

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

**AN ACTION RESEARCH STUDY**

**VOLUME 1**

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of Philosophy**

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## ABSTRACT

The main aim of this research study was to explore midwives' views and experiences of their support needs in clinical practice and then to identify how they would wish to receive such support. There was much literature to support the existence of stress and burnout in midwifery but no research that addressed ways of alleviating this. Further aims were to redress that imbalance by planning and facilitating a model of clinical supervision devised by the participating midwives.

The study took an action research approach that involved working with a group of eight National Health Service (NHS) community midwives in a collaborative, non-hierarchical and democratic way in order to achieve change. This accorded with a woman-centred approach to working with clients that was being encouraged within midwifery. The midwives were typical of many community-based midwives in the United Kingdom (UK) who were working in increasingly stressful, complex and changing environments.

Wider organisational and cultural issues are considered that affect working relationships. The nature of the way the midwives worked when they were offered and received support, and how they reacted and coped when their work team and work situation was threatened, was also explored.

Each midwife was interviewed twice; before and after the experience of clinical supervision. They also participated in two focus groups before clinical supervision. In-depth individual interviews lasted up to two hours, as did the focus groups. The interviews and the focus groups were taped, transcribed and then analysed using a relational voice-centred methodology.

The main findings were that recent and ongoing change plus the organisational demands placed on the midwives by the NHS and their managers were detrimental to working relationships with their colleagues and clients. This also inhibited the process of change. A discourse of denigration became apparent within the interviews and the midwives behaviour and coping strategies revealed some well developed defence mechanisms, as well as an apparent lack of understanding on their part and that of their midwifery managers in relation to emotion work. Resistance to change was a key defence mechanism used by the midwives.

Strong messages emerge about certain 'performances' being available to midwives and the use of defence mechanisms as a way of 'getting the work done'. There are also messages about the cultural legacy of midwifery and how this can inhibit autonomous behaviour by midwives. Developing and increasing self awareness is still not viewed as being intrinsic to the work of the midwife and midwives are being asked to undertake a level of work that they have not been adequately prepared for. Neither do there appear to be effective role models for midwives. The bureaucratic pressures of working in a large maternity unit are also addressed where the system is seen as more important than the midwives.

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## CHAPTER ONE

### Introduction

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

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

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



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

### The need for the study

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

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

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

<sup>2</sup> My feminist principles are addressed later in this chapter.

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

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

### **Aims of the study**

This research aimed to:

1. Explore midwives' views and experiences of the support they currently receive in practice.
2. Identify how midwives would wish to receive support.
3. Facilitate the teaching of midwives in order to help them draw up plans to introduce appropriate change. This would include the provision of information from the literature which midwives have identified they need.

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



4. Use an action research approach to plan programmes of action and introduce change in order to enhance the support available to midwives.
5. Plan a model of clinical supervision with the midwives for utilisation in midwifery practice.
6. Implement, test and develop the proposed model of clinical supervision with the participating midwives.
7. Evaluate in an on-going and frequently reviewed manner, at all stages of the research, and also to evaluate the impact that the new model of clinical supervision has on midwifery work.

