle" (Kirkham, 1997, p.261). The restorative function of this model enables the supervisee to debrief (Page & Wosket, 1994) and get rid of the emotional grime (Hawkins & Shohet, 1989) of the job. The restorative function acknowledges the intimate therapeutic work that supervisees engage in with their clients. However midwives work in a culture where the organisation believes it is "better to stick to dimensions of the work more subject to administrative manipulation" (Lipsky, 1980, p.188) than addressing the quality of relationships.

In theory, Proctor's model of supervision appears to address the necessary components of clinical practice in order to develop effective relationships with each other and clients. However, this model seems idealistic and does not mirror the current climate of change and disruption within the NHS. Like Faugier's model it is ill fitting and does not mirror the state of nursing and midwifery at this moment in time. Clinical supervision is aimed at the personal and professional development of individual practitioners. However the aims of the NHS as an organisation clash with this approach being more orientated towards "resource management – efficiency,

productivity, and goal clarification" (Lipsky, 1980, p.125) highlighting a fundamental contradiction underpinning the NHS as an organisation. The normative aspect of this model also has aspects that are similar to the current model of midwifery supervision in that midwives may have to share elements of clinical practice with their supervisor that require investigation. They are then expected to utilise this same supervisor for support, counselling and friendship which poses tensions and dilemmas for midwives (Deery & Corby, 1996; Stapleton et al. 1998).

Nicklin's six-stage supervision cycle

Nicklin's practice-centred model of clinical supervision is adapted from Proctor's (1991) interactive model of supervision. Managerial aspects would encompass areas such as clinical standards or appraisals, educational aspects would address issues such as mentorship and professional development whereas the supportive element would address personnel services and the growth and development of the individual health practitioner. Engagement in the clinical supervision cycle would entail exploring problem situations, for example, workload management or working relationships. However, as will be seen in Chapter 10, difficulties would be encountered in the first stage of this approach in midwifery because midwives may have to utilise skills in order to reflect on aspects of practice or relationships with colleagues that they have not been adequately prepared for.

Once this first stage has been analysed, problem areas are then clarified and objectives set to confirm "the expectations, obligations and aspirations of the organization, patients, the profession and the individual practitioner" (Nicklin, 1997). However, as was seen in Chapter 3, the values of the organisation often contradict the values held by grass root workers (Lipsky, 1980). This would make a realistic action plan, implementation of the agreed plan and evaluation of the outcome almost

impossible within a midwifery setting where there was a clash of values between the organisation, managers and workers. Realistically therefore, this six-stage supervision cycle would only be feasible in "a street-level bureaucracy that has developed processes of staff growth and development…for small group decision making…making the most of the reality that street-level bureaucrats primarily determine policy implementation, not their superiors" (Lipsky, 1980, p.207).

Problem orientated supervision

Similar difficulties identified above, in the six-stage supervision model (Nicklin, 1997), would also be encountered in the problem orientated supervision model proposed by Rogers & Topping-Morris (1997, p.14).   Once again the focus is on working relationships (particularly interpersonal conflict) and organisational difficulties and the use of problem-solving strategies to address issues that are identified.   Unfortunately "processes of supportive criticism and inquiry" (Lipsky, 1980, p.209) are not yet inherent within the working lives of midwives (Deery & Corby, 1996; Stapleton et al. 1998; Kirkham, 1999) making this approach to supervision only possible where "the bureaucracy to some degree reflects as well as reinforces and perpetuates the prevailing social structure" (Lipsky, 1989, p.208).

A hybrid model of clinical supervision

The clinical supervisor in this study drew on her own model of clinical supervision which is depicted (by Joss) in Figure 3, page113.

This hybrid model of clinical supervision draws on and combines three different models of clinical supervision; Proctor's interactive model, Hawkins & Shohet's (1989) double matrix model and Johns (1993) guided reflection.   Faugier's (1998) developmental

model of the characteristics of a 'good supervisor' was also drawn on by Joss as a way of helping to keep her focused. The model devised by Hawkins & Shohet (1989) was only used in a clinical supervision session by Joss if found to be necessary and was not drawn on with the midwives participating in this study.

Figure 3:   **Hybrid Model of Clinical Supervision**
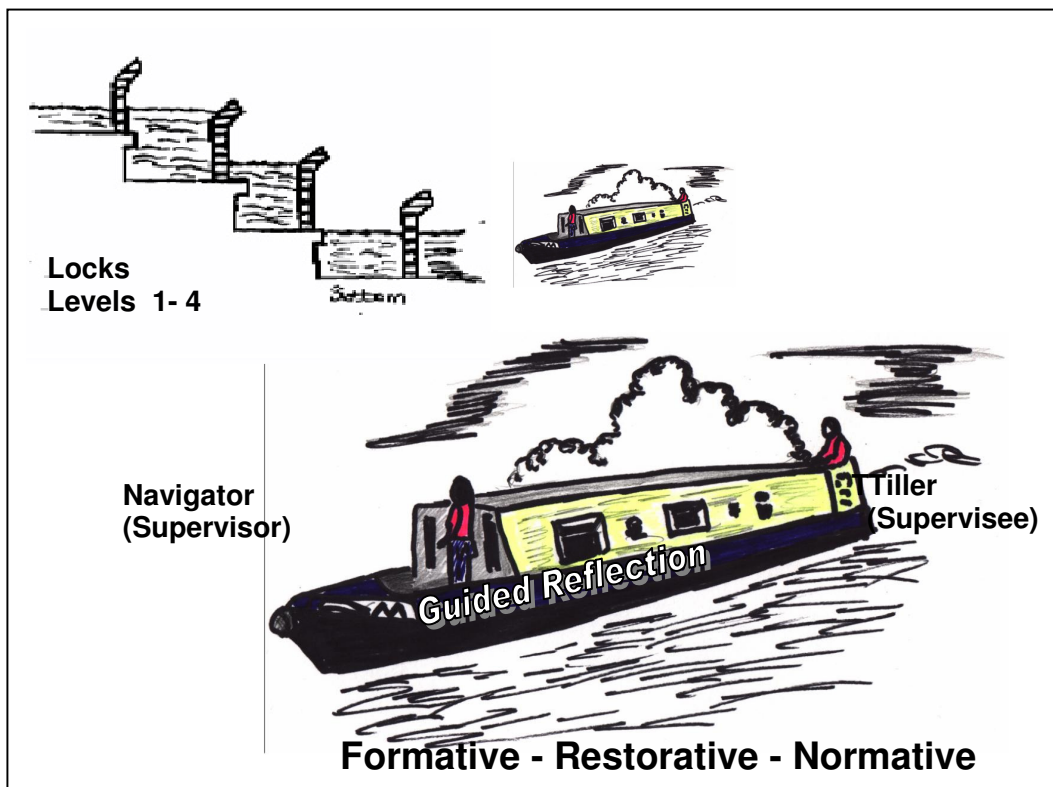
This interaction model of clinical supervision views the processes within supervision as a journey in which the supervisor and the supervisee travel together. This journey was conceptualised and described by Joss as taking place on a canal. The journey has a navigator (the supervisor) whose role involves navigating through the twists and turns, problems and diversions. The navigator has to keep the boat on the canal, in good

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enough waters and ensures that any problems ahead are spotted and the correct actions taken. This process mirrors aspects of the supervisory relationship.

The depth of the water in the canal can vary as well as in width and can be interspersed with many challenges such as locks, swing bridges, fishermen, aqueducts, via ducts, other narrow boats. There are specific 'passing places', turning places, and stopping or mooring places. The ground rules are very clear as in any supervisory relationship that has had a contract set at the outset. The navigator of the boat has to traverse the canal so as to keep the boat, the crew and the passengers safe.

The navigator works in unison with the tiller operator (the supervisee). The navigator guides the tiller and ensures that the 'map' is read. The tiller has to ensure that they listen and act on guidance from the navigator but in the final analysis the tiller operator is responsible for the boat and whether it crashes or not. Hence the supervisee holds some responsibility for the progress of the clinical supervision sessions and is thus accountable for their clinical practice. The framework of guided reflection (Johns, 1993) is the vehicle for working through the navigation process or travelling the journey just as the narrow boat is the vehicle for travelling on the journey.

The locks on the canal are a unique challenge and help the narrow boat to travel up hill or downhill. Locks have four paddles, one at each corner of the lock. Some of the locks let the lock fill water and others let the water out. When arriving at each lock one of the crew on the narrow boat has to get off and operate the lock. Only where there are complicated locks will there be help from a lock keeper. It would have been at this point that Joss would have drawn on Hawkins & Shohet (1989) model of supervision to help guide the clinical supervision session further. In any event, the narrow boat has to go through the locks, either up hill or down hill. Joss informed me that this reminded
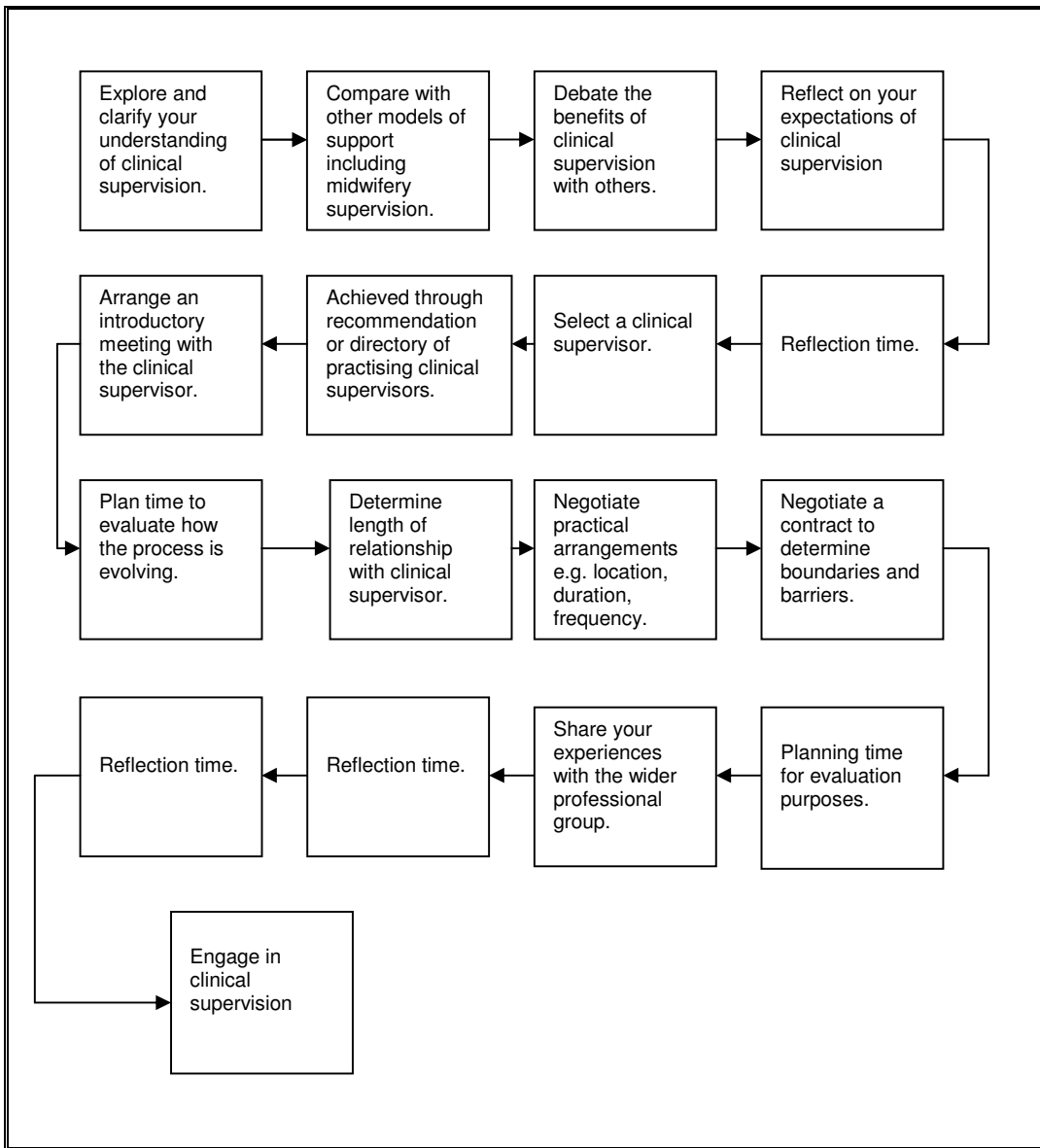
her of the journey through the formative, restorative and normative phases outlined by Proctor (1991). Supervisees would move in and out of the phases within Proctor's model according to what they were experiencing and/or learning at any given point in their clinical work.

No journey is ever the same or straight and the locks are seen as a necessary challenge to navigate in order to move up and down hills. Some locks are single, some are in pairs and others are in sets as depicted in Figure 3. Some are set apart with only a distance of half a mile and others are set apart by one or two miles. This illustrates the uniqueness of each clinical supervision session and how supervisees will reach different points of learning within their sessions. Joss believed that the process of learning, reassessment of that learning and the skills they possess is a never ending process and that supervisees will travel up and down the locks of continuing professional development.

Practical route to successful clinical supervision

Several practical routes for clinical supervision are offered in the literature (Bond & Holland, 1998; Faugier, 1998; Bishop, 1998; Wilkins, 1998). It is not my intention to exhaust these within the thesis as individual supervisees and clinical supervisors will select the route that suits them best. However I have previously devised a practical route to obtaining successful and effective clinical supervision for midwives (Deery & Corby, 1996, p.205) and although not drawn on by Joss in this study, aspects of the process used by Joss are similar to the route I have devised. Figure 4, on page116, represents the route derived from earlier suggestions.

Figure 4: The route to successful and effective clinical supervision

Explore and clarify your understanding of clinical supervision.
→
Compare with other models of support including midwifery supervision.
→
Debate the benefits of clinical supervision with others.
→
Reflect on your expectations of clinical supervision

Arrange an introductory meeting with the clinical supervisor.
←
Achieved through recommendation or directory of practising clinical supervisors.
←
Select a clinical supervisor.
←
Reflection time.

Plan time to evaluate how the process is evolving.
→
Determine length of relationship with clinical supervisor.
→
Negotiate practical arrangements e.g. location, duration, frequency.
→
Negotiate a contract to determine boundaries and barriers.

Reflection time.
←
Reflection time.
←
Share your experiences with the wider professional group.
←
Planning time for evaluation purposes.

Engage in clinical supervision

(Derived from Deery & Corby, 1996, p.205)

Key points emerging

There are many different models of clinical supervision to be found within the nursing literature. Given the diversity of nursing practice, this should probably come as no surprise, as the availability of numerous models provides practitioners with the

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opportunity to choose their preferred approach. However, in its eagerness to adopt the concept of clinical supervision, nursing may have misconceived its original intention. When the usefulness of clinical supervision was highlighted during debates on clinical governance, midwifery began to re-examine the nature of, and approach to, midwifery supervision. Just as some midwives view midwifery supervision as investigatory so too clinical supervision has had similar criticism in nursing. Clinical supervision demands "therapeutic proficiency" (Wilkins, 1998, p.201) which midwives are not yet prepared for although the Heron's Six Category Intervention Analysis could go some way towards addressing this deficit in midwifery through catalytic, supportive and cathartic interventions. A model is presented (Figure 3) that was used by Joss, the clinical supervisor in this study, as well as an effective route to clinical supervision that was used as a guide with the participating midwives (Figure 4).

Wilkins (1998) views clinical supervision as an "unshackling process – an opening of previously locked doors" (p.202) whereby supervisees can be facilitated to participate in a process that is likely to challenge, stimulate and encourage exploration of clinical practice. Lipsky (1980) also believes that "built into every week of practice should be opportunities to review individuals' work, share criticisms, and seek a collective capacity to improve performance" (p.209). It seemed appropriate therefore to adopt a research approach that would facilitate participation, collaboration and reflection on practice. The following chapter is devoted to action research as such an approach.

CHAPTER FIVE

Action research: opening new dialogues for enquiry

> No academic solution
> is satisfactory
> It has to be
> a lived posture
>
> That's why
> I can't get away
> with saying one thing
> and doing another
> or with preaching
> and not practising
>
> Everything has somehow
> to exemplify
> and be itself

from Miller Mair 1989

This chapter discusses the basis of my assumptions about ontology and epistemology and how exploring these on a deeper level has helped me to identify action research as an approach that suited my inquiry. This decision making process also involved me questioning and justifying my reasons for rejecting other research approaches (see pages 130-133) that were not practice based and did not involve reflecting on change or collaborative working. In this chapter I also draw attention to the contradictions that became apparent during the course of the study and the importance I now place on working with the dilemmas that arose as a result of these contradictions. I reflect on the potential of action research to reconstruct a different way forward although, as will be seen in Chapters 9 and 10, a different way forward can also be resisted. I acknowledge the influence of the work of Jack Whitehead and how his 'living theory' approach (Whitehead, 1993) has helped contextualise my understanding of action research. McNiff (1988, 2002) as well as Whitehead (2000) has helped me to think

differently as I have struggled with the complexity of midwifery practice and midwives' behaviour and how difficult it is to undertake action research in a "lived sense" (McNiff, 2002).

The beginnings…..action research in the making

The concept of action research is mostly attributed to Kurt Lewin's pioneering work with factory workers and immigrants in the United States of America (USA) during the 1940s (Adelman, 1993; Holter & Schwartz-Barcott, 1993; Hart & Bond, 1995) although Noffke (1997) also states that the work of John Collier in 1933-1945 was committed to the experience of developing a 'community' and democracy. The origins of action research therefore appear to be unclear within the literature. McKernan (1991) states that there is evidence that social reformists prior to Lewin used action research and cites a physician named Moreno using group participation in 1913 in a community development initiative with prostitutes in Vienna. Lewin, whilst sharing the same interests as John Collier, proceeded to develop the theory of action research following Moreno's group participatory work (Adelman, 1993; Holter & Schwarz-Barcott, 1993; Hart & Bond, 1995).

During the 1950s Lewin's ideas about social and educational issues were influential in the USA especially with regard to action research. Lewin's view was that social science should be able to improve conditions for people. However after a decade of growth Lewin's ideas fell into decline in America and "a hegemonic emphasis on knowledge that is externally obtained" (Davis-Floyd & Davies, 1997, p.145) became evident with positivist approaches to research taking precedence (McNiff, 1988). According to Carr & Kemmis (1986) this resulted in the separation of research and action and theory and practice. However with the help of Lawrence Stenhouse action

research in the UK continued to grow and develop, especially in education and the teaching profession (McNiff, 2002).

In 1988, McNiff traced action research in teacher education and in later work she identified key action research theorists (McNiff, 2002). Both Somekh (1994) and McNiff (2002) agree that John Elliot, an educationalist, had an influence on Stenhouse's (1975) thinking around curriculum development within the teaching profession. Kemmis & McTaggert (1988) encouraged use of the term 'educational action research' because they wanted to understand "the social and politically constructed nature of educational practice" (McNiff, 2002, p.45). They were influenced by the origins of Kurt Lewin's work as well as Lawrence Stenhouse's work on curriculum development. The work of Kemmis & McTaggert (1988) also demonstrates the influence of critical social science and the belief that research methodologies during the 1930s did not recognise "the historical, cultural and social situatedness of researchers" (McNiff, 2002, p.33).

Somekh (1994) has criticised Kurt Lewin as being a positivist because he attempted to apply the experimental method of the natural sciences to contemporary social problems (for example, racism, low morale and industrial unrest). This criticism is supported by McKernan (1991) who states that the literature shows "clearly and convincingly that action research is a root derivative of the scientific method reaching back to the Science in Education movement of the late nineteenth century" (McKernan, 1991, p.8). Adelman (1993) also makes reference to 'empirical' (p.10), 'quasi-experimental' (p.7) and 'experimental' (p.10) when discussing the work of Lewin suggesting that he too believes Lewin was a positivist although it is important to remember that Lewin was a product of his time.

Valuing process and outcomes

As my understanding of the nature of action research evolved I came to realise that this approach could investigate midwifery practice in a way that recognised the importance of acknowledging my own and the midwives' values and the contradictions that arose within the study. I drew on the principles underpinning the importance of placing "I" in an enquiry (Whitehead, 1993) in an attempt to embody my own values in my midwifery practice, although the potential of this approach was not fully realised until the later stages of the study. I therefore believe that this action research study was unique and individual and did not subscribe to a pre-ordained formula.

My feminist principles and values have underpinned my approach to the study and link closely to my work as an academic and clinical midwife. These same principles and values are also important in a social context for me. However, as I discussed on page 3, I detected a contradiction in my early clinical practice as a midwife as I became aware that midwives were expected to support clients when they themselves were not supported. When a woman-centred approach was encouraged that fostered trusting relationships and encouraged the notion of equal partners within midwifery (DOH, 1993a) this contradiction became even more pronounced.

A democratic and collaborative approach to working with clients lies at the heart of a woman-centred approach to midwifery. However midwives work in hierarchically organised places of employment where democracy, collaboration and empowering relationships such as those advocated by current government policy, are not facilitated (Stapleton et al. 1998; Deery, 1999a; Kirkham & Stapleton, 2001). This contradiction meant that midwives were expected to engage in meaningful, supportive relationships with clients and their peers when they themselves were not supported or prepared for this aspect of their practice.

Contextualising 'real world practice'

I think it is important at this stage to draw attention to the word 'practice' as this word is used frequently in the literature relating to action research with no real explanation as to what constitutes 'practice'. Those authors (for example Elliot, 1987, 1991; McNiff, 1988, 2002; Dadds, 1995,1998) writing about action research appear to assume that readers will know whose 'practice' is being addressed but there is a need to clarify exactly whose practice is addressed through action research. My interpretation is that action researchers carry out research on their own professional job and refer to this as 'practice' in their reports of action research.

McNiff (2002) would argue that those action researchers working in the interpretive and critical theoretic approaches to action research are exploring and scrutinising the professional jobs (or practice) of those who are collaborating in the research. Living theory approaches (Whitehead, 1985; McNiff, 2002) however place "I" at the centre of the inquiry and quite clearly explore the action researchers' professional job (or practice). This study has scrutinised midwifery work and although I did not place my own practice at the centre of the inquiry, my historical connections with the participating midwives (see Chapter 6) clearly had an impact on the study. From another perspective action research could have also explored my 'practice' as an academic in a university setting.

Defining action research

Action research is now reported globally. It is carried out in a variety of contexts and has moved beyond the teaching profession where it developed (McNiff, 1988) to include many other professions, including nursing (e.g. Meyer, 1993; Coghlan & Casey, 2001; Binnie & Titchen, 2002; Waterman, Tillen, Dickson & de Koning, 2001)

and midwifery (e.g. Fraser, 2000; Munro, Ford, Scott, Furnival, Andrews & Grayson, 2002). Although action research is now employed in many health care settings in the UK "its scope and role in this context is not clear" (Waterman et al. 2001, p.iii) and it continues to be utilised under a variety of names. This has meant that many varieties of action research have been developed and these can all be interpreted in different ways usually according to the varying perspectives of those undertaking the action research. In the early stages of planning this action research study these varying perspectives caused a great deal of confusion as I grappled with the different types of action research emerging within the literature. This was further complicated by a paucity of action research within midwifery to support my inquiry. However, it is important that definitions and descriptions have changed over time because the purpose of action research is for the researcher and the participants to engage in a dynamic relationship with constantly changing situations. This is pertinent to midwifery where action research can help respond to the complexities and radical changes of clinical practice in a constantly evolving profession.

Winter & Munn-Giddings (2001) have defined action research as "the study of a social situation carried out by those involved in that situation in order to improve both their practice and the quality of their understanding" (p.8). Interestingly, there is not an emphasis on change in this definition meaning that working with this definition action researchers can place emphasis on developing their understanding of situations rather than aiming to change them.

Waterman et al (2001) when undertaking a systematic review of healthcare action research describe the process as:

"…a period of inquiry that describes, interprets and explains social situations whilst executing a change intervention aimed at improvement and involvement. It is problem-focused, context-specific and future-orientated…is a group activity with an explicit value basis and is founded on a partnership between action researcher and participants, all of whom are involved in the change process. The participatory process is educative and empowering, involving a dynamic approach in which problem identification, planning, action and evaluation are interlinked…"
(Waterman et al. 2001, p.iii)

Waterman et al. (2001) acknowledge the complexity of healthcare action research and how "researchers, managers and funders have experienced difficulties in assessing the value and outcomes of action research protocols and project reports" (p.3). Their systematic review explores these issues further in order that action research can be used appropriately in a rapidly changing healthcare setting.

Meyer & Batehup (1997) claim that action research is not easily defined because it is more of an approach to research rather than a specific method, meaning that it is fluid and may involve many methods rather than a pre-determined methodological menu. It was both difficult and probably inappropriate at the start of this action research study to give a clear outline of the direction and methods of inquiry to be undertaken[38]. This amorphous quality of action research means that its shape arises out of the study rather than the study having a preordained character. This probably accounts for the many definitions of action research and the different emphases various authors place on "action" and "research" (McNiff, Lomax & Whitehead, 1996).

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[38] Hart & Bond (1995) have identified how this amorphous quality of action research makes it difficult when completing research bids as those commissioning the study and the researchers may have different ideas about data gathering methods. They state that "it was not…appropriate for the exact combination or sequence of deployment of such tools to be specified in advance by researchers…[t]o do so would have denied them the opportunity to collaborate from the outset in key decision-making about the nature and direction of the research and it would have placed barriers in the way of creating a shared sense of ownership of the initiative" (Hart & Bond, 1995, p.76-77).

Elliot (1995) reiterates that the defining purpose of action research is as a tool for solving practical problems experienced by people in their professional and/or community lives and warns researchers that the term 'action research' "is being used to legitimate any form of methodological deviance from the traditional paradigm. It is the buzz word which is appealed to when any researcher wants to promote the practice relevance of their work" (Elliot, 1995, p.1). One of the novice action researchers in Cook's (1998) study that explored the researchers' struggle to understand their patterns of research behaviour described the process as "a model of bumbling change supported retrospectively by theories" (p.99). These misinterpretations of the term[39] have probably led to the "bewildering array of activities and methods" (Coghlan & Brannick, 2001, p.7) within action research that further complicates a definition of the approach.

Reed & Procter (1995) have written about practitioner research stating that they believe it is the focus or concern on clinical practice and the aim to bring about change that differentiates action research from other approaches. They state that "the primary aim of practitioner research is usually to solve a critical problem or to develop an understanding about the nature of practice, and ultimately to contribute to the body of knowledge" (Reed & Procter, 1995, p.11). This attempt by Reed & Proctor (1995) to define practitioner research still does not make clear the nature of 'practice' and what actually differentiates practice-focused research from other approaches. This is probably because most research can lay claims to being concerned with changing practice. Waterman et al. (2001) state that healthcare action research has "a different context to educational action research, with consequently, differing practical issues and concerns" (p.2). However, much research that has been undertaken within midwifery (and nursing) makes "recommendations for practice" rather than being

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[39] I provide a discussion of ways to ensure rigour in action research in Chapter 6.

concerned with bringing about change[40]. Schön's (1983) analysis of 'practice' might help here as I could recognise its application to my midwifery work and also to action research:

> "In real-world practice, problems do not present
> themselves to the practitioner as givens. They must
> be constructed from the materials of problematic
> situations which are puzzling, troubling and
> uncertain. In order to convert a problematic situation
> to a problem, a practitioner must do a certain kind of
> work".
> (Schön, 1983, p.40)

This 'certain kind of work' referred to by Schön (1983) is analogous with my understanding of the nature of action research and coming to terms with, and understanding that nothing in clinical practice is a 'given'. Indeed, midwives do "frame" (Goffman, 1974) their interpretation of some situations in order to carry out this 'certain kind of work' (see Chapter 8, p.245). For example, the dominance of obstetrics in midwifery and working in a bureaucratic setting means that midwives have to resort to certain behaviours (or performances[41]) in order to 'frame' their problems. The power of the system therefore becomes a 'given' because midwives are preoccupied with meeting organisational demands and are unable to consider alternative ways of working within the system. As Winter & Munn-Giddings (2001) and Lloyd & Hawe (2003) suggest, re-framing may be the solution whereby health practitioners can identify more effective solutions to problems. As will be seen in Chapters 9 and 10 this action research study was fraught with challenges (some of them unexpected), especially in terms of the degree of collaboration from the participating midwives and also my position as a researcher[42]. This meant I constantly had to re-frame the way forward for the study.

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[40] Furthermore, whilst research can eventually lead to improved practice, it is a considerable time before the findings get implemented in practice (Foote-Whyte, 1991).
[41] Chapter 8 addresses midwifery performances further.
[42] I explore and discuss my position as a researcher more fully later in this chapter.

The research process in other approaches to research is usually clearly defined and pre-determined. Whilst establishing the research process in this way does not preclude finding unexpected results, it can nevertheless limit the degree to which the researcher is challenged. The potential for unexpectedness is much wider in action research because of the nature of collaboration. This makes action research as an approach unique but it is also means that there is the potential to generate more than usual angst for researcher and participants. Therefore, combining the workwith the unexpectedness of action research meant that as an approach, it was although it "does not give you any easy ride" (Meyer, 1993, p.1071)

Before I discuss action research further I will explore the ontological and epistemological assumptions underpinning my desire to use action research as well as my reasons for not choosing other research approaches.

The nature of reality

Guba & Lincoln (1989) and Patton (2002) provide frameworks that claim to help researchers make decisions about their choice of methodology. These authors agree that ontological and epistemological assumptions are the first stages in determining choices that are available when choosing a methodology. Ontological debates concern the nature of reality and the way people view themselves. Patton (2002) offers two perspectives here; firstly, that there is a singular reality and secondly, that socially constructed multiple realities are inevitable. However, the nature of human culture is such that:

> "No one culture defines "reality"; rather, each human group, in constant interaction with its environment and with other groups, evolves a set of adaptations that include unique ways of being, of doing, and of knowing".
> (Davis-Floyd & Davies, 1997, p.145)

These multiple realities or "spectrum of midwiferies" (Hunter, 2002, p.221) are often expressed in the language of values but this can create problems, as will be seen in this study, when one set of values is different from another. The social and cultural context of midwifery at the time that this study was undertaken espoused the values of midwives supporting clients through woman-centred care (DOH, 1993a). However these values were often denied in clinical practice because the organisational values (for example, meeting targets) were given precedence. Although I did not explicitly set out to determine the participating midwives' values at the start of the study, differences in organisational values, the midwifery manager's values, and mine and the midwives' values posed tensions and dilemmas during the course of the study. Lipsky (1980) draws attention to these conflicts of interest when describing working relationships between managers and street-level bureaucrats:

> "…it is a relationship best conceived in large part as intrinsically conflictual. The role of the street-level bureaucrat is associated with client processing goals and orientations directed towards maximising autonomy. Manager's roles in this context are associated with worker-management goals directed towards aggregate achievement of the work unit and orientations directed toward minimizing autonomy".
> (Lipsky, 1980, p.25)

As will be seen in Chapter 9 working relationships between midwifery managers and the participating midwives appeared to cause conflict within this study. However, as an action researcher I tried to work with these different identities so that new "ways of accommodating multiple values perspectives" (McNiff, 2002, p.17) could be explored. Throughout this study I have been personally committed to action and helping the participating midwives vision a future for themselves where they are supported and can improve working relationships. As an action researcher therefore I aimed to try and understand the complexities surrounding opposing values in order to help the midwives understand the reality of their work as community-based midwives.

As an action researcher I accepted the responsibility of ensuring that my own way of being was in order before I ventured to critique the midwives' practice. I built further on this responsibility by undertaking the group work course I have already described on page 8 in order to help me understand further how groups of people work together. I therefore believe that I understood some of what needed attention in my own life and took action to improve it. I also believed that I could not make judgements about the ways in which the midwives worked until I had worked to improve my own situation.

However, as I was to discover I still needed to err on the cautious side because my commitment to personal and professional development as described above was idealistic in the sense that it was too neat for the challenging nature and context of action research. I realised that I could be in danger of assuming that the midwives were as ready as I was for the questioning and challenging nature of the research. As will be seen in Chapter 9 this assumption on my part was incorrect because as well as the midwifery managers, my set of values was clearly different from those of the participating midwives.

'Learning is rooted in experience'

Epistemological debates concern how people understand knowledge, including how knowledge is acquired. Guba & Lincoln (1989) and Patton (2002) suggest that epistemological assumptions stem from accepting that knowledge can either be objectively knowable (propositional logic) or subjectively knowable (dialectical logic). The epistemological tradition of propositional logic regards theories as static models of reality that are understood intellectually. This form of logic is often most valued by Western tradition because it attempts to "eliminate contradiction from rational thought" (McNiff, 2000, p.29). Positivist researchers, and to a certain extent interpretative researchers, often work with propositional logic (Patton, 2002) although clearly

propositional logic would not have benefited this study where there was a plethora of contradictions and the reactions of the midwives meant that the research had its own momentum.

As an action researcher, rather than viewing knowledge as a separate, static entity, I preferred to work from the epistemological tradition of dialectical logic. This subjective way of knowing or personal knowledge is also referred to as tacit knowledge (Polanyi, 1958). Valuing tacit knowledge in this way meant that I viewed knowledge as something that I could generate through clinical practice. As was seen earlier, this also accords with Schön's (1983) view that knowledge can be constructed from emerging challenging situations within practice that are "puzzling, troubling and uncertain" (p.40).

Dialectics are often the result of asking questions and finding answers; answers then generate new questions and contradictions are a valued part of this process. This cyclical process parallels an action research approach. The complexity and unpredictability of midwifery practice means that knowledge resulting from dialectical logic is "never static or complete; it is in a constant process of development as new understandings emerge" (McNiff, 2002, p.18). Likewise, it was possible that the participating midwives could generate their own knowledge through clinical practice by collaborating in this action research study although, as will be seen in Chapters 9 and 10 they appeared to resist this opportunity.

Whilst knowledge can be gained from others, tacit knowledge is generated where it is experienced and valued. Within midwifery, learning in this respect is derived from clinical experience and involves reflecting on practice to consider how this can be improved. Reason (1994) supports this stating that "critical self-reflective inquiry and openness to public scrutiny, the practices of human inquiry engage deeply and

sensitively with experience, are participative, and aim to integrate action with reflection"
(p.10).

However tacit knowledge or intuition is still not viewed as an authoritative way of
knowing in Western tradition and, as was seen in Chapter 2, value is still placed on
'facts' that are obtained through scientific research so that "we often forget, or tend to
discount, internally obtained knowledge - the knowing that comes to us from the inside
of our bodies, arising as a 'gut feeling', an intuition" (Davis-Floyd & Davis, 1997,
p.145). The features of action research therefore suited my enquiry because they
were based on learning about reflecting 'on' and 'in' action (Schön, 1983), engaging
with and making new connections in clinical practice and also working participatively
with others in order to understand and value clinical practice with a view to facilitating
change. I will now examine more closely my reasons for not choosing other
methodologies.

Rejecting the search for 'truth'

The positivist paradigm in research can be seen as representing the traditional,
scientific view of research. This particular worldview sees the purpose of inquiry to
search for truth and to know more about a world of things. Positivist researchers
believe that anything that is worthwhile can only be known objectively and they attempt
to bring the world under scientific control through the measurement of quantities:

> "The positivist perceives that the object of research
> or study can only be truly understood by reducing it
> into parts and examining them in detail.
> Relationships between the parts considered
> important by the researcher can then be identified by
> repeated observation and measurement, leading
> finally to a point where it is considered reasonable to
> make predictions, based upon mathematical
> verification of the 'facts' (statistics)".
> (Ellis and Crookes, 1998, p.88)

However statistical facts are always open to different interpretations because the theories and values that individuals espouse, influence the choice of statistics to be collected. As Winter & Munn-Giddings (2001) have stated "statistics are *created*, not discovered" (p.15, italics in original) and as human behaviour is so complex and diverse there will always be individuals that are at variance with the significant statistical correlation. Therefore, reducing the participants' contributions in the research to a set of pre-coded categories does not remove "individual differences of meaning; it merely conceals them" (Winter & Munn-Giddings, 2001, p.16).

Prescription and the imposition of control

Over time positivist research has developed certain principles to guide its conduct. These principles establish a theory to identify all constructs, concepts and hypotheses while a research proposal is being prepared and before data collection commences (Morse & Field, 1996). Cohen & Manion (1994) refer to positivist research as "the systematic, controlled, empirical and critical investigation of hypothetical propositions about the presumed relations among natural phenomena" (p.4). Hypotheses are suggested in the above definition as a way of looking for relationships between variables so that causality can be explained along with accurate prediction (Morse & Field, 1996). The researcher proceeds to examine experimental variables in order to impose some degree of control over the research. By imposing this control the positivist researcher believes that relationships between variables will be generalisable and predictive in all settings and at all times (Morse & Field, 1996). Hypotheses are tested using systematic and controlled methods and are either rejected or accepted by the researcher according to the probability values they generate. The research becomes empirical because it is validated by observation, evidence, experimentation and testing. Cohen & Manion (1994) refer to Comte who believed that "all genuine

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knowledge is based on sense experience and can only be advanced by means of observation and experiment" (p.11).

Increasingly, Randomised Controlled Trials (RCTs) are being used as the evidence base for policies, protocols and guidelines (NHS Executive, 1996) within midwifery (e.g. Mugford, Somchiwong & Waterhouse, 1986; Alexander, 1996; Kirkham & Stapleton, 2001) and whilst this represents progress in scientific terms there is a danger of scientific evidence being mistaken for certainty. Evidence-based practice does not do justice to complex, messy practice situations and as will be seen, may mislead midwives by emphasising medical certainty within midwifery where clients' voices are heard. Therefore evidence-based practice can feed midwives' search for certainty which is then left unsatisfied through the nature of midwifery work.

Clearly, a positivist approach to the study would have been unsuitable because of the principles used to guide the conduct of the research. Objectivity such as non-involvement and non-participation as well as a non-dynamic, fixed and planned research design are common ideals when the above principles have been adhered to (Leininger, 1985). Positivist approaches are therefore inappropriate for research that involves people interacting in complicated and unpredictable situations where there may be multiple variables present. Under these circumstances participants cannot be measured and quantified as if they are entirely predictable (Winter & Munn-Giddings, 2001; Patton, 2002).

What about complex, messy clinical practice situations…?

This action research study explores midwives' support needs and working relationships. Therefore a paradigm in which dynamism and mutation are not core values would be unsuitable and could actually inhibit the process of change necessary

within the study. Within traditional research thinking, messiness or lack of control are all seen as negative qualities (Morrison & Lilford, 2001), indicative of weaknesses in a methodology or study, and therefore can cause confusion, angst and/or doubt, especially in novice action researchers.

When the principles of positivistic inquiry are applied to social settings, such as midwifery, the participants are often manipulated and controlled (Winter & Munn-Giddings, 2001). When applied in the context of this research the participating midwives would have received propositional knowledge from me ('the expert') and then 'fitted' their clinical practice into a theory thus ignoring the creative potential of midwifery practice and the opportunity to generate theory from practice and make new connections. Clearly, research examining practitioner working relationships and how midwives identify and mobilise support for themselves would not lend itself to the method of positivistic inquiry employed by 'traditional' researchers (Deery & Kirkham, 2000; Taylor, 2001).

Naturalistic research: Subjectivity and shedding light on complex problems.

Naturalistic research is also referred to as non-positivist or interpretive and as with positivist research reflects a particular school of thought that challenged positivism. As Ellis & Crookes (1998) have stated:

> "…the naturalistic paradigm is generally described
> as being diametrically opposed to reductionist
> positivism, as essentially it underlies the need to
> consider everything in its entirety, on the basis that
> in the social sciences everything influences
> everything else".
> (Ellis & Crookes, 1998, p.91)

The scientific need to control or measure behaviour is therefore rejected in the naturalistic paradigm and the research emphasis is on understanding social situations.

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Researchers operating in this paradigm believe that human beings need to know more about themselves and the world in which they live (Patton, 2002). Naturalistic research accepts that researchers need to distance themselves from objectivity and use subjective experiences to pursue the potential for shedding light upon complex and difficult human problems (Leininger, 1985). According to Morse & Field (1996) data collected during interpretist or qualitative research can examine "underlying assumptions and attitudes" (p.9). Davis-Floyd & Davies (1997), from an anthropological perspective, recognise that it is only:

> "[w]hen you have experienced and begun to understand another culture, you can know profoundly that your own culture is not the "real world", but just one way of interpreting that world, one system out of many".
> (Davis-Floyd & Davies, 1997, p.146)

However, McNiff (1988) argues that although the interpretist tradition is concerned with qualitative analysis of data the "concept of control by the researcher of the researchee is equally apparent" (p.18) within this approach. Qualitative researchers insist that they are being democratic and not treating participants as "subjects" (Patton, 2002). However their research still imposes a framework "into which the researchee must fit himself and his practice" (McNiff, 1988, p.18) suggesting that democracy is not possible within this paradigm.

Whose knowledge…..whose practice counts?

A researcher from the interpretist tradition is therefore still viewed as an outsider who "speaks on behalf of other people" (McNiff, 2002, p.33) and "generates a theory about an external situation" (ibid. p.33). In effect this means that power differentials exist between researcher and participants as to "who is regarded as a legitimate knower, whose practice is to be studied, and whose knowledge counts" (McNiff, 2002, p.33).

As I have discussed in Chapter 2 there are close parallels here with women's ways of knowing (Belenky et al. 1986) and the degree to which individuals value each other's knowledge. The naturalistic paradigm therefore, still did not seem to address the importance I placed on the collaborative, participatory and reflective aspects of my clinical work.

Critical theory research: challenging politically constructed situations

Critical theory research evolved from the 1930s from a group of Marxist thinking researchers who became known as the Frankfurt School and believed that research methodologies at that time did not recognise "the historical, cultural and social situatedness of researchers" (McNiff, 2002, p.33). This approach to research focuses on how subjugation and injustice shape an individual's experiences and understandings of the world (Patton, 2002). Critical theory research therefore challenged both positivism and interpretivism.

Habermas was a critical theorist who believed that knowledge is a product of a knowing subject who has certain desires and interests (Giddens, 1985) and that human behaviour is best understood through examination of "underpinning values and intentions" (McNiff, 2000, p.130). According to Giddens (1985), Habermas believed that:

> "The more human beings understand about the springs of their own behaviour, and the social institutions in which that behaviour is involved, the more they are likely to be able to escape from constraints to which previously they were subject".
> (Giddens, 1985, p.127)

An outcome of this process for Habermas (1972) was a critical theory. For example, he challenged the positivist assumption that "abstract theory drives practice as a linear process" (McNiff, 2000, p.178). Habermas believed that theory and practice had to be integrated; "the theory was embodied in, and enacted through, the practice" (ibid, p.178).

Habermas (1972) identified three 'knowledge constitutive interests'; technical, practical and emancipatory which helped to develop his theory of human interests. Technical knowledge is that which relates to "means-ends" strategies (Brown & Jones, 2001, p.34) thereby facilitating control through a scientific approach. Action research using a technical form:

> "…is orientated essentially towards functional improvement measured in terms of its success in changing particular outcomes of practices…it is regarded as 'successful' when outcomes match aspirations – when the defined goal of the project has been attained".
> (Kemmis, 2001, p.92)

Practical knowledge is about a practitioner becoming familiar with their work situation through being involved in it. This interpretivist approach entails "both increasing familiarity and personal reflection, where the practitioner seeks to understand how they are functioning within their specific job" (Brown & Jones, 2001, p.34). Practical knowledge in this sense has resonance with action research influenced by the work of Donald Schön (1983):

> "It has technical aspirations for change, but it also aims to inform the (wise and prudent) practical decision-making of practitioners…[who] aim not only to improve their practices in functional terms, but also to see how their goals, and the categories in which they evaluate their work, are shaped by their own ways of seeing and understanding themselves in context".
> (Kemmis, 2001, p.92)

Emancipatory knowledge adopts a critical attitude to the way in which language is used to describe the practitioner's situation. In this respect Habermas appeared to be influenced by Freud and his understanding of how language "sometimes has an uneasy relationship with the reality it seeks to portray" (Brown & Jones, 2001). Action research taking this approach "aims at intervening in the cultural, social and historical processes of everyday life to reconstruct not only the practice and the practitioner but also the practice setting" (Kemmis, 2001, p.92).

However, critical theorists such as Habermas appear to ignore the power differentials within human relationships and powerful hegemonising influences that some individuals have over others (Giddens, 1985). In seeking to critique society these researchers did not recognise how dominant and subordinate groups struggle over power in ways that make life political (Patton, 2002). This view contradicted my feminist principles that were predicated on the significance of power. Although critical theorists claimed to address action and change, their critiques could not demonstrate how change and improvement occurred. This is because their theorising was not grounded in practice and stayed at the level of theory (McNiff, 2002).

Kemmis (2001) has developed the above criticisms further, particularly the "notion that truth could only emerge in settings where all assertions are equally open to critical scrutiny, without fear or favour" (p.93). In further developing Habermas' views and critical social science, Kemmis (2001) emphasises a need to take account of communicative action and the two levels at which society can be viewed; the system's view and the life-world view. The system's view sees society encompassed by organisational and bureaucratic structures where there is a pressure to meet targets (see also Lipsky, 1980). The lifeworld perspective views society as encompassed by culture, social order and individual identity and according to Kemmis (2001):

> "…allows us to articulate problems which have
> emerged in late modernity as social systems have
> become more extensive, and as problems of
> integrating different kinds of social organizations and
> systems have emerged."
> (Kemmis, 2001, p.98)

These two systems do not work independently rather they function together and take on an open and fluid perspective within critical theory (Kemmis, 2001). In taking this stance, Kemmis appears to be recognising that action research has moved away from problem-solving and looking for solutions, to an approach that encourages "re-framing" (Goffman, 1974; Winter & Munn-Giddings, 2001; Lloyd & Hawe, 2003) (see also pages 126 and 246) of the tensions that exist between systems and lifeworld perspectives.

I have addressed the three most commonly identified research paradigms within the literature; empirical research, interpretive research and critical theory research. Action research lies within the critical theory paradigm although three different approaches to action research have been identified by McNiff (2002) within this paradigm. These are interpretive approaches, critical theory approaches and living theory approaches (see Figure 5).

Figure 5:   Different approaches to action research in critical theory paradigm
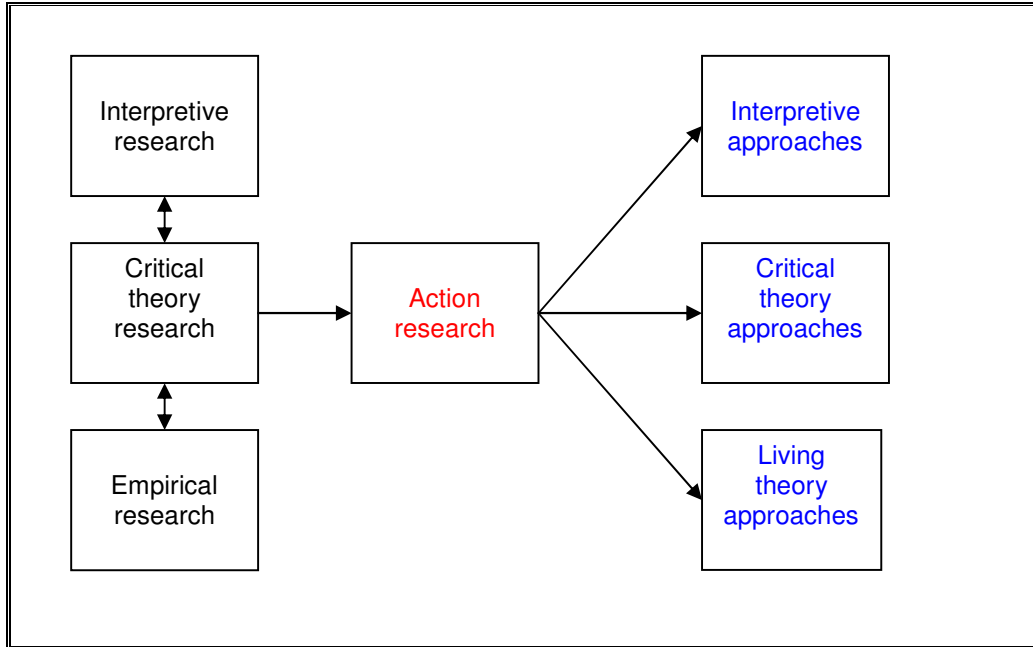
(Derived from McNiff, 2002, p.58)

Models…approaches…typologies…traditions?

Some authors have categorised approaches or typologies of action research (Hart & Bond, 1995; Holter & Schwartz-Barcott, 1993) in an attempt to clarify and enhance understanding of action research. Hart & Bond (1995), from a nursing perspective, present their action research typology as experimental, organisational, professionalising and empowering (Hart & Bond, 1995, p.40) which they acknowledge overlap and are therefore not distinct. Likewise Waterman et al. (2001) found that the action research studies they reviewed did not fall into distinct categories. Clearly, such typologies can also restrict the fluidity of the approach by imposing theoretical categorisations which, in practical action research situations, tend to merge and conflate.

Action research is, on one hand, not prescriptive; it merely offers a range of models, for example McNiff's three-dimensional spiral model, Hart & Bond's four typologies, Holter & Schwartz-Barcott's three approaches and Zuber-Skerritt's CRASP model (McNiff, 1988; Hart & Bond, 1995; Holter & Schwartz-Barcott, 1993; Zuber-Skerritt, 1992). On the other hand, this range of models can have the effect of implying that some form of order needs to be placed on action research[43]. Thus, the implication that models impose some form of order does not help with the "terminological anarchism" (Kalleburg, 1990) within action research.

Holter & Schwarz-Barcott (1993) have also identified three different approaches to action research and how they have or have not been used in nursing. These are 'technical collaborative', 'mutual collaboration' and 'enhancement approach'. In the 'technical collaborative' approach the researcher's aim is to intervene by introducing a change as a way of testing a hypothesis. Collaboration between the researcher and the participants is only to the extent of gaining the participant's interest in the study. This approach has connotations of positivistic research and the use of propositional logic thus ignoring the contribution that clinical practice and the participants have to offer.

The 'mutual collaboration' approach differs in that the researcher and the participants work together on problems and through understanding the problem, intervene and plan for change. The 'enhancement approach' has two main aims; one is to help the participants to use theory to understand and help resolve problems and the second is to raise the participants' awareness so that they feel more able to identify and make their problems more explicit. Holter & Schwartz-Barcott (1993) state that they were unable to find any studies using the 'enhancement approach' and that most action research studies in nursing appear to be of a 'technical collaborative' approach.

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[43] See Chapter 2 for similar imposition of models within midwifery.

Rather than presenting varieties and different types of action research Winter & Munn-Giddings (2001) present a set of contributory traditions that have developed in different contexts. 'Service user research' (p.28), 'community development' (p.33), action research as management or organisational learning (p.37), action research as 'responsive evaluation' (p.45) and feminism and action research (p.55) are some of the traditions identified by Winter & Munn-Giddings (2001). However there are still many overlapping, common themes within these traditions.

Cycles and steps as repressive and mechanical

Stenhouse's (1975) view was that action research should be systematic and collaborative but this alone did not distinguish the approach from other forms of research (McNiff et al. 1996). The principles outlined by Lewin of democracy, participation, reflection and change are central to most descriptions of action research (Carr & Kemmis, 1986; McNiff, 1988; Stringer, 1996) and it is these features that seem to distinguish it from other forms of research.

Elliot (1991) agrees with the basic notion of an action-reflection spiral of cycles as the basis for understanding how to initiate action within an educational situation. The principles of this notion are that the research can move from one critical phase to another through a process of systematic steps that operates in cycles of "planning, executing and fact finding" (McNiff et al. 1996, p.22). However Elliot's own critique highlights that the 'general idea' cannot be fixed and that allowances need to be made for movement. Preliminary observations or "reconnaissance" (Elliot, 1991, p.70) also involves analysis and should be a constantly recurring feature within the spiral rather than just at the beginning. Gordon (2001) also refers to the "planning and reconnaissance" (p.318) cycle as that which acknowledges the dissonance between external and internal realities or espoused values and values in practice.

Elliot (1991) also notes that implementing action steps is not without its difficulties and that the effects of such action should not be evaluated until the extent to which the action that has been implemented has been monitored. Atkinson (1994) agrees with Elliot (1991) arguing that an "observe, plan, act, reflect cycle" (p.397) does not demonstrate complex, messy real life situations when in fact all four of these components could be in action at any one time. Somekh (1994) is also critical that models can be interpreted too literally and hamper less experienced researchers.

At the same time that I realised the potential for action research with its close links to clinical practice I was struggling and feeling constrained by "models" of action research; which model should I choose? Which was the best model? Am I doing participatory action research? What is a living theory approach? I had chosen action research as an approach to liberate me from other constraining research paradigms as I discussed earlier but I was beginning to feel restrained within the very approach I had chosen to emancipate me. Cook (1998) when writing about the mess associated with action research reports similar feelings when discussing the usefulness of models of action research. Cook (1998) refers to action research models as "emancipating me from one system and shackling me to another…all this cycles and steps…it's actually repressive, it's mechanical" (p.97).

