

**ENGAGING WITH CLINICAL SUPERVISION IN A COMMUNITY  
MIDWIFERY SETTING**

**AN ACTION RESEARCH STUDY**

**VOLUME 2**

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## 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 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 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<sup>66</sup> 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':

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<sup>66</sup> There was also a reported national recruitment and retention crisis within nursing and midwifery at this time (RCM, 2000; Ball et al. 2002).

*...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). 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 (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<sup>67</sup>. 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*

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<sup>67</sup> 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.



*[...]...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)*

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<sup>68</sup> 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 other. Data analysis has also involved revisiting aspects of engagement and detachment that were explored in Chapter 3.

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<sup>68</sup> 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.

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<sup>69</sup> for the audience<sup>70</sup>. This demands a convincing performance or

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<sup>69</sup> 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.

<sup>70</sup> 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).



“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.

**Table 4: Summary of the ‘spectrum of performances’ (as described in the preliminary interviews)**

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<sup>71</sup>. 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 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

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<sup>71</sup> 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”.

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)

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:

*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 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<sup>72</sup> 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 work load. She implied that some work team members needed

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<sup>72</sup> 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.

“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:

*...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 & Shoheit (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
<ul style="list-style-type: none"> <li>• Midwives are able to balance their relationships with clients. These are lasting and valued.</li> <li>• Midwives behave autonomously and are able to think independently.</li> <li>• Midwives value spending time with clients and understand continuity of carer. They actively seek and identify client's needs and invite feedback from clients.</li> <li>• Midwives enjoy the complexity of midwifery and thrive on stimulation, challenge and change. They also value emotion work.</li> <li>• Midwives are intellectually challenged by their work and are able to use their midwifery knowledge and practical skills together.</li> <li>• Midwives are able to re-balance their relationships in order to sustain positive emotional engagement.</li> <li>• Midwives experience their work and their colleagues as a source of energy.</li> </ul>	<ul style="list-style-type: none"> <li>• Midwives relationships with clients are fragmented and experienced as "psychologically draining" and stressful.</li> <li>• In the absence of autonomy midwives become subversive and obedient.</li> <li>• 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.</li> <li>• Midwives use their professional power rather than communication skills to set the parameters of the relationship and they become detached from their clients.</li> <li>• Midwives feel "wrung out", "drained", "empty" and like "wet rags" and are unable to use their midwifery knowledge and practical skills together.</li> <li>• Midwives feel a need to be needed and their emotional capacity becomes untenable.</li> <li>• Midwives experience their work and their colleagues as a one-way draining of emotional energy.</li> </ul>



**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<sup>73</sup> 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 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

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<sup>73</sup> 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).

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<sup>74</sup> 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...*

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?*

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<sup>74</sup> See Appendix 3 for proposed plan of focus group.



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 as 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<sup>75</sup>:

*...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:

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<sup>75</sup> Jane's words support dilemmas around the word 'supervision' that were highlighted in Chapter 4.

*...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 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<sup>76</sup>.

### **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:

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<sup>76</sup>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).



*... 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 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<sup>77</sup> 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

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<sup>77</sup> 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.

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:

*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 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<sup>78</sup>. 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:

*...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)

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<sup>78</sup> 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).

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 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<sup>79</sup> showed me a flier produced by the West Yorkshire Education and Training Consortium<sup>80</sup>. 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.

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.

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<sup>79</sup> 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.

<sup>80</sup> 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.



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:

*...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 where 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<sup>81</sup>.

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 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:

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<sup>81</sup> The proverb "cutting off your nose to spite your face" comes to mind here.



*...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:

*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.

### Different ways of acknowledging endings

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 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).

### **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 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 & Shoheit, 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 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

Grace Nichols 1985

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<sup>82</sup>. 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.

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<sup>82</sup> 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).



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 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<sup>63</sup>. 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 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

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<sup>63</sup> As was seen in Chapter 5, page 157 Holian found this to be the case when undertaking action research in her work setting.

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

### Description of the midwives

**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". 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 and 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?

## APPENDIX 3

### 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

### INTERVIEW SCHEDULE (FINAL INTERVIEWS)

#### 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 they 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?