### Setting the scene

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

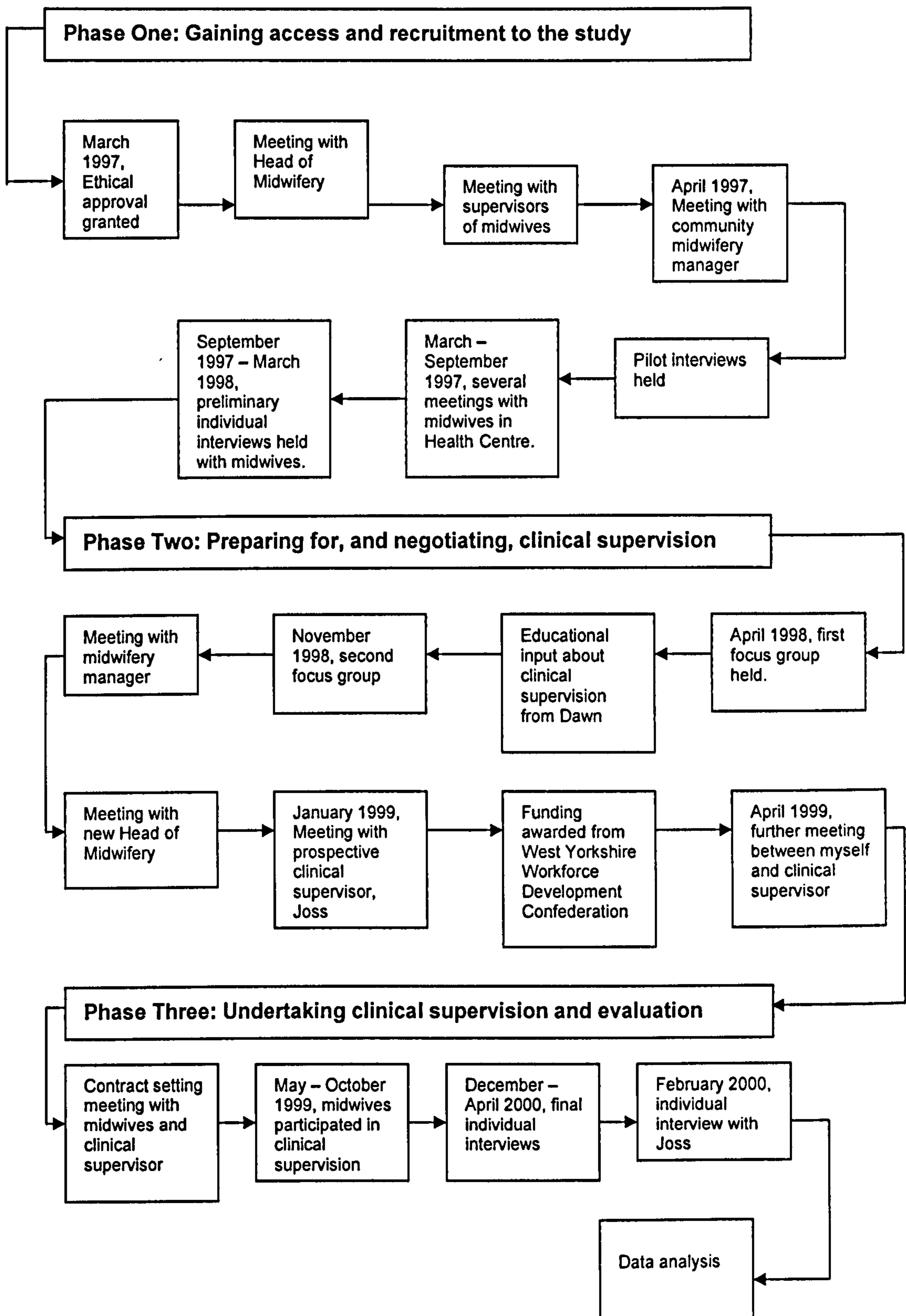
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<sup>4</sup> Community-based midwives practice midwifery in a community setting and usually provide care for women before and after the birth of their baby. Some community-based midwives update their skills in helping women to birth their babies by working on the delivery suite for one week or more every few months.

<sup>5</sup> A description of each midwife is provided in Appendix 1.

<sup>6</sup> In order to facilitate reading of the thesis I refer to the team in which the midwives worked on a daily basis as “the work team”. As will be seen in Chapter 10, “the group” is that in which the midwives experienced their planned support mechanism. The membership of these ‘groups’ was the same, except for new members to the work team, who the participating midwives chose to exclude from their planned support mechanism.

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



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

### Key theoretical issues

#### **Feminist theory**

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

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

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

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<sup>7</sup> I discuss the use of personal history in research more fully in Chapter 6.



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

### **Humanistic psychology**

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

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

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

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

### **Counselling theory**

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

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

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

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

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

### **Group work theory**

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



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

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

### **Psychotherapeutic theory**

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

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<sup>8</sup> The concept of uncertainty is addressed more fully in Chapter 4.

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

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

### **Sociological theory**

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

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



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

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

### Transforming the local maternity services

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

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

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

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

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

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

### Glendale work team

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

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

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

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

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

### Dawn's influence on my study

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

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

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<sup>11</sup> Becoming GP attached meant that maternity care would be offered to women that involved GPs and midwives working collaboratively. Care under these circumstances takes place in the GP's practice, and postnatally in the woman's home.

<sup>12</sup> The English National Board (ENB) was responsible for ensuring that standards of clinical practice were met and were also responsible for providing educational courses for midwives as well as courses of preparation for supervisors of midwives. The Board was superseded by the Nurses and Midwives Council (NMC) in April 2002.



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

### Joss' influence on my study

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

### The organisation of the thesis

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

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

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

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

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

## CHAPTER TWO

### Voices and Issues from past and present midwifery

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

From Miller Mair, 1989

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



## The move from 'disordered' to 'ordered' practice

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

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

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<sup>13</sup> Lay midwives were working class midwives who attended working class childbearing women. Their lack of formal training meant that midwifery reformers felt they were unfit to attend women in childbirth. According to (Heagerty, 1996) it was "lay midwives, working in every village, neighbourhood and town, who attended the majority of births at the turn of the century as safely...as the average general practitioner at the time and under certain conditions even more so" (p.15).