Whitehead (1994) reinforces the imposition of models when emphasising the need for originality. He states that describing action research as a logical, technical approach can inhibit those participating in action research from analysing and synthesising. The variety of interpretations can be experienced by action researchers as restrictive and in opposition to their reasons for choosing action research as an approach. One of the reasons I chose action research was because the research would become accessible to the midwives participating in the study and help them to close the gap between theory, practice and research (Somekh, 1994). Naively, at the outset of the study, I felt

that the midwives would be able to participate in action research and create their own midwifery theory whilst undertaking clinical practice at the same time. This would enable them to facilitate change in the clinical area 'on the job' rather than wait for the findings of the research to be published and then incorporating the findings into practice. Further complicating action research through the imposition of theoretical categorisations could have been disabling for the participating midwives. However I could also be accused here of protecting the midwives from the complexity brought about by action research. As will be seen in Chapter 10 their reluctance to engage in personal and professional development meant that I may well have been protecting them from such complexity in order to maintain their interest, for my benefit, in the study.

Struggling in the swampy lowlands

Whitehead (1994), Cook (1998) and Mellor (1998, 1999) have helped move my thinking forward as I gave myself permission to have uneasy feelings about the messy, disordered, complex nature of action research. In the early stages of the study I accepted that my role as an action researcher was going to be complex[44] and gave myself up to "coming to know through struggle" (McNiff, 2002, p.3). This acceptance was liberating in itself. I was reminded of Schön (1983) and his use of the metaphor of the swampy lowlands:

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[44] Although "the turbulence that accompanies the practitioner research process; turbulence caused by the shock of seeing a 'self' in one's data that one hardly recognises; turbulence caused by the release of sensitive and controversial perspectives that have the potential for causing unpredictable conflict and strife in one's workplace; turbulence caused by meeting the many human injustices and heartaches which practitioner research often reveals, as power structures and relationships are peeled away to examine people's lived experiences" (Dadds, 1998, p.43) was profoundly disabling for me, yet challenging and stimulating at the same time.

> "…there is a high, hard ground where practitioners
> can make effective use of research-based theory
> and technique, and there is swampy lowland where
> situations are confusing "messes" incapable of
> technical solution…in the swamp are the problems of
> greatest human concern".
> (Schön, 1983, p.42)

Mellor (1999) also states that he "eventually came to accept that [his] struggle in the swamp was the method, not a path to find a better method" (p.100). I found Mellor's words reassuring and helpful as I came to understand and accept complexity and uncertainty within the study as part of the "swamp" and central to the process of undertaking action research.

Accepting certainty and valuing uncertainty

As I discussed earlier there is a need for a midwifery logic of clinical practice that values all forms of knowledge, including tacit knowledge. "Importing pre-conceived ideas" (McNiff, 2002, p.4) is inappropriate for action researchers who wish to explore clinical practice. As an action researcher I wanted to create and participate in dynamic, insightful midwifery practice that has to begin in the clinical area with grass roots workers. However, I have been exposed to certainty for most of my working life as a result of the medical model of childbirth being imposed on the social model of birth and this affected, at times, my approach to my midwifery work.

Davis-Floyd (1992) also refers to the "technocratic model" of birth as that which values contemporary obstetric practices as well as the hegemonising influence of "diagnostic technologies" (Davis-Floyd & Davies, 1997, p.147). For example in obstetrics continuous electronic fetal monitoring during the labour process may create an illusion that a baby's chances of a healthy outcome are greatly improved when in fact the uncertainty surrounding the baby's well-being becomes less apparent when the situation is "technologically controlled" (Harvey, 1996, p.86). This is because medical

technology serves to mask uncertain outcomes. This is referred to by Harvey (1996) as achieved certainty "whereby an appearance of medical control may be accomplished in a situation that may remain riven with uncertainty" (Harvey, 1996, p.89).

However uncertainty also appears to have become a strength in obstetrics in that obstetricians believe that they "cannot know for certain who will be overtaken by 'potential pathology'" (Harvey, 1996, p.90). All childbearing women therefore have to comply with obstetric protocols and guidelines so that high mortality/morbidity outcomes can be avoided (Tew, 1990). As Taylor (2001) states:

> "In midwifery the search for certainty and predictability is
> found in the use of policies, procedures and 'guidelines'
> which attempt to make the characteristics of individual
> women meet some spurious norm, antenatally, in labour
> and postnatally".
> (Taylor, 2001, p.5)

As was seen in Chapter 2, risk management and the use of technology have aimed to lessen the emphasis on uncertainty enabling obstetricians and midwives to gain professional control and compliance and thus a degree of certainty. Furthermore:

> "…the ability to define the degree of certainty in medical
> situations is intimately bound-up with the control of
> knowledge and the structures, practices and artefacts
> through which this is applied…Technology is pivotal in
> this process…"
> (Harvey, 1996, p.95)

Leap (2000) suggests that midwives and clients should embrace uncertainty together. This might be uncomfortable for some midwives who depend on the achieved certainty (Harvey, 1996) of their clinical practice in order to predict events within the childbearing process. Several examples are noteworthy here, for example the date of the baby's birth is predicted through mathematical calculation or ultrasound scan, and some

midwives measure the growth of the uterus with a tape measure in order to assess

fetal growth (Neilson, 2000). The length of a woman's labour is also estimated and the

time of birth predicted on a partogram[45] and dilatation of the cervix is measured by

vaginal examinations. These interventions provide good examples of the ways in

which midwives attempt to control and predict their practice through achieved certainty

(Harvey, 1996) in order to be certain of events. Rather than trusting the physiological

process of 'normal' childbirth and the woman's body, midwives use these varied

interventions to help them feel comfortable within their sphere of practice:

> "The uncomfortable fact is that no amount of screening
> and information giving can give pregnant women and
> new parents the complete certainty they seek or indeed
> the ability to make 'the right choice'…engaging with
> uncertainty involves profound learning for each individual
> woman and her midwife in a way that is reciprocal and
> unique…Women ask midwives to join with them in order
> to draw on our expertise, our experience and our
> knowledge…in a world where there are more questions
> than answers".
> (Leap, 2000, p.4-5)

Lipsky (1980), when addressing the different ways in which street-level bureaucrats

have to work with conflicting and ambiguous values in their employing organisations,

states that:

> "When there are uncertainties over what will or will not
> work, there is greater room for admitting and tolerating a
> variety of approaches and objectives. In such a situation
> there is often a hunger for discovering successful
> techniques and an apparent willingness to modify
> objectives to suit the techniques".
> (Lipsky, 1980, p.41)

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[45]The partogram is a composite record of a woman's condition, well-being of the fetus and also a graphic record of the progress of labour and descent of the fetus. The record does not display how the woman is feeling (Gee & Glynn, 1997). The partogram has been used since 1970 but has recently come under increasing scrutiny as a tool that does not take into account individual women's labour journeys (Simonds, 2002).

Like Leap (2000), Lipsky (1980) is suggesting embracing uncertainty in the work environment although he also acknowledges that this can be organisationally inhibited. Lipsky's words also hold true for an action research approach where the dynamic, flexible nature of the approach lends itself to discovering new and different ways of working. As will be seen in Chapter 7 the "hunger" that Lipsky refers to was demonstrated in the midwives' articulated need for support. However, their willingness to change was impeded by the fact that "they operate in an environment that conditions the way they perceive problems and frame solutions to them" (Lipsky, 1980, p.27) (see also pages 126 and 246). This means that the midwives probably had no option but to resist suggested changes to their ways of working. However I did remain convinced that midwives might enjoy richer, more rewarding experiences within clinical practice if they reflected on and examined their values and then used this critical reflection as a way of guiding or "re-framing" (Winter & Munn-Giddings, 2001, p.52) (see also p.126) their practice. As will be seen in Chapters 9 and 10, the midwives were offered the opportunity to examine their values, reflect on practice and embrace the uncertainty of clinical practice through the process of clinical supervision.

I have learned to accept the fact that the nature of my practice as a midwife is uncertain and as a result I now value the uncertainty within clinical practice. Rather than searching for black and white answers to clinical practice questions I now accept that there are many grey areas within midwifery. This no longer frustrates me. I find that questions arising from these grey areas often lead me to further research questions. I have also argued (Deery & Kirkham, 2000) that the fear of uncertainty may be one of the reasons why action research is not used as frequently in midwifery as it is in nursing. Action research aims to draw attention to uncertainties so that these can be 'worked with' (Winter & Munn-Giddings, 2001). However, some midwifery researchers might prefer to conform to the traditional scientific paradigm as a result of midwifery's long history of dominance by a medical profession that favours the

certainty promised, but rarely delivered, by positivist approaches. This means that the potential for a close relationship between research and clinical practice is skewed towards the chimera of certainty.

Yet the cyclical nature of action research, with fact finding, action and evaluation within each cycle, is highly appropriate for researching clinical care in times of change (Deery & Kirkham, 2000). Uncertainties and tensions within midwifery can be reflected upon through a collaborative, democratic and empowering approach to change and through a research approach that reflects the complex, messy nature of clinical practice. This process also mirrors the cyclical framework of care planning involving fact finding, action and evaluation within midwifery.

Later action research that I undertook in 1999 (Deery et al. 1999; Deery, Hughes & Lovatt, 2000) was grounded in an approach that involved midwives:

- Identifying a practical problem and/or need for change.

- Establishing participation/collaboration between all those involved.

- Selecting methods of data collection appropriate to the purpose of the study.

- Participating in change based on analysis of and reflection on the data.

- Repeating the above until practice is developed to a point that is mutually agreed to be a point of sustainable improvement or change.

- Reflecting on the experience of the action research to build knowledge and disseminating the findings.
  (Derived from Deery & Hughes, 2002, p.1)

I hoped to be able to draw on these principles when undertaking this study; however the degree of participation from the midwives and my naivety around action research at the time, limited the scope of the above framework.

Feminisms and action research

I am aware that in Chapter 2 I have placed importance on feminist principles during my work as a clinical midwife, academic and facilitator of action research. Yet I have chosen an approach to research that appears to neglect the importance of feminist scholarship and is not fully engaged with feminism. This is a shame because feminisms and action research have much in common especially the commitment to challenge and expose "the web of forces that cause and sustain all and any forms of oppression" (Maguire, 2001, p.60). Although not made within the context of action research, Stanley (1990) also makes an interesting comparison when discussing feminist inquiry. She states that the point of feminist inquiry is to "change the world, not only study it" (p.15) again highlighting the shared intent of feminist and action research and the value placed on dialectical rather than propositional logic.

Maguire (2001) draws attention to older action research approaches (e.g. Stenhouse and Lewin) that were mainly associated with men. This could partly account for the deficit of feminist scholarship within action research. Maguire (2001) points out that even more recent accounts of action research (e.g. Kemmis & McTaggert, 1988; McNiff, 1993) still do not engage with feminist theory but a recent text by Winter & Munn-Giddings (2001) does attempt to address this deficit. As I have stated on page 137 critical theorists claim to address action, change and power but then fail to address the patriarchal hegemony. This is further complicated by the diversity of feminist perspectives and the fact that "there is no single method, methodology, or theoretical base of feminist scholarship, indeed there are competing theoretical foundations and varied methodologies" (Maguire, 2001, p.60).

Maguire (2001) draws attention to the metaphor of 'voice' in feminist and action research. Likewise the importance of understanding and evoking silence in research is

addressed in the work of Gilligan (1985). As will be seen in the following chapter, this is developed further by Mauthner & Doucet (1998). Penny Barrett (2001) in an action research study undertaken in Australia illustrates feminist commitment to hearing women's voices and facilitating their empowerment. This study was an Early Mothering Study, conducted with a group of midwives who became known as the 'Midwives Action Research Group' (MARG). Action research informed by feminist processes helped the midwives improve their practice, enhanced women's satisfaction with their early mothering experiences and facilitated women's access to informed choices (Barrett, 2001).

The living theory approach

Most action researchers would take the stance that reflexivity and dialectical critique in a democracy are important factors (Winter & Munn-Gidddings, 2001) with Whitehead (2000), McNiff (2002) and Lomax (1995) viewing self-reflective enquiry as an important aspect of critiquing the researcher's own values. McNiff (1988) criticises Elliot (1981), Kemmis & McTaggert (1982) and Ebbutt (1985) for not mapping "their own imagined frameworks" (p.34) onto their own practice. She states that these action researchers do not explain the educational phenomena that they are dealing with and fail "to demonstrate the marriage of their own theory and practice" (p.34).

As an academic and a clinical midwife I am encouraged to reflect 'on' and 'in' practice. However, neither role allows time for this and the culture of both professions merely pays lip service. Action research therefore can become accessible to researchers because of its ability to work and reflect on a clinical situation or otherwise whilst still engaged in the research process[46]. Critical reflection lies at the heart of action

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[46] I am reminded of the proverb "killing two birds with one stone" at this point.

research as it enables analysis of the researcher's actions and the potential for improvement and understanding of the situation (Winter & Munn-Giddings, 2001).

I would argue however that critical reflection is not an easy process as it is very personal and can be painful as I have highlighted on page 109. As will be seen in Chapter 7, the midwives participating in this study reported feeling stressed and under such circumstances recall can become distorted and "as a result information available for reflection may become bland and non-problematic, whilst key incidents which are threatening, but offer particular potential for learning, are omitted completely from the…reflective repertoire" (Newell, 1992, p.1329). Woodward (2000) when addressing how caring values are manifest clinically, and might be encouraged educationally within nursing and midwifery, suggests that "an individual's knowledge, understanding, values, and attitudes…determine whether experience acts as a source of learning or constitutes non-reflective, presumptive and static practice" (p.73).

In the context of this study action research facilitated the midwives and me to reflect on deeply entrenched and internalised ways of working within the culture of midwifery. At times the midwives found this process painful and distressing and they resisted reflecting on whether their values were being lived out (Whitehead, 2000) in their practice. Such resistance can "leave us with culturally entrenched perspectives that impede communication and the ability to support" (Dadds, 1998, p.43).

'Mapping imagined frameworks' onto clinical practice

As my understanding of action research developed I began to understand more fully that the values I espoused were not being evidenced in my research. After reading work written by Jack Whitehead at the University of Bath and Jean McNiff I have been particularly influenced in the living out of my values in practice and further exploration

of these values as a way to shape my action research practices. It is important to point out here that both these action researchers take a different stance from interpretivist and critical theory action researchers where the issue of values is not made explicit.

McNiff (1988) identified a "polarisation" (p.xvii) between interpretivist and critical theory action researchers in Cambridge and East Anglia and 'living theory' approaches at Bath. Whitehead (1989), the founder of 'living theory' approaches, also believed that Carr (1986) and Elliot (1987) were limited in their approach to action research by the propositional form of their discourse. Whitehead (1989) believed that these action researchers have "not taken the leap necessary to comprehend the nature of educational theory" (p.50) by questioning how they can improve their practice. However Whitehead (1989) does acknowledge that their work can be usefully integrated into constructing a living educational theory.

Putting values 'up-front'

The "values dimension" (Lomax, 1990, p.4) of researching clinical practice did not become so important to me until I had completed data collection and I was analysing the data. It was during the process of data analysis and writing up that I reflected on what I thought had been a missed opportunity to clarify mine and the midwives' values around our support needs. These values could have been "put up-front" (Lomax, 1995, p.49) at the start of the study and used to guide our actions. This strategy might have helped to resolve or dissipate some of the frustrations and anxiety that became evident as the study began to evolve (see page 302). However, putting our values 'up-front' would have meant looking right into the eye of the contradictions that were beginning to become apparent and, rather than resolving and dissipating anxiety, resistance to change might have become manifest much sooner.

Whitehead (1989, 1993) believes that values within our practice need scrutinising in order that their meaning can be communicated during the course of (clinical) practice. He suggests examining reasons why values might be negated in practice. Whilst I agree with what Whitehead is saying, the process of examining values can be painful and difficult, especially as I found that I constantly had to negotiate myself through complex, sensitive issues relating to the organisation where I was undertaking the research. At times the values of the organisation where I undertook the study seemed completely at odds with the values of the participating midwives. As will be seen in Chapter 9, the midwives found themselves unsupported by their midwifery managers. As Lipsky (1980) states:

> "Street-level bureaucracies encounter conflict and ambiguity in the tensions between client-centered goals and organizational goals. The ability of street-level bureaucrats to treat people as individuals is significantly compromised by the needs of the organization to process work quickly using the resources at its disposal…typical conflicts here are individual client treatment versus routinization and mass processing, and response to the needs of individual clients versus efficient agency performances".
> (Lipsky, 1980, p.44-45)

However despite this contradiction, scrutinisation of values can help to make links between "the way I would like to see the world with my set of values, aims and ideals and the world of our practice" (Whitehead, 1985, p. 101). Also, midwives might enjoy richer, more rewarding experiences within clinical practice if they examined and explored their values and then used critical reflection as a way of guiding or "re-framing" (Winter & Munn-Giddings, 2001, p.52) (see also p.126) their practice. This process, as was seen in Chapter 4, lies at the heart of changing and moving clinical practice forward.

Whitehead's idea of the "living contradiction" (Whitehead, 1989) means placing the "living I" at the centre of action research enquiries and having the insight to be able to see that the researcher could be a potential living contradiction. However not all contradictions exist within the researcher as I came to understand during the course of this study. Indeed the participating midwives and myself were living contradictions. I espoused feminist values of women supporting women yet when I was negotiating the progress of the study with midwifery managers for the participating midwives I knew that I did not do this effectively because I feared the managers. There was also the possibility that they might refuse further access to the midwives if they perceived me as being too demanding. I therefore felt that I was not an effective role model for the midwives and that I was negating my feminist values by colluding with the managers. Likewise, as will be seen in Chapters 9 and 10 the participating midwives decided that they wanted support in the form of clinical supervision but when offered it said that they had no time to undertake clinical supervision.

As a practising midwife my midwifery values were important but I soon realised that I was negating these during the course of the research. As Lipsky states "street-level bureaucrats…often grow in the jobs and perfect techniques, but not without adjusting their work habits and attitudes to reflect lower expectations for themselves, their clients, and the potential of public policy" (Lipsky, 1980, p.xii). Whitehead (1993) states this situation is the state of being a 'living contradiction'. I was able to sense the tension caused by these contradictions and imagine ways forward for the midwives and myself. However being able to vision the way forward appeared more problematic for the participating midwives and they appeared to struggle with their personal constructions of midwifery. Arguably if I had discussed our values at the outset of the study then recognising themselves as living contradictions might have been easier for the midwives and we might have been able to work more closely on understanding the meaning of our values and how we could try to overcome and reframe their negation.

However there was always the possibility that the midwives might have resisted such an opportunity thereby jeopardising the progress of the whole project because the revelation of these competing contradictions might have been too painful for them.

Whitehead (1985) has suggested the following framework as an action/reflection cycle within the living theory approach:

- I experience a concern where my values are negated in practice.
- I imagine a way forward.
- I so act and gather data to enable me to make a judgement on the quality and effectiveness of my actions.
- I evaluate my actions in terms of my values and understandings.
- I modify my action in the light of my evaluations.
  (Whitehead, 1985; Whitehead & Lomax, 1987)

Winter & Munn-Giddings (2001) are critical of Whitehead's interpretation of examining the contradictions between the researcher's professional values and current practice. These authors believe that "values represent ideals, and ideals are by definition never fully realisable in practice" (p.52). Therefore the relationship that Whitehead (1985) claims to exist between values and practice is not merely a contradiction that can be resolved (Winter & Munn-Giddings, 2001) because contradictions exist between competing values. McNiff (2002) acknowledges the difficulties of working with "multiple values perspectives" (p.17) and the challenges this presents for the action researcher in terms of "recognising and suspending their own prejudices" (p.17). She argues that this requires personal commitment to action and working in ways that are often not challenged.

Winter & Munn-Giddings (2001, p.52) also criticise Whitehead for suggesting that the critical dimension of action research involves a personal "confession" of the failure to enact values in practice. Neither should action research end with "self righteous claims" (Winter & Munn-Giddings, 2001, p.52) to have removed contradictions between

values and practice. Whitehead's (1985) interpretation of creating an epistemology of practice does not claim to remove contradictions from practice. Indeed Whitehead (2000) states that the living contradiction is "the experience of holding together two mutually exclusive opposite values" (p.93) thereby refuting Winter & Munn-Giddings (2001) suggestion that contradictions can be resolved. However this "holding together" of competing values is not easy because:

> "To deliver street-level policy through bureaucracy is to embrace a contradiction. On the one hand, service is delivered by people to people, invoking a model of human interaction, caring, and responsibility. On the other hand, service is delivered through a bureaucracy, invoking a model of detachment and equal treatment under conditions of resource limitations and constraints, making care and responsibility conditional".
> (Lipsky, 1980, p.71)

In order to appreciate midwifery values in clinical practice, action researchers must be ready to learn from those who hold a different perspective. In the case of this study this could be the participating midwives or the midwifery managers.

Active versus passive participation

Kurt Lewin stated that action research required democratic participation in order to achieve action for greater effectiveness or improvement. Action research has always implied some form of participation (Adelman, 1993) although the nature and degree of participation, that is, the *active involvement* of the group, will vary according to the focus and duration of the action research study. Active participation is important and is viewed by Hart & Bond (1995) as being at the heart of action research because participants can become enquirers alongside researchers and are therefore more able to develop the research agenda. Hart & Bond (1995) state that it was:

> "Lewin's guiding belief that participation was an essential component of democracy, and that change which was brought about with the voluntary participation of the individuals concerned was more effective than change imposed autocratically from above".
> (Hart & Bond, 1995, p.56)

However as will be seen in Chapter 9, in this action research study, participation remained more passive with reluctance to take ownership of the study in a way that I envisaged. Rather than facilitate the study in certain directions with me following their lead the midwives chose to make it clear to me that their increasing workloads precluded them spending time with me. Their behaviour accorded with that described by Lipsky (1980):

> "Street-level bureaucrats…believe themselves to be doing the best they can under adverse circumstances, and they develop techniques to salvage service and decision-making values within the limits imposed upon them by the structure of the work. They develop conceptions of their work and of their clients that narrow the gap between their personal and work limitations and the service ideal".
> (Lipsky, 1980, p.xiii)

Thus the midwives' reluctance to participate more fully, mainly because of their increasing caseloads, ultimately affected the potential of the study in bringing about the desired change. A different but similar action research study that I was involved in at the same time enjoyed midwives collaborating and participating on all levels (Deery & Hughes, 2002) whereas the midwives in this study appeared to participate during data collection only and avoided and resisted participation outside of this context.

Research 'with' rather than 'on': a conjoint experience

The nature and degree of democratic participation in action research are important factors (Hart & Bond, 1995). As action research is context-specific, that is, focusing on a local or discreet situation, location or group (Morrison & Lilford, 2001; Waterman et al. 2001) there is diversity in the amount and nature of participation involved. Participation involves interaction between researcher and participants and, as McNiff (1988, p.4) states, "it is research WITH, rather than research ON." McNiff (1988) goes on further to state that participation involves "this conjoint experiencing, this mutually supportive dialogue, that is the action of research that brings people together as explorers of their own destiny, rather than alienates them as operators and puppets" (p.3).

The participants are usually a group of people who know the field from an internal perspective and have a good working knowledge of the workplace. This understanding of the whole setting in which the research is to take place, including the people that work within it and the structures within which the study setting is located, is crucial in action research. Therefore in my study it was important that I understood the organisational culture of community midwifery including its location within a broader maternity service, the work team as a whole and the midwives within that work team. This understanding came from constant and meaningful interaction with the work team in its setting both in the present and past context.

Whilst participation in most action research studies is central to the dynamic of change, the converse can also be true in that participants can use their "power" to constrain and limit the progress and scope of that study. In this study for example the midwives chose to limit their involvement and the scope of the enquiry by establishing some very constraining ground-rules at the outset. These were that they did not wish to

undertake anything that was outside of their work schedule. This sort of imposition of boundaries within the study ultimately limited its scope and was disappointing as one of the aims of the study was to plan a means of gaining support with the midwives through mutual collaboration.

The balance of power…

When deciding on the methodology for my study it was important that my chosen approach was congruent with my value position. I dislike social injustice and hierarchy and prefer to work collaboratively with others where an equal power base exists. This is easier said than done especially in view of the detrimental effect that previous hierarchical relationships had on me as will be seen in Chapter 6. In the context of this study I hoped there would be an equal power base between researcher and participants and as Ellis & Crookes (1998) have identified this is crucial in research where participation is central because "when a power imbalance exists between one party and another, this has the effect of disempowering at least one of the parties (Ellis and Crookes, 1998, p.93).

This is an important quotation from Ellis & Crookes (1998) because despite the fact that I wanted an equal power base between myself and the participating midwives, at times they were insistent that I was the only person that held any power to enact change within the study. As will be seen in Chapter 9, the midwives became disempowered with regard to the study although it could also be argued that they powerfully resisted my imposing change upon them. Initially they had seized the opportunity to participate in the study but when their involvement became uncomfortable and did not produce "answers" or even mask their difficulties, they became reluctant to participate.

Becoming a political entrepreneur!

the words of McNiff (2002) Coghlan & Brannick (2001) discuss the political implications for action researchers working in their own organisations and ways in which political forces can undermine the endeavours of researchers and eventually lead to resistance to change. Coghlan & Brannick (2001) view the management of political relationships as key to "ensuring the legitimacy" (p.65) of the study.

The political role of the action researcher is elaborated further by Buchanan & Badham (1999) who refer to the political entrepreneur. Coghlan & Brannick (2001) state that a role such as this "implies a behaviour repertoire of political strategies and tactics and a reflective self-critical perspective on how those political behaviours may be deployed" (p.64). However the notion of a political entrepreneur suggests an outsider that comes to the action research study with an aim to change personally rather than collaboratively. Furthermore, Buchanan & Boddy (1992) refer to performing and backstaging;[47] performing involves the action researcher in a public performance role, being active in the change process, encouraging participation and pursuing the change agenda. Backstaging involves the action researcher using skills that intervene in political and cultural systems; justifying, influencing and negotiating. Both these roles suggest the management of a political role that is alien to action research and appears to neglect collaboration with other individuals.

Reed & Proctor (1995) suggest three researcher positions or relationships along a continuum (see Table 3). I found myself sitting comfortably within the "insider" position and moving into the "hybrid" position at times. I had worked as a hybrid researcher when undertaking research within the department in which I work as an academic.

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[47] Buchanan & Boddy (1992) appear influenced by the work of Erving Goffman (1974, 1990) although they do not state this. As will be seen in Chapter 8, the work of Goffman is used to contextualise emotion work for the midwives participating in this study.

This involved action research with clinical practitioners other than midwives. However, there was no getting away from the fact that I had a history and a future in midwifery. My position as a researcher became that of an "insider" (Reed & Procter, 1995), aiming to improve or change practice and contribute to the body of professional midwifery knowledge with the help of the midwives taking part in the study. At times, my previous work as a midwife and current work as a bank midwife did not serve me well as I lapsed into "old ways" of behaving and thinking.

Table 3: The position of the researcher

1. **Outsider**	A researcher undertaking research into clinical practice with no professional experience (hijacking). The researcher could also be described as an external facilitator or a 'political entrepreneur'.
2. **Insider**	A practitioner undertaking research into their own and their colleagues practice. This researcher position lies true to the philosophy underpinning action research.
3. **Hybrid**	A practitioner undertaking research into the practice of other practitioners. The action researcher as a 'political entrepreneur' also fits within this position.

Derived from Reed & Proctor (1995, p.10)

Williamson & Prosser (2002) discuss the roles of 'insider', 'outsider' and 'insider/outsider' action researchers working in their own organisations although they state that these roles are contextualised differently in each action research report. According to Williamson & Prosser (2002) an 'insider' action researcher can experience role duality in that the demands of the organisation in which they work can conflict with the research role. This can then lead to role conflict (Holian, 1999). Although I had considered myself an 'insider' action researcher in view of my previous

working relationship with the participating midwives and my bank midwife role, on reflection, my full time role was that of an academic and I was not working with the participating midwives on a daily basis.

Blurred boundaries – dealing with political behaviour

Holian (1999) has written insightfully and sensitively about how her research role added a complex dimension to her role within an organisation. When confidential information was divulged to her by the participants there was a blurring of boundaries as to whether this had been in confidence to her as a researcher or as a senior manager within the organisation. When the participants were asked what they wanted her to do with the divulged information Holian (1999) states that there was uncertainty amongst them although they knew that, as a senior manager, she could not forget what they had told her. I discuss in the following chapter how I felt that the midwives participating in this study may have attempted to manipulate me by divulging information during their individual interviews that they hoped I would 'act' on. The proximity of the 'insider' action researcher is therefore problematic.

Titchen & Binnie (1993) have argued that an insider role was unsuitable for their action research study about patient-centred nursing. These authors adopted a 'double-act' relationship that could be likened to the 'insider/outsider' role. Titchen & Binnie (1993) both shared the same values and worked collaboratively as 'actor' and researcher in their study. The potential conflict of Angie Titchen's study for a higher degree and Alison Binnie trying to achieve change within the study whilst also managing the ward were felt to warrant an 'insider/outsider' approach. This meant that the research elements of the study and the clout necessary for effective change to take place within the study were invested in different people.

The only limitations of this approach identified by Titchen & Binnie (1993) were those of guilty feelings on the part of the researcher not helping enough in clinical practice and the 'actor' not doing enough research activity. Other researchers (Webb, 1989; Meyer, 1993) have highlighted how involvement in both roles can affect relationships with colleagues and set them apart from those people that they are working with. The same phenomena occurred in this action research study where the research elements and the power to effect change were invested in me by the midwives.

The 'outsider' role within action research involves the researcher as an external facilitator (Williamson & Prosser, 2002). Although my role within this action research study often involved me facilitating the overall study, as an external facilitator I did not consider myself in this role because I had too much history and 'belonging' invested in the organisation to be considered 'external'. I was akin to that of 'insider' researcher in that I had "pre-understanding" (Coghlan & Casey, 2001, p.677) of the maternity services but in fact, when change came to be initiated, this was not owned, but resisted by the participating midwives.

In a way that is true to many decisions I have made along the way in this study, I decided that I did not fit into any of these categories and instead decided that I oscillated between them; sometimes I was an 'insider', sometimes an 'outsider' and sometimes both together. Positioning myself in these different roles was difficult at times and added to the complexity of the study. However, as Chisholm & Elden (1993) have stated, new approaches to action research have had to develop in response to change. These relate to the nature of the problems addressed, research methods and designs and relations between researchers and participants. This is particularly pertinent to midwifery where action research, in the context of this study, can be seen as responding to the complexities of clinical practice and new ways of working, a constantly evolving profession and radical changes in the NHS.

Key points emerging:

Positivist, interpretative and critical theoretic approaches can be clearly differentiated although they do share some characteristics. Positivist and interpretist research are primarily about adding to knowledge, not with bringing about a change in practice as critical theoretic research claims. Research that is primarily about adding to a body of knowledge can be set apart from action research because such approaches have as their focus of inquiry a static situation whereas the fundamental nature of action research means that change and improving knowledge is addressed. A static situation is usually explored through a position of detachment that does not allow for democracy and giving participants an opportunity to voice their concerns. Positivist and interpretative researchers aim to avoid any impact on the situation being investigated in order to maintain equilibrium and avoid distortion (Winter & Munn-Giddings, 2001). Critical theory researchers attempt to redress this imbalance but fail to recognise how dominant and subordinate groups struggle over power. For 26 years I have been part of a culture that has seen midwives succumbing to emotional exhaustion and I have listened to their stories about lack of support in clinical practice. I felt no need to prove this phenomenon. Instead I wanted to help midwives by facilitating change through action research with a view to understanding and improving practice.

There are clearly a number of different themes, values and principles that underpin the work of action researchers. However in each instance there is an emphasis on the importance of valuing knowledge that is created from 'practice' and more importantly there is an emphasis on developing this knowledge further through collaboration with others. Critical personal reflection is seen as crucial to the process of action research as is stating the researcher's own position in relation to the study. And finally, returning to one of my first points at the start of this chapter, the process of action research is as important as the final outcomes.

In the next chapter I explain the methods I used to generate and analyse the data.

Again my epistemological and ontological assumptions underpin this chapter.

CHAPTER SIX

Methods

> Understanding requires
> putting yourself in a position
> to be taught by
> to learn from
> to experience
> to be affected and changed
> to be humble
> to stand under
>
> It is to care enough
> to give the other
> power
>
> from Miller Mair 1989

This chapter is devoted to the methods I used to gather data in each phase of the study, as well as voice-centred relational methodology, which I used to analyse and interpret the data. My ontological and epistemological assumptions also overlap in this chapter as I highlight how they influenced the methods that I chose to gather the data. I discuss recruitment to the study and explore the use of in-depth interviews, focus groups, my personal history and contributions made by Dawn and Joss. I also address issues of ethics and rigour in this chapter.

<u>Placing 'the self' at the centre of the inquiry</u>

Shaping the research with social, political and critical insight

My experiences, values, feelings, knowledge, interpretations and responses, as well as the way events influenced me, were all part of the data I gathered during individual interviews and focus groups. Immediately after the interviews and focus groups I made methodological and reflective notes in my research diary which I often referred to

when re-reading the transcript. This enabled me to question what was going on (Koch & Harrington, 1998) and to check that what I was doing and saying corresponded. I documented my personal and professional prejudices and how these might influence what was happening in the study. All this was recorded and reflected upon in my research diary. As an action researcher this meant that I was contributing to the data by reflecting upon, and being critical of, my actions.

Marcus (1994) describes the above process as reflexivity where returning to personal history can become the 'critical gaze' (Koch & Harrington, 1998, p.888) that turns towards the self in order to understand the situation. Reflexivity therefore becomes "associated with the self-critique and personal quest, playing on the subjective, the experiential and the idea of empathy" (Marcus, 1994, p.569) within the research process. My research inquiry therefore became characterised "by ongoing self-critique and self-appraisal" (Koch & Harrington, p.888) as my personal history was incorporated into the research inquiry.

I decided to include a story of myself within the thesis where my intention was not to usurp the importance and relevance of the midwives' accounts, nor to be self-indulgent, but merely to illustrate how important I felt it was to replace "value free objectivity" (Cotterill & Letherby, 1993, p.72; Chesney, 2001) with subjectivity. I also wanted to acknowledge the importance I placed on not covering up my emotional engagement with the research and how this had been affected by my own personal history. Wilkins (1993) commented that during a search of standard methodological text books she was "astonished at the intellectual cover-up of emotion, intuition, and human relationships in the name of expert or academic knowledge" (Wilkins, 1993, p.94). Like Ruth Wilkins, I consider my emotions to be a positive resource within my research.

A story of myself (6.12.00)

I decided in the fourth year of my PhD studies that I wanted to include a personal account in my thesis in order to provide the reader with some insight into my background. The story includes my "baggage" as this was often "on top" (Heron, 1991) for me during the course of the research, much of it brought about by undertaking research in an organisation that was steeped in history and culture. The decision to include "my story" came very soon after I started the Therapeutic Group Work Course (see Chapter 1) where I realised that much of my past life had, and still was, affecting the way I facilitated and wrote up my study. As my research progressed, and at the time of writing, I realised that I was seeing, and beginning to understand, events in my life, both at work and at home, that I had experienced as painful. At the time I was worried that they might bias the research and that I would distort rather than interpret the voices of the midwives. However I did not want to depersonalise my research. The notion that the researcher should have "no personality or idiosyncratic insights [or] that they should...have no culture or political beliefs" (Reed & Proctor, 1995, p.6) to inject into their research was not congruent with my value position (see p.109). I did not want to ignore knowledge and understanding that I had gained as a woman, mother and midwife because I felt that this would lead to a "tragic waste of knowledge" (Reed & Proctor, 1995, p.4).

Childhood lasts a lifetime

I was born in Preston, Lancashire, the eldest of five children. I have two brothers and two sisters. My mother was a teacher and my father a draughtsman. My father was also a brilliant artist. He passed these skills on to me. When I was born my mother went back to work when I was six weeks old in order to help make ends meet. I went to the local village primary school and was considered a 'bright child'. I took my eleven

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plus a year earlier than every one else and passed. I used to walk to and from school (about two miles) and on the way home my cousins, who lived next door to us, would wait in the bushes and throw stones at me and "call me names". I used to dread the walk home and the look on my mother's face when she saw I had been crying.

The next school was harder but easier to bear because my mother taught there as well; I felt safe because she was close to me (see Chapter 2). This did not stop the maths teacher making me stand on my chair in the classroom when I got my "sums" wrong though. I failed my maths GCSE twice. I remember once in a sewing class being held up to ridicule in front of the whole class because the thread was too long on the sewing needle I was using. I felt humiliated. During this time my father went to teacher training college.

I used to look after my brothers and sisters on many occasions for my parents. We always ended up quarrelling and I would feel that my brothers had "got the better of me". My parents' friends used to say that I had an "old head on young shoulders". Convent school was strict and authoritarian and I struggled to keep ahead. I was constantly getting my knuckles rapped with a ruler by the nuns. Fear of reprimand and humiliation far outweighed the importance of my declining school work.

Life at home deteriorated. My parents separated and this had devastating effects on my emotional wellbeing and schoolwork (see attachment on page 54). I failed one of my A levels. I needed to feel needed (see page 282). I decided to become a nurse where I felt others might need me. I left home and went to live in the city. I missed my brothers and sisters and worried about them. Nurse training was different and there were lots of parties and socialising and I made some lasting relationships. Only some of my inner desires were satisfied. The training was disappointingly authoritarian; we learned by rote and were not allowed to speak to senior students or senior members of

staff. We were kept firmly in our places and not allowed to express ourselves. There were 120 students in my group. I could easily lose myself, keep silent and hide behind the others. I imagined what it would be like to be humiliated in front of 120 peers.

I went on to pass my State Registered Nurse finals (first time). My first post was on the Intensive Care Unit (ICU). There was no need to communicate with the patients on ICU. Most of them were artificially ventilated and could not speak; others were so critically ill that talking was the last thing on their mind. The doctors all seemed so knowledgeable, yet so detached. I decided to apply for midwifery training. Somebody told me a second qualification was good if you wanted to work abroad.

I was 22 when I started my midwifery training. I was also naïve and I still felt the need to be needed. I thought I would be able to help and support women. Instead I felt oppressed by a medical system that seemed to have no regard at all for women. Authoritarianism, humiliation and degradation pervaded midwifery and were ever present, constantly reminding me of my past. Although life as a midwife in Glendale NHS Trust was mainly rewarding it was also hard work. Our team undertook antenatal and postnatal visits in women's homes and parent education in health centres. We also attended numerous antenatal clinics on a weekly basis. I grew tired of the mundaneness of the job and my inability to be able to influence or change ways of working because of oppressive midwifery managers and hierarchical systems that seemed to be in place to police our practice as midwives. Although I did not know it at the time, I was practising as an oppressed midwife in a medically dominated setting. I had hoped that working as a community midwife would facilitate my desire to practise more autonomously. However, this was not to be.

I had easily become an 'accepting' midwife because my past career as a nurse was undertaken when 'doctor knew best' and nurses were doctors' handmaidens. I had

never seen or practised midwifery differently and as a result of being 'accepting' I became socialised into ways of working that dominated my entire working life. As a group of midwives we moaned about our excessive workloads, complained about many of the clients (especially the more demanding women), blamed our misery on midwifery managers and constant change in the NHS and talked about each other inappropriately all the time. I used to feel that I gave the women so much of myself and never got anything in return. I used to feel 'drained' and began questioning this feeling (see Chapter 8). I used to dream about how midwifery might be but never dared to articulate my thoughts because I was frightened of reprisal and being humiliated in front of my peers.

To this day, I cannot recall what changed or happened – I think it was an assertiveness course that I undertook with one of my colleagues. I realised that there was nothing wrong in challenging the status quo and that this is how change is enacted. This course acted as a springboard to my future. I decided to undertake my Advanced Diploma in Midwifery. My colleagues were disappointed and sad when I left and I felt the same. I never realised how much they had appreciated me and I remembered thinking if only we had been able to offer praise to each other when we had been working together things might have been very different.

When I was 36 and studying for my Advanced Diploma in Midwifery I had a major confidence crisis in my life. My self-esteem was at rock bottom, I couldn't stop crying, I thought I was useless and everyone else seemed so much stronger. The course was increasing my self-awareness and made me reflect on my life and self to date. I did not particularly like what I saw. I decided to go for counselling. I paid for this privately in times when money was scarce but it was money well spent. The counselling lasted for two years and marked a great watershed in my life. At last I could look on the painful moments within my life more constructively (see page 8).

I set off on a journey that took me through university education, becoming a teacher and then being employed in a higher education institution. I understood more about oppression, power relations and research and I was able to understand and articulate my value position more clearly. However I became more and more aware that I was still not "living out" (Whitehead, 1993) my values as I remained muted in the institution in which I worked. This worried me and I became immensely frustrated at times as I struggled to make my voice heard. At the time I never imagined that these very same issues would emerge as methodological issues within my study.

In 1990 I decided that I wanted to teach midwifery. My first degree increased my self-awareness further and I started to value feminist principles of women supporting women. I was like a sponge and wanted more and more of education. New found friends helped me and encouraged me. I had become a continual learner reflecting on my practice and life. I began to realise that didactic, authoritarian ways of teaching were not appropriate and that facilitation was liberating. I took risks with my teaching and encouraged students to challenge me in the classroom setting. I felt emancipated and I continue to learn from students today.

I was told in 1994 that I would not be accepted on to a Masters programme with a 2:2 degree. I had not felt humiliation like it since I was at school but rather than focus on the negativity of this person's comments I used my feelings positively. I immersed myself into MPhil research and decided to continue my learning by converting my MPhil to PhD as soon as I could.

PHASE ONE

Gaining access

I returned to Glendale NHS Trust in 1996 as a researcher seeking access to undertake this study within the maternity unit where I used to work. As the midwifery managers and midwives knew me from a previous "working life" I felt that gaining access would be somewhat easier to achieve although it was never my intention to avoid going through the correct formal procedures. In fact, getting access was tough as I battled my way through layers of hierarchy. The Head of Midwifery at the time had suggested that I attend a supervisor of midwives meeting in order to "get approval" for the study. Apart from seeking ethical approval, this was my first encounter with gatekeepers.

Gatekeeping access

I initially found it irritating that I had to seek gatekeeping access from supervisors of midwives because clinical supervision was different to midwifery supervision (see Chapter 4). Whilst I appreciated that judgements had to be made as to whether my research was going to benefit midwives and the organisation, I was left wondering whether my ideas were seen as potentially contentious and therefore damaging to midwives and the maternity service. I did not challenge the decision to meet with supervisors of midwives but duly arranged to attend their next meeting.

On the day I attended the meeting I waited in the midwifery manager's office to be "summoned". I wrote in my research diary that "I felt like a lamb going to the slaughter" (Research Diary, March 1997) and that the supervisors kept me waiting 30 minutes before they invited me into their meeting room. I realised whilst I was waiting that I had become a powerless, muted midwife again. I felt myself dithering, my mouth became dry and an overall feeling of anxiety began to wash over me. I felt helpless and

cornered as I waited to present my work to a group of midwives that I perceived to be more knowledgeable, powerful and better than me. I felt ashamed, and angry with myself, that despite many years since leaving the NHS, and making a conscious decision to try and leave old ways of working and socialisation behind, I was overcome with a kind of hysterical nausea that paralysed me. Wilkins (1993) reports much the same when she conducted research on childbirth. She refers to experiencing "acute anxiety "and resorted to carrying a "panic pack" (p.95) especially when she knew that she was going to be encountering "gatekeepers". The sweating and dry mouth that she refers to certainly had resonance with my experiences in the field.

Old habits die hard

This brings me to my current responsibilities as an educationalist and how my old socialisation habits have been at work here as well. Despite efforts to convince myself that I disliked social injustice and hierarchy and that I had feminist principles of women supporting women I continued to feel muted on many occasions within the university. I was becoming increasingly aware of my silences and how I could easily become locked into silence and use it as a safety net. Silence became for me "an insidious and unconscious process of self preservation and social amnesia" (Gordon, 2001, p.319). I felt that I was being the person other people wanted me to be rather than who I wanted to be. I was beginning to see many contradictions in my life and my work. Indeed this painful process of self-reflection led me to action research as an approach that is congruent with my own value position. After all, here I was replicating the behaviour of the midwives in the study. I was not "living out" the values (Whitehead, 1993) I professed to have and this was painful as I realised that even after many years I could still succumb to, and was still steeped in, what I perceived was their negative culture.

Silencing mechanisms at play

I survived the meeting with the supervisors of midwives although they were clearly anxious about my presence within the maternity unit and the fact that I was undertaking research into supervision that seemed to be a threat to their own model of statutory supervision. One of the supervisors thumped her fist on the table and pointed her finger at me from the back of the room shouting, "we already have good supervision here" (Research Diary, March 1997). Another of the supervisors asked me if I was "researching supervision with a capital 'S' or a small 's'". At the time this choice of words indicated to me the powerful and hierarchical nature of statutory supervision as undertaken in the maternity unit.

I was then advised by the Head of Midwifery that the next step was to meet with the community midwifery manager in order to decide which group of midwives I was going to work with. This manager directed me to Glendale Team as they were a "good, supportive team" that worked well together. I did not debate this with her as I was glad to have gained access. However thoughts went through my mind that if this was a supportive team then why would they need my help.

On reflection I felt that this midwifery manager had used this group of midwives as a ploy to skilfully direct me away from other work teams who were known at that time to need further support. She was aware that there was a lowering of morale at the time I was undertaking the research and had directed me to a work team that she perceived would not expose the underlying tensions within the maternity unit. However, the group of midwives that she had advised me to approach proved to be just as vulnerable as other midwives within the Trust.

Recruitment to the study

I met with the midwives taking part in the study a total of four times prior to commencing data collection. The meetings took place in the Health Centre where they were based from late July to mid November 1997 and usually followed an antenatal clinic. Much of the time at these meetings was taken up with informing the midwives of their role in the research and inviting any questions that they had in relation to the research. I was reluctant to start collecting data until I knew that the midwives were fully aware of what the study entailed.

The midwives were questioning about their role and asked questions like "what will it involve?" and made comments like "I'm too old for this sort of thing" and "I'm not quite sure what you are expecting of me" (Research Diary, 27.9.97). These same questions were also repeated at the start of some of their individual interviews. The midwives seemed keen not to show themselves in a bad light. This accorded with the "best face" phenomenon described by Cornwell (1984). Cornwell discusses how some people when placed in an unfamiliar situation, or their role is unclear, become aware of a need to manage their conduct. Cortazzi (1993) has also stated that the narrator (the interviewee) can be described as giving a 'performance' (see Chapter 8) that attempts to influence the audience (the interviewer) through "impression management" (Goffman, 1990, p.203).

At times, however I was disappointed that the midwives seemed to persist in denigrating their capability and that they appeared unable to recognise or visualise the potential personal and professional development that was inherent within the study. On reflection, I was thinking naively because the midwives were beginning to highlight that participation was going to become a constraining factor for them. Whilst I tried to

bolster their confidence in terms of their pending contributions, I began to question their commitment to the study on the level I had imagined.

The midwives appeared reluctant to commit to the study until I could reassure them that midwifery managers were sympathetic to their role in the research and the extra time and support that their participation might entail. I made several visits to midwifery managers when I was reassured that full support would be given for the midwives. As I had not yet commenced interviewing the midwives they were not able to articulate what their requirements were in terms of support. However, in November 1997 I was able to discuss with them how we might make a start on the study and several of them arranged dates with me when we could meet to carry out an interview.

Excluding 'others' from the research

Interestingly, and despite the fact that the midwives were feeling overworked, they chose not to include new work team members in the research. They informed me of their decision at one of our meetings at the Health Centre where they also informed me that they did not wish to include part-time members of the work team either. However the midwives were happy for me to 'brief' new work team members about the progress of the research. In the later stages of the research when the midwives went off-site for their clinical supervision, they wished any bank midwives working for them, to be informed that they were team building. As was seen in Chapter 5 this accords with the midwives' reluctance to participate on the level that I anticipated.

PHASES ONE, TWO AND THREE

Interviews as complex, social interactions

As the study had to have a starting point, I decided to use in-depth interviews in the first instance, in order to encourage the participants to relate their stories of community midwifery and thus obtain, what I hoped would be, "rich accounts" (Alvesson, 2002, p.108). My previous experience of interviewing (Cliff & Deery, 1996) had involved the use of a semi-structured interview style in which I had a set of pre-defined questions to ask the research participants. I found this restricting in that I could not enter into a more conversational style of interview (Oakley, 1981; Mishler, 1986) with the participants. This accords with the neopositivist approach identified by Alvesson (2002) that seeks to "establish a context-free truth about reality 'out there' by following a research protocol and getting responses relevant to it, minimizing researcher influence and other sources of 'bias'" (Alvesson, 2002, p.108). As seen in the previous chapter this would have involved me taking the stance of "a pipeline for transmitting knowledge" (Holstein & Gubrium, 1997, p.113) where objectivity and neutrality are seen as the ideal (Alvesson, 2002).

I was determined not to feel restricted during the interview process in future research studies, hence my decision to use in-depth interviews. I wanted to spend time with midwives in a non-hierarchical and non-exploitative way, talking with them about their experiences of midwifery and also in a way that was congruent with clients now being encouraged to become equal partners in the planning and delivery of maternity care (DOH, 1993a). This approach to interviewing is identified by Alvesson (2002) as 'romantic', whereby:

"...a more 'genuine' human interaction, believes in establishing rapport, trust and commitment between interviewer and interviewee...This is a prerequisite in order to be able to explore the inner world (meanings, ideas, feelings, intentions) or experienced social reality of the interviewee...Words like deep, full experience, definition, meaning, view, intersubjective dominate..."
(Alvesson, 2002, p.108-109)

In 1975, Laslett & Rapoport questioned the appropriateness of "placing high value on "interviewer-proof" techniques" (p.971). Since Laslett & Rapoport (1975) wrote, subsequent discussion of traditional research textbooks with guidelines that advise interviewers to remain detached, withhold information and not answer questions have been challenged (Arksey & Knight, 1999). Ribbens (1989) however, states that researchers should be more concerned about what they are trying to achieve within their studies and the types of relationships that they want to develop with their participants rather than becoming embroiled in theoretical decisions about which type of interview to use. This stance is particularly pertinent to an action research approach where collaboration and participation are seen as essential components (Winter & Munn-Giddings, 2001).

Arksey & Knight (1999) refer to in-depth interviews as 'unstructured' and the way in which they can offer flexibility in gathering information for those participating in the research. Bearing in mind that action research involves working collaboratively with others and in a non-hierarchical manner, these are important points to consider when choosing interviews as a method of data gathering. Kvale (1996) has stressed the importance of the conversational nature of interviews stating that they are "literally an inter view, an interchange of views between two persons conversing about a common theme" (p.44).

The influence of reciprocity

My chosen method of in-depth interviewing and establishing relationships with the research participants were based on the collaborative, participative nature of action research and the influence of Oakley's (1981) values of reciprocity[48]. Oakley (1981) emphasises the conversational nature of interviews and that they should not be sterile, one-way communication processes. She believes that the researcher should invest their own personal identity within the research relationship, answering respondent's questions, giving support when asked and sharing knowledge and experience. However, as DeVault (1999) points out, "making personal material more visible often stimulates strongly negative reactions, including trivialization and dismissal" (p.105) in those researchers who prefer to use "standard social science formats" (DeVault, 1999, p.105).

Nevertheless I decided that I wanted to use myself in a way that meant I became more of a resource than a contaminant (Krieger, 1991) to the research whilst at the same time ensuring that I did not make myself the centre of the research. Cotterill (1992) has stated that the best way to find out about women's lives is to "make interviewing an interactive experience" (p.594). As well as fostering an equal relationship between the researcher and the interviewee, Cotterill states that "reciprocity of this kind invites intimacy" (Cotterill, 1992, p.594).

However there were difficulties I encountered with this intimate/reciprocal approach which Oakley (1981) does not seem to address in her work. One of these difficulties was around issues relating to power within the research relationship and the ways in which participants can become "politically motivated actors" (Alvesson, 2002, p.113). As will be seen later the participants could well have had their own agendas during the

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[48] As was seen in Chapter 3, reciprocity is a recurring theme within the midwife-mother relationship. Again there are parallels with the relational aspects of midwives and clients and researchers and their participants.

research process and thus tried to influence the way I represented certain issues within the research and to midwifery managers[49].

Listening to midwives' voices

A total of 15 in-depth interviews were conducted during the study with most of these taking between 45 minutes to one and a half-hours. As one of the aims of the study was to explore midwives' views and experiences of their support needs, the interviews were loosely structured in order to get the midwives to explore their feelings, perceptions and concerns about their roles and lives as community-based midwives[50]. The eight midwives participating in the study were invited to attend over a six-month period in the first cycle of the action research study. Three of these midwives were not interviewed in the second round of interviews as one retired and the other two moved to another work team.

I had decided to interview the midwives twice, initially to capture life as a community midwife and hopefully identify a need for change, and also at the end of the study in order to evaluate their experience. However as this was an action research study I had to remember that I really wanted the participants to shape the progress of the study and that a need may arise during the course of the research to alter this initial 'plan'. All the interviews were audio-taped and transcribed in full. The typed transcripts were returned to the midwives within one month of the interview and prior to our next meeting, to check for accuracy and to invite further comments. I also re-read the transcripts myself and checked them whilst listening to the tape recording. The interviews were conducted at a time convenient to the midwives. This usually meant that I was conducting an interview following an antenatal clinic in one of the health

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[49] Once again there are parallels here with clinical practice and the rhetoric of policy documents. Midwives are encouraged to work in ways espoused within these documents but the reality of their practice (i.e. organisational constraints) means that this is often impossible.
[50] I did, however use interview schedules to guide my approach to questioning (see Appendices 2 and 5) although I very rarely needed to refer to these because the midwives talked at great length.

centres or during a lunch break. We tried to ensure that we were not disturbed and only were on two occasions.

Listening to the voices of Susan, Sarah and Stella

I was anxious about the possibility of the midwives not identifying a need for support and discussed this at length with my research supervisor. She suggested piloting my interview questions on three midwives who were not going to be involved in the study. I therefore carried out initial exploratory interviews with three community midwives in preparation (Susan, Sarah and Stella[51]). This proved to be a very useful exercise, where I was not only able to check out proposed questions, but practise my interviewing skills.

Susan, Sarah and Stella worked in three different work teams but within the same maternity service where the research was undertaken. I did not want to ignore the honest, rich accounts provided by these midwives and decided that I wanted to weave their words through the data analysis in Chapter 8 where I address emotion work in midwifery. Their insightful accounts support the words of the midwives participating in this study providing evidence that emotion work within community midwifery, as depicted by the midwives participating in the action research, was not peculiar to their work team. Susan, Sarah and Stella received copies of their interview transcripts and I sought their permission to include their words with those of the midwives participating in the action research study.

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[51] I chose pseudonyms for these midwives that began with the same letter in order to make their words distinguishable from those midwives participating in the action research.

Seeking 'spontaneous story-telling'

The initial interview question was broad and sought to seek a response from the midwives that would help them describe their work as a community midwife. All the interviews commenced with one open-ended question; "Tell me what it is like for you being a community midwife?" I had hoped that this question would lead to spontaneous story-telling (Reissman, 1993) where the midwives would relate stories that had special meaning for them. As the interviews progressed I included probes and found that, as Reissman (1993, p.3) has stated, "[r]espondents narrativize particular experiences in their lives, often where there has been a breach between ideal and real, self and society"[52]. As the midwives spoke I found that I only needed to interrupt to clarify their story when I did not understand, or to offer one or two probes in order to facilitate the interview further. Although I was keen to elicit their support needs, I did not want their stories to be moulded by my questions. Most of the midwives could talk easily about their experiences, and because I had worked with them professionally in the past (see page 160) I was able to place their stories and experiences in the context of midwifery.

As the interviews progressed I tried to move the midwives into more reflective thinking by asking questions which focused more directly on aspects of their clinical practice. As was seen in Chapter 4, there are parallels here with clinical supervision and reflective practice (Bond & Holland, 1998; Rolfe et al. 2001). I asked them about their working relationships and to elaborate on particular situations which they were relating in their stories. I asked them to describe what had been going on, why and how they did things and what their logic was behind some of their behaviour and thinking. As well as using open questions I used techniques for probing and clarification, for

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[52] This "breach between ideal and real" (Reissman, 1993, p.3) is congruent with the "conflict and ambiguity in the tensions between client-centered goals and organizational goals" (Lipsky, 1980, p.44) which is often seen in clinical practice as a mismatch or clash of values (see Chapter 4).

example, "could you tell me more about that?" or "could you explain that further?" I also included résumé or summary questions (Grbich, 1999) to help me clarify and sequence events in their stories, for example "so…is what you are saying…?" and "so the first thing that happened was…and then this happened…"

At times during the interviews I tried to paraphrase what the midwives were saying to me, not only to clarify my own understanding but also to give them the opportunity to clarify or expand on what they were saying to me. I had also hoped that this open approach might provide an opportunity for the midwives to question what I was saying. This also emphasises the importance of balancing the power relationship between me as the researcher, and the midwives as the participants in the study (Oakley, 1981; Hart & Bond, 1995; Winter & Munn-Giddings, 2001). Although the midwives appeared comfortable with me during their interviews they did not challenge my interpretation of events as we talked.

The interviewer as a therapeutic resource

The sensitive nature of some of the data was overwhelming at times. Seibold (2000) recalls similar experiences in her research study with single, midlife women and describes "cathartic" (p.149) experiences following highly emotional revelations by the participants. She goes on further to relate how she felt that the interviews took on the form of a therapeutic relationship. At times during the interview process I felt that the midwives used me as a therapeutic resource. I knew when this was happening in the interview by the nature of the language the midwives were using (for example, "I feel" and "I need") and also by their body language that was often in the form of sobbing.

Jane, for example who I interviewed in a bathroom at one of the health centres, did not sob but was clearly distressed as she vigorously stirred her cup of soup, clattering the

spoon against the side of the cup. Initially I was concerned that I would not be able to hear her words over the clattering noise she was making when I transcribed the tape but then I realised that this body language was data and she was trying to tell me that remembering these stories was painful for her. My language changed too, as I resorted to using words that I knew would let the midwives know I was prepared to listen to them (for example, "Tell me more about those feelings" or "I can see that this is very painful for you").

This then raised issues of whether or not an interview should be terminated and if so how will this affect the nature of the relationship between the interviewer and the participant. I chose not to terminate any of the interviews and I allowed myself to be used as a therapeutic resource. Although I possessed a counselling knowledge base, I did not take on the role of a counsellor, as I do not believe that the researcher has any role as a counsellor. Instead I became a "therapeutic listener" (Oakley, 1981, p.51) and let the midwives relate stories that they had probably kept hidden, in some instances, for many years. Some of the midwives found this distressing but at the end of the interview told me that they had found telling their story helpful.

Is it necessary to draw a line in the sand?

Following the interviews I struggled with issues relating to whether I had drawn an appropriate "line in the sand" between being a researcher holding feminist values of women supporting women and entering into a therapeutic relationship. I did not want the midwives to feel that I had manipulated my relationship with them in order to elicit data for my research. Although I had invited the midwives to indicate to me if they wanted the tape turning off during the interview none of them did this. In fact when two of the midwives became distressed during their interview they were adamant that the tape recorder had to be left switched on despite my attempts to stop the tape running.

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Likewise this could be likened to the midwives using the interview for their own political purposes where they tell the truth as they know it "but in ways that are favourable to them, and not disclose truths unfavourable to them and their group" (Alvesson, 2002, p.114).

To help me come to terms with this dilemma I sent all the midwives their interview transcripts following the interview and invited comments from them. I also asked them to delete any data they were uncomfortable with or did not feel was a true representation of the interview. None of the midwives asked me to delete or change data although one of them asked me not to include some data from her final interview. Ethically, I felt reassured that they had not been exploited as research participants and that their non-response meant they were keen for me to use their personal and professional experiences as data and that I had listened sympathetically.

Choosing the venue…feeling safer on your own patch

Hammersley & Atkinson (1995) have noted that the location of the interview is an important aspect for the researcher to take into consideration. Interviewees may well be more relaxed in their own choice of venue; for example, this could be either their own workplace or their own home. I therefore decided to take a lead from the midwives in terms of where the interview would take place. I also thought that this would help to break down any hierarchical barriers that existed between us. Interestingly all the midwives chose to meet on hospital or Health Centre premises. As will be seen in Chapter 7 this decision fits with their anxious feelings of wanting to feel safe.

Coping with distractions and interruptions

Phillips & Davies (1995) have stated that taking a lead from the research participants for the interview venue may mean being prepared to undertake an interview in an unusual place (e.g. the sluice in a hospital ward or the kitchen area in someone's home). During one of the interviews I undertook on health centre premises I had to change venues twice within the same interview eventually conducting the interview screened off, in the corner of a large room where a baby clinic was being held. Morse & Field (1996) identify interruptions and competing distractions as two pitfalls that can be encountered when conducting interviews. In this particular interview the distractions comprised being interrupted firstly by a health visitor requiring the room to see a mother and baby and then by a practice nurse requiring the room to see a patient. The competing distraction in this instance was that the midwife being interviewed had set a time limit to the interview as she had a long journey home. Unfortunately interruptions and distractions were outside of my control as I had given the midwives the flexibility to identify the time and place of the interview.

The interruptions and distractions I experienced during this interview then proved problematic when transcribing the tape. Crying babies and children playing in the baby clinic tended to dominate over the interviewee's voice. I decided not to suggest a quieter venue or different location for the interview as I did not want to jeopardise the development of trust and reciprocity within the research relationship. Also, getting the midwives to the point of interview had also been an achievement and selfishly I could not bear the thought of having to arrange another date and venue.

Cotterill (1992) refers to interviewees obliging the researcher by providing what the interviewees perceive to be the correct answer to questions posed. This type of

'appropriate' behaviour would conceal views that might be unacceptable to others[53] (Cotterill, 1992). Until trust had been established between the research participants and myself I was not expecting any revelations about personal feelings[54].

However, even as the first round of interviews progressed, the midwives began to disclose sensitive information in respect of their personal and professional lives. When writing in my reflective diary I put this down to my listening skills and the midwives being able to pick up non-verbal cues that I was prepared to listen to them, "to have a common viewpoint…be aware of, and able to offer respect for and support within, the [midwife's] values and priorities" (Kirkham, 2000, p.240). I also reflected that this might have been the first time that anyone had been prepared to listen to the midwives.

Articulating 'unarticulated experience': helping each other out

Hitchcock and Hughes (1995) state that concentrating on the interview as a speech event draws attention:

> "…to the communicational and sociolinguistic
> aspects of its organisation and the production of
> data contained within the interview and
> conversational materials in terms of what it is that
> the parties are doing with the words, phrases and
> idioms that they are using".
> (Hitchcock & Hughes, 1995, p.169)

As I wanted to focus on the conversational nature of interviewing and thus encourage the midwives to "tell their stories" in a safe environment this meant leaving technical

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[53] As was seen in Chapter 4 there is also the possibility of this happening within the process of clinical supervision whereby supervisees will not discuss or highlight pertinent issues relating to clinical practice for fear of reprisal or disciplinary action from managers (Butterworth, 1998).
[54] There are close parallels here to establishing trust with clients in the clinical setting (Kirkham, 2000; Stapleton et al. 2002a). "In such situations, the midwife, if she trusts the mother, becomes involved with attitudes and values that are deeply threatening in the context of her relationships as a professional and an employee. In such circumstances, relationships are negotiated and renegotiated, and trust has to be reconstituted (Levy 1998) or replaced by mistrust" (Kirkham, 2000, p.240).

issues on one side so that the linguistic style of the interview would not become masked (Mishler, 1991).

Morse & Field (1996) state that "good interviews can be detected as soon as they are transcribed. The page appears a solid block of text" (p.75). If I were to use this gauge as a measure of success in some of my transcripts then the interviews I held with some of the midwives would have been described as deficient in terms of "unarticulated experience" (DeVault, 1990, p.101). When interviewing Gemma I often offered assistance in terms of "let me help you" when I saw, what I perceived to be, her struggling to answer or understand the question I had asked. When reviewing my transcripts there were many one-line responses or even one-word responses within the data leading to copious amounts of white paper being visible. I became aware that some of my transcripts were filled with the words "you know". At first I viewed this as "stumbling inarticulateness" on the part of the midwives (DeVault, 1990, p.103) yet on reflection this seemed rather a harsh stance to take. Like DeVault (1990) I began to think that "the phrase is not so empty as it seems" (p.103) and means . Devault"something like, 'OK, this next bit is going to be a little tricky. I can't say it quite right, but help me out a little; meet me halfway and you'll understand what I mean'" (Devault, 1990, p.103).

This therefore provides a new way of thinking about such data. Instead of viewing words such as 'inarticulateness' negatively, they could according to Devault be viewed as a request for understanding. This stance seemed appropriate for the midwives but at the time I naively questioned why they had to ask for understanding in such a manner. I did not have to look very far for my answers as I reflected on my own personal history in nursing and midwifery and how difficult I had found this aspect of my interactions with those I perceived to be more knowledgeable. As I became more skilled at interviewing I was more tolerant and sympathetic to the midwives' hesitations

as I recognised my own limitations within their accounts. I reflected with them on how I had found, and still did find, similar difficulties within clinical practice.

The co-production of data within interviews

Although not specifically referring to interviewing Peshkin (1988) states that subjectivity is a virtue that pervades the entire research process. He views this as advantageous and explains how he decided to "actively seek out" his subjectivity in research by noting down when different feelings were aroused. Peshkin believes that "[subjectivity] is the basis of researchers making a distinctive contribution, one that results from the unique configuration of their personal qualities joined to the data they have collected" (Peshkin, 1988, p.18). Therefore, the importance of the researcher discussing thoughts of "this is me" or intersubjectivity (Klein, 1983) with the interviewee can help to make the research relationship more equal. Oakley (1981) has also identified this as the researcher "investing his or her own personal identity in the relationship" (p.41).

Hollway & Jefferson (2002), taking a psychotherapeutic approach to interviewing, elaborate on the notion of intersubjectivity by suggesting that "unconscious intersubjectivity" (p.45) comes into play during interviews. This unconscious dimension of interviewing accepts that the interviewer and the interviewee have feelings and that they are of value and significance in understanding the dynamics of the research relationship. As Hollway & Jefferson (2002) state "what we say and do in the interaction will be mediated by internal fantasies which derive from our histories of significant relationships…often accessible only through our feelings and not through our conscious awareness" (p.45).

Scheurich (1997) agrees with this point stating that "the researcher has multiple intentions and desires, some of which are consciously known and some of which are

not" (p.62). Scheurich goes on further to state that "the same is true of the interviewee" (p.62).   Bion (1984) states, that when emotions are being passed unconsciously from one to the other, feelings can sometimes become too uncomfortable because of past associations. Therefore, within the dynamics of the interviewing process, the defence of projection could be used to get rid of the feeling by placing it into the interviewer or the interviewee (see footnote 56). As Hollway and Jefferson (2002) state there is the possibility that the projection can be experienced as empathy or if the other person denies the feeling, reassurance often comes into play[55]. Alternatively, "the other person can contain the pain, [and] it can be returned 'detoxified' and faced as an aspect of reality" (Hollway & Jefferson, 2002, p.50)[56].

PHASE TWO

Hearing Joss' voice

One of the aims of this study was to evaluate the effectiveness of the planned support mechanism; I therefore held an interview with Joss, the clinical supervisor. I stressed confidentiality and anonymity issues relating to the study as I had with the midwives. I discussed with Joss that I wanted to obtain a clearer picture of her experience as a clinical supervisor and issues this raised whilst facilitating clinical supervision for a group of community-based midwives. I also thought that it was important to gain insight into how the midwives had coped with clinical supervision so that its effectiveness could be evaluated. We met in her office to carry out the interview[57].

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[55] I am reminded here of the difficulties midwives sometimes have when dealing with clients who are experiencing personal difficulties and the tendency to offer the words "don't worry" which are unhelpful and often deny the feelings of the other person (Hargie, Saunders & Dickson, 1998).

[56] Projection is an important concept that is not yet fully understood or recognised within midwifery. Not only does it occur during the interview process but there are also parallels within many relational aspects of clinical practice.

[57] The data from this interview is reported in Chapter 10 and combined with the midwives' evaluation of the process of clinical supervision.

Focus groups as 'natural social networks'

Market researchers began to utilise focus groups in the 1950s with the method now having gained precedence in the political arena to guide campaign advertising and image management (Barbour & Kitzinger, 1999). The use of focus groups in the social sciences however was largely ignored initially until the 1980s when there was a steady increase in their use with a paralleled increase in midwifery research (e.g. Hammett, 1997; McCourt, Page, Hewison & Vail, 1998; Kirkham & Stapleton, 2001; Hughes et al. 2002; Hunter, 2002).

I decided to utilise focus groups in the study with the intention of bringing the participating midwives together in order to gather research data[58]. I would then be able to identify important issues that had arisen for them during their individual interviews. In terms of the collaborative nature of the study I also felt that it was important for each midwife to be invited in order to contribute on the progress of the study and how they imagined support for themselves developing as a result of the research.

Interaction as synergism

Kitzinger (1994) states that it is useful to work with pre-existing groups as they provide social contexts in which ideas are already being formulated. However Kreuger (1994) warns about working with groups that are already established as this may inhibit disclosure[59] and encourage diversification from the topic area. As one of the aims of this study was to explore midwives' working relationships it was important that I was able to observe them together as a group albeit out of the work context. The midwives

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[58] I had a series of pre-devised questions in the form of a focus group schedule (see appendices 3 and 4) in order to guide the focus group but found that I rarely needed this because discussion often 'took off' without me needing to refer to the schedule.
[59] See Chapter 9 for further exploration of ways in which midwives can become silenced during focus groups.

who took part in this study already knew each other through working and socialising together. This would hopefully enhance what Twinn (2000, p.18) refers to as the "synergism" of the focus group and provide a "natural social network" (Kitzinger, 1994, p.106).

When using the word "natural" Kitzinger is referring to a pre-existing group and advises users of focus groups not to consider group data as 'natural' because they might have occurred naturally anyway. She believes focus groups should be used to "encourage people to engage with one another, verbally formulate their ideas and draw out the cognitive structures which previously have been unarticulated" (Kitzinger, 1994, p.106). I was hoping therefore that during the focus groups the midwives would be able to explain and construct their views about their support needs and a way forward during the change process. Focus groups are therefore different to interviews in that participants engage with each other as well as the researcher (Agar & MacDonald, 1995).

The group processes and interactions of the focus group members are seen by a number of authors as a key advantage to the functioning of such groups (Morgan, 1997; Greenbaum, 1998; Barbour & Kitzinger, 1999; Twinn, 2000) with Barbour (1999) stating that in theory focus groups can only reflect on, or monitor change. However there is scope for the focus group process to initiate changes in the participant's thinking or understanding of the issues being addressed. In research that I undertook in a local NHS Trust in 1999 a definite change in midwives' motivation following focus groups to address midwifery morale was reported (Deery et al. 1999).

Focus groups equate with 'time-efficiency'

Focus groups are also time-efficient means of gathering information from a number of people (Morse & Field, 1996; Grbich, 1999). In the context of this action research study being 'time efficient' was an important factor because the midwives participating in the study were adamant that because of their busy work schedules they were not able to give freely of too much of their time especially as they had also provided me with individual interviews.

Morgan (1998) suggests group sizes of approximately six and ten although he also suggests that the size of the group can vary according to the nature of the topic being discussed. In the case of this study the focus group participants constituted the focus group. In accordance with the aims of the study the focus groups were held to gain an in-depth understanding of how the midwives wished to receive support and also to explore working relationships. Morgan (1998) suggests that smaller focus groups encourage participants to share viewpoints, although as will be seen in Chapter 9, where there is an existing hierarchy within a work team this becomes difficult.

Recruitment to focus groups has been shown to be difficult and researchers have deliberately invited more than the required number to focus groups to account for participants not turning up on the day[60] (Kreuger, 1994). Constantly changing work patterns and on-call commitments can mean, in some instances, that recruitment becomes complex. In this study the midwives appeared committed to attending the focus groups confirming that personal commitment to an issue can be a powerful motivator to attendance (Morgan, 1998).

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[60] In previous research that I have undertaken (Hughes et al. 2002) we found that holding focus groups 'off-site' and providing refreshments encouraged participation. The midwives expressed appreciation during the focus groups at being able to 'escape' their busy work schedules for two hours. Individual invitations from the Head of Midwifery also added a personal dimension to recruitment.

Silent voices…remaining an outsider

However the dynamic of focus groups does not always meet the needs of all group members and might in some circumstances serve to silence or mute some of the participants (see Chapter 9). Baker & Hinton (1999) have identified this dynamic as the participants and the researcher bringing their own expectations and personal agenda to the focus group setting. In this study, the powerful forces that were evident in the day to day functioning of the work team became exaggerated within the focus group setting. Some of the midwives appeared to become muted whilst others tended to dominate the meeting. Also, some of the limitations of working with a pre-existing group became evident in that the midwives appeared to have set their own norms as to what could and could not be said (probably unconsciously) through their own internal hierarchy within the work team.

Thus, despite my eagerness to facilitate a collaborative, non-hierarchical, participatory approach (as enthused by action research and feminist approaches) by encouraging the midwives to talk freely to each other, ask questions and express their opinions and anxieties, full participation from all focus group members was not always possible. Eventually this turned out to be a reflection of the way in which the work team functioned and communicated to me as a researcher "the social pressures and the construction and the communication of knowledge" (Kitzinger, 1994, p.113) that was at play within the work team.

Therefore within midwifery, focus groups can become a rich source of data on group dynamics and views on cultural behaviour and have the potential to become a particularly good method for qualitative data collection in relation to exploring midwifery views and working practices. This is because they mirror the social organisation of midwifery practice that is dependent on a team approach and verbal communication.

Focus groups can also mirror the collaborative and participatory nature of action research.

Focus groups as a forum for change

Focus groups can also become a forum of change for participants (Race, Hotch & Parker, 1994) or they can reflect or monitor change (Barbour, 1999). Focus groups as vehicles for change make them particularly apt methods of data collection for action research studies where change is the focus of the approach. This change could take place either within the focus group itself or after the event (Gibbs, 2001). In research that I undertook in 1999 I found that midwives who had taken part in focus groups became empowered to find solutions to problems and initiate discussions with midwifery managers and doctors regarding the future of midwife-led care in the local area. Although at the time the midwives reported feeling despondent about low morale within midwifery, they appeared to become motivated to work with the researchers, give their views about midwifery services in the area and provide ideas about how the service could be improved. Change took place in the form of improved working conditions, the creation of more senior midwifery posts as well as an improvement in skill mix (Deery et al. 2000).

Facilitating focus groups

Morgan & Kreuger (1998) recommend that focus groups are conducted with a facilitator and an observer. The facilitator would normally ask questions and guide discussion whilst the observer would provide technical support and take notes that supported data analysis. I have previously conducted focus groups in this way with me facilitating the focus group and a co-researcher taking notes on a lap top computer (Deery et al. 1999; Deery et al. 2000). However, the lap top proved to be more of a

hindrance than helpful and my co-researcher found that writing notes to support the data was far easier. In the focus groups in this study I undertook both roles. I was reluctant to invite another person to take on the role of observer because of the sensitive nature of the data already obtained in interviews which I thought would spill over into the focus groups and that the midwives would be reluctant to share this with another person. I never asked the midwives if they would be willing to agree to another person assisting me in the focus groups.

The Group Work Course that I had previously undertaken (see Chapter 1) had further developed my facilitation skills and I recognised that I had the experience of working with groups, good listening and communication skills and a friendly approach that focus groups demanded (Kreuger, 1998; Sim, 1998). However, my newly acquired group work skills were rigorously 'tested' in the facilitation of both focus groups as the midwives had to be encouraged to participate and I was aware of tense group dynamics that I needed to manage sensitively. Therefore clarifying ambiguities and exploring new insights can be difficult when challenging discussion is taking place.

Observing interactions within focus groups

As seen in this chapter, the group processes and interactions of group members in a focus group are seen by a number of authors as a key advantage to their functioning (Morgan, 1997; Greenbaum, 1998; Barbour & Kitzinger 1999; Twinn, 2000). Individuals are brought together by a researcher in order to reflect on a specific topic (hence the word 'focused') in order to stimulate new ideas and build on existing ideas. Morgan (1997) and Barbour & Kitzinger (1999) identify group interaction as one of the important criteria that distinguish focus groups from other methods of data collection. Despite the importance placed on the interactive nature of these groups, Webb & Kevern (2001) have criticised researchers for their naïve use of the method in terms of

data analysis and social interaction within focus groups. These authors state that group interaction has rarely been reported on or discussed in the articles that they reviewed for their critique.

Catterall & Maclaran (1997) have described this group interaction or dynamic within focus groups as enabling insights into the 'moving picture' as well as the 'snapshots'. Morgan (1988) emphasises that "the hallmark of focus groups is *the explicit use of group interaction to produce data and insights that would be less accessible without the interaction founds in a group"* (p.12, emphasis in original). As such focus groups have much in common with participant observation that requires "sensitivity to both the facial expression and body language of participants" (Morse & Field, 1996, p.87). However, I also wanted to obtain more detailed descriptions, explanations and interpretations from the participating midwives in order to help me understand how they experienced their world. Interactions within the group thus provided me with an insight into the behaviour of the dominant members of the group, the silent members of the group and also into the values and beliefs that some of the midwives held[61].

Issues of ethics and rigour

I sought ethical approval for my study in the early planning stages of the study and permission was granted by the Local Research Ethics Committee (LREC). The Chairperson of this committee was keen for me to convince him that I was not placing the midwives under any undue pressure by taking part in the study. I was not requested to attend the LREC but instead communicated by letter and spoke at length on the telephone regarding the midwives' participation until he was fully satisfied that I was not pressurising the midwives in any way.

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[61] My observations of the work team during both focus groups are explored more fully in Chapter 9.

All the midwives were fully informed about the study when we met at the Health Centre where they were based as a work team. Following an initial meeting I left the midwives to consider whether they wished to participate in the study. They agreed that they would contact me by telephone if they had any further questions and that one of them would ring me with a decision about their participation in the near future. One of the midwives telephoned me at home five days later to confirm that they wished to participate in the study. During this telephone conversation I was informed that there were anxieties around being interviewed, the time commitment to the study and whether existing pressures on the work team could be lessened in any way. A date was set with this midwife when I would go and meet with the work team again at their base in order to address these issues.

I did not seek individual informed consent from each work team member as the amorphous quality of action research does not allow for the 'prediction' of what the participants are 'consenting to' (Williamson & Prosser, 2002). Instead we met as a group on several occasions at their work base and discussed issues that were becoming apparent to them. No data collection was started until all the midwives were happy that their questions had been answered. I also suggested to all the midwives that they, personally, were likely to benefit from the study, in terms of their personal and professional development.

I also reassured the midwives that their data would be treated confidentially and anonymously and that no-one would be able to trace information back to them although midwifery managers knew that they were participating in the research. I asked their midwifery manager to reinforce the nature of confidentiality and anonymity with other managers. I reassured the midwives that when I used quotations from their interviews I would use pseudonyms so that no-one would know whose words I was using. I also informed the midwives that they could withdraw from the study at any

time and without prejudice although we also discussed how their withdrawal might affect the dynamics of the work team and clinical supervision group. No-one withdrew from the study.

All the midwives in the study were given fictitious names and excepting for discussion during focus groups, the midwives would not be identifiable to each other. All the midwives and the clinical supervisor were sent transcripts of their interviews to read and were invited to amend any inaccuracies, and offer any further comments or interpretations on the data. Prior to each interview I reminded the midwives that their data would remain confidential to me. I also asked them individually for permission to share their transcripts with my research supervisor. None of them refused this request. The midwives appeared to be open and honest in their interviews and did not seem inhibited by the fact that my research supervisor would be reading their data. This suggests that they were keen to let others know about their lives as community midwives[62].

The overwhelmingly sensitive nature of the data was at times distressing for both me and the participants. As I have discussed earlier in this chapter when midwives became distressed during their interviews this then raised issues of how best to deal with the situation. Although I had invited them to turn off the tape at the outset, none of them did this. I therefore continued the interview and discussed with them at the end of the interview how best to deal with any unresolved issues. I always carried names and telephone numbers of trained counsellors so that I could give one or more of these contact numbers to the midwives.

Dealing with issues of confidentiality and anonymity over a period of three years was difficult and challenging at times, as the midwives knew each other well and worked

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[62] I am also reminded of "politically motivated actors" (Alvesson, 2002) as discussed on page 179.

closely together. When midwives asked me questions in their interviews about other midwives taking part in the study I had to deal with these issues honestly and sensitively. I found myself having to take constant care and be alert that I did not divulge any information that might reveal data divulged to me by another of the midwives. This was especially important in view of the fact that themes emerging from the individual interview data would be highlighted and discussed within focus group interviews. I reassured the midwives that unless they specifically identified their own data during the focus groups, I would keep all data confidential. Some of the participants did discuss issues raised in their interviews with me prior to the focus groups and requested that I did not pursue these issues. Although I respected their wishes, these very same issues were often raised by other focus group members and often left me feeling extremely uncomfortable.

Prior to the midwives putting their framework of clinical supervision into practice I informed them that when I interviewed the clinical supervisor I would not be asking her about the content of the clinical supervision sessions. Likewise, I had no intention of 'quizzing' the midwives in their final interviews about the content of the sessions. The clinical supervisor was also reassured that I would not pressurise her to divulge any information regarding the content of the sessions that might jeopardise the confidentiality and anonymity of the study.

The appropriateness of reliability and validity in action research

Throughout the study and always "lurking at the back of my mind" were the notions of reliability and validity. Both these concepts are concerned with bias (Reed & Biott, 1995) and how this is controlled. Although I knew and believed that objectivity was unattainable I still found the terms extensively used in relation to interpretive research (Brink, 1989) and this did nothing to ease my worries in the early stages of my study.

Miles & Huberman (1994) for example provide a clear account of internal and external validity in qualitative research where they transfer the ntion of quantitative validity (for example, triangulation and sample selection) to qualitative research.

Lincoln & Guba (1985) on the other hand state that trustworthiness of the data and its interpretation must be demonstrated. Four alternate approaches to demonstrate trustworthiness are suggested; credibility instead of internal validity, transferability instead of external validity, dependability instead of reliability and confirmability instead of objectivity. McNiff (2002) has argued that theoretical concepts such as these are a result of traditional researchers using "abstract conceptual terms" (p.106) to evaluate their research rather than reporting it as a "lived experience" (p.106). Hope & Waterman (2003) also argue, in a paper that discusses the validity of action research, for the "rejection of naïve rule-based formulae and for recognition of the impact of contextual and pragmatic concerns" (p.120).

Winter & Munn-Giddings (2001) refer to the validity of action research and how "its validity resides in the carefulness and rigour of [the] process" (p.21). These authors state that validity within action research seeks a different dimension, that is "the openness of its communicative processes" (ibid, p.21) and that part of this involves the way in which the action researcher "addresses the crucial issues of organisational and professional power" (ibid, p.21).

Exercising professional imagination

Reed & Biott (1995) have stated that bias has a "commonsense formulation" (p.193) which is derived from the way bias is discussed in everyday language. As such bias has become a variant of subjectivity although under such circumstances it then becomes a threat to reliability and validity (Reed & Biott, 1995). In the past

researchers have argued that subjectivity (or bias) leads to "partisan interpretations that are value-laden" (ibid, p.193). However, as I have previously discussed on page 137, values in action research are important because they form part of the way in which action research is evaluated and as such "replicability and generalisability are no longer seen as appropriate criteria for action research " (McNiff, 2002, p.105) especially as they hinder the lived experience of action research.

Reed & Biott (1995) discuss 'strong' practitioner research and explore a number of factors which they believe characterise practitioner research although they recognise that the criteria do not apply to all studies. These authors believe that the process of evaluation should be:

- integral with the process of health care;
- a social process undertaken with colleagues;
- educative for all participants in the study;
- imbued with an integral development dimension;
- focused upon aspects of practice in which the researcher has some control and can initiate change;
- able to identify and explore socio-political and historical factors affecting practice;
- able to open up values issues for critical enquiry and discussion;
- designed so as to give a say to all participants;
- able to exercise the professional imagination and enhance the capacity of participants to interpret everyday action in the work setting;
- able to integrate personal and professional learning;
- likely to yield insights which can be conveyed in a form which make them worthy of interest to a wider audience.
(Reed & Biott, 1995, p.195)

The criteria offered by Reed & Biott (1995) go some way towards addressing alternative ways of evaluating action research although they make no mention of reflection on practice or, for example, what to do if the "educative" nature of evaluation is not recognised by the participants. Winter (1989) also offers criteria for assessing action research stating six principles should be demonstrated that:

1. offer a reflective critique in which the author shows that they have reflected on their work and generated new research questions;
2. offer a dialectical critique which subjects all 'given' phenomena to critique, recognising their inherent tendency to change;
3. be a collaborative resource in which people act and learn as participants;
4. accept risk as an inevitable aspect of creative practice;
5. demonstrate a plural structure which accommodates a multiplicity of viewpoints;
6. show the transformation and harmonious relationship between theory and practice.
(Winter, 1989, p.43-65p)

McNiff (2002) commends the criteria set by Richard Winter, describing them as "linguistic criteria" (p.108) which now need developing further by showing the criteria "in terms of people's real living" (p.108). This accords with Whitehead (2000) who believes that action research can be judged in terms of whether the researcher has offered explanations rather than observations and descriptions of practice.

Therefore, as discussed earlier, as my confidence grew I espoused my personal involvement with the data and came to realise that terms such as reflexivity, rigour, authenticity and resonance seemed more appropriate within qualitative research. Usher & Edwards (1994) use the term "resonance" to refer to something important happening within the research process. This importance can only be recognised (or felt) if what is happening relates to what is being investigated. Usher & Edwards (1994) state that "[i]n this sense resonance is to do with the familiar" (p.123). As this was a study that captured a snapshot picture of life as a community midwife, at a particular time, I hoped that other midwives and action researchers would read my thesis and feel that the research story had resonance for them.

I have therefore attempted throughout my thesis to demonstrate the integrity and rigour of the research. I have tried to make it possible for others to judge its trustworthiness and also to make sure that the honesty of my inquiry has not been jeopardised by unrecognised bias and influences. I have also tried to offer explanations rather than descriptions and observations of my discoveries. As an action researcher it has been

impossible to ignore my own values and I have tried to use these constructively although this has not always been easy.

In order to check the trustworthiness of the data, the accuracy of the interview and focus group transcripts was checked by the participants. The clinical supervisor also checked the accuracy of her interview transcript. The penultimate chapter was also read by the clinical supervisor and she was invited to make amendments, add comments and offer alternative interpretations. Many amendments were made to the chapter following a long discussion involving myself and the clinical supervisor. I realised on reading this chapter again that unintentional bias had become evident as I had analysed the data. I also undertook self-evaluation during the course of the study. I was open and honest in my reflective conversations with my research supervisor and with my research peers. My research peers and critical friends also helped me in the validation of the data and interpretation.

PHASE THREE

Analysing the midwives' accounts

The data gathering procedures within the study extended over nearly three years according to the cyclical nature of action research and the needs and requirements of the midwives participating in the study. All interview and focus group data[63] were transcribed verbatim and then checked against the actual tape recordings. The transcripts were then anonymised by removing the names and places and the participants were given code names that only I would recognise. This coding also

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[63] Focus group data proved difficult to transcribe. At the start of each focus group I reminded the midwives about the importance of only one of them speaking at a time. However subsequent discussions often resulted in overlaps of talking on the tape recorder and this was difficult to transcribe accurately.

enabled me, during the course of the study, to compare individual midwives' words and how these changed, if at all, during the course of the study[64].

In the early stages of the study, data gathering and data analysis took place concurrently but once the study had ended I spent time retrospectively analysing the same data but using voice-centred relational methodology (Mauthner & Doucet, 1998). Initially however, the preliminary analysis of the data was undertaken by first reading the interview and focus group transcripts, then re-reading and generating themes that corresponded to narrative sections within each of these transcripts. As this was preliminary data analysis I used phrases or words that captured meaning of highlighted sections of the data. This was usually what had first come into my mind on reading the transcripts. I then elaborated on the themes highlighted and examined their relationships with each other more closely within the transcript. By this time I was able to provide descriptive labels for sections of narrative.

'Starting up terror' – leaping into the unknown

I was initially overwhelmed by the amount of data that I had to analyse and related to the "internal chaos" described by Ely, Anzul, Friedman, Garner & Steinmetz (1991, p.141) as I began searching for answers of "how to do data analysis" in the proliferation of texts that have arisen within the area of qualitative research. This "internal chaos" often converted to "external chaos" (Ely et al. p.141) as I resorted to doing anything except analysing data. Mellor (1999) refers to this as "normal starting up terror, the leap into the unknown" (p.118). During times that I did manage to feel comfortable with the chaos, I realised that the detailed processes of data analysis have received very little attention in the literature. Whilst there are several important books

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[64] Again this coding proved difficult when transcribing the focus group data as I tried to recall and listen carefully to the midwives' voices so that I could compare and match their words with those from individual interviews. If I did not listen to the tapes immediately after the focus groups, transcription became even more problematic.

that discuss data analysis (for example, Coffey & Atkinson, 1996; Wolcott, 1994; Silverman, 1993), and some that discuss and outline templates for data analysis (for example, Glaser & Strauss, 1967; Miles & Huberman, 1994; Wolcott, 1994; Strauss & Corbin, 1998), there is very little attention given to the tensions and dilemmas within data analysis. For example, I had to resist an urge to "clean up" the data because of its sensitive nature. Riessman (1987) provided useful insights here stating that "narratives are laced with social discourses and power relations" (p.65) that must be preserved otherwise important information will be lost.

The process of making sense

Mauthner & Doucet (1998) state that data analysis is not a "discrete phase of the research process confined to the moments when we analyse interview transcripts" (p.124). Rather it is seen as a process that is continuous and progressive from the start of data collection (Ely et al. 1991). This enables the researcher to "focus and refocus…to phrase and rephrase research questions, to establish and check emergent hunches, trends, insight, ideas" (Ely et al. 1991, p.140). The work of Ribbens & Edwards (1998) and Ely et al. (1991) goes some way towards addressing the neglected area of data analysis by acknowledging the often unsystematic and 'messy' nature of data analysis.

As I have already discussed in Chapter 5 it was important that my philosophical approach to the way in which I gathered data demonstrated the way in which I had been influenced by feminist writers (for example, Maguire, 2001) and the ways in which women's' voices had remained unheard (Belenky et al. 1986). Equally important was the way in which I analysed the data, in order that I gave the participating midwives an opportunity to have their voices heard and kept alive by listening, interpreting and presenting their perspectives accurately. Mauthner & Doucet (1998, p.120) have

pointed out that "the issue of listening to women, and understanding their lives 'in and on their own terms', has been a long-standing and pivotal concern amongst feminist researchers".

Although I knew that data analysis comprised trying to make sense out of the data, I struggled with having to find what I thought was a ready made solution to the process because, like Miles & Huberman (1994) I felt that "no study conforms exactly to a standard methodology" (p.4). This is especially the case for action research where the participants guide the path of the research and data analysis takes place according to those participating in change although the midwives taking part in this study did not interpret their own data.

Reflective conversations with my critical friends resulted in suggestions that I followed 'a template' or looked for a 'recipe' to follow as they tried to help me 'get started' or operationalise my data analysis. As discussed earlier this paralleled my earlier misgivings and hesitancy around the need to follow a prescribed 'model' for action research. This preliminary stage of data analysis therefore felt confusing and uncertain and I talked to my research supervisor about not knowing what to think when I read the data. I was also reassured to read that "this is the whole point of data analysis – to learn from and about the data; to learn something new about a question by listening to other people" (Mauthner & Doucet, 1998, p.122).

Facing myself……again

Just as I have discussed "intersubjectivity" during the interview process earlier in this chapter, and how I was confronted with 'myself' during conversations with the midwives, I was now confronted with myself again when analysing the data. Some of the anxieties I experienced at this stage were also related to insecurities I experienced

as a nurse and a midwife in earlier years and the comfort of wanting to take and know the 'right approach' for fear of criticism, even reprisal.

Nevertheless, the subjective, interpretive nature of what I was about to undertake felt daunting as I realised that I had to interpret the midwives' words, at the same time realising that my interpretation could be just 'one of many' interpretations. The reflexivity involved at this stage further complicated data analysis because not only had I to reflect upon and understand my own "personal, political and intellectual autobiograph[y]" (Mauthner & Doucet, 1998, p.121) and determine where I was located in relation to the midwives participating in the study, I also had to "acknowledge the critical role…play[ed] in creating, interpreting and theorising research data" (Mauthner & Doucet, 1998, p.121).

The principles of voice-centred relational methodology

The voice-centred relational method of data analysis "holds at its core the idea of a *relational ontology"* (Mauthner & Doucet, 1998, p.125) that focuses on understanding individuals in their social contexts and the complexities of their relationships with other people in relation "to the broader social, structural and cultural contexts within which they live" (Mauthner & Doucet, 1998, p.126). As such, this method seemed to address the way in which I could "keep respondents' voices and perspectives alive, while at the same time recognizing the researcher's role in shaping the research process and product" (Mauthner & Doucet, 1998, p.119). This method of data analysis also complemented the feminist approach I took to my work as a midwife and researcher by enabling women's voices to be heard as well as facilitating connections between the individual life histories of the midwives and their work situation.

Within this method of data analysis there are four or more readings of each interview transcript. I also used the same approach when I was analysing data from both focus groups. On occasions I also listened to the tape recordings as I was reading the transcripts as I wanted to hear the tone of voice (both mine and the midwives) as well as the length of some of the silences I had indicated within the transcript. This helped me come to terms with my own anxiety that I was interpreting the midwives' words accurately.

First reading: Focusing on the plot by losing my own plot

As Mauthner & Doucet (1998) suggest, during the first reading of the transcript I listened to occurring main events, main characters, recurrent images, words, metaphors and contradictions in the narratives of the midwives that comprised the plot[65]. These authors also suggest that the researcher focuses on their own responses to the interviews trying to recognise "how [they] are socially, emotionally and intellectually located" (Mauthner & Doucet, 1998, p.127) in relation to the participants.

I began to realise that my long history as a community-based midwife was probably hindering my interpretation of the midwives' words because I was bound up in personal background, history and experiences. My main role as an academic also meant that I had a tendency to impose theoretical interpretations on the midwives' narratives before I had actually heard what they wanted to say. It was during this process of reading the narrative on my own terms that I was more able to hear the midwives' voices relating their different, individual experiences of community-based midwifery in the NHS.

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[65] Riessman (1993, p.4) has stated that "[n]arrators create plots from disordered experience… [and]…because they are essential meaning-making structures, narratives must be preserved, not fractured, by investigators, who must respect respondents' ways of constructing meaning and analyze how it is accomplished".

I had documented the subplots that I heard within the narrative of the midwives during preliminary data analysis. However the first reading using voice-centred relational methodology provided me with the opportunity to reassess my interpretations. In fact the midwives' mutedness in relation to their roles in a complex organisation became clear not only in their spoken but also their unspoken words. Data analysis could have muted their voices even further if I had not drawn on the work of Mauthner & Doucet (1998).

This first reading of the interview transcripts gave me a greater understanding of community midwifery and relationships within the work team as well as between midwives and clients. The midwives used powerful metaphors to describe how they managed emotion work and how they coped with organisational demands and constraints. I found that I was able to relate more closely to the midwives and challenge my own assumptions and attitudes which was important in view of my previous working relationships with the midwives.

Second reading: Being with midwives

The second reading of the transcript followed on from the first and focused particularly on listening to how the midwives related their experiences, thoughts and feelings about themselves and clients. This second reading was cathartic as I realised how unsupported, stressed and angry the midwives were feeling. As suggested by Mauthner & Doucet (1998) I traced 'I', 'we' and 'you' through the midwives' narratives in order that I could concentrate on their stories. I then found I was able to build a picture of where the midwives saw themselves, whether they were struggling with words and how they perceived and experienced themselves. As will be seen in Chapter 9 I discuss this more fully when I analysed the narratives of the midwives at the second focus group. This second reading then enabled me to discover how the

midwives spoke of themselves before I spoke on their behalf (Mauthner & Doucet, 1998, p.128).

Focusing on 'I', 'me', 'them', 'we' and 'you' helped me to become more aware of how the midwives were struggling with the competing demands of working within a complex organisation and developing and facilitating the supportive relationships that were expected of them as midwives. 'Them' became structures, organisations and midwifery managers and 'I', 'me' and 'we' became the oppressed, marginalised grass root workers. I became more aware of their anger and tried to stay with their "multi-layered voices, views and perspectives" (Mauthner & Doucet, 1998) rather than becoming too embroiled in my own anxiety and the way in which I felt the midwives had intimidated me at times (see page 312). I developed a much better sense of the processes at play in their working relationships and the contradictions which were central to their roles as midwives and often used as coping mechanisms.

Third reading: Achieving a sense of balance in relationships

Although I had followed the midwives' working relationships in the previous two readings, this third reading provided the opportunity for me to concentrate on and explore these relationships more closely especially in relation to how such relationships affected the midwives. I also concentrated on the way in which they spoke about their relationships with their partners, children and their wider social networks.

I began to see how increasing demands placed on the midwives within the maternity service meant that their lives both at home and at work became intertwined and usually not to their advantage. I became more empathetic towards the midwives as I realised that the organisation of the maternity service appeared insensitive to their

needs both as women and as midwives. Just as I have suggested in Chapter 3 that emotional and psychological difficulties can become apparent within relationships as a result of earlier, less successful relationships, I now concentrated on how the relational difficulties the midwives seemed to have experienced in this study could have been similarly linked.

I therefore listened to how the midwives would prefer to experience positive relationships although this was difficult at times because some of them were not currently experiencing positive relationships. Those midwives, who did identify positive relationships described feeling listened to, heard and supported. Most of the time though I found that the midwives experienced these relationships as unsupportive, constraining and intimidating, in which their voices were silenced or rejected.

Fourth reading: Some voices are louder than others

In the fourth reading I listened to how the midwives experienced their midwifery work in the wider social context of the NHS. Mauthner & Doucet (1998) refer to this as ways in which midwives might experience the "broader social, political, cultural and structural contexts" (p.132) of their work. I studied the midwives' narratives and concentrated on the way in which they experienced midwifery (enabling or disabling) and how well these reflected dominant ideologies at that time. This involved making links between theories that I had been reading and whether they supported the way in which I was experiencing the midwives' words.

I also concentrated on how some of the midwives' voices were louder than others in the work team. As will be seen in Chapter 10 complex silencing mechanisms appeared to be at play within the work team. When I concentrated on the voices of the midwives I realised that the dominant voices often highlighted the complex relationship

between power and knowledge. Listening to the way the midwives spoke to and about each other enabled me to make links between the way in which they experienced their work and their relationships with each other. The way in which the midwives spoke about their experiences in the particular social context of the NHS linked to issues of oppression, power and resistance to change.

Fifth reading: expressing emotion through metaphors

Finally, I undertook my own fifth reading and returned to the metaphors within the midwives' accounts. In the early stages of the study, and when reflecting on these accounts, I realised that I may have ignored the midwives' use of metaphors. I felt that I had not asked questions appropriately and therefore had not provoked the "right" response from the midwives. I did not understand metaphors and felt that they were using colloquialisms.

During the fifth reading I realised that these "colloquialisms" were indeed metaphors and that they warranted closer examination, as they seemed to provide further insight into the culture of midwifery work and associated emotional consequences for midwives. I gained a clearer understanding of the midwives' use of embodied metaphors and the strategies midwives employ in order to manage the emotional aspects of their work. This fifth reading provided another way of understanding the data and highlighted neglected aspects of the midwives' emotional wellbeing and the way that they had been socialised to manage, experience and perform emotion. As will be seen, these embodied metaphors are weaved throughout Chapter 8 and present powerful images of how the midwives' varying performances impacted upon the midwife-mother relationship. It was in this final reading that I also decided to explore metaphors further.

Metaphors as a form of expression

Metaphor is a figure of speech in which a word or expression is used in other than its literal sense (Hawkes, 1972) or according to Lakoff & Johnson (1980) metaphors explain one experience in terms of another experience. Hawkes (1972) views metaphor as being concerned with the transference of meaning from one situation to another. This is pertinent in a midwifery context, where emotional labour associated with the job has not received a great deal of attention. As emotional labour has not been extensively written about or discussed openly in midwifery, as a concept it was unfamiliar and difficult to articulate for the midwives who participated in the study. Savage (1995) has stated that metaphors are particularly helpful in this situation because they help "to understand what is inchoate" (p.81). Thus the midwives' use of metaphor may help to understand their performance of midwifery work that would be difficult using more literal language (Lakoff & Johnson, 1980).

Two approaches are apparent within the literature when attempting to understand metaphor and the understandings of language that they reflect. These approaches are known as constructivist (romantic) or non-constructivist (classical). A non-constructivist view of metaphor portrays this approach as a violation of linguistic rules that does not contribute much to an understanding of reality (Ortony, 1993) although this is unlikely as western literary tradition is grounded in metaphorical use of language. Hawkes (1972) views a constructivist approach to metaphor as essential for the creativity of language. This same approach is advocated by Lakoff & Johnson (1980) and has been adopted in this research study. These authors suggest that metaphor is present throughout every day life because human thought processes are mainly metaphorical.

Three types of metaphor have been constructed and each has its own structuring properties (Lakoff & Johnson, 1980). Orientational metaphors organise a whole system of concepts with one another and appear spatial in nature (e.g. happy is up, sad is down: 'my spirits were lifted', 'I fell into the depths of depression'). Ontological metaphors allow for the understanding of experiences through objects and substances (e.g. feeling 'drained' or 'wrung out'). Krone & Morgan (2000) state that such metaphors have become so well used that they appear as "straightforward, literal description" (p.87) that quantify, group and categorise experiences. As will be seen in Chapter 8, orientational and ontological metaphors are used extensively by the participating midwives.

Structural metaphors move beyond naming and quantifying concepts and build meaning of one concept in terms of another (Krone & Morgan, 2000) (e.g. 'time is money' – see Chapter 10). Lakoff & Johnson (1980) provide examples of "argument" in order to demonstrate what it means for a concept to be metaphorical and how the conceptual metaphor "argument is war" (e.g. 'I've never won an argument with him' or 'He shot down all of my arguments', p.4) is reflected in our everyday language through a range of expressions. As Savage (1995) states "[i]n arguments 'opponents' take 'positions', which are 'attacked' or 'defended'; arguments are 'lost' or 'won'" (p.80).

Furthermore, this conceptualisation of "argument" may then inform the way in which we argue and the actions we perform while we argue (Savage, 1995). Within the culture of midwifery this metaphorical concept of argument has already become evident in the work of Kirkham (1999), Stapleton et al. (1998) and Hughes et al. (2002), where arguments are seen in terms of war within midwifery work. Although these studies do not adopt a narrative discourse analysis approach there is evidence in them that midwives talk about and understand their work as midwives in terms of 'war'. Both Stapleton et al. (1998) & Kirkham (1999), in work examining the culture of midwifery,

cite one of the participating midwives reporting her feelings about routine updating as feeling like "a lioness coming into a different pack…and they're all just sitting waiting to attack…it felt like they were breathing down my neck the whole time" (Kirkham, 1999, p.736). Hughes et al. (2002) report midwives talking about a culture of blame compounded by a lack of support at times of crisis in their focus groups, with one of the midwives stating, "[i]f something goes wrong, how many people are going to jump on your back? Everybody" (Focus group B, p.49).

Obstetricians too, use a mechanistic language that often uses metaphors of conflict, war and aggression (Kitzinger, 1999). "The aggressive management of labour", "trial of labour", "rupturing the membranes" and "trial of scar" are some examples of obstetric language employed. Metaphors therefore, are "shaped by the linguistic and cultural context within which [they are] found" (Froggatt, 1998, p.333). This implies that the metaphors, which are present within the vocabulary of the midwives, can reveal the values and assumptions underpinning the culture of midwifery within the NHS and the wider culture of their lives.

In a study about the nature of hospice work and nurses' experiences of professional and personal bereavements, Froggatt (1998, p.333) used what she refers to as the "root" systems of metaphors "in order to provide a coherent conceptual system of thought and language which was used to frame nurses' own experiences". According to Lakoff & Johnson (1980) root metaphors are rooted in physical and cultural experience. Lakoff (1993) implied that when considering emotions, metaphorical understanding is usual and easier because of the sensitive nature and invisibility of emotions. In this study I found two root metaphors present within the midwives' accounts of their work.

The 'body as a container' and 'emotions as energy' are two root metaphors that have influenced the way in which emotions and the body are understood in Western society (Froggatt, 1998; Kovecses, 2000). The language the midwives used in their interviews to describe the emotional consequences of their work was dominated by the container metaphor where their emotions were conceptualised in terms of a metaphorical substance in a container and where the container responded to the body (Kovecses, 2000). This metaphor is further subdivided into two parts by Kovecses (2000) who states that 'emotions are fluid in a container' (e.g. 'she was full of emotion') and 'emotions are the heat of a fluid in a container' (e.g. 'she was seething with anger'). As will be seen in Chapter 8 these metaphors abound within the midwives' accounts.

Voice-centred relational methodology and metaphor analysis provided me with the opportunity to listen to and interpret the midwives' narratives by being as true to their words as I possibly could. Metaphor analysis provided particularly valuable insights into associated emotion work in midwifery. In earlier readings of the transcripts I felt that I was being too hard on the midwives and that my interpretations were not respecting their voices. As I grew more familiar with their voices and I listened more intently and deeply, I heard them and was then able to take account of and analyse their different voices, especially through the use of metaphors.

In the following chapter I introduce the midwives participating in the study and begin to explore their views and experiences of midwifery work in an NHS maternity service that continued to undergo radical, unprecedented change. I also begin to broach the area of 'support'. A more detailed description of each midwife, including Susan, Sarah and Stella who contributed pilot interviews, is provided as Appendix 1.

CHAPTER SEVEN

Phase One: Preliminary interviews

The challenge of change: confronting crisis and pain in midwifery

> The daily going out
> and coming in
> always being hurried
> along
> like like cattle
>
> In the evenings
> returning from the fields
> she tried hard to walk
> like a woman
>
> she tried very hard
> pulling herself erect
> with every three or four
> steps
> pulling herself together
> holding herself like
> royal cane

from Grace Nichols 1985

This chapter analyses data from preliminary individual interviews with the participating midwives that aimed to explore their views and experiences of support in clinical practice. The effects of service and workforce developments, as well as the bureaucratic pressures of working in a large maternity unit, begin to surface ominously in the midwives' accounts. When I approached the midwives in July 1997 to ask them if they would collaborate in an action research study, although they did not articulate at the time, I am now convinced that they viewed my request as just one more change being imposed on them in a climate that was already demanding that midwives change their working practices.

Data analysis of the midwives' accounts provided insight into their perceptions of community-based midwifery at that time and how the experience of change was felt to

be debilitating. Their words suggested an overall lack of support within the maternity service and, as will be seen in the following chapter, they suggested their emotional well-being had been compromised. Even though their accounts highlighted a variety of problems within the current service, they did not appear able to visualise a future for their maternity service. Further data analysis suggested that there were many issues that were deep seated and of long standing, that seemed to be giving rise to a certain despair and a sense of despondence, low morale and stress within the midwives.

The roller coaster of constant change: onerous or exciting?

The midwives' cited change as a constant burden in their working lives and Helen reported that all recent externally imposed change (for example, team midwifery and changing to GP attached community midwifery) had had a detrimental effect on the midwives and their working lives. Their words suggest feeling saturated with change and Jane said that there was "just constant…constant change…" as well as "constant management changes". Rachel stated that most midwives had reached a point where "[they] just won't change…they can't…they're saturated." Helen was an exception in the work team. She had just completed her first degree and her words suggest she found change exciting:

> *I find it quite stimulating and I go to great lengths to*
> *create situations where things will change because I*
> *don't want things to stagnate really…*
> (Helen)

Frances who was about to retire after a long career in midwifery admitted a lack of flexibility in her approach to midwifery care and that she disliked anything other than routinised care:

> *I don't like change…I'm not very good with change*
> *because I'm older…but you don't like it as you get*
> *older…you get used to one routine and you don't like*

> *the change…you try to go along with it but you find it*
> *more difficult…you're not as flexible…you want to*
> *be…*
> (Frances)

Muller-Smith (1994) has suggested that approaching change with excitement and enthusiasm means that it can be perceived as an adventure and as a challenge thus leading to opportunities to improve professional roles. Helen's words suggest that she was able to envisage future working practices and relationships and her idea of being able to discuss cases was reassuring to me especially as this was reminiscent of how I envisaged the study developing. Her words suggest that support should be offered as:

> *…not too formal but an opportunity to maybe go and*
> *discuss cases…things that have happened to*
> *you…things that you come across at*
> *work…somebody I could go and see…just to share*
> *experiences.*
> (Helen)

Helen's words also suggest that she is not prepared to tolerate periods of stability within midwifery as this is when clinical practice 'stagnates'. At the time Helen made this statement she was practising as a community midwife. However during the course of the research she left the work team to take up a post as midwifery manager in the maternity unit. As will be seen in Chapters 9 and 10 further comments by Helen contradicted her words.

Helen reported that she would like to become more of an "all round" midwife who was empowered. She stated that midwives should become involved in all aspects of midwifery work including home birth so that "they don't get too self-important". Helen clearly does not mind experiencing the discomfort of new learning often experienced through change (Rolfe et al. 2001). However for most of her colleagues the reversed role of having to work on delivery suite was threatening because as Helen suggested, there was "no real mechanism to facilitate them".

There are close links here to "intra-occupational boundary maintenance" as identified by Hunter (2002, p.278) in her ethnographic study. Previously, the construction of boundaries had been identified between occupations or disciplines (for example, midwifery and mental health nursing). However, Hunter (2002) has suggested that her study has identified that:

> "The basis of these boundaries appeared to be
> related partly to work context but more importantly to
> occupational ideology. The effect of context was
> most obvious in the clear separation between
> hospital and community based midwives…It was
> also apparent in groupings within the hospital…"
> (Hunter, 2002, p.279)

As will be seen later in this chapter, and in Chapter 9, the participating midwives appeared to have divided their own work team, hospital-based midwives and midwifery managers into 'them' and 'us' groups. Maintaining these boundaries was often a potential source of conflict and stress for them, supporting the findings from Hunter's (2002) study.

The tyranny of team midwifery: an unfair imposition

All the midwives reported that the intensity of their jobs had increased when team midwifery was introduced (see page 13) and Rachel talked about "the sheer volume of numbers that we have been dealing with." The midwives appeared to be constantly comparing the differences and workloads between traditional community midwives and team midwives. Helen reported that all extra staff and resources were initially ploughed into team midwifery and its organisation, to the detriment of traditional community midwifery. These differences highlighted by the participating midwives reinforce the presence of "intra-occupational boundary maintenance" (Hunter, 2002, p.278).

Of the 6000 births in the unit, the team midwives were allocated 2000 women to care for, meaning that traditional community midwives cared for the rest of the women:

> *…one of the problems has been the intensity of the work since team midwifery…its [team midwifery] thrown more work onto everybody really but particularly the traditional community midwives.*
> (Helen)

Jane had worked in team midwifery since 1994 when teams were first instigated but her words now suggest that "it was taking too much from [her]" and that it was "infringing on [her] home life, personal life and on [her] husband's life". She therefore requested to move to a work team that practised traditional community midwifery hoping that this would not affect the quality of her home life as much. Jane's words suggest that the imposition of team midwifery appeared to have had a detrimental effect on working relationships with other midwives and that tense group dynamics were kept hidden rather than addressed within work teams:

> *I just wasn't happy in the team…underlying nastiness…dreadful group dynamics…personality differences…I know we're all different but there was more going on under the surface than ever came to the top…*
> (Jane)

Rachel stated that team midwifery had been "thrust upon them" and questioned its effectiveness stating that she did not really know whether "it [team midwifery] worked quite like team is meant to work ideally". Rachel's words appear to allude to dysfunctional team working. This as well as the extra work imposed by team midwifery led Jane to state that:

> *…it's [team midwifery] made me more stressed…I mean I only did four months of team midwifery and I was just on my knees…its really made me compare teams with groups…*
> (Jane)

Gemma also reported that team midwifery was "taking too much from [her]". On calls were seen as a stressor for nearly all of the midwives with Penny reporting:

> *I remember one night I was out three times and the third time when the phone rang after going out once, coming back, going out again and coming back...I was close to tears because I just thought "let me sleep".*
> (Penny)

Team midwifery therefore, was reported to have had a detrimental effect on their lives as midwives, and instead of changing working practices to their benefit, Helen's words suggest that such organisational changes and policies have had:

> *...a really big effect on morale and sickness and everybody has just got a bit fed up of it really...*
> (Helen)

The midwives' accounts of their experiences of team midwifery accords with that found in the literature (Sandall, 1998, 1999). Mander (2001) reports that although enthusiasm and commitment were present at the initiation of most team midwifery schemes, these qualities were not adequate to overcome problems of ensuring cover, providing intrapartum care and meeting other demands within community midwifery.

This lack of insight could have led Todd, Farquhar & Camilleri-Ferrante (1998) to report that changes in the midwives' responsibilities associated with team midwifery may have been grossly underestimated during the planning of team midwifery. Increased stress levels, relating to this changed responsibility, could well have accounted for the high levels of sickness that occurred during the life span of team midwifery where this research was undertaken. Indeed, Sandall (1998) has now provided evidence that some new organisational structures (e.g. team midwifery) are associated with higher levels of staff burnout and she implies that low control over

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decision making and work patterns, low occupational grade and longer working hours are all predictors of burnout that need to be taken into account when planning new ways of working.

Idealising past ways of working

Some of the midwives spent time in their interviews romanticising the past and talking about how much midwifery had changed and was still changing. Frances's words express a "fear of the unknown" that current working practices had brought and anxiety as to whether she can cope with change. She stated that:

> *…when you're experienced you should be able to*
> *cope with anything and handle it…*
> (Frances)

Frances's words appear to be suggesting that many years of clinical midwifery equates with the ability to be able to cope with change. Whilst it is a truism that some experienced midwives have coped well and changed accordingly with the times, others have fared less well. Those midwives who appear to have coped less well are often those midwives who have not undertaken any personal or professional development other than the statutory requirements (Sandall, 1998). Gemma and Frances are both experienced midwives but have undertaken little in the way of further professional development. I interpreted their words as indicating a sense of struggle around change in clinical practice and resentment at the lack of recognition of their ever-extending role. These midwives appear to have become entrenched in the myth of idealising midwifery as it used to be. Gemma reported that there was "more respect for people then" as she described to me her difficulty in accepting students calling her by her first name. Frances, who was due to retire soon, after more than 40 years in midwifery, had found continuity of care and carer a difficult concept to adapt to, even though she would have experienced it much earlier in her career:

I think in the olden days the patient was more appreciative of what was done for them…I may be wrong saying this but I do feel they were…it's a different world we live in now…we seem to concentrate more on the patient's needs…many more patients complain…some are a bit indifferent or a bit arrogant…
(Frances)

Frances's words also seem to suggest that she is having difficulty coping with clients who have rising expectations and are more able to express their needs. Her words also seem to suggest that she found clients easier to care for when they did not question working practices or express their needs as much. Frances seems to be implying that empowered clients are difficult to cope with and that she finds them potentially threatening.

Coping with stress: feeling uptight, depressed and unable to go to work

There was no reluctance on the part of the midwives, or hesitation in articulating the manifestations of stress, throughout their interviews with me. Their words suggest that they were "depressed", that they "didn't want to come to work" and that they had "too much work". They reported not being able to "think straight" when they experienced stress and expressed fears around "missing something important" relating to work "that is hitting you between the eyes". The midwives' words seem to suggest that morale was perceived to be low and there appeared to be some evidence of burnout, as will be seen in the following chapter. As was seen in the previous chapter, some of the midwives cried during their interviews when they talked about the effects that stress had had upon their working lives and home situations.

Jane had decided to take long term sick leave because she "couldn't cope with it [work] any longer" and that she was in fact thinking of leaving midwifery after "hitting that brick wall" after she had "coped…plodded…done her best" and finally realised that

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it was not right that her "hair was coming out in lumps". Jane also talked about the

physical and psychological manifestations of stress that she had experienced:

> *I was so uptight that I had chest pains, palpitations,*
> *not sleeping…all the usual things that go with*
> *stress…and then I reached a sudden barrier and I*
> *just couldn't go beyond that barrier…I couldn't go to*
> *work the following day and I thought I don't care you*
> *can sack me.*
> (Jane)

The midwives reported that they knew of several midwives in other areas of the

maternity service who were seeking help from the staff counsellor. It was

acknowledged that some of these midwives had their own personal issues to deal with,

e.g. bereavement, but Rachel's words imply that if the maternity service had a more

effective support mechanism in place, then stress might be reduced:

> *…but a lot of it [stress] I know from talking to them is*
> *work based and maybe if there was something in*
> *place it wouldn't need to get that far that they had to*
> *see a counsellor…*
> (Rachel)

The way in which Rachel expresses herself shows some insight into how she visions

that her work situation could be changed positively. She appears to be suggesting

that there is a need for supportive structures in clinical practice to help midwives,

although she does not state exactly what she is alluding to. Helen too, suggests that

there is a need for some tangible support structure in place for midwives:

> *…because then I wouldn't have to be mean to my*
> *children…I could let it [stress of the job] out on*
> *someone else formally and in a safe environment…*
> (Helen)

Although some of the midwives talk about counselling in their narratives, they agreed that there was a general lack of understanding and indifference around counselling as a support mechanism. Jane who had been in clinical practice for many years stated that:

> *…in my day you didn't have counsellors for every*
> *time you fell off your push bike and had a fall out*
> *with your husband and had a spot on the end of your*
> *nose…you got on with it…I'm not quite sure about*
> *counselling.*
> (Jane)

Jane's words are interesting and contradict earlier statements she made in her interview. Her words appear to suggest a certain arrogance that probably comes with her long standing in health service culture. This has taught her to "[get] on with" her work without challenging the status quo. Previously however, she has stated that this standpoint has driven her to breaking point and long term sick leave. This contradiction could suggest that, over the years, Jane has built up defence mechanisms (Menzies, 1960; Raphael-Leff, 1991) to protect herself to the point that she cannot now withstand the damaging effects of this behaviour any longer. Instead of projecting a tough exterior to her work colleagues, her words now suggest that she has taken the stance of worrying about what they will think of her perceived inability to cope with work:

> *…you weakling…you can't cope…you're*
> *stressed…just because you're having a bad hair day*
> *it doesn't mean to say that you don't have to do an*
> *on call.*
> (Jane)

Rachel's words suggest that she is not able to cope any longer with the stress of working with staffing problems and inadequate staffing levels[66] given that her role as a community-based midwife was changing all the time. Yet she later contradicts herself implying that she has learned to put up with this situation because if midwives appear not able to cope in this culture then they might as well 'give up':

> …you get on and do…you put up
> with it…you put up
> with the shifts that cause stress to your family and to
> yourself…that's part of the job and it goes with it…if
> you can't cope…well…
> (Rachel)

The work team tried to spread the work equitably particularly in view of each other's personal circumstances and workload. However, on calls were acknowledged as a great source of stress within the work team supporting the findings of Sandall's (1998) study. The midwives were often 'called out', not knowing where they were going or what clinical situation to expect when they arrived. Rachel's words report a culture of self-sacrifice where midwives were expected to work extra shifts and on calls despite the fact that this might seriously affect their home lives:

> …it's very stressful for me…being on call for about
> five weeks…sometimes I've pulled the plug out
> [telephone] in desperation because I technically
> wasn't on duty and I just couldn't have another…not
> being paid on call either and I'd had enough…I'd had
> enough… the pressure to cram more and more into
> a day…and I couldn't believe it…that we do this…
> (Rachel)

Green, Curtis, Price & Renfrew (1998) suggest a number of parameters that affect the way in which midwives experience on-calls. These are length and timing of on-call, who the midwife is on-call for, what the midwife is called for, what happens when the on-call midwife is already busy and payment for the time spent on-call (p.125-126).

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[66] There was also a reported national recruitment and retention crisis within nursing and midwifery at this time (RCM, 2000; Ball et al. 2002).

Gemma's words also report that one of her main sources of anxiety is being on call and she relates a real fear of the unknown:

> I hate being on call…hate it…I don't actually mind
> being on duty…it's not knowing what's coming…it's
> not knowing where to go…I'm frightened to
> death…it's awful…not knowing who you are going
> out to…
> (Gemma)

At the time the research was undertaken three community-based midwives were on-call for the whole of the city. Clients, including women in early pregnancy, were encouraged to telephone the ambulance service if they had any problems and the ambulance clerk duly passed this to the on-call midwife. The midwives could be called to clients that they had never met before. An on-call system where midwives knew their clients, and had met them previously, might not have been so stressful and emotionally demanding for Gemma because she would have been able to inform her clients about when and when not to use the on-call system. This is supported by Sandall's (1998) study where evidence is provided that being on-call for a personal caseload is less stressful. Therefore, 'knowing the client' makes it possible for midwives to increase control over their workloads and reduce the uncertainty of on-calls (Sandall, 1998) thus reducing 'fear of the unknown'.

Kathy appears to have taken a more positive approach to her stressful situation and found that one way to reduce her stress was to finish work on time, not take work-related issues home with her and to discontinue her studies at the local university:

> I went to the university and it absolutely did my head
> in…I couldn't cope with it…but a lot of us felt bullied
> into it…I did two years and I'd had enough…it made
> me really poorly…so I go home now and try to think
> of something completely different…
> (Kathy)

Kathy's words seemed to suggest that she has experienced a range of problems relating to the organisational culture and policies of the maternity service in which she works. As well as there being a statutory responsibility for each midwife to maintain their own professional development (UKCC, 1998), there has also been a move towards an all graduate profession (ENB, 1996). Kathy seems to be suggesting that she has had difficulty in adapting to this change especially as her words suggest that she has been set unachievable tasks, which is a form of bullying (RCM, 1996; Hadikin & O'Driscoll, 2000).

Bullying has been associated with the oppressive culture of midwifery (RCM, 1996; Hadikin & O'Driscoll, 2000) which in turn has been found to inhibit change (Kirkham, 1999) and also to explain some of the difficulties in realising change broadly in other research studies (Stapleton et al. 1998; Hughes et al. 2002). Kathy's coping strategy in this culture, and for the rising expectations of the profession and the maternity services, was to discontinue her studies at the university.

Sandall's (1999) study of the impact of the organisation of midwifery on the life of the midwife found that social support, meaningful relationships with peers and clients and autonomy were all significant themes in helping midwives to cope with their work. It is interesting to note that when social support was present, it was valued by midwives as a stress reducer, but when absent became a major source of stress for midwives.

Habitual ways of working…collusive interaction and refusal to talk

Helen reported that there were "some very stressed midwives that have worked on areas for a very long time and have burnt out almost". Her words state that these midwives had become "immobilised" and "stuck in a rut". Helen also reported that these same midwives were reluctant to discuss or expose their experiences of stress

and refused to "let you in and talk about it". Kathy's words suggest that midwives have built up defence mechanisms over the years especially when they have worked in the same place for a long time. She was referring particularly to those midwives who work in the hospital setting:

> *…they're [the hospital-based midwives]*
> *institutionalised…you become really hardened to it*
> *all…because that's your way of protecting yourself…*
> (Kathy)

As was seen in Chapter 3 this is a defence mechanism used by nurses to protect themselves from anxieties that threaten to overwhelm them. {Menzies 1970 65 /id} Menzies (1979)has suggested that the social structure of the nursing service has developed, perhaps unconsciously, as a system of socially constructed defence mechanisms against anxiety. Midwifery, it would appear, is no exception where social defence mechanisms are often enacted by midwives as a way of coping with their work.

Menzies (1960) suggests that these defence mechanisms develop over time as a result of collusive interaction and agreement. Therefore some hospital and community-based midwives appear to have been defending themselves through habitual ways of reacting to each other because they have worked in the same area for a number of years. As Kathy suggests they have become "hardened" and probably appear cynical and disinterested in their work. Roberts (1983) might have identified these midwives as oppressors in line with her theory of oppressed group behaviour.

The socially constructed defence mechanisms used by midwives therefore appear to have become an everyday reality to which both experienced and less experienced midwives have to try and adapt. It is not surprising therefore to find repression,

reprimand and an avoidance of change commonplace in midwifery. Although Menzies (1960) study is now 42 years old and only focuses on hospital nursing, the work is as relevant today as it was then.

Bad care days…no time to listen and a fear of complex clinical situations

Penny talked about the pressure of being confronted with problems as soon as she entered a client's home. The feeling of knowing that it was not going to be a 'quick visit' as well as being short staffed and 'one midwife down' in the area left her feeling stressed. Her words suggest that she was not able to perform in the way that she aspired to:

> *I know if I'm busy and I know I'm thinking if I don't get out of here soon I know I've got another nine visits to do and then I've got a clinic at one o'clock and this is going through the back of your mind…that probably you aren't as attentive and aren't as good as when I know I've only got another couple to see…*
> (Penny)

Penny's words also seem to suggest a real fear around not being able to set boundaries with her clients. Whilst her words imply that she is putting the needs of the organisation before those of the clients, her words also suggest that there might be an unconscious fear about not being prepared for, or able to deal with the complexities that clinical practice presents. It therefore seems easier for her to attribute this unconscious fear to the pressure of work rather than a need to change working practices.

The anxieties that Penny expresses about being unfamiliar, and not being able to deal with certain situations in clinical practice was expressed as a need to have the support of another midwife immediately on hand to ask for advice. Penny gave me the

example of a jaundiced baby and making clinical decisions as to the severity of the jaundice and whether it was necessary to obtain a blood sample from the baby. She admitted going home and questioning "am I doing it right?" Penny also reports that she had never seen a baby with its umbilical cord off until she started practising as a community midwife and that she spent some time worrying about this until she got used to observing the umbilical cord at different stages of separation:

> *I mean when you're in [the hospital] you never see a baby with its cord off…on the wards they're in two or three days and then go home so you never see them with the cord off.*
> (Penny)

Margaret Chesney (2000) refers to "bad care days" (p.146) when undertaking postnatal care as a community midwife and describes similar feelings to Penny when visiting clients. Chesney states that she would:

> "…pray on the doorstep that there were no problems. If it was a visit for my colleague's practice and non-Pakistani women, I would pray for the woman not to be in, but the Pakistani woman would always be in."
> (Chesney, 2000, p.146)

Like Chesney, Penny too had a caseload that comprised mainly ethnic minority clients. She undertook antenatal and postnatal visits with the help of an interpreter and found that she was able to undertake twice as many visits when visiting Pakistani women. White, middle class clients were reported to pose different problems that were often time consuming. She therefore experienced the same difficulties as Chesney (2000) and this added to her stress and anxiety as a newly qualified midwife.

The rudderless ship…pulling differently and needing direction!

The midwives' accounts have described a helpless situation in which they have no option but to 'get on with it' or take sick leave. However, Jane believes that:

> *There is an element of we're all in the same boat*
> *and we're all pulling together…we're all pulling in the*
> *same direction.*
> (Jane)

Jane's words suggest that as a work team the midwives are "pulling together…in the same direction". This is despite them reporting that they had no guidance or direction from their midwifery managers. As will be seen in Chapter 10, Jane contradicts her words above, describing the work team situation as being "like a rudderless ship". These words conjured images of 'no power' and 'no direction' and accorded with findings from research I undertook in a different maternity unit (Hughes et al. 2002). In this study midwives appeared to have difficulty in adapting to a change of culture in which management structures had been flattened and midwives were being given more opportunity to make change themselves (Hughes et al. 2002). Uncertainties about the future organisation of midwifery work and feelings of a loss of direction within their work team could have contributed to the midwives' increasing anxiety levels.

Therefore, as I discussed in Chapter 2, no sense of direction can be seen to provoke feelings of uncertainty for some midwives, as this sits uncomfortably within their spheres of practice. There are close parallels here between midwifery work as experienced by midwives and the experience of clients. Professional power points to the ability of midwives and other health practitioners being able to exercise direction and control over the lives of clients seeking maternity services (Kent, 2000). Midwives,

for example, may attempt to exert direction and control over women by withholding information from them (Kirkham & Stapleton, 2001).

Obstetricians, on the other hand, attempt to exert direction and control over women and midwives by arguing that birth is only normal in retrospect and therefore uncertain. In order to reduce that uncertainty, obstetricians believe that birth must be brought under complete control (Murphy-Lawless, 1998; Oakley, 2000). Likewise, the midwives taking part in this study appeared to feel threatened by uncertainty and sought to direct and control their working lives and those of their clients through socially constructed defence mechanisms.

Pseudo-cohesion as a mask for unsupportive behaviour

Kathy reported that the work team in which she worked "is the best team that I've worked in". Communication was reported as being good within the work team and the data suggested that they had built what they thought to be effective working relationships and lasting personal friendships. Frances had found her colleagues "incredibly supportive" at a particularly stressful time in her life. She also reported that:

> …they [colleagues] don't belittle you or look down on
> you…they all understand…which is really great…
> (Frances)

She was pleased that they "gave [her] consideration…they're [the midwives] very good". Overall the midwives reported supporting each other and that made the work team worthwhile. Helen reported that:

> *…if somebody rings up and says that their children*
> *are really ill and they can't come – that's okay – it's a*
> *reciprocal kind of support system really…the team*
> *you work with makes or breaks the job…*
> (Helen)

Kathy reported using colleagues as "unofficial debriefing", a concept that some of the midwives reported did not exist within the maternity service and Rachel enjoyed the "camaraderie in the group…you know we are a really good group". Gemma too, thought that "we are a really good group…and we all get on".

Ladylike saboteurs…'flies in the ointment' or 'doing good by stealth'

The midwives' words suggested that they were a supportive work team and that they had an awareness of the importance of group dynamics. However, the data suggests that talking about sensitive issues was "too risky" and "unnecessary" and made me question further their understanding of a 'supportive group'.

Helen acknowledged that "there's flies in every ointment". Challenging each other and confrontation were acknowledged as not being part of their repertoire of skills as community-based midwives. Jane and Gemma reported feeling uncomfortable and ill prepared around the area of confrontation. They used their many years of experience as an excuse for their reluctance to change and reported "putting things on the back burner" rather than addressing issues within the work team. Helen found such skills lacking throughout, and not at all inherent, within the midwifery profession. She feared the other person's lack of understanding or misinterpretation when having to deal with sensitive issues:

> *I find it very hard to deal with someone who is not*
> *acknowledging that there is a problem…and I have*
> *to approach her…*
> (Helen)

Rachel, Gemma and Kathy reported misunderstandings between members of the work team that contradicted the notion of a supportive work team. These were misunderstandings in terms of a lack of communication or scheming behind each other rather than being honest and forthright. There seemed to be a fear within the work team of hurting a colleague through clumsy communication and in their efforts to save each other from emotional discomfort they reported dealing with work related issues superficially, sometimes manipulatively, often destructively, and in a manner that often sabotaged their good intentions. Such behaviour could be termed as that akin to a ladylike saboteur[67]. As Gemma's words suggest some of the midwives behaved manipulatively in order to communicate with each other:

> *…I've got a good example of this…the meeting that they had this morning about GP attached midwifery…I offered to be the representative for our group and em…and we had the meeting last Tuesday and we got everything sorted out and decided what we wanted to say at the meeting and then on Wednesday when I was at clinic and the phone rang and it was for me…it was […]…and she said oh Gemma…do you really want to go to that meeting on Tuesday…so I said yes…why…so she said well what do you think about […] going because we've heard that…and we think that you're too nice and she'd just stamp on you and walk all over you so…and I only offered to do it because I feel that […] and […] both take everything on and they both get quite stressed at times…you know they always have all the home deliveries in their area…so that's really why I offered…I would have been quite happy for somebody else to do it. So I said…well no…that's fine if […] wants to do it but then I was in the position where I thought well has […] offered because she thinks I don't want to do it…you know I twisted it round… So I said if […] wants to do it then I'm quite happy for her to do it so that was that…so then…on Friday morning at the clinic I thought […] is really quiet this morning…I hope she's not thinking that lazy bitch she never does anything you know…* (Gemma)

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[67] The clinical supervisor, Joss, first used the term 'ladylike saboteur' in a discussion we had about the ways in which midwives behaved and interacted with each other.

Kirkham (1999) reports midwives behaving similarly in a paper examining the culture of midwifery where she states that midwives "engineer changes by a process of subtle manipulation" (p.737). Street (1995) also refers to the 'tyranny of niceness' within nursing culture that "constitutes a technology of power that makes it difficult for nurses to accept criticism or even acknowledge the existence of problems" (Robinson, 1995, p.66). I began to realise that the notion that the midwives were a supportive group could have been a defence mechanism that they used to hide their vulnerability and instability (Menzies, 1960; Raphael-Leff, 1991).

Kirkham (1999) refers to midwives behaving surreptitiously and "doing good by stealth" (p.736) in their efforts "to achieve objectives which cannot be voiced clearly and directly" (p.736). The effect of such behaviour, plus a perceived lack of support from peers and midwifery managers, can manifest itself as scapegoating, in-fighting, backstabbing and sabotage which Leap (1997) identifies as horizontal violence. This can then often result in feelings of being undervalued, low self-esteem, isolation and feeling a need for support in midwives.

The experience of supportive working relationships is therefore not the same for every midwife who took part in this study. Sensitive issues around clinical work, tense group dynamics and differing personalities within the work team were reported to impinge on, and sometimes impede working relationships. Helen was perceptive to this, implying that the work team suppressed their true selves:

> *…we bury a lot because we don't want to fall out as a team…we all recognise the value of having this gelled team and we all swallow bits and pieces that we are maybe not happy with and then we don't act on things that we think should be acted on because we don't want to destroy this…*
> (Helen)

Jane reported feeling guilty about having to take sick leave and was worried what the other work team members would be saying; "but then they'll be saying she's gone off sick with her nerves". Overall Jane suggests that midwives were "do or die" and above all, she did not want to expose her weaknesses to anybody else:

> …you're supposed to be strong and wise and
> sensible aren't you…that's your job…especially if
> you're a woman…it's all to do with sage femme you
> know…wise woman.
> (Jane)

This was reinforced by Gemma who was reluctant to partake in the strong work ethic she reported existed in the work team and the maternity service as a whole:

> I wanted to come to work and do my work to the best
> of my ability but then go home because I have a life
> at home…I felt that people thought you shouldn't be
> like that and that you should be thinking about work
> all the time…But I can't do that…I've got to put
> myself into my home life as well as at work…I know
> it's the age we live in…
> (Gemma)

Kirkham (1999) found that there was a distinct ethic of service apparent in the midwifery profession:

> "…a distinct culture of midwifery emerged from their
> many, very similar, descriptions. This was seen as
> essentially a culture of women which emphasizes,
> and internalizes, the values of caring and
> commitment, irrespective of personal sacrifice."
> (Kirkham, 1999, p.734)

This work ethic accords with Jane's perception that there was an expectation within the NHS that she would continue to care for clients irrespective of her own personal and professional support needs. Without doubt, she needed support more than ever when this research took place because of her expressed fear of not being able to cope with

the challenge of complex changes occurring within the work team, the maternity services and the NHS. However, as found in Kirkham's (1999) study, "a resigned acceptance of 'women's lot' featured strongly" (p.737), in Jane's work ethic as well.

Self-denigration as a learned response and a way to discount needs

Sadly, there was a discourse of denigration that ran throughout some of the interviews. Gemma, who was an experienced midwife, saw herself as a "wimp and a bit of a yes man" and appeared to blame herself for being "really sensitive and weak." Her words suggest that she blames herself for tense work team dynamics; even if she had not been part of these, and she would imagine that she was at fault:

> *I'd try and get them on one side and say "is there a*
> *problem"…because I'm really sensitive and I often*
> *think, what have I said…have I done something and*
> *I always try to blame myself…*
> (Gemma)

Her self-denigration and self-blame seemed deep rooted, having become learned responses to everyday situations in midwifery practice. Gemma appeared to use self-denigration to emphasise that she was no threat to me or the rest of her work team. Kirkham (1999) suggests that such responses "subsequently become fossilized as a generalized attitude" (p.735) when midwives automatically apportion blame to themselves in this manner.

Gemma also had difficulty in articulating around some of the concepts we discussed during her interview and I felt perturbed by her helplessness. I found myself having to help her out with statements such as "let me help you" because she persistently saw herself as "not one of the most confident of people". She reported feeling threatened by newly qualified midwives and how she perceived them to be "really up to date." Yet

when she had "taken the bull by the horns" and approached the midwifery manager to ask if she could undertake some further professional development at the local university, she was told:

> *you don't want to be doing that...there's enough in*
> *your group doing studying...have a bit of time off.*
> (Gemma)

Responses such as these may have served to reinforce Gemma's perception of herself as being "weak". Her apparent position within the work team and the structure and organisation of the maternity service seemed to mute and disable her. On the other hand Frances did not like the way management "forget what it is like to be down here" and reported that "when you are being put down all the time then the first headache you get you just want to go off sick".

Jane apologised to me during her interview for sounding like "a right whinger". Tannen (1990, 1995) comments that when women feel powerless they tend to apologise all the time and that the apology then "frames the apologizer as one-down" (Tannen, 1990 p.232). She further elaborates that an apology may not be meant in the spirit it is offered and that women frequently apologise when they mean to express sympathy or concern. Whilst I did not feel that Jane had put herself in a "one-down" position, I did interpret her words as trivialising her story through the form of an apology.

Jane also reported not being fully honest with her colleagues in terms of her increased stress levels because she did not want to "let them down". This supports Kirkham's (1999) view that "whilst midwives gave care, their role as professional carer discounted their own need for personal and professional support" (p.467). Jane told me that she talked herself into feeling better by thinking, "I'll just keep going...I'll just keep going...because you don't want to let people...your colleagues down". As will be seen

in Chapter 10, discounting her own needs for support does eventually lead to Jane becoming so unwell that she has to take long term sick leave.

'Shared' or 'clash' of personal philosophies

Kathy's words suggest that she enjoys being in control of her own caseload and thus "being in control of things done to [her] standard". Jane too, enjoyed a sense of control and a certain isolation that community-based midwifery brought to her working life:

> *I like it when I am out there and I am being my own*
> *boss…there is nobody looking over your shoulder…*
> (Jane)

As well as reinforcing the notion of professional power, this phenomenon can be likened to midwives not having subscribed to the same philosophy of midwifery care within their work team. Instead the midwives appear to enjoy practising in isolation, not realising that they are not providing individualised care or working in partnership with clients. Instead they are sharing their personally, often differently constructed philosophies of midwifery care with clients. Tensions could then arise between individual work team members because they have not identified a shared philosophy of partnership between themselves and clients. Likewise clients then become confused when they receive conflicting information. The midwives then enjoy the notion of "being their own boss" when in fact they are exerting their professional power and subjecting women to "tailored information, least choice and…institutionalised care at its worst" (Demilew, 1990, p.11). This apparent superficial commonality could then lead to dysfunction within the work team.

Generations of dinosaurs…the birth and death of oppressors

Kathy reported that working relationships between community midwives and hospital midwives working on delivery suite were improving and that "what we call the dinosaurs are fizzling out now". However this statement was contradicted later in her interview when she was quick to point out that "there are one or two young ones on delivery suite that you can see the little dinosaur coming out in them". Kathy's words seem to be suggesting that hospital midwives do not value the experience that community-based midwives bring to the profession and that hospital-based midwives do not appear to value each other. Helen's words suggest that hospital midwives who have worked for a long time in the same area should come out into the community to experience different ways of working:

> I think it does everybody good to spend some time
> outside their safe area…then you don't get too self
> important and sort of tunnel visioned…
> (Helen)

Frances, Kathy and Gemma reported an intense dislike of working in the hospital and the thought of returning there to practise filled Frances "with utter horror". Kathy expressed anxiety around working on delivery suite especially as she had not worked there for a considerable period of time:

> …we hear such horror stories about going to work
> on delivery suite…you're there for ten minutes and
> the next thing you are in theatre…and basically you
> don't get any support.
> (Kathy)

Most of the midwives at some point reported feeling "ostracised" and that there was a sense of "them and us" between hospital and community midwives. As discussed in Chapter 1, this polarisation had tended to exacerbate when the two hospitals had

merged a number of years earlier. Lisa, who had reported working as a bank midwife, suggested that she was more "accepted on delivery suite" perhaps because her up-to-date skills seemed to be valued by the hospital-based midwives. Being able to change and interrelate roles from hospital to community work or become a "turncoat" (Hunter, 2002, p.247) accords with Lipsky (1980) who states that being able to alter behaviour helps workers "modify their concepts of their jobs so as to lower or otherwise restrict their objectives" (p.83).

Community-based midwives in Hunter's (2002) study were found to identify with the position of hospital staff whilst they were working in the maternity unit and were even critical of their community-based peers. However these midwives reversed their position when working back in the community setting (Hunter, 2002, p.214). The fact that Lisa appears to alter her role and behaviour when working between delivery suite and community in this study is consistent with internalising the values of those in power (Kirkham, 2000). This is a common pattern of behaviour for those individuals with less standing in hierarchies (Freire, 1972; Roberts, 1983).

Overall the data suggested that hospital-based midwives appeared to hold the dominant culture within the maternity unit. This accords with Bent's (1993) view that "dominant groups have…the ability to identify their norms and values as the right ones in society, and they have…the power to enforce" (p.26). Robert's (1983) theory of oppressed group behaviour explains the destructive and hostile behaviour of nurses. There is now also an increasing body of literature that relates this theory of oppression to midwifery work (Hastie, 1995; Leap, 1997; Kirkham, 1999; Hadikin & O'Driscoll, 2000; Kirkham & Stapleton, 2000; Ball et al. 2002). Hastie (1995) in a story of horizontal violence in midwifery found that when she worked on the labour ward as an agency midwife she was intimidated by a "group of older midwives renowned for their attitudes of superiority and hostility vented on midwives outside this select group" (p.6).

These midwives were also renowned for their lack of support for less experienced midwives. Hastie reports becoming "bumbling, inept and clumsy" (p.7) as these midwives behaved in a harassing manner towards her.

The 'dinosaurs' in the maternity unit that Kathy alludes to in this study appear to have adopted similar characteristics to those midwives described by Hastie (1995) and will probably belong to the dominant oppressed group (Roberts, 1983). These midwives are now trying to oppress the less experienced midwives or the "little dinosaurs". The term "little dinosaurs" implies that this group of hospital midwives is already exhibiting characteristics similar to that of the dominant, oppressed group.

Key points emerging:

Change was viewed as constant by the midwives and all recently externally imposed change, including participation in this study, was seen as generating extra work and creating further stress. Only one of the midwives viewed change as exciting. Team midwifery was criticised for exposing dysfunctional team working and increasing workloads and stress levels. Radical changes in working practices had left some of the midwives wanting to practise like the "olden days" and they used self-denigration as a way of discounting their own needs. Acknowledging that professional power was detrimental to effective working relationships with clients and peers had left some of the midwives feeling vulnerable and exposed, with a fear of complex clinical situations. What might be termed 'pseudo-cohesion' was projected as a defence mechanism in order to mask unsupportive behaviour within the work team. There were also instances of midwives behaving manipulatively, in a manner akin to ladylike saboteurs, in order to avoid the fear of what they perceived as bumbling and inept communication. Some of the midwives preferred to feel in control of clinical situations which highlighted how tensions arose between individual work team members and their personal

philosophies of midwifery. The absence of a shared philosophy of partnership between work team members meant that clients were usually disadvantaged in terms of continuity of care. The midwives reported an intense dislike of working in the hospital and they perceived the midwives on delivery suite as not valuing their community midwifery skills.

In the next chapter I address the complexity of the midwives' situation further and how the bureaucratic pressures of working in a large maternity unit appeared to affect the way in which they managed their emotions.

CHAPTER EIGHT

Phase One: Preliminary interviews

Midwives as 'emotional labourers'

I need your need
Otherwise I will never sense and find
Anything of what my hidden longing
Longs towards
You are the gate
And the life itself

My need is at least as deep as your need
Perhaps even more lost and removed than yours
Since I need the honesty of your cries
To touch and find at least some of the cries
I cannot find

My need is as needy as yours
so I cannot stand before you as a helper
to one in need of help
My need for you
and the generosity of your offered need
is what I have to give
If I am able
helped by you
to receive your need
into the aching arms of my own
forgotten longings
and let myself be held
by the strong arms
of your offered weakness
I will be blessed by your love
More surely than you by mine

All my life I have struggled
to appear strong, stronger than I am
composed, when I have been
ragged and in disarray
self sufficient, when I have been
so lacking that I dared not show
even the tiniest edge of my emptiness
superior, when I have always sensed
that I am nothing in comparison
with so many I have and do despise
I'm trying to say to you that my bitter need
my lack, my failure, is my only gift to you
whatever strength and honesty
courage and love I have

It is easy to talk of need and feel quite comfortable
with that neat, well packaged, little word
scarcely a hair out of place
clean and surprisingly composed
I can even be very proud of recognising
that I have needs like these
They are like extra possessions
the riches of the appearing humble

But need is in so many unwanted and unlovely shapes
and textures and colours and smells
It is where you fear and despise and reject and are ashamed
where you are dirty and unlovely
quite beyond what you would wish to appear to be
It is easy to offer well packaged

and fashionable needs
But enduring needs are baggy and old, smelly and torn
not dressed as those you might wish to come to the party
but really the beggars and buggers
the outcasts and the half-castes
the desperately proud and the utterly rejecting
Is there anything more awful than
the pride of the nouveau needy?
The coinage of need is so quickly debased

Miller Mair 1989

This chapter[68] contributes to understanding midwives' emotional well-being in a culture that it has been argued is rooted in "service and self sacrifice where midwives lack the rights as women which they were required to offer their clients" (Kirkham, 1999, p.732). Whilst one of the aims of this study was to explore midwives' support needs, the revelation of the extent to which their emotional well-being was compromised by their midwifery work was overwhelming and I therefore decided to explore this aspect further. As well as exploring the literature relating to emotion work, this chapter analyses data from the preliminary individual interviews that relates specifically to the midwives' emotional well-being.

Initial data analysis of the midwives' accounts provided insight into four different, but interrelated aspects of their roles as community-based midwives (see Table 4, p.247). Further analysis revealed how they were expected to relate to, and develop partnerships with clients, when they themselves were inadequately prepared for this aspect of their role. The midwives articulated feelings of being overwhelmed by the organisational demands of the maternity service and their increasing workloads. Their words also suggested that they had been overwhelmed by their relationships with each

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[68] During the writing of this chapter the parallel of a labouring woman has been profound for me. The chapter has undergone a prolonged labour with lengthy first, second and third stage revisions. At times I felt my labour was obstructed. There was also a lengthy transition period where at times I felt that I could not go on. There were also parallels in my role as an academic at the same time. Action learning groups in our new curriculum generated much 'emotional labour' for me as I listened intently to students' stories of their experiences in clinical practice and the increasing theory-practice gap, which at the time, felt more like a canyon. My coping strategy for the pain was to discuss the writing of the chapter openly with my research supervisor and to reflect meaningfully on my writing with friends who were willing to be critical, listen patiently and 'stay with me'. The birth of the chapter eventually took place close to submission of my thesis but I feel that the work is still evolving and that I will explore emotion work further at some point.

other. Data analysis has also involved revisiting aspects of engagement and detachment that were explored in Chapter 3.

This chapter draws on the work of Erving Goffman (1990, 1974) and his analysis of the performance aspects of social encounters. Also, as I have discussed in Chapter 6, the midwives used many embodied metaphors within their accounts to describe their experience of midwifery and relationships with clients and each other. Similar metaphors were also found in the data that was elicited from three exploratory interviews that I held with Susan, Sarah and Stella (see page 180) demonstrating that the views reported by the midwives participating in the action research were held by community midwives in other work teams. The imagery that was created in my mind when reading and analysing their accounts reminded me of Goffman's analysis of the workplace and I therefore decided to describe the midwifery workplace in terms of a social drama.

'Framing' the story…midwifery work as 'performance'

Erving Goffman's (1990) analysis of social interaction and his use of the drama metaphor draw parallels between the stage and performance aspects of social encounters. However, the sociology underpinning Goffman's work is concerned with the nature of the way people organise face-to-face interactions rather than emotion work. There are nevertheless comparisons to be made with the way midwives manage their emotions at work. Life is viewed as a drama, taking place in a "theatrical frame" (Goffman, 1974, p.124) on a stage, with human beings as actors.

As Czarniawska (1997) states every culture has its own particular stock of characters; the midwives in this study represent characters. Goffman's (1990) work also highlights

how characters within organisations work together to present a united front[69] for the audience[70]. This demands a convincing performance or "dramaturgical discipline" (p.211) whereby "[a]ctual affective response must be concealed and an appropriate affective response must be displayed" (p.211). Goffman's use of the word 'discipline' suggests that characters have to control their emotions according to social norms. As will be seen in this chapter the accounts of the participating midwives contextualise their performances and inform the ways in which they attempt to control their emotions when dealing with clients, their peers and midwifery managers. Table 4 summarises the demands made upon the midwives, that they reported during their individual interviews, and the performances they undertook in order to cope with these specific demands.

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[69] As was seen in the previous chapter, and will be seen in further chapters, this united front or 'togetherness' was a frequently used defence mechanism for the participating midwives.
[70] In the context of this chapter the audience comprises the midwives' clients and midwifery managers and the midwives attempt to influence the audience through "impression management" (Goffman, 1990, p.26).

Demands reported by the midwives	Performances to cope with the specific demands
Relating to, and developing partnerships with clients. (see page 256)	'Impression management' performance (pp.256, 257) Personally energising performance (pp.258, 260, 263) Role-model performance (pp.263) Defensive care performance (p.267) 'Personal touch' performance (p.258) 'Holding in' performance (p.259) 'Detached' performance (pp.260) 'Task-orientated' performance (pp.261 & 267) Mentoring performance (p.263 & 269) Well informed performance (p.270) Anxiety performance (p.266)
The organisational demands of the maternity service. (see page 271)	'Impression management' performance (p.274 & 276) Anxiety performance (p.271) Defensive care performance (p.271) 'Task-orientated' performance (p.273) Compliance management performance (p.272)
Feeling overwhelmed by their relationships with each other. (see page 274)	'Impression management' performance (p.276) Self-protection performance (p.276) 'Holding in' performance (p.275)
Increasing workloads. (see page 278)	'Above and beyond' performance (p.278) Self-protection performance (p.279) 'Detached' performance (p.280) Selective performance (p.281) Anxiety performance (p.284)

Czarniawska (1997) has examined the drama of bureaucratic life in Swedish organisations using a narrative approach and shows how the application of cultural metaphors to public-sector work can uncover the hidden workings of organisations. She states that we are now witnessing:

> "…an increasing theatricality of politics, in which
> events are scripted and stage-managed for mass
> consumption and in which individuals and groups
> struggle for starring roles (or at least bit parts in the
> dramas of life). This theatricality is a
> natural…feature of our time."
> (Czarniawska, 1997, p.33)

This theatricality of politics referred to by Czarniawska (1997) supports Goffman's (1974) interest in transformed reality and how it can be possible for actors to act in complex layers of their situation or in multiple realities. The theatricality of midwifery becomes apparent in this chapter as the different performances of the midwives are identified, described and explored. The midwives set the stage; some of the work team become the leading actors and others the followers and just as Czarniawska (1997) found in her study:

> "The play proceeds along generally prescribed lines:
> the setting, with its suggestion of a continued
> diminution of resources (the decline), demands a
> certain performance; the actors playing the leaders
> will tighten their control, and the actors playing the
> followers will to some extent oppose this…"
> (Czarniawska, 1997, p.38)

I use the term 'emotional labourer' metaphorically in the title of this chapter to illustrate how the participating midwives experienced and performed their work.

Emotional labour

The metaphor of 'emotional labour' is derived from Hochschild (1983) who was influenced by the work of Erving Goffman. She has drawn attention to the importance of emotions within the work setting and their invisibility, as well as the energy that is

spent by workers in managing and modifying these emotions. 'Emotional labour' is defined by Hochschild (1983) as:

> "…the management of feeling to create a publicly observable facial and bodily display …to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others."
> (Hochschild, 1983, p.7).

According to Hochschild (1983), 'emotional labour' is that which is undertaken in the public domain and "sold for a wage" (p.7). On the other hand, she uses the term 'emotion work' to refer to the management of emotions in a private context or in the home. However, Bolton (2000) states that "emotion work is the act of attempting to change an emotion or feeling so that it is appropriate for any given situation" (p.581). Rosenberg (1990) uses the term "emotion management" to make the same point, whilst Ashforth & Humphrey (1993) define 'emotional labour' as "the act of displaying the appropriate emotion" (p.90). Within midwifery this would involve the midwife "performing" or taking control of her own composure or emotions.

Hochschild's (1983) definition acknowledges emotion as displayed as well as emotion that is internalised and furthermore, Hochschild (1979) suggests that emotional labour is also guided by 'feeling rules'. These rules govern both *displayed* and *felt* emotions in a situation and remain intangible until a contradiction is perceived between what *is felt* and what *should be felt* by an individual. Workers will tend to use social guidelines, "a set of shared, albeit often latent, rules" (Hochschild 1983, p.268) in order to assess situations and produce the expected feeling. Smith (1988) describes these as "the scripts…that guide our action…they come from within us" (p.7).

"Feeling rules" are also referred to as "display rules" by Eckman (1973) although Ashforth & Humphrey (1993) state that "display rules" is more appropriate terminology

as this implies a behaviour focused approach rather than 'taken for granted' emotion. "Display rules" therefore acknowledge those emotions that 'should' or 'should not' be displayed rather than those that are felt. As will be seen in this chapter, the midwives frequently use "display rules" in their performances as midwives but they also use metaphor to describe situations where emotion has a much greater impact on their performances suggesting that "feeling rules" and "display rules" are interrelated.

Longer client interactions = feeling 'psychologically drained'

In a paper examining the dimensions of 'emotional labour', Morris & Feldman (1996, p.994) contend that "as the duration and intensity of interactions increase, employees often are called upon to display a wider and wider set of emotions". Midwives who interact with different clients on a continuous basis have to contend with different types of emotion work (Hunter, 2002). Therefore their performance will be adapted according to the client being visited and, as was seen in Chapter 3, the balancing of engagement with detachment has to be learned. A client with high expectations and many questions may not be content with a 'quick visit' just as a client experiencing breastfeeding difficulties may require a longer, more intense visit.

Burnout syndrome

Hochschild (1983) has stated that when longer client interactions take place the consequence is longer emotional displays which require greater attention to performance and emotional stamina[71]. In 1993, Cordes & Dougherty developed the consequences of longer and/or more intense client interactions and reported that these are associated with higher levels of burnout. Freudenberger (1974) first used the term burnout to describe symptoms of clinical fatigue caused by excessive demands being

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[71] As discussed on page 2 this has resonance for me in my past clinical work, when I found spending time with those women requiring my attention for longer periods of time, stressful and "psychologically draining".

made on the personal resources of staff in clinics in the USA. This concept has been

further developed by Maslach & Jackson (1993) who undertook work with staff in

human services and educational institutions. These authors describe burnout as:

> "…a syndrome of emotional exhaustion,
> depersonalization, and reduced personal
> accomplishment that can occur among individuals
> who do "people work" of some kind…emotional
> resources are depleted, workers feel they are no
> longer able to give of themselves at a psychological
> level."
> (Maslach & Jackson, 1986, p.1)

Further research that I have undertaken found midwives expressing these same

tensions in similar circumstances (Hughes et al. 2002):

> "They want that intimate one-to-one…it's
> psychologically draining…they want you there all the
> time…it's just as stressful as some of the extreme
> situations on the labour ward."
> (Hughes et al. 2002, Focus group B, p.48)

Longer, more intense interactions also mean that clients will often disclose further

information about themselves thus making it harder for the midwife to avoid showing

her own personal feelings (Smith, 1992), yet drawing them further into the developing

relationship. In this situation the midwife has no option but to listen to the client thus

having to manage and adapt her own performance, including her own emotional

layers, at the same time. Such performances may be hard for some midwives for fear

of leaking their personal feelings. Leaking in this manner might mean that they

become diminished in the client's eyes.

Whilst it can be argued that "feeling rules" and "display rules" exist in all forms of work,

midwifery work is different in that midwives are required to engage with clients at a

time of transition in their lives (Niven, 1994) and when they are experiencing extreme emotion. Caroline Flint (1986, p.14) acknowledged this in "Sensitive Midwifery" when she stated that "[m]idwives and women are intertwined, whatever affects women affects midwives and vice versa – we are interrelated and interwoven". However, according to Hochschild (1983) when midwives become 'interrelated and interwoven' with their clients their level of emotional labour is increased requiring them to suppress their own feelings in order to manage the feelings of their clients. As will be seen in this chapter, this process also occurs for the participating midwives in their interactions with other midwives.

Hochschild's (1979, 1983) analysis suggests that each worker has a "self that we honor as deep and integral to our individuality" (Hochschild, 1983, p.7) and that workers can become estranged from this uniqueness through suppression of emotion which then has damaging effects. Hochschild (1983) suggests that workers use 'acting' techniques that may in fact be personally harmful. 'Surface acting' involves consciously changing outer expressions in order that inner feelings correspond accordingly. 'Deep acting' requires a person to change their feelings internally using a variety of methods such as physical and verbal prompting so that the feelings that are intended show on the face (Hochschild, 1983, p.33).

Hunter (2002) provides a useful critique of Hochschild's work drawing attention to her assumption that all workers are passive victims in the workplace. As she rightly points out, there is now evidence provided by Bolton (2000, 2001) that nurses demonstrate autonomy in emotion work suggesting that they are clearly not estranged from their uniqueness or emotions. However, as will be seen, this level of autonomy was difficult to detect in this study. Hunter (2002) also draws attention to Hochschild's emphasis on the negative consequences of emotional labour. Whilst there is clearly evidence to support this argument (James, 1989, 1992; Sutton, 1991; Smith, 1992) there is now

also evidence acknowledging the complexity of emotional labour as well as evidence to support the view that emotional labour has positive as well as negative outcomes for workers (Bolton, 2000, 2001) and thus the potential to enrich the lives of midwives (see Table 5).

Hochschild's (1983) study concentrates on the relationship between the worker and the client as the absolute source of emotional labour thus invalidating other origins (for example, the relationship between workers themselves). However emotional labour is also performed outside of the worker-client relationship and has now been identified in organisations as well as in interactions between workers (Kunda & Van Maanen, 1999; Fineman, 2000). Whilst a growing interest in emotional labour is healthy because this means that emotion is an acknowledged part of the worker's performance, the increasing body of literature is hampered by inconsistent agreement as to the nature of emotional labour.

Emotional labour in the health care setting has received increasing attention in recent years with James (1989, 1992), Smith (1991, 1992) and Bolton (2000, 2001) providing further understanding of how nurses manage their emotions at work. As was seen in Chapter 3, when caring work began to incorporate psychosocial and therapeutic aspects (Barker et al. 1995), this meant that the concept of emotional labour became a justifiable part of the wider 'caring' debate within nursing. Most of the nursing research relating to emotional labour offers an explanation of the concept from an illness perspective (that is, the research involves nurses and their clients). This research has also been undertaken in a variety of settings. James (1989, 1992) and Froggatt (1998) have explored emotional labour and hospice nurses whereas Bolton (2000, 2001) concentrates on nurses working in gynaecology. Scheid (1999) provides useful insights into mental health nursing and Smith (1991, 1992) provides similar insights into nursing in general.

Midwifery, however, has not embraced the concept of emotional labour with as much fervour even though there has been a concerted effort to move away from task-orientated work to a deeper understanding of relationships with clients (Page, 2000). Some authors have alluded to the concept (Hunt & Symonds, 1995; Kirkham, 2000; Mander, 2001) within the midwife-mother relationship although Hunter's (2002) study acknowledges that "there are other, unanticipated sources of emotion work in midwifery" (p.34). As will be seen in this chapter, these sources often lie between midwives and their peers and midwives and managers.

'Professional closeness' or detachment

In the past, task-orientated work had the perceived advantage of protecting health practitioners from anxiety by reducing their emotional contact with patients (Menzies, 1960). However, when investigating low morale and absenteeism amongst nurses, Menzies found that the defence mechanisms they mobilised to contain and modify their anxiety often contributed to their angst. One of the coping strategies they mobilised was 'the denial of the significance of the individual' (Menzies, 1970, p.14). Task-orientated work and distancing are also evident as coping strategies that workers use in published work other than nursing (see Lipsky, 1980).

Smith (1992) also found that task-orientated work was used as a coping strategy in her study of the socialisation of student nurses. Within a "caring trajectory" (Smith, 1992, p.112) task orientation, distancing and treating patients in an impersonal manner were observed as ways of coping with emotion work. Smith (1992) also found that as the students progressed through their training their ability to attend to the more therapeutic aspects of their relationships with patients was reduced and they were more likely to resort to distancing. She contends that as the students became more bound up with

the demands of their training they were less able to manage complex feelings and used distancing as a coping strategy.

Peplau (1969) has described "professional closeness" as sharing some of the features of physical closeness and interpersonal intimacy found within non-professional relationships. However, "professional closeness" focuses exclusively on the interests and needs of the patient. Peplau (1969) goes on further to state that rather than being physically closer to the person; "professional closeness" involves being "closer to the truth" of that person's problems. According to Peplau (1969) the skill of being able to "put herself aside" (p.348) meant that health practitioners, as well as being able to demonstrate competence and interest in the patient, should also be able to maintain emotional distance from the patient. Thus Peplau (1969) remains concerned with the maintenance of detachment in the professional relationship suggesting that "professional closeness requires a special kind of detachment" (Savage, 1995, p.11).

Savage (1995) has pointed out some of the difficulties of this kind of relationship. She states that nurses may become unclear about the boundaries of their work and also that a relationship of any depth with another may be "emotionally costly" (p.12) for the health practitioner concerned. Bowers (1989) states that as well as becoming emotionally involved health professionals also run the risk of "over-involvement" and that this in turn may lead to disagreements between team members. As will be seen later in this chapter, one of the participating midwives was often accused of "over-involvement" with clients.

Similar coping strategies have been identified in midwifery research. Hunt & Symonds (1995) in an ethnographic study of labour ward culture found that midwives often concentrated on the physical aspects of care and used labelling and stereotyping as ways of controlling their interactions with clients. Likewise, Kirkham, Stapleton, Curtis

& Thomas (2002b) in a paper reporting the findings from a funded evaluation project, found that midwives used stereotyping as a way of keeping control over their work situation as well as protecting themselves when they were feeling "impoverished in terms of time, resources and relationships" (p.552).

The four interrelated aspects and demands that I identified in Table 4, and within the midwives' accounts, will now be considered in turn.

Relating to, and developing partnerships with clients

'Psyching one's self up' – a coping strategy

Gemma's words suggested that when she had to deal with complex issues within the midwife-mother relationship she used a coping strategy that involved her 'putting on a front' in order that she could deal with the situation:

> *I had to psych myself up to go into someone*
> *particularly if their circumstances were sensitive or*
> *there was a language barrier…*
> (Gemma)

The ability to "psych one's self up" (Van Maanen & Kunda, 1989, p.55) (or down for that matter) may become an "artful" (ibid, p.55) performance that is really a coping strategy for midwives. Rachel too, has learned to cope on the job ensuring that she always put on a polished performance for her colleagues so that they were not able to detect her stress or distress:

> *…people think that you cope and think that you are*
> *alright…this is something you often perpetuate*
> *because you wouldn't have them know anything*
> *else…I think there are times inside when I've thought*
> *"god if my colleagues knew how I was feeling right*
> *now"…you've got this image haven't you…you've*
> *got to keep going…*
> (Rachel)

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This accords with Goffman's (1990) analysis who sees a person's 'self' as a socialised entity, created in and through social interaction. Rachel's words suggest that she resorts to "impression management" so that her self-presentation portrays deception in order to maintain face and status with her colleagues and clients (impression management performance).

Self presentation; coping and performance

Lisa, who was one of the less experienced midwives, addressed the importance of learning about coping skills during her interview. She remembered learning about interpersonal and communication skills and "touching on counselling" in her midwifery training but this was never addressed in any depth or related to the ways of helping her cope as a midwife. She reported that now she was "on the job" she was only beginning to learn and that her skills were growing:

> *I don't think it [interpersonal skills] is something you can cover in your training and write down and say you've passed…you've done that module and now you're equipped to go on.*
> (Lisa)

Helen reported that having two children of her own during her midwifery career had aided her personal and professional development and had thus increased her confidence as a midwife. She stated that having birthed two of her own children seemed to have given her more confidence within her relationships with clients.

> *…and I just think having my own children and just being more mature and I don't worry about how I'm going to get on with women now and I know I have a good relationship with 99.9% of them…there's always a clash with one in a thousand…but I think my relationships are good and I've just become a better communicator with experience and a bit of awareness…*
> (Helen)

Helen's words therefore implied that birthing her own children had increased her confidence and communication skills and thus enhanced her performance as a midwife (personally energising performance).

Being 'their friend', feeling safe and suffering pain

Frances, who had been a community midwife for many years, reflected on how midwifery work used to be and how the organisation of midwifery now meant that time spent with clients had been reduced to a minimum. The lack of opportunity to perform friendship with clients was seen as a retrograde step by Frances who had enjoyed performing that "personal touch" (personal touch performance):

> *…we used to spend hours with them in their homes and you know you were really their friend…you were their friend in the end…but you're so busy now…that personal touch is lost…*
> (Frances)

Jane too missed the opportunity to "just be there…to listen…to support…to give time". Attending clients and their families with social problems was reported to be stressful by the midwives especially when they disclosed events that had been distressing. Rachel described some of the problems that had been shared with her over the last few weeks by some of the clients she had attended:

> *…so many of my women recently have found out their boyfriend is having an affair or one girl came to clinic yesterday and told me her mother was dying of cancer…another girl I looked after – her twin son has just died…a girl came to see me last week and told me that her little girl was undergoing chemotherapy for leukaemia…*
> (Rachel)

Susan's words suggested that she too had noticed that many of the clients had problems, some of which she believed were present before they came into contact with the midwife. She reported an over reliance on the part of clients and how their fears that they would not cope without her, made her role as a community midwife all the more demanding although she seemed to accept that midwives sometimes have to perform certain roles as part of their job:

> *…it's very difficult…people [the women] are very upset…they feel that they'll never cope without you but I think that we are looking at people that have on-going maybe emotional problems…not just postnatal issues…but it goes with the job…*
> (Susan)

The midwives stated that there was only so much of the woman's distress that they could listen to and that deciding when this point had been reached posed difficulties for them. Penny reported undertaking an antenatal interview with a client who had disclosed that she had had a termination at 22 weeks gestation, more than ten years ago. Penny had found this disclosure distressing and stated that "just her telling me her experience of that was quite traumatic really". Penny told me that she thought about the disclosure for the rest of the day and admitted "dwelling on it" and feeling hopeless that all she could do was give this client the name of a bereavement counsellor. Penny had clearly been perturbed by this disclosure and was tearful during her interview. Penny also informed me that this was the first time she had told someone about how she had experienced feelings of distress and helplessness following this disclosure. This 'holding in performance' is reminiscent of "practitioners keeping their emotional lids on tight" (Bond & Holland, 1998, p.65) to their detriment although Penny reported that such experiences were "something that you need to go through…to learn".

Emotional engagement: a source of energy or a stressor

Penny reported that the effort she put into continuity of care for the clients was more rewarding with team midwifery than traditional community midwifery. More importantly, she appeared to use the emotional labour involved in her work as a midwife to improve her clinical practice and saw emotional engagement with clients as beneficial for her own personal development (personally energising performance). Therefore, rather than experiencing emotional labour negatively, Penny appeared to experience this as a source of energy:

> *I found the continuity for myself was good…I found*
> *that I knew my women better…I got to know the*
> *antenatal women, got to know them postnatally…so I*
> *found it was good for me…*
> (Penny)

Experiencing emotion work as energising accords with work undertaken by Henderson (2001) who reported that the degree of emotional engagement/detachment associated with nurses' work is linked to the degree of satisfaction experienced in the emotional rewards of their work with clients. Bolton's (2000, 2001) analysis also reports nurses experiencing emotion work as satisfying. Penny's words therefore suggested that she appeared to value the emotional engagement that continuity of care brought to her midwifery work and she seemed to achieve a greater sense of job satisfaction than some of her peers. Rachel too reported that it was important to spend time with clients and her words suggest that she actively sought and identified client's needs:

> *…I'll think I'm glad I spent time with her doing*
> *that…it made a difference to her and I really do feel*
> *if you invest…particularly early on with these*
> *women…if you invest some time with them and*
> *listen to them they find their feet so much faster…if*
> *you just spend that time initially...*
> (Rachel)

However, Rachel's words also implied the importance she placed on making herself available for clients, the organisation of midwifery care and her workload. When I interviewed Stella she talked about one of her colleagues and how she was unhappy with the way Stella entered into interpersonal relationships with clients. The midwife that Stella described appeared to prefer performing her midwifery work in a manner that detached her from clients (detached performance). Although Stella did not state that the midwife she was referring to had become stressed there was a suggestion that client's higher expectations of maternity care probably caused this midwife to work in a detached manner with clients. Stella's words suggested that this colleague preferred to use her professional power to dictate to clients rather than communicate with clients through effective interpersonal relationships:

> *I think she has always had a problem with the way that I am with women…she thinks that I take too much on…she thinks that I am too friendly with them…that I should cut off…but I don't see my job as just for nine months…I see it as a job that goes on forever…and with other pregnancies…she thinks that you should forget about it at the end of the day and not have anything more to do with it [the job]…but maybe women are a bit more…I don't like to use the word demanding because I don't think they are…maybe their expectations of us are greater…and for some of the older midwives they prefer to work more traditionally...whereas rather than turning it round on the women and saying "well what do you want to do about this?"…it's been more that she has told them what to do…*
> (Stella)

The approach to care described above by Stella also brought into question her colleague's ability to be able to use her practical midwifery skills and midwifery knowledge at the same time. The midwife that Stella described seemed to prefer to ignore any midwifery knowledge that she had acquired and was likely to resort to 'traditional' ways of working as opposed to using her midwifery expertise and knowledge. This midwife was also likely to leave all problem solving and decision

making processes to the doctor and was unlikely to be intellectually challenged by the midwife-mother relationship preferring instead, a task-orientated performance.

Penny related the traumatic story of a woman who birthed a baby at 23 weeks gestation that only lived for one hour. Her words suggested that she felt obliged to rush around; making sure everything was done, in order to meet the demands of the service. Neither did she want to expose the clients to a lack of continuity:

> *…but that was horrible and after that I just had to do as much as I could…and then that was it...that was the end of my shift…I was rushing to try and get things done so that I wasn't passing her onto someone that the woman hadn't met before…*
> (Penny)

Possibly, Penny's words suggest that she did not want a midwife taking over the client's care who would not perform the midwifery role in the way that she preferred to perform, thus indicating how aware midwives are of different performances.

Practical and intellectually challenging performances

Stella appears to view interpersonal relationships with clients differently from the midwife she described. Like Penny previously, she experienced these relationships as lasting and of value. Stella's words also suggest that she was more able to cope with disclosure and she implied feeling privileged to share client's experiences:

> *…they [the women] do sort of open up to you…the things that people tell you…even when you've only known them for a short time is outstanding really…*
> (Stella)

Helen also reported that "some people have got it [ability to engage] and some haven't" implying that some midwives are more skilled than others when dealing with

clients on an interpersonal level. Helen reported that she had learned through experience that:

> *I just feel that I can give them…I've got quite good at*
> *assessing what [the women] need and listening to*
> *her about her needs and it's all about communication*
> *skills or if I can't listen to her because I can't*
> *understand her…then assessing her in different*
> *ways…and then build up the relationship*
> *accordingly…*
> (Helen)

Helen's words are important as they seem to suggest a desire to perform midwifery work on a practical level as well as performing the midwifery role so that she became intellectually challenged and was thus energised by her performance as a midwife (mentoring and personally energising performances). This accords with work undertaken by Henderson (2001) and Bolton (2000, 2001). Helen and Stella appeared able to perform their role within the dynamics of the midwife-mother relationship in a problem solving way and they found their performances and relationships with clients rewarding. These midwives appeared to find their performances and relationships with clients intellectually challenging and a source of energy reiterating that emotional labour can be performed with satisfaction as well as with negative consequences). Such performances demonstrate midwifery skills that are under recognised and rarely written about within the profession. The consequence of this is that these skills are not role-modelled and adapted by other midwives and are therefore not passed down from midwife to midwife (role-model performance).

Finite energy: running on empty

The language used by some of the midwives was derived from the metaphor of "emotions are fluid in a container", the container of emotions being the midwife's body. Jane clearly expresses how she feels after visiting some of the clients on her caseload:

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> *I feel wrung out…they [the women] drain you…I feel*
> *wrung out by them…I feel as if there is nothing else I*
> *can give them…and yet they expect more…*
> (Jane)

Jane's words indicated that her body was empty of emotion and that she was feeling drained by the nature of her relationship with clients on her caseload. She implied that her emotional state meant she had nothing left to give clients and that her levels of emotional energy were very low. Gemma too expressed much the same feelings as Jane, as she described how she felt when she had completed some of her postnatal visits:

> *…some of the postnatal visits are like that…you*
> *come out feeling like a wet rag…they've absolutely*
> *wrung every ounce out of you and you've tried to*
> *give everything…*
> (Gemma)

Both Jane and Gemma therefore experience the emotion work in their performances negatively. Interestingly, Krone & Morgan (2000) have further suggested that the container metaphor means that whilst emotions are fluids inside a bodily container, ideas and thoughts are contained in the mind. The person is seen as the upper container (the mind) which acts as a lid to prevent the often dangerous contents of the lower, bodily container from overflowing or leaving (Kovecses, 2000). Jane's words suggest that the upper lid on her container has not served its purpose and has allowed the contents of the lower, bodily container to flow away. This also highlights the contentious relationship between thought and feeling (mind and body) that reinforces a mechanistic perception of the world. This dichotomy between the mind-body split states that the rational mind dominates and that the body has lower status and is separated from the mind. This has the effect of viewing a person as a mental rather than a physical being.

Rachel too described her relationships with clients as emotionally draining to the point that she felt empty and at the end of her emotional resources. However, at no point within this study does Rachel make any suggestions or present any imagery of refilling or refuelling herself:

> *I just feel empty…I feel like they've just absorbed*
> *every bit of energy…my duracells [batteries] are flat*
> *when I come out…*
> (Rachel)

The clients on her caseload were seen as 'absorbing' all her emotional energy and then leaving her feeling as if she had no energy left. Her words suggest that she is mentally worn out.

Down and worn out

Kathy too expressed her emotional wellbeing negatively in terms of 'emotions are down' with the type of problems she encountered when visiting clients determining whether or not she allowed herself to 'get down'. The fact that she feels 'worn out' also reinforces the mind as a machine and provides a different metaphorical perspective of the mind. The machine metaphor provides a conception of the mind having a level of efficiency, an internal mechanism or an operating condition (Lakoff & Johnson, 1980). This reinforces the non-rational aspects of a person (Lakoff & Johnson, 1980). Thus, when a machine has been over-used it wears out, eventually ceasing to function:

> *…it depends on the problems...sometimes I get*
> *down about some of the problems that I encounter or*
> *I feel worn out…*
> (Kathy)

Susan too reported that she had clients on her caseload that presented with problems. Her words suggested that she did listen to clients and stayed with the emotion work but then realised that some of the clients became dependent on her and this is when she found difficulty in ending the relationship. The metaphor of 'cutting off' draws on the 'body as a machine' metaphor again reinforcing the superiority of the rational above the emotional. Susan's words implied that she had difficulty in drawing a boundary around her emotional responses to clients and that she reached a point where her emotions would not come out:

> *...particularly people who have got problems...you listen...you are sympathetic...but then you can get over reliance...and I think it's difficult where you cut off because I have had episodes in the past where it had been difficult to dissolve the relationship...*
> (Susan)

Susan's words implied that she needed to dissolve relationships with clients or learn distancing strategies because she had reached the limit of her capacity for dealing with them emotionally (anxiety performance).

Defining relationships: holding on to professional power

Despite her many years of experience and the fact that she spoke of building relationships with ethnic minority women in her care, Kathy's words suggested that she had difficulty in accepting that clients also hold responsibility for their care. Although she did not report feeling irritated by clients setting the parameters of their own care, her words suggested exasperation as she talked about having to cope with clients who presented with different needs and who requested care that was in direct conflict with obstetric policies:

*…and how do you know when you've done enough
for women to say…this woman is just not complying
with any antenatal care we've offered…she's refused
to come to hospital and everything else…when can
you sort of decide that you've done enough so that
there would be no come back on you if anything
went wrong.*
(Kathy)

Kathy's words, especially "complying", also implied that she wanted to, or had decided

to keep hold of, her professional power (see Chapter 2). In doing this she was then

able to set the parameters of the caring relationship and defined what she and the

maternity service thought the clients needed rather than the clients defining their own

needs. Kathy therefore seemed to expect clients to perform a compliant role. In

setting these parameters Kathy appeared to be stating that she felt a need to give a

task-orientated performance in order to have fulfilled her role as a midwife as well as

having met the needs of the organisation. As a result she appeared to worry about

clinical situations and appeared irritated when clients did not "comply" or wanted to

diversify their care to what they considered was appropriate for their needs. This

seemed to result in Kathy performing defensive care as she appeared to prefer not to

cede control to childbearing clients (defensive care performance). There are close

parallels here with medical staff and their apparent desire to hold the initiative for

midwifery practice as well as obstetric practice and thus do all that can possibly be

done to clients. This appeared to provoke a lack of flexibility in Kathy's care-giving

skills.

Expecting nothing other than what is received

Kathy's caseload consisted mainly of ethnic minority women, which she reported

brought a different dimension to the midwife-mother relationship. Kathy worked mainly

in the inner city area where there was a large percentage of high risk births and clients

often did not speak English as their first language. Kathy's words suggested these clients were not as demanding and therefore interactions between Kathy and her clients seemed to be less intense:

> *…mine are not as demanding…they're different*
> *women…we have different problems because*
> *there's lots of poverty…big families…there's one or*
> *two problems with relationships…they come*
> *pregnant from Bangladesh…but they're not the*
> *same problems…*
> (Kathy)

She stated that ethnic minority women were better supported by the extended family and that they "don't have the same perception of motherhood as white middle class clients". Hence she reported that Pakistani clients saw the whole childbearing process as normal although her words could also be interpreted as suggesting that these clients expected nothing else from her other than what they received. Her words did not appear to suggest performing midwifery work other than in a way expected by these clients and she appears to have placed them as passive and accepting individuals:

> *…a lot of them are happy doing what they have to*
> *do…getting married and having babies… because*
> *there's no expectations of anything else…this is for*
> *the Bangladeshi women more than the Pakistani*
> *women…and most of mine are Bangladeshi…*
> (Kathy)

Sarah was an experienced midwife who had worked with many ethnic minority women during her midwifery career. Her words suggested that midwives did not have to engage in a high level of interpersonal communication with Pakistani women; interaction is less intense because their first language is often not English. Sarah's

words suggested that the clients sensed this reluctance on the part of the midwife to give a full performance and thus did not expect a longer visit from the midwife:

> *…if you work on a mainly Asian area where you don't have to communicate very well and you are only popping in and out…obviously they [the women] get the vibes about that…I don't think they actually want you to stay any longer than you do…*
> (Sarah)

Nevertheless Kathy commented that getting to know the clients on her caseload was "like having your own big family". She enjoyed knowing clients over a long period of time and told me that she had:

> *…women coming four and five times…and then her sister gets pregnant and they come running along because they know who you are and where you are…*
> (Kathy)

The use of euphemisms such as "running along" suggests 'mothering' or 'nannying' (Stapleton et al. 1998, p.102; Kirkham & Stapleton, 2000). Their use has been criticised by other midwifery authors as patronising (Leap, 1992; Hunt & Symonds, 1995). They could however be a way of helping Kathy to cope with her increasing workload and to gain a rapport with clients. Kirkham (1989) has suggested that midwives tend to infantilise clients, especially in labour. She goes on further to state that midwives may be seen as mother figures in the postpartum period when mothers have much to learn. Rachel also stated that the postpartum period was a crucial time for clients and stressed, through her own experience, the importance of postnatal care:

I've always had a thing about postnatal care...I think it is the most crucial time...it was for me...the most crucial time of anyone having a baby and you're there at the start of it and you can make a difference...but you can also make it worse by discharging too soon...
(Rachel)

I think Rachel draws attention to a very important aspect of the midwife-mother relationship within postnatal care.   Clients, who have just birthed their babies, especially for the first time, are keen to draw on personal experience from others and 'soak up' parenting advice.   Within the developing relationship it is crucial that midwives inspire clients rather than dictate to them regarding their parenting skills.   At this point in the developing relationship some midwives may infantilise or patronise clients (Kirkham, 1989) when in fact offering a mentoring performance might be more acceptable.   Cronk (2000) supports this view and states that:

"...our assumption of power over the women for whose benefit we practise at the beginning of their parenting can begin their disempowerment as parents and take from them the feeling of responsibility for their children on which good parenting depends".
(Cronk, 2000, p.23)

Kirkham (2000) has suggested that the way in which some midwives appear to infantilise clients is not surprising as they themselves work in institutions as employees and are often expected to receive orders from their employers, and subsequently give orders to their clients.   Kathy therefore appeared to be in danger of performing detached, hierarchical professional relationships with the clients in her care which may actually disempower them rather than empower them (Pratten, 1990; Kirkham, 2000).

Rachel was aware that some of her colleagues were critical of the relationships she developed with clients and also the different performances that some of the clients on

her caseload demanded of her and the rest of the work team. The clients on Rachel's caseload comprised mainly white, middle class clients who had high expectations of childbirth and the maternity services:

> …there's often comments about "my women" or "your women have been ringing again"…the demands are different…I get "can you tell me how to perform neonatal resuscitation on my baby" from my women – not, "how do I change a nappy?"
> (Rachel)

Rachel's words above highlighted the anxiety levels of some of these clients and how they appeared, what might be seen as, disproportionately worried about their parental responsibilities. Sarah who worked in a different work team but also with mainly white, middle class clients stated that:

> I think the further you come up the social class…then the more demands they [the women] make on you…the demands they make are emotionally draining…they've got two sides of A4 paper of questions…
> (Sarah)

The needs of these clients were perceived by Rachel and Sarah as demanding a highly polished, well informed performance which also demanded a high level of their emotional energy. As seen earlier, rather than viewing relationships with clients as a challenge and experiencing them as energising, Rachel depicts her relationships with women as a one way draining of emotional energy where she finds it impossible for clients to energise her (see Table 5). Nevertheless, her words suggest that she may not be comfortable performing at the same level as Helen and Stella.

The organisational demands of the maternity service

In this study, Lisa provided a good example of the stressful effects of having to respond to the organisational needs of the maternity service whilst suffering the negative consequences of emotion work. In her interview she describes working a 12 hour shift as a bank midwife and caring for a client with an intra-uterine death. She talked of physical and emotional exhaustion and expressed anxiety around not remembering some of the practicalities of the job:

> *I went home and I sat in the chair for about an hour*
> *and a half…just like zombified…thinking about what*
> *had gone on…and if I had done everything…*
> (Lisa)

Her words suggested that her anxiety was more related to whether she had "done everything" and therefore probably more linked to the needs of the maternity service as an organisation rather than the needs of the woman she was attending. Lisa appeared concerned that she had filled in the necessary paperwork and informed the client of hospital protocol around the death of her baby (defensive care performance). This appeared to have taken precedence over engaging emotionally with this client resulting in Lisa feeling drained of all energy. Susan supported Lisa's concerns when she stated that "the agonising over sorting everything out was harder than doing it" (anxiety performance).

'Protocolisation' inhibiting the spontaneous performance of midwifery

The notion of 'protocolisation gone mad' (see footnote on page 37) that had inhibited Lisa's spontaneous performance as a midwife also appeared to have exacerbated Lisa's physical as well as emotional exhaustion suggesting that both had been compromised and stretched to the limit. Gemma too, suggested that "we have to do as

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we are told don't we?" implying not only hierarchical working relationships but also the need to meet organisational demands as a priority (compliance management performance). Susan reported how her role as a community midwife meant that she often had to meet the demands of the organisation by working on her days off and during the evening:

> *…we were so bad…I worked my days off…two out*
> *of three weeks…because we were so bad…*
> (Susan)

Helen's words suggested that her successful performance as a midwife was affected if she found herself having to cope with situations that required immediate attention and that were stressful:

> *…you don't think it's getting to you and then*
> *something else gets on top…work's a big part of the*
> *picture…*
> (Helen)

In a paper discussing the findings of an ethnographic study in a fertility unit, Allan (2001) observed caring as 'emotional awareness' and non-caring as 'emotional distance' (p.54). She describes non-caring as an activity where the fertility clinic and the doctor became the focus of nursing rather than the patient and "'[n]ursing the clinic' met patient and staff expectations of the practical nature of the nursing role" (Allan, 2001, p.54). It is likely that that this same phenomenon exists in midwifery work. Responding to the organisational demands of the NHS often meant that midwives were not able to develop or focus on their own or clients' needs. 'Nursing' the service or responding to the ward ethos became the preferred option as task-orientated work took priority over building relationships with clients. Kathy's words suggested that recent policy initiatives have demanded that organisational demands and adhering to

protocols within the service were more important than spending time with clients (task-orientated performance):

> I mean there's all this patient's charter stuff and everybody gets a copy in their notes and they're [the women] all told what they should expect and they're all told they'll get a named midwife and they'll be seen within twenty minutes of their appointment time and the midwife will come and see you within two hours when you get home after the baby and you pole in half an hour late and they say "where have you been…I've been waiting for you"…you can't do eleven visits between 9 and 12…how can you possibly do that…not and give quality care to somebody…
> (Kathy)

Stella's words described the emotional distance she had been forced to develop as a community midwife and which she now maintained with clients. She also alluded to her own emotional well-being and how this had become subordinate to the organisational demands of the NHS:

> I don't think you include yourself in women's needs…I think we see ourselves as…I try to respond to the needs of the service if you like…so we make ourselves available…we give everyone the mobile phone number…and we've got four hundred women between us…we have to give a time when we visit and we have to go within two hours of this time and if not we ring the person and give a reasonable excuse as to why not…
> (Stella)

Stella's words highlighted tensions between the emotional well-being of health practitioners and the pressure to conform to organisational practices, which may have ignored emotional well-being (Menzies, 1970; Obholzer & Zagier Roberts, 1994). The midwives' words suggested that they have to respond to the demands of the organisation and that they are also accountable if those demands are not met. There

appeared to be an emphasis placed on 'being on time' rather than 'spending time with' clients ('impression management' performance).

Rachel objected to having to use her own time to undertake the administrative aspect of her role as a community midwife. She reported feeling stressed with the amount of work that she had to get through in a day:

> *I get myself all worked up…I'm coming in to work late…you keep putting things off that you should be doing there and then…so at the end of the week you've got a pile of stuff that needs sorting out…you're always off late at night and then when you get home you've forgotten to do something so you have to sit down and do it at home…in your own time…*
> (Rachel)

Therefore Rachel's performance as a community midwife and the demands that this placed on her appeared to limit her ability to perform other roles with the boundaries of her personal and work life having become blurred.

Feeling overwhelmed by their relationships with each other

The demands the organisation placed on the midwives and their increasing workloads left them little space for concentrating on their relationships with each other and ways in which each of them could build on their contribution to the work team. It had been Frances's observation that other work teams in the same maternity service were viewed as:

> *Women working together…who don't see eye to eye…they just argue and bicker…they don't particularly get on…they're not compatible with each other or they're not a particularly good group because they don't help each other out…they're not flexible...so therefore always falling out…*
> (Frances)

Interestingly previous literature has identified relationships between doctors and midwives as a potential source of conflict (Curtis, 1991; Murphy-Lawless; 1991, Deery et al. 1999, 2000). However there is now evidence in this study and others (Hughes et al. 2002; Hunter, 2002) that this is far from reality and "the impression was that this was a battle that had been fought, and whilst not won, at least a workable truce had resulted" (Hunter, 2002, p.277).

The strain on working relationships within the work culture that Frances refers to became a source of stress for the midwives participating in this study and I suspected that Frances's words may have been referring to the group dynamics within her own work team. She also commented that signs of stress were easily recognisable in her colleagues:

> *…they become sort of strained and they…how can I put it…they don't always seem to be handling their work as well as they did previously…they're agitated and a bit anxious and they miss what they normally wouldn't or take offence when normally they wouldn't and they complain that there's too much work and too much of this...and too much of that…you can see it in them…*
> (Frances)

The effects of working in a culture that demanded efficient "service and sacrifice" (Kirkham, 1999) appeared to have taken its toll on the midwives and their working relationships seemed to suffer. Their words suggested that they were unable to 'connect' with each other and that they deferred their own needs ('holding in' performance). Sarah's words summed this up:

> *…midwives are their own worst enemies…we don't back each other up…*
> (Sarah)

Susan reinforced Frances's words as she described how the demands of the organisation had affected working relationships with colleagues:

> *…and it was very stressful…very stressful because we were…we had two people's work to do in a day basically and with the best will in the world you can only be in one place at once can't you…and then the mobile phones…meetings to attend….study leave…we were getting…arguing amongst ourselves…niggly…bickering…one person felt another wasn't doing enough…the situation put us under such pressure…*
> (Susan)

Sarah reported avoiding confrontation with her colleagues because she did not want to be accused of upsetting the status quo (self-protection performance). Sarah was an experienced midwife who had lived in another country for several years. Prior to this she would not have hesitated to challenge her colleagues however, since her return to the UK maternity service, she had become more passive and less confrontational:

> *…but a lot of it is you don't confront things because you don't want to rock the boat…I've had such a rocky road since I came back here that I try not to…I walk away from things a lot more now…*
> (Sarah)

Jane reported feeling comfortable "hugging, smiling and laughing with her patients" but showing such demonstrative behaviour was less comfortable to her peers. Jane is therefore unable to perform closeness with her colleagues. She also reported having to make judgments about the way her colleagues might be feeling when she met with them in the base room in the morning. Although she stated that she would be her usual self, her words also suggested that she had to adapt her performance according to her initial observations of certain midwives in the work team (impression management performance):

> *…if her face is smiling she is happy…or oops she's*
> *in a bad way today…she's in a bad mood…avoid*
> *her…*
> (Jane)

Rachel has previously highlighted the stressful nature of her life as a community midwife (see Chapter 7) and she reported behaving "like a coiled spring". This metaphor implied a sense of anxiety and tension in Rachel herself as she probably responded to pressure by feeling extremely tense or vibrant. She also described herself as "a giddy kipper" that was "up one day and down the next" thereby leaving her work colleagues in turmoil as to how best approach her on some days.

Unequal work loads despite being 'all the same'

Rachel's words suggested that she felt angry about some members of the work team having the same job description as her but not undertaking the same amount of work:

> *…we're all the same…all the same*
> *responsibilities…not everybody pulls the same way*
> *but we've all had the same responsibility and the*
> *same job description and everybody's been up to the*
> *task so to speak…some of us need a bit of*
> *pushing…*
> (Rachel)

At the time that this study was undertaken, community midwives were paid at G-grade[72] and the midwifery managers had only just initiated the process of integrating E and F grade midwives into the community setting. Rachel knew that "some people knocked off early" and suggested that all work team members need to have an equal

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[72] Clinical grading was introduced into midwifery in 1989 with the effect that there was a national reorganisation of both nursing and midwifery career structures (Demilew, 1990). Previous research that I have undertaken highlighted that midwives viewed this process as "the worst thing that ever happened" (Hughes et al. 2002, p.48) and that the process failed to recognise midwives' ever extending roles. Midwives participating in research undertaken by Ball et al. (2002) into why midwives leave the profession found midwives articulating similar views. Clinical grading in this study was described as a 'turning point' (p.9) into how or whether midwives experienced job satisfaction. Skills and responsibilities were felt to have not been given appropriate recognition, midwives doing the same job were not allocated the same grade and midwives were downgraded if they chose to work part time. Overall clinical grading was felt by the midwives to have initiated major change in their working lives (Ball et al. 2002) and to their detriment.

work load. She implied that some work team members needed "pushing" in order to fulfil their work commitments. I interpreted an underlying current of 'bullying', not nurturing, in Rachel's use of the word "pushing" and an obsession with meeting organisational demands rather than fostering good working relationships.

Increasing workloads

Susan compared her situation to those midwives working in the hospital and, whilst she appreciated that they too had their difficulties, her words suggested that once their shift had finished meeting the needs of the organisation also ceased for these midwives:

> *…when in high tech it's obvious you've got to go for it…you've got to respond now…you've got to get it right…you've got to recognise when things are wrong, people need you now, lives can depend on it so obviously I realise that that's stressful… but you can walk away from it once the shift is over…for us we often have to ring each other in the evenings and days off and say look this has cropped up and needs dealing with now…or somebody rings…*
> (Susan)

Susan's words were at variance with Lisa's earlier words that she became "zombified" (as discussed on page 271) when she arrived home and was only able to sit in a chair pondering the shift she had worked.

'The cult of busyness'…self protection or avoiding too much work

Despite the fact that their work and caseloads had increased enormously, Gemma's words suggested that several of the work team members insisted on performing a work ethic 'above and beyond' what would normally be expected within their job description

(above and beyond performance). However, Gemma was not prepared to undertake the same amount of work:

> I must own up to the fact that I don't want to go to
> meetings after work, I don't want to do things in my
> dinner hour. I want to go to work to be a midwife
> and come home.
> (Gemma)

On occasions Gemma had "grudgingly" agreed to attend meetings that were out of her usual working hours but this had just made her "fed up". Her reluctance to become involved with extra commitments in order to meet organisational demands suggested that Gemma wanted to protect herself from the stress that she observed in her work colleagues. This self-protection added another dimension to the performance of the midwifery role for Gemma and as a result she sometimes experienced feelings of isolation within the work team. Her words also suggested that the other midwives in the work team attempted to intimidate her:

> Well I think they're wrong, I think they want to be up
> to their arm pits in work you see, they want to do
> things on the computer at home at night, like working
> out protocols and things, well I don't…and yet
> because you don't feel that you're involved all the
> time they make you feel guilty.
> (Gemma)

In a culture of economic rationing of resources the midwives appeared to be "do[ing] more with less" (Robinson, 1995, p.66) where "priority [was] given to the completion of technical and physical tasks resulting in a pervasive ethic that 'a good nurse is a busy nurse'" (ibid. p.66). Stella's words suggested that midwives often resort to sick leave because they are unable to undertake or perform changed working practices. Sarah too reports an increasing number of midwives taking sick leave because of stress, probably associated with increasing workloads:

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> *…I think it is very worrying…I'm extremely worried about the number of nervous breakdowns that has gone up…and I'm not talking about minor ones…I'm talking mega ones…and it's all to do with stress…*
> (Sarah)

The voices of Sarah and Stella could suggest a lack of identified opportunities for further personal and professional development within the maternity services around managing stress and working relationships:

> *Sickness…we had a lot of sickness last year in the team…de-motivation…not wanting to do anything especially parent education because it has changed…some of the midwives are not comfortable doing it so they are off sick quite often…so it throws more pressure on everyone else…*
> (Stella)

Changed working practices thus meant that midwives took more sick leave and as a result the midwives left to carry the caseload within the work team were forced to cover their colleagues work in their absence. This then led to more stress and ultimately more members of the work team taking sick leave.

Frances talked about clients being offered more choice, continuity and control and was under the impression that this was being performed in their work team. However she did comment that whenever there was sickness in the work team or colleagues on study leave "it went a bit haywire". This meant that colleagues were left with double the amount of visits or clinic appointments and that the midwives could not perform "effective care or safe care" (detached performance). Thus it would seem that an increased workload makes emotion work even harder for midwives.

Differentiating between clients: rejection and acceptance

Kathy admitted to not feeling comfortable with, and detaching herself from, white, middle class clients and that she "got rid of them like hot bricks" when Rachel was back on duty. Her words suggested that she differentiates between clients, rejecting those clients who demand a great deal of energy from the midwife (selective performance). Although she does not say so, I suspected that the level of emotional engagement these clients demanded was not comfortable for Kathy. She disagreed with Rachel's view of visiting clients as often as they wished and stated that midwives should be empowering clients, not fostering dependence on them as midwives:

> …we think we can cure everybody's problems and we can't…we should be empowering them to think for themselves instead of saying we'll come all the time…and running here and running there…they should be thinking for themselves…I just think it's inbred in us to think that we have to do everything…
> (Kathy)

Although Kathy's words incorporated the concept of 'empowerment' her words suggested she had interpreted this often used rhetoric narrowly. On one hand she appeared to be expressing a desire to care for clients in a way that she knew was congruent with the aims of woman-centred care (DOH, 1993a) but on the other hand she seemed to distance and detach herself from those clients who might need more in terms of emotional support. One solution to help Kathy cope with this situation was to differentiate between clients and provide her own ideal service for the clients on her caseload. As Lipsky (1980) has stated "the street-level bureaucrat salvages for a portion of the clientele a conception of his or her performance relatively consistent with ideal conceptions of the job" (p.151).

Thus Kathy prefers not to visit Rachel's white, middle class clients because she is more likely to achieve a successful midwifery performance with her own clients. Kathy's words could also suggest that she finds white, middle class clients more difficult to infantilise. She prefers to work with clients who are more likely to respond to her way of working and this does not appear to include Rachel's clients. There is a danger here that Kathy's selectivity has the potential to result in prejudice which is not congruent with a service that purports to have a woman-centred approach (DOH, 1993a).

The need to be needed

Lipsky (1980) has stated that "those who recruit themselves for public service work are attracted to some degree by the prospect that their lives will gain meaning through helping others" (p.72). This then implies that some people enter nursing and midwifery because they need to feel needed or valued and they get that back somehow through the work they carry out with others. Thus, when midwives differentiate between clients and become selective in their visits, this may be one way of fulfilling their need to feel needed. As Lipsky (1980) has stated "[t]he teacher's pet is not only an obedient child but also one who confirms to the teacher the teacher's own capability" (p.152). The provision of an individualised, idealised service to obedient clients thus provides some midwives with the emotional gratification and confirmation necessary to give a competent midwifery performance although as Hawkins & Shohet (1989) point out "we do not have to live through our clients, dependent on their successes for our self-esteem" (p.9). However, Kathy's words suggest that this is her preferred way of working:

> *…we all like to feel that we are needed and as long*
> *as you feel you are needed it makes you feel*
> *good…makes you feel that you are worth*
> *something…*
> (Kathy)

As I have developed personally and professionally, my 'need to feel needed' has resolved and I am challenged by the complexity of midwifery. Other individuals however might have wanted the challenge of midwifery at the outset and felt positive about the complexity of the job. These midwives do not particularly need to be needed but they do require stimulation, challenge and change within their working lives. However the midwives that participated in this study, with the possible exception of Helen and Penny, appeared to be lacking personal and professional development which resulted in them viewing midwifery negatively and becoming swamped and selective with their increasing workloads. As will be seen, in an NHS culture that insisted that organisational demands were met, this meant that the midwives had little time to concentrate on their relationships with each other or their professional development. Indeed, 'impression management' was a key performance that appeared to be important in all relationships for the midwives (see Table 4 on page 247). This meant that they spent most of their time at work participating in 'impression management' which resulted in them having no time for managing their emotions.

In a paper exploring how workers try to manage their emotions under conditions that are impossible, Copp (1998) identifies "occupational emotional deviance" (p.299) as that which workers experience when they cannot manage their own or their client's emotions according to organisational expectations. Workers thus feel that their performances are inadequate. Rachel provides a good example of a midwife whose emotional energy has been sapped in this way making her more vulnerable to burnout (Thoits, 1985; Copp, 1998). Rachel's clients demanded longer interactions and she was not able to undertake as many visits as other members of the work team. She appears to feel guilty about this but when I suggested that spending time with clients was beneficial for them and could be energising for her she replied:

*…it's [the job] killing me…it's affecting me… she's
just told me this [a problem]…and you might have to
bottle it up…*
(Rachel)

Rachel's words therefore suggest that her emotional capacity has become untenable. This coupled with her tendency to blame problems on her personal weaknesses meant that she provided evidence of "occupational emotional deviance" (Copp, 1998) or burnout. As a result she was not energised by her performance as a midwife; in fact, she appears to depict what could be termed 'performance anxiety' and is unable to perform her role as a midwife. She appears to have succumbed to role tiredness through a lack of new and personally energising challenges. Table 5 below sets out the parameters of negative and positive emotional engagement as identified by the midwives participating in this study.

Table 5: Midwives' ways of emotional engagement in a bureaucratic context and their subsequent effects

Positive emotional engagement	Negative emotional engagement
• Midwives are able to balance their relationships with clients. These are lasting and valued.	• Midwives relationships with clients are fragmented and experienced as "psychologically draining" and stressful.
• Midwives behave autonomously and are able to think independently.	• In the absence of autonomy midwives become subversive and obedient.
• Midwives value spending time with clients and understand continuity of carer. They actively seek and identify client's needs and invite feedback from clients.	• Midwifery work becomes task-orientated with decision-making left to the doctor. Midwives become swamped by the demands of midwifery and selective with their clients.
• Midwives enjoy the complexity of midwifery and thrive on stimulation, challenge and change. They also value emotion work.	• Midwives use their professional power rather than communication skills to set the parameters of the relationship and they become detached from their clients.
• Midwives are intellectually challenged by their work and are able to use their midwifery knowledge and practical skills together.	• Midwives feel "wrung out", "drained", "empty" and like "wet rags" and are unable to use their midwifery knowledge and practical skills together.
• Midwives are able to re-balance their relationships in order to sustain positive emotional engagement.	• Midwives feel a need to be needed and their emotional capacity becomes untenable.
• Midwives experience their work and their colleagues as a source of energy.	• Midwives experience their work and their colleagues as a one-way draining of emotional energy.

Key points emerging:

The findings presented in this chapter suggest that there are only certain performances available to midwives during their daily work. Although as community-based midwives they were in an ideal position to offer an individualised approach to their work, the midwives were constrained by excessive organisational demands and limited resources within their maternity service. The pressure to meet organisational demands meant that they had to regulate and control their performances which required considerable energy on their part. Regulating their performances in this manner also meant that their working relationships were affected and the midwives reported not being able to connect with each other. Some of the midwives subsequently experienced role tiredness resulting in anxiety performances that led to a one way draining of emotional energy rather than a fulfilling, energising process.

CHAPTER NINE

Phase Two: Focus groups

Clarifying support needs and planning for change

This chapter analyses data from two focus groups that were held with the participating midwives following their preliminary interviews. In accordance with the aims of the study, the focus groups were held to help the midwives identify and clarify how they wanted to address their support needs and then to plan a means of gaining support through mutual collaboration. The first focus group (28.4.98) was held to reflect on the content of the individual interviews and decide how the midwives wanted the study to progress. The second focus group (9.11.98) was held to construct their support framework for use in clinical practice.

I also report on the midwives' interactions during the focus groups in order to try and gain further insight into their working relationships. In order to stimulate discussion during the focus groups I asked the midwives to imagine how far they were prepared to go to get their support needs met. Also in this chapter, I report two meetings that I had with midwifery managers. These meetings were held at the midwives' request following the second focus group.

Focus group one: a forum to reflect on support needs and change

All the midwives had received a copy of their interview transcript and I had suggested to them that they read through the data prior to the focus group in order that they could verify the content and also contribute to discussion. At the start of the first focus group I informed the midwives that reflecting on their interviews might mean further discussing their experiences and opinions of support. During the focus group I also

posed questions around what was expected of the midwives in the maternity unit in which they worked and also what was difficult for them about working as a community midwife in the NHS. This then led to further discussion about what support meant for them as practising midwives. In terms of presenting a resolution at the end of the focus group I wanted the midwives to inform me how they took care of their own needs and to prioritise those issues which were the most important for them. I also wanted to clarify how far they were 'prepared to go' in this study in order get their needs met.

Observing group interaction

Although I was familiar with the inner workings of community midwifery, I did not work with the midwives every day in clinical practice; therefore this first focus group formed an important cycle of the research in that, according to the aims of the study, I wanted to observe and explore how the midwives interacted with each other so that I could gain further insight into their working relationships. This is reminiscent of ethnography where the researcher is concerned with "capturing, interpreting, and explaining the way in which people in a group, organization, community, or society live, experience, and make sense out of their lives, their world, and their society or group" (Bentz & Shapiro, 1998, p.117).

As was seen in Chapter 6, I was able to reflect on how working relationships used to be when I was part of the work team but I also needed to see if these had changed in any way since different ways of working had been encouraged within the NHS (DOH, 1993a; DOH, 1999; DOH, 2000). This 'observation' would therefore give me what Hammersley & Atkinson (1995) refer to as a status akin to that of participant-observer. However as discussed later, the focus group was not a natural setting for the participating midwives and I was therefore only a participant-observer to the group interactions in the focus group setting on that day. Clearly, their individual accounts,

as well as the interactions taking place between the participants are an important source of data and play a crucial part in the analysis of focus groups (Webb & Kevern, 2001). During their interviews the midwives had reported their experiences as community midwives in Glendale Team and now I was hopefully going to be able to observe their interactions during the focus group, albeit out of the work context.

Whilst the focus group we held in the maternity unit was not a natural setting[73] for the midwives, observing them interacting as a group would help me to put into context some of the issues that had arisen in individual interviews. For example, some of these issues were around dominance of certain work team members, lack of communication within the work team and a perceived 'supportive' work team. I was particularly interested to note whether their interactions complemented what they had discussed with me in their individual interviews. I also wanted to check that my interpretations of the data from the interviews corresponded with their interactions in the focus group. As I discussed in Chapter 6, in terms of analysing the data, this would help me develop an understanding of what was happening in the work team as well as *why* it might have been happening. I did not inform the midwives that I would be observing their interactions as I thought that this would inhibit their spontaneity within the focus group. The silent voices in the focus group might also have been inhibited even further had I announced my intention to observe their interactions.

Silent voices huddling together

Penny, Gemma and Lisa appeared mute and withdrawn during the focus group despite the fact that during their individual interviews they had been articulate and revealed feelings and personal information that helped me gain insight and understanding of the

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[73] That is, a focus group is not something that is part of their everyday routine as a community midwife although it mirrors the social organisation of midwifery practice that is dependent on a team approach and verbal communication (Hughes et al. 2002).

ways in which they worked as midwives. These midwives seldom spoke and offered mainly non-verbal agreement to statements made by the more vocal members of the focus group. I observed them sitting huddled together at one side of the table as they revealed nothing about their views of midwifery or their status within the work team. I was aware that keeping silent can be interpreted as agreement (Willott, 1998; Kirkham & Stapleton, 2000; Stapleton et al. 2002a). However, I felt confident after observing interactions between work team members that, had focus groups been the only source of data collection in this study, their stories would have remained untold.

Getting started…different forms of anxiety

The focus group took place in a room at the maternity unit that I had previously booked. All the midwives attended. I had arrived early in order to prepare the room and set out some refreshments. However when I arrived the room was already being used for a midwifery manager's meeting. The managers knew that we had the room booked and were aware of our presence outside the room. Despite this they seemed to encroach into our allocated time and continued their meeting for an extra ten minutes. As the managers filed out of the room one of them commented on the way I was dressed. I felt humiliated and angry by her comments and some of these feelings stayed with me. Reflecting on the focus group afterwards I decided that the comments made by the midwifery manager had not provided me with the best start to my first focus group although I also thought that the comments made could have been interpreted as a form of anxiety. The midwifery manager may have been worried about possible negative issues that I might uncover in the focus group.

The midwives' choice of seating round the table was interesting, with the ones I had experienced as being dominant and vocal clustered together and the quieter, less articulate midwives sitting at the opposite end and close to me. I wondered whether I

should encourage them to move closer together but decided against this, as I wanted them to feel comfortable and safe although I never felt during the focus group that the quiet members of the focus groups felt either comfortable or safe. Indeed my own comfort and confidence had been compromised on the way into the focus group by one of the midwifery managers.

There was a lot of laughter from us at the start of the focus group and I put this down to anxiety on both our parts. Interestingly I was wearing a red blouse and there were some comments from the midwives that I "blended in" with them as their uniform comprised a red tunic and navy blue trousers. On reflection I wondered whether I had unconsciously put the blouse on that morning in order to feel part of the work team or whether I was trying to convince the midwives that I was part of their team. Once we had settled down I started the focus group[74] by asking the midwives what was hard for them about working in the NHS. I had already asked the midwives about what life was like as a community midwife in their interviews and I now wanted to probe further into their roles and working relationships. Helen was quick to respond but rather than wait and collect views from the rest of the work team, I quickly went on to determine how the midwives would see that happening:

Ruth:	*Can I ask you what's hard about working for the NHS?*
Helen:	*That there is no formal mechanism for support…that's what…when I've read through mine that's one of the things that come out of it…*
Ruth:	*How would you see that happening?*
Long silence	
Frances:	*With a support group…*
Ruth:	*How would you see it running?*
Frances:	*Not too high up the administrative field or ladder…*

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[74] See Appendix 3 for proposed plan of focus group.

Helen:	*I think it's important to think about who does it…like you say…*
Lisa:	*What…would it be somebody in the group or…outside the group…?*
Gemma:	*Personally I think we need someone else here don't we?*
Kathy:	*You see we're lucky 'cos not every group is like us…are you talking about it as a whole across midwifery or just this group…?*

This tendency to rush the focus group along was a sign of my anxiety as well as my awareness that they all had 'visits' to collect from the base room. However the choice of facilitator was important to the midwives and warranted further exploration. Helen started a discussion about who would actually facilitate such a support group. Three of the midwives, Helen, Lisa and Gemma were of the opinion that they needed someone to lead such a group other than their current midwifery managers. At this point Kathy reminded the group how lucky their work team was because of the support offered to each other. The impression of the work team being supportive had been a recurring theme throughout the individual interviews and persisted throughout the focus groups and the final individual interviews.

At times I felt that the constant references to their supportive group were made to avoid talking about difficult or sensitive issues that arose within the work team. Kathy's interjection into the discussion about who should lead a support group seemed like a deliberate distraction in order to smooth over what might turn out to be painful discussion in the focus group. At the same time her words also appeared to act as a warning to other work team members not to reveal or talk about personal or sensitive issues relating to their team, as she might not be able to cope with any conflict. Rachel appeared to be still giving thought to the type of person to help them at this point and opened the discussion further by informing the work team how she perceived support in the wider arena of midwifery:

> *There are lots of different personalities and people with different skills in this job…you might go to one individual with something and another individual with something else.*
> (Rachel)

At this point in the study Kathy was still keen to convince me of the supportive nature of the work team and whilst she was right to think that a supportive group could build on its strengths for the future, I found her rhetoric unconvincing especially as other 'voices' participating in the focus group were not supporting her words and the less vocal members of the work team continued to stare at the floor. Rachel's words above, however, suggest that there were different personalities in the work team and that this needed acknowledging by using the different skills of other work team members.

Keeping 'team spirit' alive…despite obvious differences

At this point, Helen returned to the previous discussion to dispute Kathy's comment that Glendale Team supported each other all of the time. She appeared to ignore and discount Rachel's contribution above as she took the opportunity to discuss working relationships within the team:

> *When I read through mine [interview transcript]…I think it's because we have all worked in different situations that…haven't been so supportive and I think a lot people think that the team you work with might make or break the job really…even though there are obvious differences…there are those things that we need to sort out but a lot of the time we don't confront them because we don't want to break down that team spirit thing because it's really important to us all to keep it going.*
> (Helen)

Helen's words suggest an awareness of sensitive interpersonal and communication issues that need addressing within the work team. Her words imply that she was aware her comments might appear threatening to some of the work team so she finished what she was saying by referring to "team spirit" and how this was important to the team. Helen's words could be interpreted as her way of not wanting to break down team spirit. This was probably her way of coping with anxiety around challenging the status quo in the focus group setting. This coping strategy is interesting, as the 'team spirit' she talks about may not even exist to start with.

Rachel appeared to relate to what Helen was saying and started to tell the team about the difficult situation she had encountered at the weekend:

> *I had a conversation with someone from another*
> *group on Sunday and there it was…I've been*
> *working with her for twenty years and can't tell her*
> *that the way she is working has become a*
> *problem…what can I do…these work issues…I'm in*
> *a terrible situation.*
> (Rachel)

I was conscious at this point in the focus group that there only appeared to be a dialogue between two of the focus group participants, namely Rachel and Helen. The other members of the work team continued to sit staring at the floor. Kathy was fidgeting with her mobile telephone and appeared to be disinterested. I tried to salvage the situation by stimulating the team with a question.

Ruth: *What could Rachel do about this? What do the rest*
        of you think about Rachel's situation?

Helen: *I think that's a problem where someone from outside*
        might be able to help…

Jane: *We're frightened of saying something that might offend…em…*

Kathy: *But we do say things…I mean we are all adult*
        enough to be able to accept that and work it out…

Pussyfooting and 'smoothing over' as alternatives

The midwives' words suggest that they were avoiding bringing issues out into the open and they were what Heron (1991) refers to as "pussyfooting". This became even more evident when team members began to reflect on their own ways of working. Clearly the midwives seemed to find it much easier and more comfortable to smooth these difficult issues over and talk about something different, namely their individual ways of working. Once again Kathy led what appeared to be a "smoothing over" process by informing the focus group that she knew she was a vocal member of the group:

> *I think we all accept that we are different and that*
> *they all know that I am gobby and that when I do say*
> *things I don't necessarily mean to upset anybody…*
> (Kathy)

On a superficial level Kathy's words imply that she has insight into the effect her behaviour has on other midwives but on a deeper level she appears not to want to understand how her behaviour affects the other midwives with whom she works. This "pussyfooting" around was a common feature throughout the life of the study as the midwives struggled to find ways to address issues within the work team. I also came to understand that challenging another individual supportively was not part of their repertoire of skills. Neither was this their fault. The midwives' words suggest an avoidance of issues as they realised that there was no other option but to do this. This avoidance and their discussion around who might facilitate support for them in the clinical area suggests that there were no effective role models for them (Kirkham & Stapleton, 2000; Kirkham, 1999). Pussyfooting then appears to become the best option.

I felt however that Kathy's words above were offered as a distraction to the rest of those present. Superficially her words suggest that she was self-analysing but in fact her statement is more self-protective. Her words "we should just accept people for who they are" could be interpreted as Kathy's way of masking her naivety around her own self-awareness. Her words suggest that she is publicly making her views known to the work team that if they became upset by her behaviour then any misunderstanding was their fault not hers. She appears to be reinforcing her role within the work team and at the same time suggesting that this was not open for discussion. Her words imply that she was not going to change her behaviour and that her colleagues were going to have to put up with her as she was. Whilst I agree with Kathy that accepting people at face value is necessary on one level, this does not appear to take account of a situation where a midwife might feel disadvantaged in some way and need to report the situation to someone else.

Conversational rituals…trying to restore balance

The focus group discussion about individual behaviour appeared to give Rachel food for thought. She suddenly interjected stating:

> *I know that I'm a bit too much on the go and all*
> *that…*
> (Rachel)

Rachel's words suggest that she was concerned she had portrayed a negative image of herself and she was keen to find out if others had done the same. As was seen in Chapter 8, Rachel had described herself as "a coiled spring" suggesting that she knew her moods could be variable and unpredictable for the work team to deal with. Her words also suggest that she portrays an impression of bustling efficiency and that she worked extra hard in order to keep this impression alive. She seemed to be using the

focus group as a forum and as a vehicle to acknowledge her unpredictable behaviour and apologise to work team members.

Tannen (1995) refers to apologising as a conversational ritual that occurs amongst women at work and that sometimes the tone of an apology can be heard in conversation without one even being spoken. Rachel's words suggest an undercurrent of self-deprecation that was synonymous with 'putting herself down'. She almost appeared to be trying to restore balance within the work team in order to make up for times when she knew her behaviour might have been erratic. Frances also made a contribution at this point albeit to return to elaborate on a comment that was made by Rachel earlier in the focus group. Frances's words suggest that if she needed support there were certain people she would go to:

> *I think you do identify with certain people for certain*
> *problems…*
> (Frances)

Frances seemed to be trying to pick up the focus group discussion earlier by echoing Rachel's comments about midwives accessing individuals with certain skills as and when they desired support. Frances's words could be interpreted as her way of rescuing Rachel from a situation where she believed Rachel might be revealing too much about herself. This situation seemed to have made Frances feel uncomfortable and her words suggest that she wanted to change the direction of the focus group.

Fear of exposing feelings…letting colleagues 'see inside'

Despite Frances's efforts to change the direction of the focus group the discussion reverted back to the midwives' own problems and how they take problems home with them often to the detriment of their partners and children (see Chapter 8). We

discussed what they wanted to do about this and I challenged them about how far they were prepared to go to do something about their situation by asking "how do you want to go about finding support for yourselves?" Jane expressed anxieties about having to expose and express her feelings to someone she was not familiar with:

> *…how much of ourselves will we bare to one another…how much of the feelings that we are feeling will we let other group members see…we all know we feel the same things and we all have different levels of stress…whatever it might be…but how much of that will we let our colleagues see…it's very difficult?*
> (Jane)

Jane's words suggest she is speaking in generalisations and for the whole team, rather than owning her own feelings of anxiety. This probably felt easier and more comfortable for her especially as talking openly about such issues is not familiar to midwives (Taylor, 1996). I was therefore not surprised that none of the midwives challenged this generalising and just appeared to accept her thoughts on this situation just at they did at the start of the focus group. Jane's words suggest that she is not at ease with exposing her feelings to other members of the work team. She seems to be suggesting that her vulnerability and proneness to feeling stressed is a weakness and not for others to observe. This is despite the fact that the work team was reported to be 'supportive'. Helen was quick to pick up on this and acknowledged Jane's concern and anxiety at having to expose feelings in a team situation:

> *…some people would feel very threatened by doing it [exposing feelings] in a group…you might have to start off by doing it individually…*
> (Helen)

Rachel stated that she would need to know how to "handle" expressing her feelings in a group or individually. She appeared 'prickly' and was sitting up very straight in her

chair as she said this, almost daring other members of the work team not to upset her in any way. Other members of the work team appeared tense when they were talking about their problems; again sitting up straight with folded arms and crossed legs. This anxious body language did not match the words they were using as they continued to maintain a "united front" (Goffman, 1990). I reflected later that I had probably been harsh in my interpretation of their words and that I could not have expected them to behave any differently in a culture where they struggled to meet organisational demands rather than their own needs. Revealing any cracks in the work team would have meant extra work for them in terms of mending over the cracks and this was not possible for the midwives when they already felt over-burdened and stressed with their work commitments.

Attempting to meet support needs

Helen expressed her concerns at not feeling able to confront someone because she had not received any specific training in how to deal effectively with other people. Helen's words are important because they highlight a desire on her part to know how to do this, yet the opportunity has not been provided for the midwives. Interpersonal and communication issues such as these are crucial to the midwives' repertoire of skills if they are to engage in effective working relationships that ultimately benefit clients and their families. The majority of the midwives present had been practising for many years and this opportunity had never arisen for them:

> *I've never been trained in how to confront*
> *somebody…without me feeling that I take it back on*
> *myself and I go home and if I've managed to do it*
> *[confrontation]…I go home and feel guilty about*
> *doing it.*
> (Helen)

Rachel agreed with her wholeheartedly and added that her difficulty would then be "having to face them the next day." Rachel also recalled a midwives' support group that was initiated a few years ago and how "it never really took off...it looked like it was really promising and then it just fizzled out." Helen added that the reason for this was that midwifery managers were present at the support group and that a manager led the group itself:

> Well there were managers there...it was led by a senior manager...and the midwives that wanted to come did not feel able to come because of this.
> (Helen)

Kathy, on the other hand, suggested that midwifery managers on the wards had not viewed the support group as important and beneficial to midwives and they therefore refused to release midwives from the ward to attend the support group meetings:

> ...not only did they think it was not important enough, they thought it was wrong...
> (Kathy)

Helen said that one of the midwifery managers had told her that she found the group threatening to her managerial status, as it should be the managers providing support for the midwives. Helen also stated that the midwifery managers had suggested that the person facilitating the support group was the wrong person:

> ...because it was a midwife who had lost a baby, they thought she was too near the situation...but I'm sure it was helpful to those people that had personal difficulties...I'm sure it was helpful...but it was politics.
> (Helen)

This happened to be a midwife who had personal experience of the loss of a baby and had stated that she was emotionally equipped for the role.

Taking things further…new style of clinical support!

Helen then asked me directly about the nature of clinical supervision and queried who would actually take on the role of clinical supervisor for them. I admitted to the work team that I had thought how we might utilise Helen in her role as a supervisor of midwives but she said that she would not be happy to take on this role:

> *I'm too close to the group and I don't think it would*
> *work at all…I wouldn't feel like I could be anybody's*
> *clinical supervisor.*
> (Helen)

Her response to my suggestion is not surprising in view of her previous comments about her perceived lack of skill in certain areas of communication. However I felt that it was important she was given the opportunity to take on this role. Helen also seized this opportunity to inform the group of her feelings about midwifery supervision. Although she was a supervisor she was not convinced of the benefits of midwifery supervision:

> *…there's this system called supervision and I've just*
> *been through this training for it…it amazes me that*
> *people that set and organise these systems of*
> *training think that it is working…but it isn't*
> *working…it's not working for the midwives on the*
> *ground…*
> (Helen)

Kathy also recounted her experience of going to see a supervisor of midwives for support, as she was experiencing difficulty with a midwife in another team. She related her experience as "horrendous…it was just a battle…horrible." Jane expressed her

uneasiness with the word 'supervision' and expressed a desire to name their

framework for support differently[75]:

> *…can't we have something with the word support in*
> *it rather than supervise…could it not be clinical*
> *support rather than clinical supervision.*
> (Jane)

Jane then continued to explore her perception of the person who would facilitate their

support group:

> *Would the supervisor of midwives and the clinical*
> *supporter be the same person or would it be a*
> *separately created post for someone?*
> (Jane)

I interpreted Jane's words as having an undercurrent of anxiety that the supervisor of

midwives and group facilitator should not be the same person. Helen's words also

suggest that she was unhappy with a supervisor of midwives taking on this role:

> *…they don't have the skills…because otherwise we*
> *would be going to them now...*
> (Helen)

As was seen in Chapter 4, Kirkham (1996) has argued that a management role might

provide conflicting allegiances with a supervisor's role and thus place "unfair and

unforeseen demands and dilemmas upon them" (Deery & Corby, 1996, p.207). The

skills of 'managing' and 'supporting' therefore do not appear to sit comfortably together

(Kirkham & Stapleton, 2000). Jane and Helen's words reinforce this lack of skill when

they suggest that the supervisor of midwives does not possess the skills to undertake

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[75] Jane's words support dilemmas around the word 'supervision' that were highlighted in Chapter 4.

the role of a clinical supervisor. The work team's decision to opt for someone different is therefore not surprising.

Fear of a new hierarchy

At this point in the focus group the discussion became lively and I wondered if this was because the midwives did not have to talk about themselves. They appeared to find directing criticism at supervisors of midwives much easier than dealing with their own difficulties. Kathy also agreed with Helen and stated:

> *…if they think it's working so well why aren't they*
> *inundated with all these midwives that want to be*
> *supported with their problems.*
> (Kathy)

Helen's words also suggest that she has observed a hierarchy within supervision of midwives:

> *I mean within them we are not all equal*
> *supervisors…there's the hierarchy of*
> *supervisors…we sit round on the edges…its very*
> *horrid and we're quite vocal but it's still really hard to*
> *establish yourself.*
> (Helen)

The maternity unit in which the research took place had appointed several new supervisors of midwives in accordance with recommendations from the LSA (see footnote page 91) and clinical governance initiatives. Helen's words imply that this had only served to create yet another hierarchy within an already established hierarchy[76].

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[76]At a later date, and during a conversation I had with Rachel, she referred to the appointment of extra supervisors of midwives as "window dressing" implying that they had been appointed to conform to recent recommendations rather than to address a real need for extra support in the clinical area. Goffman (1990) refers to this as presenting a "front of respectability" (p.106). Rachel also talked of less experienced supervisors of midwives "living in fear" of more experienced supervisors (Research Diary, 15.3.99).

Celebrating midwifery versus use of a 'black book'

Discussion took place around the process of clinical supervision and whether it would be necessary to go on every occasion. Kathy appeared to be having difficulty understanding the positive aspects of clinical supervision. I tried to help her focus around the fact that midwives very rarely celebrate their practice and that clinical supervision is not just about 'problems', it was also about reflecting on good practice. Jane related this to the culture of midwifery:

> *…it's very lacking and not within our role…we're not encouraged to stand up and say haven't I done well this month…I personally have never been encouraged to do that…then again I trained twenty years ago…you knew when you did something wrong then but you never knew when you did it well…you were never encouraged to bring that out from within yourself.*
> (Jane)

Rachel suggested going to their current supervisor of midwives every month to seek support as a work team and then to go and see the same supervisor of midwives privately if there was an issue an individual midwife did not want to discuss within the team. Her words appeared to be met with hostility from some of the work team members. Kathy was adamant that:

> *… a lot of us would feel threatened…we wouldn't be open…*
> (Kathy)

Helen agreed and said "it's got to be somebody different". She was adamant that because their current supervisor of midwives was also their manager the combined relationship of clinical supervisor would not work:

> *…she's our manager and there's always that power*
> *thing…*
> (Helen)

Frances added some humour to the group by stating that:

> *…the only way that you get over it [feeling*
> *threatened] is if you are older than her and then you*
> *don't care…then you don't feel the power.*
> (Frances)

Frances was soon to retire and appeared to be taking the stance that if she was uncomfortable or threatened in any way then she could make a hasty retreat with no fear of recrimination. Rachel however, appeared to take issue with this comment and disagreed with Frances:

> *I'm sure that's not the case because if I respected an*
> *individual and I thought that I could talk to them*
> *confidentially and that she could support me without*
> *criticising me…I could still go to that person.*
> (Rachel)

Rachel's words reinforce the importance of confidentiality, respect and empathy within a supportive relationship. She makes her views clear to the other midwives stating the qualities she would expect from a person she was accessing for support. Kathy added to the discussion by also expressing anxieties around a manager taking on the role of clinical supervisor:

> *…but if she was your manager you'd be frightened of*
> *letting slip something that you'd done that wasn't*
> *quite right…because no matter how she looks at it*
> *she's got a little black book.*
> (Kathy)

As the focus group progressed the group appeared to be reaching consensus that someone from outside the midwifery arena might be a good choice. Helen's words were quite clear around this issue:

> …if they were a person from outside…we would
> know there were no repercussions for any of us.
> (Helen)

A breach of confidentiality within a support group appeared to be the main repercussion that worried the midwives although some of them feared for promotion prospects and strained working relationships. Jane appeared to summarise the discussion quite succinctly:

> …this person then would have to be somebody…an
> outsider…outside the group but within the
> community setting…that would understand the
> swings and roundabouts rather than somebody from
> within the hospital setting who would think
> differently…I think the impression is no-one from
> management…
> (Jane)

Discussion around whether the clinical supervisor needed to be a midwife followed. Helen stated that she believed midwives were not very good at coping and dealing with difficult situations and that there were interpersonal issues within Glendale Team that the midwives needed to address. Kathy questioned whether the clinical supervisor needed to be a midwife. Discussion then took place about the nature of clinical supervision and whether the midwives would meet as a group or take clinical supervision individually. The work team finally agreed that they would like to experience clinical supervision as a group with someone who was not a midwife. There was general agreement that the midwives would like to meet this person and also that they would like some educational input in terms of the nature and range of clinical supervision.

The focus group ended with the midwives requesting that I approach someone to facilitate some clinical supervision education for them, on three separate occasions, and lasting for approximately three hours. We had already discussed the possibility of Dawn, an experienced community psychiatric nurse undertaking this facilitation and if she was in agreement the midwives were happy for this to be arranged.

Key points emerging from focus group one

In this focus group the midwives appear to be articulating that their support needs are not being met. The supervisor of midwives was considered unsuitable as a support person in this context as there were issues around a lack of confidentiality and their position as managers. An inherent contradiction appears to lie within the midwives' words; they feel unsupported yet the midwives state that they are a supportive team and appear keen to project a "united front" (Goffman, 1990). This pseudo-cohesion made me question their understanding of support and what supporting another individual actually entailed.   On the other hand, there appears to be some dysfunctional interpersonal and communication issues within the work team that the midwives state need addressing.   There were attempts by Helen and Rachel to address this within the focus group but Kathy, Jane and Frances appeared to work hard to ensure that this aspect was not allowed to develop in any depth.   This avoidance of issues meant that the work team could not could work seriously with their anxieties and hopes for the future. Penny, Gemma and Lisa remained mute for most of the focus group. I wanted to challenge their muteness within the focus group but decided against this. Their behaviour also mirrored my own in times of turbulence.

Dawn's input following the first focus group

Following the first focus group, and at the midwives' request I met with Dawn. She had agreed informally on a previous occasion to facilitate some workshop sessions on clinical supervision with the midwives. Without disclosing confidential information from the focus group I explained to Dawn that the midwives had identified that they needed some sort of structured support in practice and that their initial deliberations resembled clinical supervision. I also explained to her that they had identified that they needed help and guidance in terms of dealing with some sensitive interpersonal skills, particularly in relation to managing conflict or confrontation. I explained to her that once she had met with the midwives for the first time the format and plan of the sessions might need renegotiation with the midwives.

I therefore asked her to address:

- What clinical supervision is…?
- What the midwives' role is in this process…?
- What the role of the clinical supervisor is….
- The benefits of clinical supervision….

Dawn held the first of the sessions during August 1998. She reported to me that she had covered concepts of clinical supervision – including definitions and analysis of key terms, models of clinical supervision and that discussion had taken place regarding what she believed were important concepts of support and empowerment. Dawn had found the midwives keen and interested in the study but they had talked to her about lack of time being really important for them and how they did not have the time to be taking part in the study. Dawn had found that the midwives constantly addressed

issues of support and power and that their words had suggested to her they were working in a climate of fear.

Dawn had found that the midwives did not appear able to visualise clinical supervision just as they had not been able to visualise the future of their maternity service in their individual interviews. Dawn also voiced her concerns to me that ownership of the study did not lie with the midwives yet and that they believed the study had been imposed on them by midwifery managers.

Also during August 1998, Dawn held a second session with the midwives. In this session she gave a brief overview of the previous week's presentation and then proceeded to facilitate a session around the essential requirements and qualities of a clinical supervision relationship. Dawn had based this mainly on two of the six categories from the work of John Heron, i.e. 'confronting' and 'supporting' (Heron, 1991). Discussion had also taken place with the midwives on 'boundaries' within the clinical supervision relationship; similarities and differences between clinical supervision and the statutory supervision of midwives and the skills and education required for clinical supervisors.

Dawn discussed with me that she had offered the midwives a 'taster' of clinical supervision and thought that the midwives may benefit further from having time to reflect on issues that were raised in the session. She also suggested that in order to help the midwives visualise the clinical supervision experience it might be worth considering a 'role-play clinical supervision session'. Although we discussed this at length we eventually decided against this because of the time factor and also because I wanted the midwives to develop a framework of support that best suited them. Dawn also suggested that the midwives have a chance to read some of the key texts on the subject of clinical supervision. I provided a reading list for the midwives but to this day I

do not know, and I never asked, whether they read or accessed any of these text books or articles.

Dawn offered to provide a refresher or revision session for the midwives. Her experience with other professional groups led her to believe that the midwives may identify a need to build on existing interpersonal skills to prepare for their active role in the clinical supervision relationship. She believed that this could only be successfully achieved in a supportive, well-facilitated experiential learning setting and offered to co-facilitate this with me. When I discussed this further with the midwives they declined an experiential workshop building on interpersonal skills even though they had identified to me within the first focus group that there was a need for them to develop this aspect of their role. This contradiction served to reiterate the midwives' fear around addressing issues within working relationships. Dawn also reiterated to me that the midwives seemed unable to take ownership of the study and that she believed they were not aware of their choices or role within the study. She suggested that there was almost naïve ignorance on their part as to what the study entailed. I found this difficult to comprehend especially as we had spent so much time talking about these issues at informal meetings, individual interviews and in the first focus group. I reassured Dawn that I would clarify these issues in the second focus group.

Focus group two: working towards a supportive framework

The second focus group formed a further cycle of the action research study. We began to devise a model of clinical supervision following Dawn's previous educational input about clinical supervision. The focus group took place at a time when the study was beginning to feel overwhelmingly 'messy' for me. I had now undertaken a series of individual interviews and a lengthy focus group and this had produced vast amounts of data. I was also being given 'tasks' by the participating midwives as part of the

study and was having to arrange informal meetings with prospective clinical supervisors. This feeling was intensified when the focus group did not start or proceed according to plan.

I knew that the midwives had had difficulty in finding space in their diaries to attend the focus group because we had been trying to set a mutually convenient date for several weeks. I had also begun to suspect that they were feeling unsupported by their midwifery managers in respect of their input to the study and this added to my anxiety about the meeting. Indeed, the focus group opened with angry expressions about their time commitment to the study. I had reassured the midwives at the start of the study that midwifery managers were fully supportive of the collaborative work and that they had reassured me, when gaining access to the site that cover would be provided for their area.

'Them' and 'us': pseudo-collusion as a defence mechanism

Throughout this focus group the midwifery managers are constantly referred to as "they" or "them" as the work team members view themselves as being in a "them" and "us" situation. The midwives had arranged to meet me on a Monday morning, following a very busy weekend. There were a number of clients who required visits and understandably, because there was an antenatal clinic in the afternoon, the midwives had requested that we finished our meeting by 1100 hours so that they could visit those clients who needed their attention.

I was nervous throughout the focus group because I had sensed their anger and dissatisfaction. When listening to the tape recordings following the focus group anxiety is clearly evident in my shaky voice as I talk with the midwives. Interestingly whilst one of my reasons to use focus groups had been to observe group interaction, this focus group was about interaction between me and the group members. Quite rightly, Helen

had an agenda about lack of support from midwifery managers for the research and her dissatisfaction formed the main thrust of the focus group. Helen had contributed a great deal to the study and had been instrumental in organising the work team for the focus groups. To date she had worked collaboratively with me. However, on this particular occasion she had chosen to interact angrily with me and furthermore she had not discussed this with the rest of her colleagues.

Helen appeared to be identifying me with the midwifery managers and this felt uncomfortable. I had strived hard to foster a sense of collaboration within the study but was now experiencing a growing awareness of the conflicts and contradictions around power in my relationship with the midwives (see Chapter 6) and a distinct reluctance on their part to collaborate in the study. Therefore when Helen chose to take centre stage at the start of this focus group, rather than viewing her participation in a positive light, I found myself feeling disempowered because I did not have centre stage and I was worried that they were going to cease participating in the study.

'Punching lights out': no power, anger and dissatisfaction

Helen appeared to have come to the focus group determined to address issues around lack of support from midwifery managers. I had noticed that she was sitting very quietly at the end of the table with her head lowered. Her anger, and at the same time anxiety, were almost tangible. Before I had a chance to welcome everyone to the group and to thank them for attending Helen took centre stage stating that what she had to say had not been discussed with other members of the group. She looked directly at me and stated "I'm sure you think I'm being really stroppy but...". She continued to vent her anger:

…and if anybody else says to me that they can't knit a midwife I am going to punch their lights out because I am just…I do feel…I don't think you have...obviously I don't think that you have let your side of the bargain down…I didn't mean to imply that at all…but it has come to point where you have just got to restore what isn't happening…not us…because we can't…in a way we're in even a less powerful situation than you are…they're our managers.
(Helen)

Helen's words saddened, and at the same time frightened me, as I realised how unsupported and angry she was feeling. Her words intimated a real sense of helplessness as she implored me to mediate on their behalf with the midwifery managers for extra help on the area whilst they spent time with me. Helen insisted that "I think it is your responsibility" to sort out the lack of support from managers. At this point in the focus group I noticed that the majority of the work team were nodding their heads in agreement. I found it interesting how much power they were investing in their managers instead of concentrating on the power they held as individuals and working with this. In a paper reporting midwives support needs described in a large study of supervision of midwives, Kirkham & Stapleton (2000) found midwives reporting similar experiences where "they lacked the…sense of their own power that is needed before power can be shared" (p.467).

'Jumping on board' or resisting collaboration and responsibility

The notion of collaboration within the study seemed unfamiliar to the midwives even though they had agreed to participate. Helen even implied that the research was only for my benefit:

> *…but it's your research…I know you are saying you*
> *want it to be our study and we have agreed to be*
> *involved in it and I will…I am committed to it…but at*
> *the end of the day it's still yours and your PhD…it's*
> *not mine…and I know all the good things that can*
> *come out of it…I am perfectly aware of that…but I*
> *don't think that it is joint responsibility…I think it is*
> *yours.*
> (Helen)

Kathy joined Helen in arguing on this issue and reinforced her view:

> *It's when you said to us that it's joint and*
> *collaborative…I'll never feel that it's just as much my*
> *study as it yours…how can I…that would be just*
> *naïve wouldn't it…you couldn't ever expect us to*
> *believe that…*
> (Kathy)

Despite my efforts to convince them that I genuinely wanted it to be their study and to try to get them to see the benefits of the work they appeared to be resisting any collaboration. However on reflection I realised that I was being unfair in my interpretation of their words and that in fact they had probably never experienced collaboration. How, then could I expect them to collaborate? Rachel further reinforced this by stating:

> *I just don't think I'll ever think that because you*
> *initiated it…it's yours…people take ownership and*
> *rightly so…*
> (Rachel)

Their words should have been no surprise to me because as was seen earlier in this chapter, Dawn had previously highlighted her concern that the midwives were not taking ownership of the study.

Rachel agreed with Helen that support from midwifery managers had not materialised and even suggested that some work team members had felt pressurised to join in the study. As was seen in Chapter 6, I had been very careful about not putting individual midwives under pressure and had clearly stated at the outset that they could withdraw at any point from the study. Rachel's words also suggest that they had participated in the study because they wanted to 'please' me:

> *I jumped on board for two reasons…one that we*
> *would get the support to be able to do it and the other*
> *was because it was you and we knew you…and the*
> *first just hasn't materialised…and the pressure has*
> *built for everyone regardless of how they felt…*
> (Rachel)

Rachel appeared to be almost gloating when she pulled Frances in to support her argument by stating that:

> *…you were definitely against it…but you were*
> *right…you were right…you said we wouldn't get the*
> *support.*
> (Rachel)

I found it interesting that when conflict arose Rachel actively drew on a quiet member, Frances, in order to defend and support her argument. Frances stated that it was her experience that midwifery managers were quick to delegate tasks to midwives in order to relieve their own workloads:

> *…whatever you take on board…once they have*
> *given it to you that's it…it's off loaded…they're not*
> *there to back you up with help when it's needed.*
> (Frances)

Rachel agreed with Frances, "they've gone back on their promise really…they're not interested…not interested". Lipsky (1980) refers to this as "husbanding resources" and states:

> "Confronted with complex task and limited resources, organizations develop work patterns to conserve the resources available. Managers strive to deploy resources more effectively or reduce the costs of work processing. They also may overtly or covertly redefine their objectives, so that what they are trying to achieve becomes easier to accomplish".
> (Lipsky, 1980, p.125)

I then posed a question to the work team that made me feel apprehensive; *"do you want to stop doing it [the study]?"* I felt nauseous and panic stricken as I watched and waited for a response. Gemma who had remained quiet for most of the focus group managed to comment that it would be a shame from my point of view if the study ceased. I appreciated her efforts at supporting me and again reiterated to Gemma and the others that we were undertaking the study collaboratively. The more I reiterated the collaborative nature of the study, the more isolated I felt within the focus group as the midwives rejected the notion of collaboration.

Managing change… or not… through the study findings

I then tried to talk to the midwives about how these issues surrounding lack of support from midwifery managers could be addressed in the writing up of the study. They seemed surprised that I would address such issues and shocked that I had no intention of hiding issues that had arisen in the study:

> *…so is then what you are saying…that this particular problem will come out through the research…?*
> (Rachel)

Gemma suggested that bringing issues into the open was even more reason to carry on with the study and I saw a glimmer of understanding in a woman who had remained quiet and frightened for most of this and the previous focus group.

Suddenly the tone and atmosphere within the group changed from feeling tense to more relaxed and I became aware that the midwives were retreating 'backstage' (Goffman, 1969). I hoped that they were not going to become mute. I regretted saying that nothing would be covered up in the study because this seemed to have scared them. The fact that I would be using their views about feeling unsupported by midwifery managers was giving them food for thought. They now appeared to be ignoring what had happened previously and wanted to move on to discuss how we would approach midwifery managers to negotiate more support.

Collaborating or colluding: yet another contradiction!

We then huddled together as a group and discussed how we might approach midwifery managers in order to offer them the opportunity to reiterate their commitment to the study and negotiate more support. This felt more like collaboration although I struggled with feelings of wanting to keep them on my side and maintaining participation in the study. As we huddled and 'collaborated' we darted from one 'solution' to the next. The midwives seemed to view themselves as being in a situation whereby they were helpless, powerless and unable to remedy the situation. Engaging with midwifery managers to negotiate more support felt like 'just one more thing to do' for them.

We discussed who might approach the midwifery managers. Frances's words suggested that "we all of us go…" but Helen had had "some nasty encounters with them already and I don't want to…I don't want to do it…I don't want to take them on…I don't". Rachel stated that she was "too frightened to go down" with Frances suggesting that because she was retiring she would 'go down' because she had nothing to lose. Their sense of isolation and insecurity was pronounced within a culture that has already been described by some midwives as having "the fear factor"

(Kirkham & Stapleton, 2000, p.467). Indeed, these midwives feared their midwifery managers.

Later in the focus group Helen talked quite openly about how she had had to prepare herself to confront me in the focus group and how this had provoked high anxiety levels for her. As was seen in Chapter 8, this is a coping strategy used by midwives as part of their "impression management" (Goffman, 1969):

> *…but you do have to psyche yourself up…like I*
> *thought I just have to say this to Ruth this morning…I*
> *don't want to hurt her feelings and all that but I've*
> *just got to make my point…*
> (Helen)

I found it reassuring that Helen was giving consideration to my 'feelings' and her need to confront me supportively. This is important in a climate where midwives often experience "horizontal violence" (Leap, 1997). Although the atmosphere at the focus group had often felt tense, on reflection I was pleased that Helen had felt able to 'make her point' as this meant that I had gone some way towards creating a safe environment in which she was able to do this.

Different ways of working really means 'double visits'

At this point in time during the study there was no head of midwifery in post. Interviews were being held and one of the senior midwifery managers was holding temporary responsibility for this role until someone had been appointed. This lack of consistent leadership seemed to be having an adverse effect on the work team as a whole and Jane stated that they were like "a rudderless ship".

When thinking of different strategies to improve our situation I reminded the midwives of what their midwifery manager had suggested in terms of managing their workloads. She had stated that it was not a problem for midwifery managers if the midwives left visits until the following day. This accords with Lipsky (1980) who states that "[f]rom management's perspective street-level bureaucrats are resource units to be applied to a task" (p.31). However such a stance created a problem for the midwives with Rachel's words summing up the situation for all the work team:

> *…and then you see it's like this…if we put the visits*
> *off until tomorrow, its double visits tomorrow…*
> (Rachel)

I[77] agreed to go down and make an appointment with the midwifery manager and the new head of midwifery when she was in post in order to discuss the progress of the research and extra cover and support for the midwives.

Also at this point I suggested that it might be time that we presented some of our work to the midwifery managers and perhaps let the rest of the midwives in the maternity unit know what we had achieved. This suggestion was met with hostility especially from Helen who stated that at the start of the study we had agreed to keep our work confidential. She questioned why I was so concerned in the first place to keep it confidential if I now wanted to talk about it with midwifery managers. The midwives appeared adamant to exclude midwifery managers from the study and indeed, were exercising their power, as they did with new members to the work team (see page 176). I sensed the focus group returning to a state of hostility and that the midwives were re-forming to attack me again:

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[77] I note my use of the word "I" and how this does not denote much partnership, ownership or collaboration on the part of the midwives. However the midwives were clearly not prepared to meet with midwifery managers and in order to maintain their participation I agreed to do this on their behalf. They wanted me to participate for them.

So why were you so concerned in the first place to
protect us…to be confidential and now you think we
should tell everyone…sorry I'm not trying to be
difficult…it's just that I remember you saying we would
keep it confidential.
(Helen)

I sensed an air of defiance in Helen's words and I wondered whether in fact she was

now trying to sabotage the study in some way. Her words suggest that I was implying

that managers might give them extra help if they knew they were collaborating in a

research study:

…what you're saying is…if people knew that it was
us they might cut us a bit of slack because they'd
know we were in an ongoing study…is that what you
are saying?
(Helen)

Rachel was worried that the work team may be affected in some way if their identity

was revealed:

Will it adversely affect us individually, personally and
as a group if we come out and say who we are?
(Rachel)

Finally the midwives reached a decision that they did not want to inform midwifery

managers or others in the maternity unit of the progress of the study to date. This

decision on the part of the midwives also informed my decision not to interview

midwifery managers because this could have potentially destroyed any trust within the

research relationship that I had developed with the midwives. As Rachel's words

above suggest, interviewing midwifery managers might have affected them personally

or the work team as a whole, and they were not able to cope with this situation. Once

this decision had been reached we huddled together as a group again deciding how

best to confront the situation with managers. Rachel suggested saying:

> *…that we are the ones complaining because we are*
> *not getting support…it's us that are shouting because*
> *they promised things that they are not delivering.*
> (Rachel)

Helen, Gemma and Kathy agreed with this all stating that the managers are good at saying "if you need me". We agreed that when the next meeting was held the midwifery manager must allocate a named midwife to their work team in order that essential visits could be carried out.

The way forward for the work team

Finally we reached a point where we could discuss how clinical supervision was going to take place. Kathy put her point of view forward with regards group versus individual supervision:

> *Well I can see for and against both really…I can see*
> *that if it is in a group, some people talk more than*
> *others…but then by speaking in a group ideas are*
> *circulated where as I could be on my own and there is*
> *only what is there…*
> (Kathy)

Jane was anxious in case she was to be expected to work with midwives other than those in her work team. She seemed not to have grasped the essence of the study although she did suggest that clinical supervision in a group might be good idea:

> *Well this might be the way forward for community*
> *midwives who work in a team.*
> (Jane)

Finally and nearing the end of the focus group I managed to get the midwives to reflect on their priorities and needs and discuss the differing approaches to clinical supervision. They decided fortnightly, group supervision sessions that were held off

site. I had already approached a non-midwife who was an experienced clinical supervisor (Joss) who would facilitate clinical supervision sessions for the midwives. I informed the work team that I would set up an initial meeting with her so that they could discuss the framework and contract setting for clinical supervision further.

Even researchers get hurt… 'emotional pebbles and potholes'

This section contains my thoughts immediately following the second focus group as well as what I have come to know from the experience. Whilst I have come to realise that I was in a privileged position as the researcher and that a "neutral stance is preferable" (Ely et al. 1991, p.121) I nevertheless experienced feelings of humiliation, anger and fear towards the managers and midwives both before and during the focus group. Being with the midwives during such an intensely angry process meant that I felt alienated, frightened and isolated and I had a knot in my stomach for the duration of the focus group. The experience actually became my worst nightmare as the midwives' words became 'confrontations' and 'challenges' rather than pleas from the heart for help. Despite reading that "[i]t is typical for the researcher to experience a slew of unanticipated, perhaps chaotic or disorganizing emotions during the course of the research" (Ely et al. 1991, p.109), I felt unable to stave off their anger and I interpreted and experienced the midwives' words as personal affronts. I described feeling bullied and persecuted to my research supervisor as I found myself making judgments based on my personal biases.

It was only during the later stages of data analysis and writing up that I felt able to embrace the midwives' words with more of an understanding of their plight and "step back and perceive the contours of the data" (Glazer, 1980, p.29). I accepted the inevitability of "emotional pebbles and potholes" (Ely et al. 1991, p.111) and attempted to understand the midwives' words as honestly as I could so that I did not distort the

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data. However I do think it is important to remember and acknowledge that even researchers can get hurt.

Key points emerging from focus group two

This focus group was held to help the midwives devise their framework for clinical supervision but it did not start off as such, rather the midwives needed to express their anger and resentment at midwifery managers who were perceived as not keeping their part of the bargain in terms of support for the study. A lack of consistent management prior to the commencement of the study had left the midwives feeling unsupported overall. The midwives viewed themselves as being in a "them" and "us" situation. Collaboration and participation as concepts were unfamiliar to them and something that they had not experienced previously. Their sense of isolation became pronounced in a culture where midwives have reported experiencing fear and isolation (Stapleton et al. 1998; Kirkham, 1999; Kirkham & Stapleton, 2000). They implored me to help them re-negotiate the support of the managers although they refused to accompany me to do this. Their decision not to include midwifery managers or other midwives in the study informed my decision not to interview midwifery managers. The focus group ended with the midwives agreeing and stating their preferred framework for clinical supervision.

Making time to meet with the midwifery manager

I went to make an appointment with the midwifery manager immediately following the focus group. I was fortunate enough to get an appointment straightaway. We discussed the midwives' anxieties about not having enough time to work effectively and participate in the study at the same time. The midwifery manager seemed interested that the midwives had decided to exclude new members to the work team

from the study. This decision by the midwives appeared to give her a reason for not placing extra help into the work team. She decided that if new members were excluded from the study then they could work 'on the area' whilst the rest of the work team were participating in the study. Whilst I could partly see the reasoning behind her decision this did not take account of the fact that the midwives had to take 'days off' and that these could not all be taken on the same day.

No answers……yet!

I felt despondent following the meeting and talked to one of my critical friends about my analogy with a washing machine. I felt like I was going round and round in circles with the study, being tumbled and tossed around by others. Data collection and working relationships looked, and were experienced, as dirty. As more data were collected there seemed to be more mess evolving (too much powder in the washing machine makes even more bubbles). I wanted everything to be clean and tidy and just to move forward but unfortunately washing machines sometimes go backwards in their wash cycles. My critical friend listened patiently and asked me to 'stay with' the complexity of the study. She sent me a card the following day which said, "remember there are no answers …….yet".

Making time to meet with the new Head of Midwifery

I arranged to meet with the new Head of Midwifery a week after she took up her post. We had a positive meeting and I wrote in my Research Diary that I felt "relieved and unburdened" following the meeting. We discussed the study to date and I informed her that the support that had been promised for the participating midwives had never materialised. The midwives' line manager had been on long term leave during the

course of the study and this had affected the progress of the study because the midwives were reluctant to share their involvement with anyone other than her.

As agreed with the midwives I informed the Head of Midwifery that time had become a constraining factor for them and that they did not want to carry on with the study unless they were further supported by the midwifery managers. The Head of Midwifery was keen for the study to continue and agreed to come and talk with the midwives. Unfortunately when I spoke with one of the midwives on the telephone on 22 February she informed me that this meeting did not need to go ahead as they were now satisfied that their 'work area was covered'. I did not question that this decision had been agreed by all the work team. As will be seen in the following chapter this decision is contradicted in some of the final interviews I held with the midwives.

In the following chapter I present the findings of the final interviews where the midwives were asked to describe their experiences of clinical supervision and whether they felt this had benefited them.

CHAPTER TEN

Phase Three: Final interviews
Challenges ahead: developing an awareness of reality

> I had never seen
> so many stars,
> so old, so far away,
> shining down
> their messages of light
> from centuries ago.
> I didn't know the constellations,
>
> I lacked the skill
> to make the stars reveal
> their names and myths –
> until one
>
> slid then hurtled
> down the sky. Next day
> the floods came down.

Sarah Maguire 1997

This chapter analyses data from final individual interviews with the participating midwives and the clinical supervisor (Joss), during phase three of the study, which aimed to evaluate the process of clinical supervision.   During their preliminary interviews (see Chapter 7) and at the first focus group (see Chapter 9) the midwives had identified that they felt unsupported in practice and that they wanted to see 'something' tangible in place to help and support them. Although they were not able to discuss the concept of clinical supervision, as it was not familiar to them, the facets of support that they identified as useful, within their interviews and focus groups, could be likened to those within clinical supervision (see Chapter 4). I therefore introduced the idea to them at the second focus group (see Chapter 9). After initial discussions regarding terminology, the midwives agreed, during this focus group, to work towards the development of their own framework for clinical supervision.

As I have already indicated on page 4, footnote 6 I refer to "the group" as that in which the midwives experienced clinical supervision. I refer to the team in which they worked on a daily basis as "the work team". The membership of these groups was the same, except for new members to the work team, who the participating midwives chose to exclude from the clinical supervision experience (see page 176).

An 'opportunity' or a 'different space'

Three of the midwives, Rachel, Helen and Jane, described the clinical supervision experience as "an oasis". Gemma, who appreciated having legitimate, formalised and protected time for the process of clinical supervision, remembered that:

> …it always seemed to be a sunny day when we
> were there and it was lovely, it was peaceful and we
> just sat down, we had an hour just for ourselves…
> (Gemma)

This comment from Gemma suggests that the midwives appreciated retreating to what they perceived as a secure, safe place where they felt less vulnerable and more able to relax[78]. Jane reiterated Gemma's words by reporting that "[she] enjoyed what [she] did…once [she] got there" and that "the good part of it [clinical supervision] was being away from the work place in a totally different place." Helen reported feeling more inclined to express herself in the relaxed and safe atmosphere of clinical supervision:

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[78] As discussed in Chapter 8, the notion of retreating to a safe, secure place or oasis accords with Goffman's (1990) 'back region' or 'backstage'. As Goffman states "it is here that the capacity of a performance to express something beyond itself may be painstakingly fabricated; it is here that illusions and impressions are openly constructed…Here the performer can relax; he can drop his front, forgo speaking his lines, and step out of character...control of backstage plays a significant role in the process of 'work control' whereby individuals attempt to buffer themselves from the deterministic demands that surround them" (Goffman, 1990, p.114, 115-116).

> *…one day I ended up saying an awful lot of things about my new job and my new role that I was quite surprised at myself afterwards…I thought "Oh gosh" and I sort of commented "that I must feel very secure because I haven't talked to anyone like this" apart from outside of work…like a friendship.*
> (Helen)

Jane and Gemma's words suggest that the midwives made some use of the formalised time (that is, they appreciated being away from the work place setting). Helen's words begin to broach the issue of being able to talk more openly in the company of peers and Joss. However, as will be seen throughout the chapter, none of the midwives, with the exception of Gemma, appeared to make effective use of this "oasis" to refuel or recharge themselves.

Kathy reported that clinical supervision "started off really well and everybody turned up". Rachel stated the same although 'getting there' was difficult for her:

> *…and to be up there as well…out of the hospital…was good…it was just making the effort…making the effort was hard sometimes, but when you got there you thought "oh it's good".*
> (Rachel)

'Making the effort' was probably difficult for the midwives because as was seen in Chapters 7, 8 and 9, they were feeling overworked and stressed with their increasing workloads. I was now encouraging them, by introducing them to clinical supervision, to consider and experiment with different ways of working and thinking. However, as will be seen, the data seemed to suggest that this was provoking fear and anxiety in some of them. As I have discussed in Chapter 4, clinical supervision is not yet seen as a legitimate process in midwifery. This could have led the midwives to believe that attending clinical supervision was not work-related but rather, an imposition. Although the midwives' words seem to be expressing relief in getting away from the workplace, the data suggested that there seemed to be an underlying feeling of guilt that they

were not knuckling down to their usual work as community midwives. The "inevitable routinization of practice" (Lipsky, 1980, p.209) appears to have taken hold for the midwives. However, Rachel's words above do seem to recognise that taking part in, and initiating change, can feel good.

Cohesiveness as a means of keeping problems hidden

By the time the final interviews were taking place the maternity unit was in turmoil with staff shortages and high sickness levels. Five established midwives within the work team, Helen, Jane, Penny, Frances and Gemma had also left, taking with them their vast and varied experience but also their misgivings about the number of changes within the work team, cohesiveness and the supportive nature of the team:

> *In the last six months there has been a lot of*
> *changes in our group…different people in and out of*
> *the group…everybody has just sort of spread out*
> *now…*
> (Helen)

Lisa who was about to commence study leave reported that stress levels appeared higher than they were before the study started. Her words suggested that she was concerned at the disintegration of the work team and she expressed sadness and regret over the changed work team:

> *There's only four of us left…and that's it…that's all*
> *that's left out of the team…so yeah everybody has*
> *gone their different ways…*
> (Lisa)

Lisa's concern over the work team's disintegration could have also been related to her imminent study leave and the personal implications this held for her in terms of endings. In her preliminary interview Lisa had also referred to the work team as being "family orientated". Although at the time I interpreted her words as the work team being more sympathetic to their peer's family commitments, I was now inclined to take

a somewhat different stance on this. Lisa's words suggest that the work team being 'family orientated' meant that the team held a stabilising influence for her because she 'belonged somewhere'. As part of that family she had been experiencing feelings of instability and now, as she was about to "leave home" on study leave, she seemed to be expressing the need for the family to focus on its 'integration' rather than 'disintegration'.

The importance of getting together as a work team on a regular basis was acknowledged by Gemma who seemed to have learnt a great deal and benefited from the clinical supervision experience. As was seen in Chapter 7, Gemma had self-denigrated throughout her interview. However clinical supervision had acted as a catalyst for her and the experience appeared to have mirrored her personal aspirations as a midwife within the work team. Although her words suggest that there is a lack of cohesiveness within the team and that this can affect communication amongst team members, she expresses a willingness to effect change and does not feel guilty about the 'different space' that clinical supervision offers:

> *I've learnt that in the hurley burley of everyday work*
> *we do need something to bring a group of people*
> *together…we're all going in our different directions*
> *all the time and we only have five minutes in a*
> *morning to see each other and it was a good*
> *opportunity to get together and relax and speak our*
> *minds and I think to have one person there who is*
> *impartial, who can make you see things in a different*
> *light…I think it's good.*
> (Gemma)

Yalom (1995) states that cohesive group members are "accepting of one another, supportive, and inclined to form meaningful relationships" (p.67). Other factors identified are greater security, relief from tension in the group and self-disclosure (Yalom, 1995). This accords with Helen's perception of the work team as expressed in her interview:

I mean, this is one, I think this is one of the best groups to be in, supportive with colleagues…talking to each other…I think everyone does really try to be supportive to one another and if anyone has got any problems, we try and help out, whereas I know in other groups they don't…
(Helen)

However, as will be seen below, Kathy believes that work team members were not as supportive as she thought. Despite the fact that she thought the clinical supervision process was beneficial, recognising and acknowledging that the work team was not the supportive entity she thought it was, had been a painful process for Kathy. She implies that there were issues within the work team that needed addressing and stated that "it was helpful for people to get things off their chest" in order for the process to be beneficial. Rachel too, acknowledged that the work team had "gone from a really sort of solid group with great team spirit to chaos and turmoil…we've ceased to have a sense of humour."

'Pseudo-cohesion' as a means of masking unsupportive behaviour

Kathy's words below acknowledge that she benefited from clinical supervision. Her words suggest that she has been provided with the space to reflect on problems that existed within the work team. However, as will be seen later in the chapter, the data suggests that these same problems had been ignored during clinical supervision and also that they needed addressing if the work team was to function productively. Her words also imply that clinical supervision provided effective 'time-out' in order for the midwives to reflect and realise that issues within the work team needing sorting out:

I think it [clinical supervision] made us realise you know… like we're always saying we gelled well and we…it did make us… well it made me realise that we weren't as honest as we could be with each other and that there were issues that needed sorting out and I think personally it made me aware of problems

> *that needed sorting out… that we'd been shoving*
> *away…but it did benefit me.*
> (Kathy)

Kathy's words therefore seem to be contradicting the notion of a supportive group. Kathy related how Joss had challenged the midwives about their continual referrals to being a supportive group:

> *…and she said "just a minute, you've been telling me*
> *that you're all a supportive group and you've done*
> *this and you've done that, but what you're doing and*
> *what you're saying don't match up to me as an*
> *outsider…I think you need to look at yourselves*
> *because you're not being honest…*
> (Kathy)

According to Nitsun (1996) when groups choose to project themselves as supportive when in fact they are not, this means that they are resisting and choosing to ignore the unsupportive nature of their group. As was seen in Chapter 7, this suggests that the participating midwives may have been denying the existence of problems and protecting themselves through 'pseudo-cohesion'. As Kathy's words suggest the midwives appear to prefer to try to convince others, and themselves that they are a supportive group rather than understanding and experiencing the group processes that exist within a truly supportive framework (Whitaker, 2000). Yalom (1995) has stated that being more willing to listen to others, and accepting of others, have been shown as factors contributing to better group cohesiveness (Yalom, 1995).

In order to continue this apparent façade of cohesion they appear to have built up their own individual defence mechanisms (or certain performances) to guard against, and meet the organisational demands of their midwifery work and also to help them manage their emotions at work (see Chapter 8). The use of pseudo-cohesion as a defence mechanism probably meant that the midwives had no option but to choose to undertake clinical supervision within a group setting in order to carry out their apparent

façade further. However, pseudo-cohesion also suggests that as a work team they were papering over the cracks within their work team. The work team's choice to undertake group clinical supervision might be one way that they can be sure of what other work team members are thinking. Such defence mechanisms, quotes Nitsun (1996), tend to destroy "the capacity for emotional growth" (p.126).

Hyrkas, Appelqvist-Schmidlechner & Paunonen-Ilmonen (2002) in their study describing the experiences of five supervisor pairs undertaking multi-professional team supervision, found similar behaviour in supervisees. These authors refer to supervisees "cherish[ing] the idea that they are great" (p.393) and report that the supervisors found the supervisees were part of a work culture that promoted "an ideal façade of efficiency" (p.393). The pseudo-cohesion in this study also involved the supervisees denying the existence of job-related stress and burnout. Hyrkas et al. (2002) found that when real problems within the group, such as stress and burnout, were not addressed they eventually manifested themselves in other forms such as sickness, absence and the promotion of a negative work culture. Such findings have clear resonance with this research.

Lisa reiterated the enabling process of clinical supervision particularly in relation to embracing difficult issues that were hard for the midwives to talk about. She too, reported that she had derived benefit from the process:

> …it [clinical supervision] let issues be raised that
> were probably not talked about in the group [work
> team]…
> (Lisa)

However Lisa also suggests that difficult issues were not talked about, reinforcing a lack of cohesiveness within the work team. Lisa commented that if the reasons for low morale and high stress levels were to be understood, the midwifery profession needed

to consider 'different ways of thinking' and that the process of clinical supervision might

be one way of addressing this:

> *I think it [clinical supervision] is a different way of*
> *thinking…it's not the usual way of thinking…it*
> *[clinical supervision] would be a good thing for*
> *morale and stress levels…*
> (Lisa)

Rachel's words suggest that she had found gathering the motivation and enthusiasm

for clinical supervision difficult and that this had involved immense effort on her part.

Her words seem to imply that she has enjoyed and prefers more 'traditional' ways of

working:

> *…it was really hard to get used to doing something*
> *like that because we've never done things like that*
> *before….*
> (Rachel)

Lisa develops this further by stating that she too, had found the clinical supervision

sessions a revelation as they helped her appreciate other midwives' anxieties and

problems within the work team:

> *…it [clinical supervision] makes you appreciate*
> *what's going on with other members in the group…to*
> *try and support wherever you can…*
> (Lisa)

Kathy stated that she had found the experience beneficial although she acknowledged

that if the midwifery profession were to adopt and engage in clinical supervision the

facilitation of such a process would be a massive endeavour:

> *I think we've all benefited from it [clinical*
> *supervision]…and there is a place for it, but how you*
> *are going to do it…it's a big job but everybody*
> *should have access to it.*
> (Kathy)

The midwives had enjoyed and appreciated the support offered by Joss, the clinical supervisor. They valued not being disturbed, especially by clients ringing them on their mobile telephones and the opportunity of being able to "talk things over" was experienced as being beneficial.

A challenge: time for reflection and possible change

Helen's words suggest that clinical supervision "certainly makes you reflect on your listening skills and giving other people's point of view time". She appears to have found clinical supervision challenging and conducive to her work as a midwife. She also reported that she had found the clinical supervisor an effective role model:

> *… it does make you reflect on the way that you deal*
> *with people and the way that you sort of engage with*
> *them and talk with them, giving them the time of day*
> *and actually I think I learned quite a lot about*
> *facilitating from observing [the clinical supervisor]*
> *which wasn't necessarily the object of the exercise.*
> (Helen)

The midwives' words suggest that they had not been exposed to the facilitation skills used by Joss. The data suggests that she dared to raise, challenge and articulate difficult issues within the work team that had previously been ignored by the work team. Jane acknowledged that addressing these issues was beneficial:

> *She sees inside your mind a bit and she could tell*
> *perhaps if somebody wasn't coming out with*
> *something, which was good…*
> (Jane)

The midwives seemed to value skills possessed by Joss that they had previously identified as being absent from their own or their peers' repertoire of skills. Honesty on the part of Joss, for example, was appreciated and Jane felt that she was "very straight and kept the group on a level". I suspect that this is also a reflection of how Jane would wish the work team to function.

Too great a challenge: no time and no support during turbulent change

The data suggests that all the midwives found clinical supervision beneficial although it was needed over a longer period of time and probably in a less turbulent period of change. Ever increasing workloads and a subsequent increase in stress levels within the work team meant that the demands of the organisation had precluded their ability to see how clinical supervision could benefit the work team. Lisa states:

> *…yes I benefited from it but I think we needed it over a longer period of time and hopefully in a period when there aren't as many changes because it [turbulent change at work] has been very stressful…*
> (Lisa)

Jane stated that she had really enjoyed the sessions but once she returned to the work setting she chose to function as before and ignore any new learning from the clinical supervision group. This seems to highlight a preference for routine behaviour and thus passive resistance to change that is not uncommon in a workforce that is stretched to the limit (Lipsky, 1980):

> *I felt in the hour session I enjoyed it [clinical supervision]…I felt good about it, "oh yeah, I've enjoyed that"…but then I took myself out of that box and put myself back into community midwife mode…and went on doing exactly the same as I had been doing…so…*
> (Jane)

As will be seen later in this chapter, and understandably, Rachel had been reluctant to participate in the clinical supervision group claiming that midwifery managers were not supporting their input to the study. However her words suggest that she perceives the benefits of clinical supervision:

> …it's not a concept that management understands because they still haven't been able to pull it away from midwifery supervision but we know how it can help our practice and how it can help us to cope with our day to day stresses.
> (Rachel)

Kathy commented that when everyone turned up for the sessions the clinical supervision group worked well, "I mean when it was your turn to present it was a bit 'oh god what am I going to talk about?' but once you got into it was okay." Interestingly, Kathy reported that she had "become more assertive" and that she had decided that she was "fed up of being sat on" indicating the beginnings of change on her part.

Gemma reported feeling "really disappointed that it's [clinical supervision] over" and that the whole process had "made [her] feel closer to certain members of the group than [she] felt before". She had previously expressed anxieties about clinical supervision so her new found strength and the positive nature of her comments were reassuring.

The need to feel safe: negotiating a safe environment

As was seen in Chapter 9, Dawn facilitated an introduction to the process of clinical supervision for the midwives. I wanted the midwives to experience clinical supervision positively, in a safe and supportive environment, so that they could state what their needs were. Further to Dawn's introduction to the process the work team proceeded to develop their framework for clinical supervision (see Chapter 9). At this focus group

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they expressed preference for a *non-midwife* as the clinical supervisor and a desire to undertake *group supervision*.

I was so relieved that they had agreed to participate in the study that I missed the opportunity to explore their decision making around taking group clinical supervision. I can only surmise that at the time they were feeling threatened by new ways of thinking and working and wanted to experience this together, although to this day, I remain unclear as to whether they actually sat down together and made a conscious decision to reject individual clinical supervision.

Discussion around timing of the clinical supervision sessions took a great deal of time. Lack of support from midwifery managers dominated discussions and as a result they had decided that they were not expecting to receive additional help whilst attending clinical supervision, even though this had been promised. It was therefore important to them that they were able to build the sessions into their working day. They had to think about this for several weeks before they contacted me by telephone to confirm when they would prefer to hold their sessions. This then had to be agreed with the clinical supervisor at a 'contract setting' meeting. Once clinical supervision started and 'no additional help' became reality, the midwives attributed their non-attendance to receiving 'no help' with their work.

'Contract setting': working towards a clinical supervision framework

The conditions necessary for an effective clinical supervision relationship have been dealt with in Chapter 4. Joss reinforced this aspect of clinical supervision as being of crucial importance and had requested that she meet with the midwives for a 'contract setting' meeting prior to the sessions starting so that they could set a mutually negotiated working contract. At this meeting Joss discussed with the midwives her

qualifications, background and experience and her style of clinical supervision. She was keen that the midwives were clear about what they were signing up to before the working conditions of clinical supervision were agreed. At this meeting Joss addressed the frequency of sessions, continuity of group membership (that is, attendance) and confidentiality. She also suggested to the midwives that reflecting on a topic of their choice, relating to their clinical work, might be one way of proceeding with the process.

Originally the midwives had wanted me to pursue someone who was not a midwife as their clinical supervisor. This was for confidentiality reasons (that is, the clinical supervisor would not know anyone in their midwifery area and they would therefore feel more comfortable expressing their views). However as the clinical supervision sessions progressed they realised other benefits to having a non-midwife clinical supervisor:

> *…and as time went on I became more and more glad that she wasn't a midwife because I felt more free to talk about things that happened within this part of the organisation and she didn't know any of the people involved and she didn't have any agenda with anything to do with midwifery.*
> (Helen)

The midwives' decision to choose someone with a different professional background paid off for them as Joss brought a different perspective to their working lives:

> *She said what the solution might be in mental health as opposed to midwifery so that we could see it from a different angle.*
> (Helen)

Helen had appreciated this alternative way of looking at issues and her words suggest that Joss was "the absolute key to it [clinical supervision]". She had also given them the space to be able to talk freely about their midwifery work and their working relationships without feeling intimidated:

> *…it was good having her because she wasn't midwifery orientated…she brought in a different slant, she brought the mental health, she could see things where we couldn't see them as midwives…she saw it from a mental health perspective.*
> (Lisa)

The participating midwives had also requested that the clinical supervisor was a woman who had experience of working with women and was approachable and attentive. The clinical supervisor then, had to be a woman, an 'outsider' but not too much of an 'outsider' (still in the NHS) and most importantly the midwives' words seemed to be suggesting the need for a credible 'outsider'. This supports work undertaken on midwifery supervision where a lack of credible role models was identified within midwifery (Stapleton et al. 1998).

Making time for clinical supervision

During and after the second focus group (see Chapter 9) I remember feeling anxious that the midwives were going to say that they wanted no further participation in the study. Despite initial promises of support, their words suggest that midwifery managers were not recognising the amount of time and effort that they were putting into the study:

> *…we never got the back up from managers…you know like promised.*
> (Gemma)

Their own midwifery manager had agreed that 'flexible working practices' could be used. However 'flexible working practices' meant that the work still had to be done, without additional help and somehow slotted into the working day. Understandably, this compromise was not enough to ease the burden of work for the midwives and their

dissatisfaction seemed justified. They were insisting that they wanted additional help when they were taking clinical supervision:

> *…you'd still have that amount of visits to do after the time had been taken out of the morning…by the time we got back to the office…finished sorting out the work…it had nearly always gone 10 o'clock, so it did have an implication on work.*
> (Jane)

As I wanted to help the midwives (and maintain their participation) I discussed with them the possibility of seeking funding so that a bank midwife could be employed to cover the area in which they worked. They agreed that this would be a good idea. This would then mean that they did not have to return to the office and spend time sorting out their work for the rest of the day.

Buying time: money makes midwives

The Head of Midwifery in one of the Trusts I visit in my capacity as a link teacher[79] showed me a flier produced by the West Yorkshire Education and Training Consortium[80]. The flier invited submissions of proposals for small grants to aid the development of innovations in clinical practice. I decided to apply for funding and sought the help of a colleague from the University who had submitted successful bids in the past. In March 1999 I was informed that my bid had been successful and I was awarded almost £6000 to assist the progress of the study.

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[79] Link teachers in the institution where I work provide structured educational support to student midwives on clinical placements and to those mentors who supervise students.
[80] The West Yorkshire Education & Training Consortium is now known as the West Yorkshire Workforce Development Confederation.   Workforce Development Confederations are leading the Government's agenda for the development of integrated workforce planning for health and social care communities (RCM, 2002) and as such they commission education from universities for pre and post registration nursing and midwifery education.

I informed the midwives that I had been successful with the bid and I proceeded to negotiate with the Trust the amount of money I would pay them for a G grade (salary points) midwife to cover the area. I spoke to Helen about this and informed her that we were now ready to employ the bank midwife and that they could start clinical supervision. However I was informed by Helen that the group had decided this was not necessary and that because clinical supervision was taking place from 0830–0930 they would be able to return to the office to pick up the morning's visits without clinical supervision breaking into their working day. I was surprised (and somewhat frustrated and perplexed) to say the least but pleased and relieved that the midwives were maintaining their participation.

Whilst undertaking the final interviews it became apparent that the rest of the midwives within the work team had not been informed that my bid had been successful. Jane had no hesitation in voicing her dissatisfaction with the situation:

> *…we were made to believe that it would be easier if*
> *we just added…just went about normal workload*
> *after it [clinical supervision]…which we did…it did*
> *actually work quite well but that was through our part*
> *of trying to arrange our work load to suit*
> *that…knowing that on these mornings we had a*
> *commitment.*
> (Jane)

Neither did the midwives seem aware that a bank midwife could have been employed. The data suggests that Helen had decided that she would not consult with the rest of the work team following my telephone call. Jane's words suggest that there had been a lack of communication within the work team and her anger was evident during her interview. I also felt that I had deprived the midwives of something that was rightfully theirs. It was not until these final interviews took place that some of the money was used for additional help. I then worked as a bank midwife to help with 'visits' so that

Rachel and Gemma could reduce their 'visits' in order to spend time with me whilst I interviewed them.

My efforts to 'buy' the midwives time in order to help with their participation in the study were in fact futile but nevertheless provided a good example of how the work team actually functioned. The data suggests that communication between work team members appeared to be problematic and a hierarchy within the work team became evident and the money I obtained was not 'spent' on midwifery 'time'.

Time out to talk: spending valuable time

The midwives' accounts suggested that they viewed time as a finite "unit of value" (Lipsky, 1980, p.89). Time was something that they could 'give' and 'take' but as a commodity it was not something that they could 'spend' or 'self-manage' because they simply did not have enough of it. As Lipsky (1980) suggests "worker compliance is affected by the extent to which managers' orders are considered legitimate" (p.18). The data suggests that the midwives preferred to adhere to 'traditional' ways of working. This is understandable as any change in working practices would have meant investing more energy and work for them and in times of turbulent change and acute staffing crises they chose not to undertake 'flexible working practices'. Lipsky (1980) states that:

> "The fact that street-level bureaucrats must exercise
> discretion in processing large amounts of work with
> inadequate resources means that they must develop
> short cuts and simplifications to cope with the
> pressure of responsibilities."
> (Lipsky, 1980, p.18)

Clinical supervision therefore, appeared to create more work for the midwives rather than enabling them to create a 'short-cut' or to 'simplify' their existing workload. Time

as a constraining factor, their apparent inability to self manage their time because of work commitments and not always being in the office together were constantly cited as reasons for not addressing issues within the work team. All the midwives, at some point during their interviews, commented on the importance of finding and making time to talk as a group. Rachel found the concept of "time out to talk about issues" useful and Lisa thought clinical supervision was beneficial because "you don't always get time to talk over problems within the group". Jane stated that:

> We weren't interrupted and our thoughts were
> focussed on "right this is an hour for us"...I enjoyed it
> because it's time out…
> (Jane)

The data suggested that the midwives needed to spend 'time' together as a work team and they acknowledged that clinical supervision provided this 'time'. However, Helen suggested that midwifery managers did not provide 'time' for them and that if they had placed more value on clinical supervision by allocating reserved time for the process (Lipsky, 1980) then their enthusiasm might have transferred to the midwives:

> …but it's very difficult to see that something is
> valued if they [midwifery managers] won't give the
> time for it [clinical supervision]…
> (Helen)

Although Helen's words appear to be suggesting that midwifery managers give them time for clinical supervision her words could also be interpreted as suggesting that the midwives are only able to function with the approval of their midwifery manager thereby reinforcing a dependency culture. I asked the midwives how they felt they could convince midwifery managers that clinical supervision was worth giving time to and adopting into their working lives. Kathy's words suggest that there would be resistance to such change from the managers:

> *Well I think I'd have a bloody awful job trying*
> *to...because it's something new and it's something*
> *that's time consuming and you need time to do it.*
> (Kathy)

There appeared to be many contradictions when the midwives talked about 'time'. They were happy to acknowledge that time for clinical supervision was important and that they needed clinical supervision. However, having experienced the process their words seem to convey that the demands of the organisation outweighed the need for clinical supervision. The data suggests ambivalence to the study that is attributed to midwifery managers for not supporting the process and giving them more 'time'. I was surprised that none of the midwives referred to clinical supervision as an investment that might help them to address more effective ways of working or contributing to their continuing professional development.

Time as a finite commodity – it costs money!

I asked Helen, who had previous managerial experience, how she might convince midwifery managers that clinical supervision should be put high on the agenda for midwives. She stated that she would ask questions around "right, what's in it for me…why would it be good for my staff…what's in it for the organisation?" Already she appeared to have "different job priorities" (Lipsky, 1980, p.18) to the work team as a manager although she was able to view clinical supervision from a different perspective and acknowledged that managers needed to value the process:

> *I feel that those kinds of things [clinical supervision]*
> *need value from management because it's all part of*
> *a support system and network…I'm not saying*
> *clinical supervision will resolve everything, but I can't*
> *see that it would hinder it [working relationships]…*
> (Helen)

However Helen stated that "when you've got a massive staffing crisis, no development work gets done because there is crisis point". In other words, crisis management had taken priority during a difficult period of recruitment and retention and new ways of working were probably far removed from the day to day agenda of keeping the midwifery service going. This was reiterated by Rachel who stated that in order for clinical supervision to be valued and recognised as an important entity by midwifery managers these new ways of working and supporting each other have to prove their worth. Rachel's words suggest that the 'time' involved for clinical supervision costs money and that the 'time' has to be sold profitably in order to benefit clinical practice:

> *You have to sell it [clinical supervision] to them*
> *[midwifery managers] before it will percolate through*
> *as an important thing…*
> (Rachel)

Perkins (1997) when discussing the implications of change for midwives acknowledges that "new schemes require time to plan" (p.161) and that this time has to come from somewhere. Unfortunately, and not always a priority for managers, is the fact that time costs money. This concept of time costing money is often ignored by those urging or imposing change to the point that existing members of staff are over burdened or there is a reduction in the level of service (Perkins, 1997). As Lipsky states:

> "…efforts to free street-level bureaucrats of routine
> tasks so that they may attend to more important
> aspects of their work do not necessarily reduce the
> tensions associated with that work or improve the
> quality of interactions between workers…"
> (Lipsky, 1980, p.31)

The midwives taking part in this study appear to have become over burdened by their participation because midwifery managers had expected them to incorporate clinical supervision into existing work schedules. The managers did not appear to

acknowledge and legitimate the fact that 'time' is needed to undertake clinical supervision and that this time costs money.

Time as a 'sacrifice': encroaching on others' time

Rachel had found it difficult to understand how she could possibly benefit from clinical supervision. She considered her participation in the study to be for my benefit and the achievement of my PhD. She challenged my feminist principles of women supporting women and seemed unwilling to see the positive aspects of the process of clinical supervision and how these might benefit her in terms of personal and professional development or reflection on practice:

> *…we were doing something that seemed as if it was going to encroach on our time for your ultimate benefit. It was very hard at times to see how we would possibly benefit from this, other than more work, more commitment and more hassle…*
> (Rachel)

Attendance at the midwives' group supervision had been patchy for some members of the work team. Joss suggested that, had everybody become engaged in the process, the time allocated for clinical supervision would have become valued and in turn become a precious commodity. She reported that only when clinical supervision and reflection became valued by the midwives would they view clinical supervision on a different level. This dichotomy presented a disjunction between midwives being "with women" in their professional capacity and the fact that the midwives could not "be with" each other in a group setting.

Kathy acknowledged that group members were keen to attend clinical supervision at the start but she gave having to attend on her days off and stress as reasons for non-attendance at some of the sessions:

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…at the beginning everybody was enthusiastic and we all went and we all turned up, but then you see, when people start getting stressed and you were having to go and do clinical supervision on your day off because there was no other way round it, it [clinical supervision] just fell apart.
(Kathy)

Kathy's perception of "having to attend" is also interesting bearing in mind that a contract setting meeting was held by Joss, with the midwives, at the outset of the study. Although regular attendance was encouraged by Joss, as important for effective functioning of the group, she did inform the work team that nothing was being forced on them at this initial meeting. Kathy also refers to the clinical supervision group as "falling apart" and I wondered whether this was an unconscious reference to the work team falling apart.

Whilst changing off duty might have been a solution to the problem of attendance this was not an option for the work team. The midwives had stated from the outset of the study and through the setting of rigid boundaries that they did not want clinical supervision to encroach into their private lives. Changing the off duty also created extra paperwork that they were not prepared to undertake. Non attendance at clinical supervision might therefore have provided an easier option for those midwives who were seeking to avoid any extra stress in their daily working lives and the anxiety provoking feelings that clinical supervision was bringing to the forefront for them. Time therefore appears to serve only one function for these midwives; it is something that they are 'given' and that they 'take'.

All the midwives were in agreement that the clinical supervision sessions needed to last longer than six months. They had found that the first few months had been necessary to become further acquainted with the concept and process of clinical supervision before they started to address unresolved issues within the work team.

Kathy's words suggest that she would have preferred to carry on with clinical supervision given the time that this involved:

> If we'd gone on longer, it [clinical supervision] would
> have given us time to get to the bottom of it
> [unresolved issues] and then be able to say what we
> thought... we didn't go long enough...
> (Kathy)

Interestingly, Joss had encouraged the midwives to meet and use the room for clinical supervision when she was on annual leave. This would have given the midwives longer to concentrate on clinical practice issues although Joss' efforts to foster a sense of autonomy and responsibility within the midwives fell on deaf ears and Helen predicted and reflected back their helpless, dependent stance very well:

> …"oh no, we can't, it won't be the same without you,
> we can't do it without you, we don't want to do it
> without you" because we'd have just chatted,
> because that's her job isn't it, to sort of bring you
> back to focus.
> (Helen)

Yalom (1995) refers to leaderless meetings and previous unpublished work that he had carried out in relation to these. Participants had referred to the group straying from its task, losing control of its emotions and being "unable to integrate its experiences and to make constructive use of them" (p.420) without effective leadership. This may have been a fear that the midwives had if they had continued with clinical supervision in Joss' absence.

Rachel and Jane both suggest that clinical supervision was "a bit of a luxury" with Rachel stating that, "it was like a frill on the toilet roll cover in the bathroom". Jane reported that if clinical supervision were a regular undertaking for midwives then it would not be such a luxury. Rachel reported feeling tormented about clinical supervision. She knew that clinical supervision was a valuable, supportive concept for

the work team at that moment in time but on the other hand she stated that there was no point going through the process if 'time' was not available for the group. This contradiction meant that when Rachel was faced with making a decision, she chose not to attend some of the clinical supervision sessions. Once again the pressures of work far outweighed any investment of energy and time to the study.

> …it was like well what's the point of it [clinical
> supervision], we just haven't got time for it and yet I
> suppose if there was ever a time we needed it, it was
> at that time.
> (Rachel)

Kathy too was reluctant to attend and reported that many of the issues the midwives addressed during clinical supervision could have been discussed outside of the sessions:

> I didn't always want to go and I did feel that a lot of
> the issues we talked about, we could have done
> without being in the clinical supervision arena.
> (Kathy)

However despite recognising the need to discuss work related issues and working relationships, the midwives did not appear to discuss these in clinical supervision because they reported feeling uncomfortable. Kathy's reluctance to attend could have been related to her discomfort around discussing sensitive issues that impinged on working relationships, which was the same reason these issues were not discussed within the work team.

Taking time that is needed elsewhere

Gemma's words suggest that she had found taking 'time' for clinical supervision a burden. Self-denigration became evident again, as she imagined having something imposed on her and then having nothing to offer in terms of discussion:

> *I thought this is a bit of a nuisance, taking our time,*
> *we're going to drive through rush hour traffic and I*
> *don't know this woman and what is she going to do,*
> *you know, what are we meant to talk about, my*
> *usual negative self you know.*
> (Gemma)

She also appeared to resent that members of the work team were being deprived, even robbed of their own time by the clinical supervisor and me. This is despite the fact that a clear contract had been set in place with Joss to which they had all apparently agreed.

Rachel had been reluctant to attend clinical supervision sessions and had missed several of them, only turning up when she knew she was almost in breach of the agreed contract. She was also extremely difficult for me to locate in order that I could arrange a final interview. On several occasions during the course of the study she rang me to cancel appointments as she "could not afford the luxury of sitting with me for one hour while we talked" (Research Diary, 1998) suggesting that I was 'taking her time' when she was needed elsewhere.

The experience of clinical supervision was marred for some of the midwives because they worried about their "waiting" workload during the sessions. The importance of finishing the session on time was always at the forefront for Jane even though

agreement had been reached in contract setting with Joss that sessions would not go beyond the agreed time span:

> …always at the back of your mind you're thinking "oh god I hope we finish on time because we've got x number of visits or clinics waiting…"
> (Jane)

This fear of not finishing on time could also highlight a lack of containment (Whitaker, 2001) on an emotional level for Jane. As was seen in Chapter 7, she had already expressed her concern around the demise of effective working relationships and she knew that she was feeling stressed. This stress and anxiety now appeared to be translating into doubts as to whether Joss would be able to facilitate the group effectively or whether this would prove too much for Joss to deal with. Jane's anxiety about the group finishing on time suggests a fear around "letting go" and how Joss as the clinical supervisor might react to this. The data suggests that this had become a genuine fear for Jane.

The midwives reported that if clinical supervision was to be of any future benefit for them the length of the experience needed to be increased. This had also been reinforced by Joss during contract setting. Helen's words suggested that the six month trial period was an insufficient time span to appreciate the benefits of such a venture:

> I don't think anything particularly changed, partly because of the time, I mean six months is nothing…
> (Helen)

The data suggests that a perceived lack of support from their midwifery managers and the short time span for clinical supervision were attributed as reasons for avoiding clinical supervision. However, at the same time the midwives had also begun to find addressing sensitive work related issues painful and this could have contributed to

their avoidance. Rather than getting to grips with working relationships and making effective use of clinical supervision to help them during the time span allocated, the midwives chose to reject clinical supervision and turned down Joss's offer for more clinical supervision once the group and/or study ended. Neither did the midwives ever ask for more clinical supervision

Group supervision: feeling safer in numbers

Yalom (1995) views offering support within a group situation as one way that a facilitator can make the group feel safe. Helen clearly felt supported by Joss and had appreciated this:

> *…she [the clinical supervisor] made everyone feel*
> *that they were valued and an equal part of the group,*
> *a very safe environment and it [clinical supervision]*
> *all worked.*
> (Helen)

However, in relation to how the clinical supervision sessions functioned, her words contradict the other midwives' views in the group. Helen suggests that the process of clinical supervision "worked" whereas Jane appears to have worked very hard at not addressing and avoiding sensitive work related issues in order to avoid conflict and maintain the status quo:

> *I didn't want to particularly open up a can of worms,*
> *because at the end of that hour, you've still got to go*
> *out of that door and work with those people…that's*
> *tricky not using something that may have been an*
> *issue.*
> (Jane)

Yalom (1995) also points out that the creation of safety in a group by the facilitator can also mean that conflict is avoided and important interpersonal and work issues are not

addressed. Indeed some of the midwives appeared to have worked hard at avoiding such issues. Lipsky (1980) reminds us that:

> "Professionals are notoriously reluctant to criticize each other and at best direct attention only to the most extreme violations of ethical norms. Informal peer review is normally avoided and formal peer review focuses on immoralities unrelated to professional performance or to narrowly defined technical capabilities."
> (Lipsky, 1980, p.203)

Gemma commented that agreement was reached over various issues in relation to the work group during the clinical supervision sessions. However, when some sessions had finished discussion outside of the clinical supervision setting contradicted this:

> *…it [group dynamics] was completely changed when we came out of the meeting and it was "oh I wanted this and I wanted that" you know…*
> (Gemma)

Gemma's words also suggest that the midwives did not maintain boundaries in that they were unable to address issues within the allocated time for clinical supervision. They seemed to prefer to discuss these issues outside of the session highlighting their inexperience around addressing such issues. Jane's words suggest that safety within the clinical supervision setting was very important to the midwives probably because they were feeling unsupported and unstable as a work team. Her words suggest that they could have maximised on the experience more, especially in the face of uncertainty:

> *…it [clinical supervision] was all new and we didn't know what to expect of it…we did it together…to support each other and feel safer in numbers…I don't think we knew what we were doing anyway, we didn't know what we were in for and I suppose it could have taken a different format completely had we decided to move it that way…but we didn't we just went along with it [clinical supervision]…*
> (Jane)

Feeling safer in numbers also brought to my mind the metaphor of a gang. Nitsun (1996) suggests that the concept of a gang can be used to describe an internal process that seeks to "obliterate need, dependency, and, in particular, envy, by denying external reality" (p.125). Although Nitsun (1996) discusses this in relation to the anti-group (p.126) he states that even in normal group development the concept of a gang is often used to describe the membership of a group. I recalled my early negotiations with Glendale Team and how Rachel had referred to the group as the "Del Monte Team" (Research Diary, 1998). This is very similar to "playful associations…the 'A Team', the 'class of '89'…" highlighted by Nitsun (1996, p.126), although referring to themselves as the "Del Monte Team" could be a defence mechanism guarding against their vulnerability at that time. I remembered the midwives' anxious laughter as Rachel referred to the work team as the "Del Monte Team".

Gemma commented that when clinical supervision started "[they] were a really steady group" but in the last year "[they've] just gone to pieces". The process of clinical supervision could have helped here through exploration and reflection on their clinical practice in a safe, supportive, relaxed and open environment.

Feeling valued through equality and consistency

The midwives reported that Joss addressed them all equally and that her manner never changed reinforcing that the relationship between supervisor and supervisee(s) is a key to effective clinical supervision (Faugier, 1998; Sloan, 1999; Griffiths, 2002). She provided a degree of consistency for them that was not present in their turbulent everyday clinical practice:

> *She made sure that we all took a part and had a turn*
> *and were able to contribute.*
> (Helen)

They reported that she was approachable and was able to offer her own perspective on what they were discussing. She did not detach herself and was able to clarify issues for them. She was also able to pull the group together if the midwives became distracted during discussion in the clinical supervision sessions:

> *When we went off on a tangent, she pulled us back*
> *every time and she was fair.*
> (Kathy)

Regrettably as the clinical supervision progressed, and despite a clear contract being in place, attendance began to fall off. Jane's words suggest that some of the midwives had simply not turned up and she could remember:

> *…one session vividly because there was only me*
> *and the facilitator there because the others had got*
> *their wires crossed.*
> (Jane)

The data suggests that those midwives who had been most vociferous about feeling unsupported were those whose attendance diminished and those midwives who had been less keen to participate in clinical supervision seemed to benefit the most. As was seen in Chapter 9, the vociferous midwives were generally those who appeared to hold a locus of power and control within the work team. The process of clinical supervision probably began to highlight these power struggles, as well as work related issues that were not addressed within the work team. The more silent members of the work team found clinical supervision beneficial possibly because the process appeared to provide them with an opportunity to start to address these issues. Joss's facilitation skills were reported to enhance this situation:

…she's got the listening skills, she's got the prompting skills, she's got the "let me draw it out of this person because they have obviously got something to say but they're not able to say it or let me shut this person up for a while because they are taking up too much time".
(Helen)

The more vociferous members of the work team appeared to deal with Joss's facilitation style by denial and avoided facing differences within the clinical supervision group through their non-attendance. Halton (1994) states that denial is a defence which involves pushing certain thoughts, feelings and experiences out of conscious awareness because they are too anxiety provoking. Denial is also a response to stress (Lazarus & Folkman, 1984) and can be used "as a tactic to buy psychological time-out before resuming the struggle of life" (Butler & Wintram, 1991, p.124).

Imposing boundaries: limiting involvement or avoiding responsibility

The midwives chose to limit their involvement and the scope of the enquiry by establishing, and laying down, what appeared to be, some very constraining ground-rules at the start of the study. The main ground rule being that they did not wish to undertake anything that was extra to their usual work schedule. Whilst this might not seem so unreasonable, as was seen in Chapter 5, this sort of imposition of boundaries ultimately limited the scope of the study. Joss reported to me that she had offered the midwives the opportunity to negotiate another clinical supervision contract once the study had finished. This was not taken up by the midwives, and in times of great change within the NHS when clinical supervision could have helped them enormously, the midwives reported feeling burdened and further stressed by their involvement in the study and rejected offers of further help and support from Joss.

Prior to data collection, and in preliminary discussions, the midwives decided to impose boundaries on the study in terms of their participation and they informed me that these boundaries were non-negotiable. I either conformed to their terms and conditions or they did not take part in the study. However, when Joss had suggested some dates and times for clinical supervision at their first contract setting meeting, this imposition of boundaries had appeared to irritate them. She told me that during the final clinical supervision evaluation session they appeared to attribute not getting cover for their area and inflexibility around time slots for clinical supervision as reasons for their non-attendance. However, on reflection Joss had thought that this was more related to the midwives inability to articulate their preference for a different slot during the negotiation process. She reported that there might have been some irritation within the group because she had offered her availability from the outset and, rather than talk this through with Joss, the midwives appeared to prefer demonstrating their feelings by not attending for clinical supervision:

> *…the rules and boundaries were set up and laid down…she suggested that these are the areas that I think we need to cover and the first thing within that was confidentiality…*
> (Helen)

Joss stated that she was willing to negotiate some changes in dates and times; otherwise firm boundaries were set as to her availability. The imposition of these boundaries appeared to irritate some of the midwives. The fact that they imposed similar boundaries for me at the outset of the study in terms of their participation appeared irrelevant to them at this point. Their behaviour appeared to parallel similar encounters between midwives and clients where there is an emphasis on professional power over that of clients (Kirkham & Stapleton, 2001) and where midwives prefer to feel in control. Joss was articulate in stating her preferred times for the group to meet and presented as a woman that the midwives would not be able to 'manipulate' or

'control'. This situation was outside of their usual remit as community midwives and they did not appear able to deal with Joss' assertiveness.

The data also seems to suggest that the midwives may have been envious of Joss and that their difficulties around boundary setting might stem from "a sense of being an inevitable loser in a competitive struggle" (Halton, 1994, p.15). The midwives had already begun to realise that the survival of their work team was under threat. This realisation, states Halton (1994), can "stimulate an envious desire to spoil…success" (p.15). Helen's words above suggest that the midwives could have been envious of Joss's confidence and her stable status within a different Trust and unconsciously decided that they would "operate[s] like a hidden spanner-in-the-works" (ibid, p.15). Ultimately this spoiling envy (ibid, p.15) or inability to be able to manipulate or control others then appeared to sabotage the success of clinical supervision and could be interpreted as resistance to change.

Rachel's words suggest that the uncomfortable feelings that setting boundaries stirred within the midwives were probably related to the added individual responsibility this brought to their role within the clinical supervision group. Setting boundaries with Joss will have highlighted the responsibility each of them had in order to 'make or break' the creation of their clinical supervision framework:

> *…just one more demand on us…it was another responsibility…it was something else we had to keep going, it was another meeting we had to arrange and keep together and I think we just got to a point were we wanted things to be simple…*
> (Rachel)

Setting boundaries meant that the midwives had a responsibility to turn up for sessions, present "a topic" when it was their turn and enter into interpersonal and inter-professional dialogue with other members of the clinical supervision group. This

responsibility seemed to prove too much for some of the group members and highlighted what could be interpreted as their inability to be able to manage their professional boundaries.

Feeling elitist: better to exclude than include

The midwives had decided in the early stages of the study that they did not want to include new members of their work team to the clinical supervision group. The midwives saw their involvement as creating more work for themselves in terms of explanation of what had happened to date in the study. I had offered to inform new work team members about the progress of the study and what their involvement might entail but the existing midwives had declined my offer. I found myself reflecting on the midwives' ability to be able to voice their needs but then not being able to adjust to their needs being met. I also reflected on how I perceived their exclusion of the new work team members as a group of midwives probably under threat and appearing to behave in a hostile manner towards excluded members of the work team. I felt saddened that they could not see how this situation was probably mirroring the vulnerability their new work team colleagues might be feeling within a new area of work.

Yalom (1995) states that hostility towards new members is evident even in groups where the group leader has been besieged with requests to add or include new members. This closely parallels the midwives' requests to midwifery managers for more staff to help with increasing workloads. The data shows that once new members of staff were allocated to the work team by midwifery managers they were then promptly excluded from the clinical supervision process (see page 176). Those midwives who viewed the work team as cohesive may have viewed any proposed membership changes to both the work team and the clinical supervision group as

threatening to their position in the hierarchy of the work team.

Lisa's words suggest that she was sensitive to this situation. She appeared more insightful, perhaps because she had not been working in the work team as long as some of the other midwives. She commented on new work team members and how they might feel watching some of the work team leaving for clinical supervision two mornings out of every month:

> *They felt they were outside of it…you couldn't*
> *discuss anything with them…I felt a bit elitist…you*
> *couldn't tell them what we had discussed because*
> *they were not part of the group [clinical supervision*
> *group].*
> (Lisa)

Obholzer & Zagier Roberts (1994) comment that new members to a work team such as Lisa often see worthwhile issues to address but feel they have no power to comment. Unfortunately when such work team members do feel strong enough to comment they have either forgotten how to 'see' or even more worrying, have learnt not to 'see'. Lisa's words suggest that she was not far enough up the hierarchy within the work team to pass comment on this and she seems to have learnt not to 'see':

> *…that's for senior members to discuss…not for me*
> *to discuss…there's hierarchies you know…because*
> *I've only been here three years…*
> (Lisa)

This also accords with Roberts (1983) theory of oppressed group behaviour whereby midwives have learnt to cope by internalising the values of those holding powerful positions (Kirkham, 2000). Lisa is referring to the fact that senior members within the work team have internalised the values of the NHS thus forgetting the 'traditional' values of community midwifery.

The dumping ground: a place for unloading distress

The midwives reported that there was a constant stream of different midwives being allocated to the work team by the midwifery managers. By the end of the study there were only two of the original sample, Kathy and Rachel, left. This disintegration of the work team disturbed them and the midwives reported that their work team had become a "dumping ground" for midwives who did not seem to "fit" in the organisation or who had problems of their own. This can be likened to what Orbach (1994) refers to as "dumping distress" (p.31). In other words, the midwifery managers, having difficulties deploying midwives appropriately, appear to have used what they perceived to be a supportive, functional work team, as a dumping ground in which they could unload their own distress and frustrations. Kathy's words strongly suggest that:

> …it just felt like a dumping ground because we were
> getting people that had problems of their own,
> dumping them on us…we already had our own
> problems and it just felt like a big dumping ground at
> one point.
> (Kathy)

This situation exacerbated the problems they were already experiencing within their own work team. Yalom (1995) supports this and comments that a group that "is actively engaged in an internecine struggle" (p.319) will often reject new members and view them as burdensome or intrusive. This situation also highlights how the midwives have become victims of the image of a supportive group that they themselves have created. Their words suggest that they were beginning to realise that they are a 'needy' group of women and their objections to becoming a 'dumping ground' suggests they want to put a hold on having to contain others' distress so that the work team can sort out its own difficulties.

'Help rejecting complainers': expressing resentment or reflecting reality

During her interview, Joss reported that the midwives appeared to be questioning their own behaviour, their working relationships and also their own clinical practice. However their questioning approach did not always find appropriate answers. This was because when suggestions were made as to how they could help themselves the midwives seemed to refuse or reject help outright and engage in an apparent passive resistance to change.

I was reminded of the term "help rejecting complainer" first introduced by Frank, Ascher, Margolin, Nash, Stone & Varon (1952). This is a term now used by most group facilitators in relation to problems and opportunities that arise in groups (Whitaker, 2001). Help rejecting complainers constantly complain about problems they are faced with but then reject any offer of help from other people. The data suggests that the midwives complain about not having enough time or support from their midwifery managers yet when Joss offered to continue her support by renegotiating another clinical supervision contract after the study had finished, her offer was not pursued further. Rejecting help may also be a covert way of expressing anger and resentment (Whitaker, 2001) at midwifery managers and other work team members who have not helped in the past[81].

On the other hand, rejecting help and presenting themselves as being in a helpless or hopeless position might serve a useful purpose for the midwives in that the reality of their situation is being reflected. Covering up the reality of the situation with excuses of not being able to get together could be more related to anxiety around addressing sensitive work related issues and thus provided an effective avoidance strategy for

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[81] The proverb "cutting off your nose to spite your face" comes to mind here.

them. Bernard (1994) suggests that such people are expressing uncertainty about personal change.

Interestingly, Bernard (1994) goes on further to state that this dynamic within the group can only be sustained with the participation of the rest of the group thereby implying that collusion must also occur within the group. Berger & Rosenbaum (1967) suggest that help rejecting complainers are motivated by a need to control and manipulate others (see Kirkham & Stapleton, 2001) and that such people may feel insignificant and empty themselves (see Chapter 8). Indeed the data in Chapter 6 suggests that some of the midwives felt manipulated and persecuted by their colleagues.

Joss recalled how the midwives had begun to question why they had not been able to discuss work related issues within the work team previously. They had questioned the need for a "facilitator" and that they could not have "done this on their own". Again I was reminded of a dependency culture as the midwives appeared to need some degree of control over their situation. Joss had challenged them to reflect on their reasons for not doing so and thus tried to break the help-rejecting pattern:

> *…why didn't you, what stopped this well knit,*
> *cohesive team from having a team discussion about*
> *something that's concerning every member of the*
> *team?*
> (Joss)

Kathy's words suggest that Joss's forthrightness and honesty was appreciated by some of the midwives but nevertheless still provoked painful feelings and highlighted their manipulative behaviour:

> *…I'm glad she said it because it was underneath you
> know… that feeling that we were supposed to be
> honest with each other and we were supposed to be
> saying this and that and getting it out of our systems,
> but we weren't and when she said that [as quote
> above] I thought she's right really and I'm glad she
> said it because it made us think that there were
> issues that were always brushed under the carpet…*
> (Kathy)

Kathy had found Joss's honesty almost a relief, as she appeared to give herself permission to acknowledge that working relationships were not as effective as they could be. Following some of the final interviews, I reflected on the midwives' honesty with each other and how this could be improved so that the work team situation would be so much more enriching for them. When I asked Jane what stopped her from being fully honest with other members of the work team she stated:

> *I would imagine…personally speaking, fear of
> upsetting somebody or something, the situation,
> work related life and nobody wants to be hurt.*
> (Jane)

Jane's words seem to provide a passive view of working relationships within the team. Her words suggest that she is fearful of upsetting another member of the work team and her words "nobody wants to be hurt" imply that she herself is frightened of being upset by someone else. Her words could also be interpreted as wariness around relating more closely with other midwives on an interpersonal and inter-professional basis. Griffiths (1999) refers to such behaviour as "etiquette" (p.91) and "harmonious team hypothesis" (p.91) suggesting that there are codes of behaviour to be adhered to in order to get through the working day (see 'ladylike saboteurs' in Chapter 7). This is reinforced by Jane whose words imply there is a need for midwives to interact with each other on a superficial level because open or frank discussion might hinder working relationships:

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> *I don't know if it did…I don't know…I think we were
> only as honest as we would allow ourselves to
> be…nobody would want to be honest to the point of
> brutality.*
> (Jane)

The data suggested that the work team did not deal honestly with each other and that challenging each other constructively was not in their repertoire of skills. Jane perhaps was one of the brave members of the work team who chose to put this into words. Although she equates 'honesty' with 'brutality', her words also suggest she is fearful of others being brutal towards her. She reinforces this by stating that:

> *…feelings were aired and views were offered that
> were honest, I mean I can't say how honest any of
> the others were, but I can only say what I perceived
> the level of honesty to be and I think we all held back
> slightly because nobody wanted to get hurt and
> upset.*
> (Jane)

Clinical supervision offered the midwives the opportunity to reflect upon their working relationships and clinical practice. However the data suggests that some of the midwives appear bound up in a profound level of helplessness. Their words suggest that the demands placed on them by the organisation in which they work means they have had no option but to use defence mechanisms (or different performances) as a means of getting through their work. As a result the midwives seem to have lost their vision for midwifery and they have cut themselves off from the bigger picture of midwifery. Their current work situation has become "normalisation" for them and they seem to believe that this is how midwifery should be practised. This seems to have occurred without any of them noticing that this has happened. When I 'imposed' action research on them and stopped the 'roller coaster', the midwives appeared to become disabled. They appeared to realise what had been happening to their work team and rather than help themselves through clinical supervision they chose to resist the change.

<u>Different ways of acknowledging endings</u>

Rachel expressed sadness that the clinical supervision sessions had come to an end as well as regret around the changed work team:

> *I'm sad its [clinical supervision] stopped but I'm sad*
> *that the group is different.*
> (Rachel)

Although her words could be interpreted as ambivalent I found what Rachel was saying somewhat reassuring. This was probably the first time she had acknowledged clinical supervision positively as well as her distress around the changed work team. Articulating this to me might well have been a huge step for her as well as a step in the right direction for a change in practice to take place.

Some of the midwives were not punctual for clinical supervision sessions. Joss informed me that this could be a form of acting out. Those midwives concerned may be anxious about the process, trying to protect themselves or trying to call the clinical supervisor's or group member's attention to themselves. The midwives might also want to protect themselves from becoming involved in a process that involves emotional effort on their part and will then have to come to an end. When Joss had challenged the midwives about their punctuality one of the midwives insisted "well I live a long way away". This brought declarations of "I do too…I live just as far as some" from other members of the clinical supervision group. Joss discussed with me that if she had worked with the midwives longer she would have explored their acting out behaviours in more depth. She suggested that this behaviour could be a reflection of their anxieties around endings.

Joss recalled the final clinical supervision session where one of the midwives had brought material relating to abortion but referred to "termination". Abortion equates to

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premature death and Joss reported making a connection with the midwives between the clinical practice issue of "termination" and the fact that this was also the termination of the clinical supervision group (that is, the last session). Her words suggested to me that she thought very few of the midwives could openly accept the possible unconscious motive behind the subject material:

> *The material was right, it was proper and good stuff*
> *and it was extremely good material to bring to that*
> *forum. I ventured to make a connection between the*
> *actual material and the parallel with the reality for the*
> *group…*
> (Joss)

Joss told me that she had anxieties about asking the midwives to make connections and reflected that maybe she should have "kept that to [her]self". She then reported keeping other connections to herself and I wondered whether she was trying to protect the midwives in some way from facing the realities of difficult work situations and relationships. In relation to making connections between the final clinical supervision session and "termination" she stated that she was sure one of the midwives was going to say, "trust a mental health person to say that". However her words suggest that she had views that:

> *…it's not about mental health, it's just about human*
> *behaviour and what goes on in the work place or*
> *clinical practice. Human behaviour must influence our*
> *practices and our working relationships.*
> (Joss)

Joss recalled how she had observed one of the midwives set herself up in competition with her role as the facilitator. She reported that had the life of the group been longer then this person would have tried to take on this role. I recalled the focus group again in which I felt bullied by the midwives and how one of the midwives had opened the focus group seeming to attack me personally. I then observed her take on, what I perceived, to be a dominant role for most of the session (see page 310).

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The empty chair: avoidance behaviour or a call for help

Bond & Holland (1998) view attendance at clinical supervision as crucial and necessary for the relationship to happen and the experience to be positive. Attendance at the clinical supervision sessions had been a problem for the midwives despite them agreeing at the outset, with Joss that groups work best when all the members are present for most of the time:

> *I think the benefit of a group is if everybody turns up*
> *and not withstanding that there are times when*
> *someone is on holiday then there's always going to*
> *be an empty chair.*
> (Joss)

Whitaker (2001) states that "different dynamics underlie absences" (p.135) and suggests that particular group members may be protecting themselves in some way from disturbing or painful events within the group by "regulating their exposure to the group" (p.135). Despite setting a contract at the start of clinical supervision and discussing boundaries, two of the midwives were persistently absent from the clinical supervision group and just as Joss was about to write to them to remind them of their attendance, in accordance with the contract, they would turn up.

As Joss discussed with me, "forgetting" is an interesting reason for non-attendance and can be interpreted in many ways. She believes that individuals forget what they do not want to remember. I was never able to determine whether one of the midwife's absences meant that she was protecting herself from painful interpersonal and inter-professional issues that had arisen with the clinical supervision group. In this case her absences might have been a call for help or on the other hand merely avoidance behaviour. When these issues had been raised within clinical supervision Joss

reported "denial of anything other than a genuine reason for forgetting". Interestingly though Joss reported that the midwives would collude with each other and make excuses for each other's non-attendance:

> *They were very, very supportive of one another,*
> *saying "oh well I don't know where she is, I saw her*
> *the other day and she might be coming, I'm sure she*
> *will be coming" and the person never arrives, so I*
> *would wonder what's that about?*
> (Joss)

However this could also be interpreted as a fear of challenging the status quo within the work team or even being challenged by another work team member on an individual basis. Joss states that the less vocal members of the clinical supervision group also seemed to express a need to support the more dominant members of the group and that they colluded with each other. This could well have mirrored a similar process in the work team where ambivalence towards working relationships appears to reinforce uncertainty around personal change and underlying stress and anxiety within the work team.

Joss had also been surprised that none of the clinical supervision group members ever commented enquired after or got upset by the "empty chair":

> *This group never commented or got upset by the fact*
> *that there were empty chairs, it was almost as if we*
> *would ignore the empty chair, but the fact is, you've*
> *got an empty chair and it means that somebody is*
> *present without being present if you know what I*
> *mean…that was never commented upon…they*
> *didn't want to pick those things up.*
> (Joss)

When Joss was recounting this to me I thought of Gemma and how upset she had been when no one from the work team contacted her when she was absent through

sickness. Gemma words had suggested that she felt ignored. The psychological distress she was suffering did not appear to warrant attention from the midwives in the same way that sick leave for a hysterectomy might. I believe it was easier for the midwives not to acknowledge Gemma's distress, as this would have meant even more work for them. Work in the sense that they would have to invest more emotional energy than was necessary. The emotion work associated with their role as a midwife and its effects on them (see Chapter 8) possibly meant that they had 'missed out' on learning how to value each other. Organisational demands were such that as a work team they had no time to spend on nurturing a work team member. Likewise, admitting that they had not capitalised on the opportunity of getting help from each other through clinical supervision was another way of stating that they had nothing of value to offer each other.

The "empty chair" at the clinical supervision sessions could have symbolised a member absent, for whatever reason. However, as Joss stated, the midwives chose to ignore the empty chair either indicating their indifference or their need for relief or protection from the thought of having to address work related issues that they might be finding painful. The midwives who were absent may have chosen to regulate their exposure to group dynamics that they did not feel able to cope with. The same could be argued for the midwives in the focus group who appeared to choose not to take part in, or ignore, Helen's challenging behaviour. Their decision to behave in this way or their acceptance of her behaviour may have been one way of protecting themselves.

Gemma's absence through sickness had meant extra work and stress within the work team; more postnatal visits to carry out, more antenatal clinics to cover, more on calls to cover and more homebirths to attend. Maintaining contact with her could have reinforced the stress within the group and the midwives indirectly expressed hostility by not contacting her. Again this hostility could be interpreted as professional jealousy

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in that it was less painful and easier just to ignore Gemma's "self-care" (Carmack, 1997, p.142) as she could have reminded the midwives of their own inability to take care of themselves.

Joss's previous experience as a clinical supervisor had led her to believe that when clinical supervision is set up on a regular basis, health professionals do not want to hold back from it and attend willingly. The time constraint of six months for clinical supervision that was imposed by me meant that Joss made a conscious decision not to challenge the midwives non-attendance. She suggested that "to have pursued it would have damaged the group" and that if you "open a wound you have to heal it". However she commented that if she had been facilitating the group for a longer period of time she "might not have let that go".

Facing the challenge: presenting clinical material of concern

The midwives were encouraged by Joss to take it in turns to 'present' material of their choice at sessions. Sharing an issue and reflecting on it with supportive, challenging and informative help was the thrust of the interactive model of clinical supervision used by Joss (see Chapter 4). Helen was really appreciative of the fact that she was able to take part in a study that could ultimately lead to improved support for midwives in clinical practice. When I asked her how she had coped when it was her turn to present material she said:

> *…personally fine…I've always got lots to say for myself and I'm confident…my problem is keeping my mouth shut because I knew that I had to.*
> (Helen)

During earlier focus groups the midwives had expressed anxieties around how clinical supervision would be structured (see Chapter 9). Their concerns were reiterated to

Joss. Choosing a topic had presented a dilemma for some of the midwives in terms of the nature and importance of material. Some midwives had suggested to me that inappropriate material had been presented at some of the sessions and others had been overwhelmed by the nature of some of the material e.g. termination of pregnancy.

Gemma, who was on long term sick leave at the time of the final interviews, informed me that she felt ashamed that she had cried in one of the clinical supervision sessions. "I blubbered in one of her sessions you know" and then she told me she felt even worse when she "never had the guts to bring it [the issue] back up". She had wanted to discuss her anxieties around shift patterns and "strike while the iron was hot". However, her suggestion had been met with derision and this had muted her. Interestingly she did not meet with the derision until the group had left clinical supervision and returned to work. Gemma's words suggested an avoidance of issues because of an underlying fear of one or two dominant midwives in the group. I interpreted this dominance as debilitating other work team and clinical supervision group members as well as sabotaging the ground rules of the group.

Joss acknowledged that encouraging supervisees to present clinical material of concern was not the only way to facilitate group supervision:

> *…but it's one way and the benefit is that you know when it's your day to present, so you can think it through and prepare it in your mind and everybody gets an equal turn, which is fair and useful when the life span of the group is limited. It also helps to balance the dominant and passive members and I believe it promotes group support.*
> (Joss)

The midwives reported that thinking about material to 'present' was a stressor for them "in case they couldn't think of anything". Joss reassured them that they did not have to

come to clinical supervision having rehearsed material. The first six supervision sessions took the format of a rota (taking turns) but Joss suggested to the midwives that the second set of supervision sessions could be done without a rota to see if that reduced stress for the midwives. The midwives had agreed that this was a good idea but Joss was interested to note that at the start of the sessions there was always some banter as to who would "take the floor". This type of behaviour could reinforce the midwives insecurity around working without a focus of control. There were times when one of the midwives would try to draw another member of the clinical supervision group without prior warning:

> *…there were occasions when two people together*
> *would share a subject, like one would start off with*
> *"well I've got something that we were talking about,*
> *I've got something that's been on my mind and I*
> *know it concerns you as well", so and so would then*
> *be brought into it…*
> (Joss)

Joss highlights reticence on the part of some of the midwives to accept responsibility or exercise choice in their own material without involving another member of the clinical supervision group. Some of the midwives reported that issues relating to management dominated for most of the clinical supervision sessions:

> *…everybody brought up problems with*
> *management…you know…going to your manager,*
> *not getting support from your manager and that sort*
> *of issue and not being able to go and ask for what*
> *you want…issues around your work and the way*
> *you've dealt with a patient or something…there was*
> *nothing like that.*
> (Kathy)

Kathy's words also highlight the midwives' avoidance of discussing issues that were within their control and reinforces their need to work within a dependency culture.

When discussing the term clinical supervision and how they had run the sessions, Jane also stated:

> *I suppose at the level we are at anyway, as G grade*
> *midwives, I don't think we particularly questioned our*
> *clinical judgement or clinical expertise in any way, it*
> *was always peripheral subjects that we discussed or*
> *management subjects or coping strategies…clinical*
> *things were never discussed…I could see the newly*
> *qualified people wanting to discuss their clinical fears*
> *and worries in full…but at the level we were at none*
> *of us questioned our clinical judgement or ability…*
> (Jane)

Some of the midwives therefore did not appear to have discussed or reflected on personal midwifery cases. Jane too, admits that when the clinical supervision group was not addressing management issues they discussed "peripheral subjects" thus avoiding what was really going on in the group:

> *Maybe we were too complacent, I really don't*
> *know…no it probably isn't good to not question…*
> (Jane)

The midwives appeared to have focused on issues in a wider context and discussed management-related issues. Jane also implies that because they were all G grade midwives there was no need to reflect further, ask for help with individual cases or question each others' practice. This suggests that the culture of midwifery in which they practised had been superseded by an organisational culture that did not appear to value reflection on practice. I found this disturbing and wished that they had focussed more on clinical issues so that they might be able to start to address some of the difficulties they might be encountering in expressing or achieving change. At the time of the research the midwives appeared to have ceased learning about midwifery and to have become out of touch with the fears and worries of every day clinical practice.

This is probably a result of becoming buried under organisational pressures and increasing workloads. They have in fact become midwives created by the organisational culture in which they work rather than their own personal philosophies of midwifery.

Joss was sympathetic to the fact that some of the midwives found 'presenting' material stressful and therefore arranged for some of the sessions to be 'open'. This meant that group members could bring items for discussion with no pressure to feel obliged to 'present'. However Joss had found that this meant that the less vocal members of the clinical supervision group rarely participated. She reported that over a longer period of time the more silent members of the group would have "missed out" on opportunities to develop their self-awareness or to reflect on practice. Joss had also found that the more dominant members of the group were presenting more than once with "the quiet ones, the least confident ones being dominated". When I asked Joss whether the dominance in the group was addressed she said that the midwives had conveyed their thoughts in a humorous way:

> *I think they made reference in a humorous way to some of them being more forward than others, you know, so I think they have a clear awareness that there are some of them that are a bit more verbal and a bit more assertive and a bit more pushy. So I think they know it because they said "oh yeah, well so and so is a bit quiet and they never speak, but that's not me, I'm not backwards at coming forwards", but they never actually got into looking at that as an issue and looking at how that might affect the dynamics of the team or with clients.*
> (Joss)

This humour that was being portrayed by the midwives could have been a mask or defence for their anxiety or inability to address work related issues.

Towards a new understanding

Rachel reported that getting other midwives who had not taken part in the study to understand the concept of clinical supervision would be really difficult:

> *It's really hard to get that sort of concept into a group*
> *of people who have never known it or understood it.*
> (Rachel)

I feel that her perception of this difficulty is very much built on her own frustrations of not wanting to, or be able to, participate fully in clinical supervision and is a reflection of her response to the process. I think her words also imply how difficult a task she feels it would be to begin moving towards a positive culture of midwifery.

Avoidance of issues

Issues pertaining to clinical practice and interpersonal issues seemed to be constantly avoided by the midwives. Lisa and Jane clearly stated that personal issues should not spill over into clinical supervision. Lisa's partner also refused to listen to her talking about work issues when she got home and I wondered where she was able to take her emotional 'baggage'. Work came first for this midwife and personal issues were only addressed when absolutely necessary:

> *I mean we all talk about different aspects of our*
> *personal lives but obviously you're here to work*
> *aren't you?*
> (Lisa)

Kathy also acknowledged that everybody has their problems but that not everyone prefers to talk about them, either at work or in clinical supervision. This midwife preferred however, to talk about and share her anxieties within the work team:

> *I just think that everyone has got their problems and they don't always talk about them. Some people don't bring their problems out do they? Like if I've got a problem at home I'll come in and say "that bloody husband of mine" you know…get it all out and get it off my chest. Some people can't do that and you've got to respect that.*
> (Kathy)

There were obvious fears around not feeling adequately prepared to be able to deal with complex interpersonal and work related issues when they arose both within the work team and clinical supervision. The midwives therefore appeared to ignore, conceal and keep their feelings under control. This was reiterated by Jane who when describing how clinical supervision was facilitated also made some comparisons with counselling:

> *…but it wasn't at all like a counselling session…it wasn't "oh god here's my heart, I'll pour it all out, you know, mend it and give it back to me", it wasn't like that, it was very work related, but there was underlying feelings that did come out…*
> (Jane)

Clearly the personal and interpersonal stress experienced by the midwives within the work team was disabling. Although they knew that not questioning their practice was wrong, they were unable to untangle issues that preoccupied their working lives. Jane had originally expressed an interest in becoming a clinical supervisor or support person and when I asked her further about this she said:

> *I think I'm doing it now…I really do…I'm absorbing*
> *people's problems and giving them back to*
> *them…but not in a nice quiet "let's have an hour out"*
> *situation…I'm doing it amongst horrendous running*
> *up and down the ward with the phone ringing…*
> (Jane)

I was interested in Jane's use of the word "absorbing" as this could imply taking on too much responsibility in order to make others feel better. She appears to be rescuing others and trying to take away their emotional discomfort but in fact, she could actually be making herself feel better, thus diminishing the other person (Butler & Wintram, 1991). I would also question whether Jane knows what to do with "people's problems" when she has "absorbed them" as she runs the risk of dealing with the absorbed problems inappropriately (Orbach, 1999).

'Pit-head time' – an opportunity to discuss 'casework moments'

The midwives had decided that they would take an issue pertinent to them when it was their turn to present material at clinical supervision. Initially I had hoped that clinical supervision would provide the midwives with "pit-head time – the right to wash off the grime of the work in the boss's time, rather than take it home with them" (Hawkins & Shohet, 1989, p.42). However despite spending time discussing this in the second focus group (see Chapter 9), Lisa expressed anxieties about how the clinical supervision was going to run:

> *I wasn't right sure what to expect to tell you the*
> *truth…I just thought what are we going to talk about*
> *you know, at these groups…people were a bit*
> *hesitant about what to bring up…but as the hour*
> *went on they did develop.*
> (Lisa)

In the main they reported that issues were raised which were not talked about in the work team at other times. They talked about the dynamics of the work team in their interviews and feelings of safety in clinical supervision which they had found reassuring. The stress of working on delivery suite recurred as a theme but they commented that their stress levels could have been even higher if there had been no clinical supervision in place. Lisa conceded that:

> You know you'd think you didn't have anything to
> say, but you probably did at the end of it.
> (Lisa)

Helen had realised through clinical supervision and Joss that the culture of the NHS and its associated pervading problems were the same across professional boundaries:

> …the issues that we brought up… I found that they
> don't just apply to midwives…they apply to all staff
> and areas of the NHS…all the things that we are
> dealing with…other people have exactly the same
> kind of dilemmas and problems really.
> (Helen)

This realisation had broadened Helen's thinking and she liked the idea of working across professional boundaries with clinical supervision. She was also the only midwife who acknowledged the possibility of change:

> I'd even be prepared to become involved in clinical
> supervision with a mixture of people who weren't all
> midwives…I think something really beneficial could
> come from that…whereas if you had suggested that
> to me six months ago I would have said "rubbish,
> she doesn't know what she is talking about".
> (Helen)

The midwives had agreed with Joss that if there was an issue that needed addressing at one of the clinical supervision sessions then one of the midwives might have to miss their allocated time. Helen's words also suggest that these sessions were some of the

most interesting that took place. I could only surmise from her words that this was because the pressure to participate had been relieved for her to a certain extent. She was not the one under the spotlight and could sit back and reflect more during the session:

> *…where somebody had a really burning agenda that we had to talk about that day and maybe that meant knocking someone else off their slot…those were interesting sessions.*
> (Helen)

During the process of clinical supervision Jane had decided that she was going to change her work setting. She had not yet discussed this with her colleagues and chose the clinical supervision setting to announce her departure:

> *I hadn't let the rest of the group know that I was in the process of changing, until it [leaving the group] suited me to tell them and when I did tell them, unfortunately it did have an impact on one or two members.*
> (Jane)

The decision to make this change had clearly been a difficult one to make for Jane. She was aware that she belonged to a group of midwives that were feeling stressed, used and undermined and had therefore chosen the time carefully to tell the rest of the work team her intentions. Unfortunately this still had implications for some of the group members in that her departure was almost too hard to bear. I asked Jane if she felt that clinical supervision had challenged her to review her professional development and thus her decision to ask for a move:

> *It may have subconsciously...I don't know...there's*
> *so much that we do and change that we don't realise*
> *until much later that maybe that [clinical supervision]*
> *did have an impact after all...but I was less stressed*
> *because I was changing my work situation anyway...*
> (Jane)

Jane admitted feeling less stressed because she was changing her work environment but on the other hand acknowledged that she was moving from one stressful situation into another:

> *I was changing my work situation albeit for an*
> *equally stressful if not more stressful situation, but*
> *hell, change is change, let's go for it...same but just*
> *hits you from a different angle.*
> (Jane)

Although Jane appears to be acknowledging the positive impact of change she also highlights the stressful effects that change can bring and feels that change "hits" her. She thus views change as having impact although she does not state whether this is positive or not. In her preliminary interview when I asked her how supported she felt in clinical practice, this midwife had referred to being part of a work team that felt like a "rudderless ship". During her final interview Jane referred to this ship again but in the context of her new role on the antenatal/postnatal ward:

> *I feel now in this post that I'm the rudder, I'm steering*
> *up here and they're [midwives] starting to fall in*
> *behind me and follow and it's nice that I'm able to do*
> *that...maybe I'd been floundering out there*
> *[community] for years and I didn't know.*
> (Jane)

Orbach (1999) comments that when a person disparages or criticises previous areas of work that this is a sign of "undigested change" (p.129). Jane therefore, may have been implying that she was unable to cope with the complexities of the changing work team

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she was part of previously. Her words suggest that she is more able to cope when she is being dominant and able to mould others to her way of working. This highlights a need for structure, control and hierarchy within her midwifery practice. Orbach (1999) refers to this as a form of defensiveness that is present to "bolster uncertainty, squash down questions and ward off that which doesn't fit" (p.129). Jane's belief that a top down approach is the correct way to work may be countering feelings of helplessness and rather than recognise her vulnerability she has chosen to use what power she has (her rudder) with "shrill officiousness" (Orbach, 1999, p.130) in order to steer midwives and get them to fall in behind her.

Key points emerging:

This chapter has analysed data from final interviews with the participating midwives and an interview that I held with Joss, the clinical supervisor. The interviews were undertaken at a time when the maternity unit where the midwives worked was undergoing a recruitment and retention crisis. The challenge I presented to them in the form of taking part in an action research study, with the aim of identifying and mobilising support for themselves as well as moving towards a more positive culture of midwifery, seemed to present an opportunity they were unable to contend with at that time.

Even though the midwives said they felt unsupported in clinical practice, they continued to state that were a supportive group. This contradiction meant that they appeared to project an image of pseudo-cohesion, probably as a defence mechanism. Although the data suggested that they found clinical supervision to be of benefit, and necessary for the midwifery profession, they stated that they had no time in which to undertake this process. The midwives' apparent resistance to this change and what

seemed to be subsequent subversion of clinical supervision meant that they almost certainly missed the opportunity to improve and change their working lives.

Time as a "unit of value" (Lipsky, 1980, p.89) became pronounced during the clinical supervision process and time costs were experienced as 'taking too much of their time'; 'time as a sacrifice', 'spending valuable time', 'time costing money' and 'taking their time that was needed elsewhere'. A contract was set with the clinical supervisor and the midwives put into place their devised framework for clinical supervision. This process highlighted their pseudo-cohesion even further but at the same time, their vulnerability in an ever changing climate where the demands of the organisation took priority over their own needs. Clear messages had been received from midwifery managers that they supported the study, but in the absence of this support, a passive resistance to change appeared to surface that reinforced the pressure to meet organisational demands.

The clinical supervisor found that the midwives were not able to keep to their contract and attendance levels were sometimes low. The data suggested that the midwives found sensitive interpersonal issues and the sometimes dysfunctional dynamics of the work team difficult to address. This was not surprising when any further investment into working relationships through clinical supervision just seemed like extra work for them. Rather than use the opportunity of clinical supervision, in a safe environment, to address these issues the midwives chose to continue working in the same manner.

In the following chapter I present the key findings of the study and draw conclusions.

CHAPTER ELEVEN

Concluding thoughts…and beyond

> I have crossed an ocean
> I have lost my tongue
> from the root of the old one
> a new one has sprung
>
> <div align="right">Grace Nichols 1985</div>

In this chapter I present the key findings from the study. The conclusions of the study are drawn as well as the utility of the findings and an action research approach. I discuss the limitations of the study and how undertaking the study has been a huge learning experience that has enabled me to know and understand organisational culture and change within the NHS, on a micro level, in much more depth. I also discuss how I would approach action research differently if I was to undertake a similar study again. I also address in this chapter the implications for clinical practice, midwifery education and further research.

Overall the aims of this study (see Chapter 1, page 3) have been met by providing many insights into midwives' support needs and the ways in which they would wish to receive such support. In fact, the aims have grown and expanded providing further sociological insights into organisational culture, emotion work and the performance of midwifery. The study has also highlighted tensions and difficulties within action research when it is operationalised and the use (or not) of clinical supervision as a support mechanism within midwifery. The study also reiterates tensions between midwifery supervision and clinical supervision. Most importantly, this action research study has attempted to move beyond acknowledging the existence of stress and burnout and that midwives need support, by devising and mobilising a support mechanism for midwives to use in clinical practice.

The rhetorical challenge of midwifery

One of the many threads running through this thesis has been that life as a community-based midwife working within the NHS arouses anxiety for midwives, and that the emotion work associated with the job is not acknowledged or understood by midwives, managers and the wider organisation. The maternity unit where this research was undertaken was being challenged by new and different government policy initiatives (DOH, 1993a, DOH, 1999) which appeared to threaten the midwives' existing work situation, as well as compromise their well-being. The findings of the study indicate that the midwives were clearly able to articulate that their needs were not being met and also that their needs were not congruent with the needs and interests of the NHS. However on a more productive level (that is, through clinical supervision) they were unable to address this deficit in any depth because of various constraints, not least of which, was a clash of goals and aspirations between them and their midwifery managers.

'Cultures of conflict'

Flexible working practices that were encouraged by managers meant that midwifery work still had to be done and somehow slotted into the working day without additional help. Flexibility appeared to be interpreted broadly by managers who, not only expected midwives to be excellent 'all rounders', but also be able to flexibly manage their working practices as well as their emotions. The midwifery managers were seen as powerful people and fear of reprimand or retribution for not meeting organisational goals far outweighed the desire to meet clients' needs for some of the midwives. As a result they spent most of their working lives in "cultures of conflict" (Lay, 2000, p.16), meeting the needs of others, not able to work with their own personal philosophies or practices of midwifery. This rhetorical challenge has not been questioned, yet

continues to be disseminated through local and national policy directives, educational philosophies and not least, the midwifery literature.

In Chapters 2 and 3 I identified key issues in the history of midwifery where some of the earliest rhetorical challenges are to be found. As well as historical issues, wider political issues are identified and ways in which these may have impacted on midwifery and subsequently affected the way that midwifery work is 'performed'. An uneasy relationship between the hegemonic culture of technologically-based knowledge systems as compared to the experientially knowledge based system of midwifery continues to pervade the profession (Jordan, 1997; Lay, 2000; Davies- Floyd, 2001). Once again, this is clearly evidenced in the rhetorical strategies used within NHS strategic planning, which has rarely been informed by the formal contributions of community-based midwives, and has often resulted in contradictions and conflicting values becoming apparent amongst the workforce. The findings of this study indicate that such contradictions reflect a midwifery workforce that is struggling to voice its concerns over the future of the maternity services and where the values of managers are often not congruent with the values of grass roots midwives. The midwives participating in this study articulated that midwifery needs "re-creating" (Page & Sandall, 2000, p.674) as well as a different way of thinking. Yet, as previously pointed out, the midwives worked in a bureaucratic, hierarchical NHS system where a technocratic paradigm of health care existed that has been shown to be intolerant of different ways of thinking (Davis-Floyd, 2001).

The findings also indicate that the nature and pace of change within midwifery has contributed to creating a sense of instability and anxiety within the midwives. The effects of such changes, within a culture that the midwives expressed as being unsupportive, have been explored through listening to the participating midwives. The findings indicate that a constant cycle of change was too much for some of the

midwives and could have led to there being continual sickness and absence within their work team. Furthermore, the increased support midwives were expected to offer their clients as a result of woman-centred care (DOH, 1993a) contradicted their own impoverished support. This was an interesting contradiction especially as the midwives participating in the study preferred to project an image that they were a supportive work team. Moreover, the findings also indicate that working within a culture of midwifery where common goals are not aspired to, inhibited autonomous behaviour and independent thinking within midwives that was necessary for the woman-centred care (DOH, 1993a) that clients now expected.

Insights into the 'performance' of midwifery

In Chapter 8, Erving Goffman's (1990) analysis of the workplace is used to describe midwifery as a social drama where only certain performances were available to the midwives during their work. The pressure to meet organisational demands meant that the midwives had to regulate and control their performances which required considerable energy on their part. The findings of this study indicate that regulating their performances in this manner meant that their working relationships were affected and the midwives were not able to connect with each other. Some of the midwives subsequently experienced role tiredness resulting in anxiety performances that led to a one way draining of emotional energy rather than a fulfilling, energising process. Relationships that become starved of positive energy are not reciprocal or fulfilling for midwives, or their clients, and often result in a preference for the dominant 'power-over' style (Casey, 1995; Gallant et al. 2002) when dealing with clients as this becomes an easier option for midwives. I have provided a summary of the spectrum of performances exhibited by the midwives during their preliminary interviews on page 247 although this is in no way meant to indicate the full spectrum of performances that are available to midwives. Indeed many other performances (see ladylike saboteurs in

Chapter 7) can be seen in this study but these do not necessarily relate specifically to midwives' emotion work although they may contribute in some way.

Although not an unexpected finding, the degree to which the midwives experienced and managed emotion in their performances was profound. In-depth interviews and focus groups provided an opportunity for the generation of rich data, some of it sensitive with a discourse of denigration, around midwives' working relationships. The insight provided by some of the midwives into their lives suggested that emotion work impinges not only on their relationships with their clients but also on their relationships with their peers and their relationships at home. As was seen in Chapter 8 this is contrary to the way in which emotion work is depicted in the wider literature. The lack of literature relating to emotion work in midwifery was disabling for me at times as I struggled with contradictions and conflicting values that became apparent within the broader culture of midwifery, the maternity services and the NHS. There were often parallels during the course of the research between emotion work as experienced by the midwives and my own emotions. The findings of this study clearly indicate that a greater understanding of emotion work is essential for midwives and managers within the NHS if midwives are to 'perform' effectively and better understand their own emotional intelligence (Goleman, 1996).

The midwives viewed themselves as being in a helpless situation with no sense of direction and had numerous defence mechanisms in place to help them cope, the main one being their articulation and 'acting out' that they were a supportive group. Such defence mechanisms were borne out in the form of 'performances' for various aspects of midwifery work. All the participating midwives appeared to collude at some point in the study to make the point that they were a cohesive work team with a shared vision. This contradicted an apparent erratic approach to their work as midwives and each other that I observed, and they articulated on an individual basis. The midwives'

projection of pseudo-cohesion appeared as a safer, unconscious way of staving off any criticisms or challenges from outside of their work team and was seen as the best way of performing the task by the midwives. Thus the findings of this study indicate that it is easier for the midwives to project an image of supportive behaviour rather than challenge the status quo as this would have involved them scrutinising their working relationships and practices more closely. Having no sense of direction meant that they were unable to set boundaries with each other and their clients and this seemed to provoke feelings of uncertainty for some of the midwives.

Performances as bound by the clock

The midwives' performances were also bound by the clock and they used the metaphor of time to describe tensions and dilemmas that faced them in their everyday practice. Just as "obstetrics works on women's bodies to make them stay on time and on course" (Simonds, 2002, p.563), so too, the bureaucratic pressures of the NHS worked on midwives' bodies to make them be 'on time' for clients rather than 'spending time' with them. This was confirmed in the final interviews with the midwives where they articulated being able to give and take time but they were unable to spend or self-manage their time. Buying time became necessary on my part to move the study forward. Time then became a sacrifice as the midwives suggested that I was encroaching on their time that was needed elsewhere with clients. The findings of this study indicate that organisational pressures affect midwives' conceptualisation of time and there was an emphasis placed on being 'on time' for the sake of the organisation rather than 'spending time' with clients.

Insights into working relationships

The midwives in this study have highlighted a variety of ways in which connectedness and relationship formation, with colleagues and clients, are made problematic by the organisation of midwifery work. As seen in Chapters 2 and 8, an understanding of attachment can provide insight into the participating midwives' need to feel valued by their peers and their clients. This is then likely to provide a better understanding of the working relationships midwives develop over time. Healthy, supportive working relationships between midwives and clients and midwives themselves are crucial to positive childbearing experiences for clients and midwives (Flint, 1986; Kirkham, 2000; Wilkins, 2000).

Clinical supervision as an 'unshackling process'

In Chapter 4 I identified clinical supervision as one way of supporting and further addressing and understanding emotion work and relationality in midwifery. The midwives in this study identified the supervisor of midwives as a key support person but the majority of them declined this support for varying reasons (see Chapters 7, 9 and 10). A lack of clarity and confusion over the way in which the supportive role of the supervisor of midwives is facilitated posed tensions and dilemmas for the participating midwives and they articulated feeling unable to seek support from someone who could one day be their professional friend and counsellor (Isherwood, 1988; Flint, 1993a) and the next day a manager who could investigate their practice as midwives (Stapleton et al. 1998).

Clinical supervision, as undertaken in this study, offered the opportunity for support from someone from a different professional background who had no vested interest in the midwives. As well as providing a supportive mechanism, the findings indicated that

the midwives benefited from the experience of working with a clinical supervisor who had a mental health background[82]. Indeed, working with someone from another professional background had provided fresh insights for the midwives into the culture of the NHS and they articulated a sense of relief that other health practitioners experienced the same feelings as they did.

The findings from this study have indicated that midwives are not prepared educationally, in terms of how groups function, and were grouped together and expected to 'perform' as a team with no due regard given to the effect this might have on them as individuals and on their working lives as midwives. The midwives in this study articulated feeling ill-prepared to deal with some of the difficult situations brought about through collaborative working. Clinical supervision provided the opportunity for the midwives to start addressing this aspect of their work. However the findings indicated that their conceptualisation of time and organisational pressures inhibited this taking place.

Clinical supervision requires that the supervisee develops a level of "therapeutic proficiency" (Wilkins, 1998, p.201) that will be paralleled in their clinical work. It is therefore crucially important that the skills necessary for effective group working and relationship building are addressed by midwifery, especially by educationalists. Curriculum design and development needs to take account of this deficit and build learning and teaching strategies into programmes of education that foster closer exploration of relationships. Returning to the point I made in Chapter 1 (see page 11) psychotherapeutic concepts and group work theory are neglected areas in midwifery's

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[82] This is not to say that someone from a nursing or physiotherapy background could not have provided the same support. It is the process of clinical supervision that is of paramount importance as well as the communication and supportive skills of the clinical supervisor (Deery & Corby, 1996; Sloan, 1999) and their ability to develop a collaborative, trusting relationship (Todd & Freshwater, 1999).

repertoire of skills even though they can help midwives become more psychologically aware of their interactions with others (Raphael-Leff, 2000).

Midwives who balance well

The findings of this study indicate that engaging in reciprocal relationships with clients demanded a degree of emotional engagement (and detachment) that often left the midwives having to "pick the right balance" (Levy, 1999). Moreover, the midwives often had to engage with clients on different levels in order to cope with organisational pressures. As identified in Chapter 3, technical and emotional detachment were used by the midwives to help them cope with the lived experience of midwifery because the emotion work that was demanded, proved too much for some of them.

The findings indicate that technical detachment meant that midwifery work became task-based and was then the favoured way of working for most of the midwives because the carrying out of tasks was the quickest and easiest way to complete their work within the constraints of the organisation. Herein lies another contradiction as the midwives found that technical and emotional detachment limited and fragmented the development of relationships as they tried to fit their clients into the bureaucracy of the maternity services. Indeed, they appeared to reach a point at which their increasing workloads precluded client's needs being met and then emotion work became either impossible, could not be entered into, or became a stressor and not a source of energy. The midwives who balanced well in this study were sensitive to their own emotional needs, and they chose their level of engagement according to the situation they were presented with at a particular time. Moreover, they were also able to constantly rebalance their work situation and rather than experiencing emotion work negatively they found their work to be a personally enhancing experience. Table 5

provides an overview of the factors necessary for either positive or negative emotional engagement in a bureaucratic context and their subsequent effects.

Pseudo-cohesion as a defence mechanism

The facilitative nature of action research meant closer observation of the midwives' working relationships, which in turn revealed that challenging each other and confrontation were not part of their repertoire of skills as community midwives. Manipulative behaviour that accorded with that of a ladylike saboteur (see Chapter 7) was manifested and the midwives resorted to behaviour that denigrated their own capabilities and unconscious strategies (e.g. pseudo cohesion, projection and an avoidance of change) that redistributed painful feelings associated with dysfunctional working relationships. However such behaviour also meant that defence mechanisms remained unchallenged, and change was resisted, with tensions becoming apparent within the work team. The painful reality that they were not as supportive as they thought, as well as their inability to be able to address and confront complex interpersonal issues within working situations, became evident as a deep-rooted fear for the midwives. As Kirkham (1999) has stated "the way midwives treat each other is fundamental in defining, and maintaining, the culture of midwifery" (p.736). In this study defence mechanisms were revealed that had probably impeded communication and support within the work team for a long time.

Struggles and contradictions within action research

Action research provided me with a strategy to pursue the aims of the study; to work with the midwives in order to help them recognise and address their support needs at work and also to help bring about change in midwifery practice. My initial aspirations were that action research would be an apt approach because it appeared to

acknowledge and allow for the complexity of everyday practice (Deery & Kirkham, 2000; McNiff, 2000; Winter & Munn-Giddings, 2001) although it is clearly not a magic wand. The midwives reluctance to participate and collaborate in action research paralleled their own struggle in response to the need for reciprocal relationships with clients and managers, despite a process of collaboration being crucial to the current ethos of a woman-centred approach (DOH, 1993a).

MacLure (1996, p.283) warns about reporting action research as a "victory narrative" where personal struggles, contradictions and painful experiences are "smoothed away into heroic and happy-ever-after tellings of…work" (Dadds, 1998, p.43). I have tried hard not to tidy the mess away by 'telling it as it is' thus avoiding this situation. I have been able to consider the way in which midwifery practice appears restricted and confined by rigid institutional routines and practices that ignore, and do not take account of, midwives' struggle for autonomous practice. Throughout the study this has mirrored my own struggle to overcome being silenced and becoming mute and thus being able to express my midwifery values. The complex interpersonal demands of this action research study, and the ensuing change process (or not), brought about turbulence and heartache within the study that was uncomfortable at times. This discomfort was an important aspect of the study and became increasingly more uncomfortable as "power structures and relationships [were] peeled away to examine people's lives and experiences" (p.43). Such considerations meant that action research was no "easy ride" (Meyer, 1993).

As I discussed in Chapter 3, I hoped that using action research would help to stimulate and then direct change within the midwives. Change however had no clear beginning within the study because the midwives were already bound up in complex change processes happening within their maternity service. I hoped though, that addressing change, would lead to the promotion of personal and professional development for the

participants. However the methodological challenges brought about through the process of action research meant that it proved to be complex and demanding for the midwives. The findings of this study indicate that the degree of participation is crucial to the success of action research as is the support of managers. If I was to use action research as an approach again enlisting the support and understanding of all participants would be pivotal to the study. Action research that I have undertaken in a different maternity unit (Deery & Hughes, 2002) has seen a slow and on going replacement of a negative culture with positive culture. This positive culture comprised midwives, midwifery managers and researchers with shared and articulated values and beliefs in what they were doing, where they were going and what their roles comprised.

A further methodological challenge was the reciprocal relationship I established with the midwives participating in the study. My willingness to listen to their stories often meant that they revealed aspects of their personal and working lives that I found overwhelming. At times I also questioned whether the midwives had tried to manipulate me in some way by disclosing such personal and sensitive issues. If this was the case they viewed me as someone who could make their situation more bearable by acting as a change agent on their behalf with midwifery managers[83]. However, this contradicted their desire not to include midwifery managers in the study.

Although action research provided the opportunity for the midwives to help them change clinical practice, the opportunity for change was not fully embraced being characterised by a degree of resistance. The data that was produced within each cycle of the action research meant that the midwives had to confront difficult issues within their work team which they seemed to find threatening. Action research as an approach therefore proved to be effective in making visible ways in which the midwives behaved and coped when faced with change. The desire to change brings with it a

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[83] As was seen in Chapter 5, page 157 Holian found this to be the case when undertaking action research in her work setting.

degree of responsibility to carry out a particular course of action but this all appeared to become too much for the midwives as they appeared to collude and avoid their task (Bolton & Zagier Roberts, 1994).

The way forward

There is a clear picture emerging from this study that, in the absence of shared common goals and aspirations within the organisation in which the midwives worked and also within their work team, a negative culture of passive resistance to change appeared to have permeated their existing work situation. The midwives in this study appear to have become paralysed by conflicting ideologies and as a result they may have lost sight of any of the values and beliefs in relation to childbirth, women's lives and midwifery as a profession. The findings indicate that negative attitudes seemed to occur when some of the midwives did not feel challenged or could not adopt different approaches to care because of events beyond their control. Several of the midwives were only able to look inwards at their own locality, maternity unit and work team, experiencing their relationships as a one-way draining of energy and as a result they appeared to have imploded. They appear unable to make connections as to how they can help themselves and as a result cannot vision the future for themselves or the midwifery profession. I tried to help the midwives visualise, build and maintain the beginnings of a positive culture for themselves but the process of clinical supervision was not reinforced by other positive input (except Joss and myself). For instance, midwifery managers with the same articulated values and beliefs and I therefore felt that a positive cultural change did not take place with the midwives. In a different context clinical supervision would have been valued and hugely successful.

Implications for midwifery education and further research

The findings of this study indicate that midwives need to find new and different ways of dealing with the realities of practice. The contradictions that exist within current practice need to be acknowledged rather than resisted so that midwives feel nurtured and valued as people. There is evidence within this study that when midwives feel threatened or unable to cope with their work they are likely to become detached from their clients and experience midwifery as a one way draining of emotional energy which is unlikely to meet the needs of clients. Only one of the midwives participating in this study felt personally energised through her relationships with clients.

As was seen in Chapter 2 there is now empirical evidence in a study investigating why midwives leave the profession (Ball et al. 2002) that suggests there is a "contradiction that midwives experience between what their education prepares them to expect, and what they find in practice" (p.94). Ball et al. (2002) identified younger, more recently qualified midwives and those holding higher educational qualifications who were most likely to leave the profession. As these midwives are most likely to be those of the future (Ball et al. 2002) it is crucial that existing contradictions are addressed urgently.

The relational aspects of midwifery which place an increasing emphasis on self-awareness are still not viewed as being legitimate or intrinsic within the current culture of midwifery. Evidence from this study questions whether midwives are ready, able or even understand the emerging dynamics of the midwife-mother relationship. Assumptions cannot be made that because midwives have been trained and educated to work with others, that they possess the required skills and ability to deal with the emotion work that midwifery entails. The psychotherapeutic concepts exploited in this research offer a new way of thinking about current relationships in midwifery and how current ways of working often replicate 'old ways' that are detrimental and destructive

to both midwives and the women they attend. As was seen in Chapter 10, some of the midwives in this research refer to a deficit in their midwifery training and education in relation to this aspect of their work.

Although developing relationships with clients is encouraged, within the rhetoric of policy initiatives, this aspect of midwifery has not been recognised as a valuable entity for those midwives working in institutions. Instead there appears to be a culture that encourages midwives to work towards increasing their professional image and status based on their grasp of technological achievement rather than their relationships with women. The development of midwives to maximise their performance often entails attendance at in-house study days focusing on medical management of care and interventions in midwifery. As a result midwives learn to value what they can measure. It is unlikely that the same attention is given to the communication and interpersonal skills necessary for effective mother-midwife relationships through which midwives give physically intimate care within an emotionally close relationship.

Attention to the relational aspects of midwifery and emotion work has become central to the new curriculum at the university in which I work. Action learning is utilised as a way of helping midwifery students on their education journey. Their action learning groups are used as a means to help them discriminate factors within a given midwifery issue, to identify significant learning events as they occur, to reflect on practice, to constructively link theory with practice and also to review their learning. Threaded throughout this process is constant evaluation of their interpersonal and communication skills which are practised within the groups on an experiential level. There are close parallels here with the process of clinical supervision.

Progress Theatre (Baker, 2002) engage in a form of participative dialogic theatre and are also invited to the university where I work on a yearly basis where they give three

performances relating to bullying, cultural aspects of midwifery and sexual abuse. This technique enables the students to explore and share their cultural experiences of midwifery as well as ways of effecting change in a culture that has been described as oppressive (Kirkham, 1999; Kirkham & Stapleton, 2000). Hunter (2002) found that student midwives in her study provided "compelling evidence of the difficulties created by the juxtaposition of conflicting ideologies, and the implications of managing such tensions, not just for themselves as novices, but also for the occupation as a whole" (p.360). This year these Progress Theatre performances are being widened to include registered midwives from the clinical areas where the students are placed.

The rhetorical challenges and contradictions identified within this study need addressing although this will require that the status quo within midwifery is challenged. It is likely that some of the methodological challenges within action research and clinical supervision in this study have already mirrored some of those potential challenges for the profession. The findings of this study have indicated that personal midwifery philosophies can often clash in work teams (see Chapter 8). The work team in this research was one of many in the maternity unit (although Susan, Sarah and Stella belonged to different work teams) and there were also many hospital midwives who no doubt have their own personal midwifery philosophies. As Hunter (2002) suggests there may need to be an acceptance that there are "different types of midwife" (p.367). Rather than having a collection of midwives working together where there is a clash of philosophies it might be more appropriate to scale down the size of maternity units and work towards groups of midwives with shared aspirations and common goals. Whilst there will always be a place for the medicalisation of childbirth, some clients prefer midwife-led care or to go to a birth centre or homebirth (Kirkham, 2003). Moving the location of birth may be one way of achieving a cultural shift that addresses not only the needs of clients but also those of the midwives.

The limitations of this action research study relate to the site of the research and the sample. The site of the research had particular problems in that it had a high ethnic minority population and a massive staffing crisis at the time the research was undertaken. The sample was limited to a work team of community midwives and has not considered the support needs of hospital midwives or midwifery managers. After discussing my work with colleagues, research peers and hospital midwives in other maternity units I am aware that the findings of this research have clear resonance with midwives from all walks of life. Indeed initial findings from the study were presented in Australia and New Zealand close to submission of my thesis where the response to the findings was overwhelmingly positive. I would therefore like to recommend that the research is extended to hospital midwives and midwives who work in settings other than hospitals. There is no research that addresses the emotion work of midwifery managers; this too needs addressing if midwifery is to see a cultural shift from working under organisational pressures to working with clients.

Recommendations for midwifery practice

1. **The culture and organisation of midwifery:**

   The priority that is now given to delivering high quality midwifery services means that midwives are often working in complex, and sometimes difficult, circumstances. Competing organisational and client demands, within a culture of childbirth that is resisting change, can arouse anxiety for midwives as well as compromise their wellbeing. There is a need to foster a culture of midwifery where autonomous behaviour and independent thinking are nurtured and common goals aspired to. Ways of achieving this need to be considered e.g. the provision of structures and appropriate training whereby midwives can work with their own personal philosophies.

2. Support:

The increased support midwives are expected to offer their clients as a result of woman-centred care has contradicted their own impoverished support in this study. Insight has been provided into midwives' support needs through the initiation and development of the midwives' own framework for clinical supervision and highlighted that all the midwives found this support strategy to be beneficial. Support mechanisms, such as clinical supervision, highlight a need for the effective facilitation of midwifery support.

3. Recreating midwifery:

Incorporating differing perspectives (e.g. woman-centred care) into the practice of midwifery has often resulted in contradictions and conflicting values becoming apparent amongst the midwifery workforce because NHS strategic planning has rarely been informed by the formal contributions of community-based midwives. The midwives in this study stated that midwifery needed a different way of thinking. Therefore, there is a need to address the bureaucratic, hierarchical nature of the maternity services and the prevalent medicalised, technocratic paradigm of health care that is intolerant of different ways of thinking.

4. Understanding and managing emotion work:

The pressure to meet organisational demands meant that the midwives taking part in this study had to regulate and control their performances. In turn, this required considerable energy on their part. Regulating performances in this manner meant that working relationships were affected with managers, clients and amongst themselves. Only one of the midwives in this study experienced emotion work positively indicating that there is a need for a greater

understanding of emotion work for midwives and managers. Clinical supervision offers the opportunity to further understand emotion work and relationality in midwifery.

5. Working across professional boundaries:

The midwives taking part in this study valued, and found benefit from, the opportunity for support from someone with a different professional background. This was achieved through clinical supervision where knowledge of midwifery was secondary to the process of clinical supervision. The midwives taking part in this study described this process as a different way of thinking.

6. Developing therapeutic proficiency:

There is a need to ensure that midwives are prepared educationally (both pre and post-registration) for the difficult situations that are brought about through collaborative working. The midwives in this study articulated that they felt ill-prepared in terms of how groups function and that they had been grouped together with no regard given to the effect this might have on them as individuals. They identified a deficit in their midwifery training and education in relation to this aspect. Midwives need to develop a level of therapeutic proficiency that will be paralleled in their clinical work. It is crucial that skills for effective group working and relationship building are addressed by midwifery and especially educationalists. Curriculum design and development need to take this deficit into account and build effective learning and teaching strategies into their programmes of education. Clinically, midwifery managers need to place the same emphasis on communication, interpersonal skill building and therapeutic proficiency that they place on mandatory updating focusing on medical management of care and interventions in midwifery.

7. Action research:

Action research is a tool that can help to bring about change in midwifery practice although it demands the use of interpersonal skills on a level that acknowledges the complexity of real life situations in the clinical setting. The degree of participation is crucial to the success of action research and this concept needs to be fully understood by both participants and midwifery managers prior to the start of the study. Participants of action research and managers need to give sufficient consideration to the potential problems that might arise as a result of conflicting goals and aspirations within the clinical setting.

Recommendations for further research

1. Clinical supervision needs further exploration within midwifery and to be adequately resourced. Further action research on clinical supervision in other settings, and including midwifery managers, is recommended.

2. Further action research in a new birth centre, with a view to exploring resistance to bureaucracy in a midwife-led setting, is also recommended.

3. Further research is needed on emotion work in midwifery and this should include midwifery managers.

4. Interprofessional working warrants further exploration and research within midwifery especially as midwives are being encouraged to work across professional boundaries.

5. Further research is needed to explore the level, and therapeutic proficiency of student midwives, midwives and managers.

6. The potential role of action research to incorporate direct participation in strategic planning cannot be ignored and needs to be embraced by midwifery as a means to integrate education, research and practice development.

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APPENDIX 1

<u>Description of the midwives</u>

Frances, a widow, has been a midwife for many years and has worked as a community midwife for almost all of those years. She remembers being "a bit short tempered with the children" when she was stressed as a community midwife. She described herself as "really out of date". Her presence in the group provided a secure base for the midwives maybe because "I'm older…and part time…at the end of my career and they give me consideration". She had "stayed on after retiring age" because she "didn't want to be at home". She enjoyed the camaraderie within the work team. She believed that "you can't shut off" and that "counselling and often talking to somebody" was the way forward. She expressed her reservation about support for the study from the outset and stated that midwifery managers would not show their commitment.

Rachel describes herself as "a coiled spring…with a fair bit of energy…a bit of a giddy kipper". She felt that she had "gone on in a negative way" in her interview. Rachel has a young family and a partner who is critical of her high level of commitment to work. She has been a community midwife for a number of years and insisted that she did not work there because "it suits your family" or that "it's a cop out". She had wanted to be a community midwife since being "a little girl" and she "still pinched herself sometimes to think that she was one". She was "looking forward to the day I can slap all them files on the desk and concentrate on one GP". She gets fed up of "having to palm her kids off" in order to cover the work team rota. She told me that her partner was always telling her "that [she] put work first". She stated that she didn't "really talk to him much about work" because he would say "you're spending too much time doing this and that". She was devastated when one of the midwives left the work team to take up a

different post within the maternity service. She lamented that she had lost a "soul mate".

Helen is married with two teenage children. She has "been a midwife for a long time". She stated that her colleagues knew "she was there for them". Helen's partner is supportive of her commitment to midwifery and shares the childcare arrangements. Part of her midwifery career has been undertaken in Canada where she lived for a number of years. She is a graduate and stated that she "blew hot and cold about education" but admitted that "it does make you more aware of looking at the whole picture". She expressed disillusionment by the midwifery model of supervision and stated that she was a silent voice sitting on the periphery of a "secret organisation". She had a vision for midwifery supervision that corresponds with clinical supervision. She was sensitive to individual midwives' needs and is attuned to interpersonal relationships. She "felt scared" when she had to go onto labour ward. She was aware that some of the less experienced members of the group found her forthright but appeared unable to change her behaviour in order to ease their discomfort or take their views into account. In the early stages of the study she became the voice for the work team and was the one that asked all the questions. Part way through the clinical supervision process she left the work team to take up a post elsewhere. She was shocked at the effect her departure had on some of the work team members and had not realised how dependent some of the other work team members had become on her. She continued to take an active part in the study even after she had taken up her new post and stayed with us for the life of the study.

Kathy has worked as a community midwife for "ten years". The stress of midwifery had taken its toll on her health and she "had quite a few months off here and there with depression…can't sleep at night…and I feel terrible…it's terrible pain…I think I was off three months with that…and it's all to do with getting stressed out." She stated that it

was "four, five years since she's been in [labour ward]". She has been a community midwife for many years and only undertakes the necessary statutory refreshment. She commenced a degree programme at the local university but found this interfered with her family life too much and withdrew. She stated that the course "absolutely did her head in". She felt that "it would be nice if we [the midwives] could be appreciated" and that "the ones higher up [midwifery managers] forget what it is like to be down here". She felt that "confidentiality had gone out of the window". She appreciated the support of her colleagues and stated that "nobody would leave you in a mess out of all of us".

Gemma has been a community midwife for many years. She has many interests outside midwifery and is learning yoga. She makes it clear to the other work team members that she has a life outside midwifery and this is not always well received. She said that she could "switch off" and that she could "leave [her] work at work" and that she "liked being comfortable". She constantly self-denigrated throughout the life of the study and saw herself as "weak" and a "wimp". She stated that "sticking up for her own rights" had "made her more stressed…and depressed". Her partner was "willing to listen" and "he came out with [her] when on call at night". She said that she "was a good listener and quite sensitive to peoples' moods" and she "could usually tell if someone has got a problem. She said that "in a group [she] had to make herself talk". She "grew" during the life of the study and appeared to cease self-denigrating.

Penny is a newly qualified midwife and is the only one in the work team who did not train in the local area. Ironically, she had come to this area to practise as a midwife because she "wanted to do teams". She found the postnatal wards "pretty much like a production line" whereas on community she liked "the continuity of it…a bit more freedom". She said that she "could take quite a bit before she reached" peak stress levels when she would "off load" on her partner and say "take me to the pub". She was a quiet, reserved person and I saw her as a silent voice within the work team. At

times, especially in focus groups, I felt the more vociferous group members overwhelmed her. Again I sometimes sensed frustration within other work team members at her silence. She told me that she felt unable to share some of her experiences as a community midwife with other work team members and as a result "bottled things up". She left during the course of the study to take up a midwifery post in another trust.

Lisa is fairly new to life as a community midwife having worked in the hospital environment since she qualified as a midwife three years ago. She also worked as a bank midwife for "financial reasons". Although she liked "travelling around by [herself]" she was always keen to "mix with other midwives and get different ideas". She was assertive and "used to make sure that she got what she wanted even when [she] was an E grade". She described herself as "a private person" who did not "like big shows of emotion". She usually off loaded "at home or with colleagues that [she] had been friends with for a long time". She said that she "a really good understanding partner" but stated that in the past her work had "caused a lot of problems in relationships". She "really enjoyed the challenged of midwifery". She avoided some of my probing questions very skillfully. This led me to believe that she kept her feelings under wraps. She approached clinical supervision with an open mind and decided at the end that midwifery needed a "different way of thinking". When I undertook the final interview she was 38 weeks pregnant and on maternity leave. When she returned four months later she requested to go and work back in the hospital environment.

Jane described herself as a midwife "in her twenty second year" and a community midwife "on the area for nine to ten years". During the life of the study she seriously considered leaving midwifery because "it had got that bad…it was a total nightmare". She has worked in several work teams in the local area and came to this team because she was seeking to work in a supportive environment where workload was

shared out equally. Although forthright there was also an air of vulnerability about her that became evident in individual interviews and she referred to herself as a "right whinger". She hated being "told it's going to happen…and not having any choice in it [change]". She appeared reluctant to share her feelings and the pain she was suffering around her personal and professional life. She admitted thinking "leave me alone I'll keep this to myself…I won't share this with you" but at the same time longed for "a sympathetic ear". Her eyes would fill up and her voice would become unsteady as she spoke during some of our many conversations and her individual interviews. She stated that it would "take an awful lot of guts to be honest about your own failings and problems and worries". Following the initial interviews Jane went on long term sick leave with a combination of complications around her diabetes and stress. The other work team members missed her but I was unaware as to whether they kept in touch with her.   Jane returned to work in time to undertake clinical supervision with the other work team members but halfway through the sessions she revealed that she had negotiated to return to work in a different setting. She finished clinical supervision and then returned to this setting. When I interviewed her in her new work environment she stated that she "felt in control" and that she was steering her ship well. She suggested that the midwifery profession needed to "give midwives a pat on the back and say well done".

Those midwives contributing pilot interviews

Susan has been a midwife for as long as me. We have worked together in all areas of midwifery at some point during our careers. She was also trying hard to finish her first degree at the local university but has found that her "house is always a tip…I am so tired…too tired to tackle assignments". She felt that she was always "trying to respond to the needs of the service" and that clients were "always ringing for advice, ringing to moan…worries" although she did feel that clients had "to fit into our system".

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Community midwifery for her had become a system of trying to "please too many people". She told me that she wanted to see a place where she could go to "talk about feelings, worries, concerns, moans". Her role as a community midwife encroached into her personal life ands she said that she often went home to find "the kids are at the door…mum…mum…you haven't forgotten it's my swimming lesson". When I asked her about her needs as a midwife she talked about "colleagues on long term sick because they are stressed".

Sarah has been a midwife for many years and describes herself as "having a leaning towards community". Her caseload comprised clients "in housing estates" where there was "a lot more solo mums or mums who have numerous partners and not really in fixed relationships". When I asked her how she dealt with the extra pressures this might bring she stated "well I don't I just switch off…I just switch off from it…so I don't do anything". Rather than feeling responsible for her own workload she felt that "everybody else seems to have taken on responsibility for your workload". Sarah had lived in another country for several years and had only recently returned to the UK. She admitted that she was "not as confrontational as she used to be" because she did "not want to rock the boat". She felt that "nurses and midwives were their own worst enemies and that they didn't back each other up". She stated that "team building things are no good…I think they're a load of rubbish". She admitted to having "major mega problems" when she first returned to the UK because she was feeling vulnerable. However her "outside network of people" had helped here.

Stella has been a midwife for many years. At the time of her pilot interview she had only recently been practising as a community midwife, desiring a change from hospital life and "management breathing down your neck". She has two children. When I approached her prior to data collection, to ask if I could interview her in order to practise my interviewing skills, she was only too delighted to help out. Stella was

honest and forthright and shared her aspirations as well as her regrets about midwifery. She felt that "midwifery restricts you sometimes…it infringes more on your social life…it's a big deal for some people who have got kids." She had also recently been approached by one of the supervisors of midwives to consider undertaking the course leading to the title of supervisor of midwives. At the time she was a little disillusioned with supervision because she felt "it was just another on-call commitment" but was going to seriously consider applying so that she could act as a catalyst in changing the face of supervision. Stella believed in engaging with women during the childbearing process and went to great lengths to spend time with women. Her work colleagues often grumbled about this stating that this was not what being a midwife was about. She commented that her work team has "a lot of sickness…demotivation…not wanting to do anything" and that these midwives had "worked in a particular area for too long". She stated that if midwives did not start "thinking about things different they would be on their own".

APPENDIX 2

INTERVIEW SCHEDULE
(Preliminary interviews)

GUIDANCE NOTES

1. **Introduction**
   Welcome/aim of the interview
   Taping the interview
   Turn off tape at any time

2. Tell me about life as a community midwife

3. What makes you feel positive about the service you offer to women?

4. What makes it difficult working for the NHS?

5. How would you like to see support for midwives being offered?

6. What changes would you like to see?

7. What sort of education have you had to prepare you for change?

INTERVIEW SCHEDULE
FOCUS GROUP 1 – 28.4.98

GUIDANCE NOTES

1. **Introduction**
   Welcome/aim of the group interview.
   Taping the interview as I do not want to miss any of their comments.
   I am there to learn from them.

2. **Groundrules**
   - Only one speaking at a time and speak up.
   - Value each other's contributions.
   - No side conversations with your neighbour or across the table.
   - Everyone to participate if possible.
   - There are no right or wrong answers, just differing points of view

3. **Reflections on their individual interview**
   Get them to name important issues that came up for them and this may mean further discussing their experiences and opinions of the support they receive in practice.

   What's expected of you in the service/what's hard about working for the NHS?

   What does support mean for them?

4. **? Presenting a resolution**
   How do they take care of their own needs?

   Of all the needs that were discussed, which one is most important for you?
   Prioritise those issues presented.

   How far are they prepared to go to get their needs met?

5. **Ending**
   Summarise what has been achieved.
   Discuss meeting again and whether to make date and time.

Examples of questions:

- Suppose you had one minute to talk to _____ on the topic of _____ .
  What would you say?
- One thing I've heard several people mention is _____ . I wonder what the rest of you have to say about that?
- One thing that I am surprised no-one has mentioned is _____ . Does it matter or not?
- I recall that some of you mentioned something a little different earlier, and I wonder how things like _____ fit into the picture?

APPENDIX 4

FOCUS GROUP 2 – 9.11.98

GUIDANCE NOTES

1. **Introduction**
   Welcome/aims of the next focus group.
   Taping the interview.

2. **Groundrules**
   - Only one speaking at a time
   - Value each others' contributions
   - No side conversations with neighbour or across the table
   - Everyone to participate if possible
   - There are no right or wrong answers, just differing points of view

3. Where are we now?
   They've had time to reflect on research to date and Dawn's sessions.
   What now?
   How are they feeling?
   Movement within the sample.
   What are their priorities and needs? This will affect the model of clinical supervision devised.

4. **The resolution**
   Models of clinical supervision, discuss differing approaches.
   Deery & Corby (1996), Bond &Holland (1998) suggest 7 conditions need to apply in order to develop an effective relationship in clinical supervision.

   - Frequent sessions e.g. monthly.
   - Individual 'air time' e.g. one hour.
   - Continuity of supervisor or group.
   - Mutually negotiated contract; including confidentiality
   - Training: supervisee, clinical supervisor skills, group skills.
   - Some choice of supervisor and supervisee.
   - Choice of mode.

5. Main principles from Kohner (1994), the UKCC (1996) and Swain (1995) developed by Bond & Holland (1998) into a practical six stage framework for setting up clinical supervision.
   - Information sharing
   - Skills training
   - Decision about mode
   - Pilot
   - Evaluate, redesign
   - Establish, monitor

Consider the advantages and disadvantages of one-to-one clinical supervision versus group supervision. Should the potential clinical supervisors be part of this planning? Outside facilitator or peer group facilitator?

6. Possible records of clinical supervision.

7. **Ending**
   Summarise what has been achieved.
   Discuss meeting again.

APPENDIX 5

<div align="center">

**INTERVIEW SCHEDULE
(FINAL INTERVIEWS)**

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GUIDANCE NOTES

1. **Introduction**
   Welcome/aim of the interview
   Taping the interview
   Turn off tape at any time

2. How have you been……?

3. Tell me about clinical supervision and how it worked?

4. Did it meet your expectations?

5. Tell me what has been good about it.

6. Tell me what has not been as good.

7. Tell me about what you have learned from the experience.

8. How do you think it fits to midwifery practice?

9. Is it suited?

10. What sort of forum has it provided for you?

11. What have you been able to do in clinical supervision that you would not normally do?

12. Is there any difference between the way things are now within the work team, to what the y were before?

13. What has clinical supervision offered you that is currently not available for you within the NHS?

14. Can you tell me about one significant incident from your clinical supervision which you have found to be helpful or unhelpful or something that sticks in your mind?

15. Do you think that we achieved what we set out to do?