<sup>14</sup> Currently there is a resurgence of interest in the public health role of the midwife. 'New public health' (Harlem Brundtland, 1999) encompasses the old concept of public health involving health hazards in the environment with current thinking around lifestyle and behaviour change. There is a much greater emphasis on the socio-economic environment and the impact of poverty and health inequalities (Kaufmann, 2002). Sure Start midwives (DOH, 1999a) are now working in areas of deprivation across the country to provide midwifery care for disadvantaged or isolated mothers and their families.

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

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

#### **Achieving professional status or a means to control practice?**

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

## **Dominant doctors and 'disabled' midwives**

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

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



### Statutory compliance: 'supervising' or 'policing' midwifery work?

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

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

The deliberations of this working party probably provided the impetus for the United Kingdom Central Council (UKCC)<sup>19</sup> to suggest radical change to the education of supervisors of midwives who are now required to have completed appropriate education before they take on the role (UKCC, 1994). As will be seen in Chapter 4, the idea that a supervisor can be a friend and counsellor one day and investigate a midwife's practice the next day remains contentious (Stapleton et al. 1998, Deery,

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<sup>19</sup> The United Kingdom Central Council for Nursing and Midwifery (UKCC) was set up in 1983 and replaced the General Nursing Council and Central Midwives Board. The UKCC claimed to represent and regulate midwifery although Tew (1998) argued that subsuming midwifery with nursing made midwifery a subsection of a much larger nursing profession exchanging control by doctors for control by nurses (Sargent, 2002).



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

### **Medicalisation of childbirth**

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

### **Who knows?**

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

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<sup>16</sup> As will be seen in Chapter 5 there are comparisons here with an action research approach.

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

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

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

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

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

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

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

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



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

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

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

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



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

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

### **The subjugation of midwifery knowledge**

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

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

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

### **Invisible midwifery expertise and invisible women**

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

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

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<sup>18</sup> As will be seen in the following chapter, page 69, this has resulted in the gendering of work, especially caring work being viewed as women's work.

<sup>19</sup> The proverb "do as I say not as I do" comes to mind here.

<sup>20</sup> I analyse the concept of caring more fully in the following chapter.

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

### Technological surveillance and intervention

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

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

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



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

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

### **Adapting to, and changing ways of working**

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



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

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

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

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

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

### **The effects of changing approaches to care**

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

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

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

### **The impact of changing work patterns on the midwifery workforce**

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

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

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<sup>21</sup> As will be seen in Chapter 4, I argue how action research is one way of encouraging collaboration and partnership with clients, peers and managers.

<sup>22</sup> The concept of burnout is addressed further in Chapter 8.



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

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



## CHAPTER THREE

### Change, culture, 'caring' and relationships

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

#### Part 1: Culture and change in the NHS

##### The culture of midwifery in the NHS

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

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

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

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

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

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

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

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

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

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

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

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

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

### **The context of change in the NHS**

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

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<sup>25</sup> As will be seen later in this chapter health care practitioners use different types of detachment as coping strategies in their work.



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

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

## Differing approaches to change

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

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

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

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

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

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

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



## **Sowing the seeds of change**

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

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

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



## Culture as a key influence on change

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

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

Schein (1992) has defined culture as:

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

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

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

### **Midwives as obedient technicians**

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

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

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

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

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



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

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

### Change managing midwives

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

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



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

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

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

## **Detachment as a monitoring process**

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

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

### **'Militating organisational imperatives'**

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

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

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



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

**Key points emerging:**

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



## Part 2: The midwife-mother relationship

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

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

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

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<sup>27</sup> The importance of attachment theory, and implications for those working in groups, was also brought to my attention during the Group Work Course that I undertook.

<sup>28</sup> Midwives working in the NHS can be hospital or community-based. Some NHS Trusts have now instigated midwife-led units and birth centres. Some midwives also practise independently.

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

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

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

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

### First relationship crucial to subsequent relationships

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

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

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



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

### **Providing a holding environment**

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

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



## Providing a secure base

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

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

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

## Community-based work as a refuge

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

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

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

### The slipperiness of 'care' .....

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

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

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



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

#### **...makes caring complex**

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

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

### The balancing act....becoming emotionally involved

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

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

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

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

### **Staying connected despite differences**

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

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



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

### **Reciprocity: mutual aims and aspirations**

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

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

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<sup>30</sup> As will be seen in Chapter 4, being accepting of each others' different values is important in the work setting.

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

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

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

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

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

### **Mediating between 'connectedness' and 'detachment'**

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

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



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

### **Picking the right balance**

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

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

### **Different levels of engagement**

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

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

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

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

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

(Carmack, 1997, p.142)

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

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



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

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

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

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

### **Women as 'natural carers'**

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

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

### The sentimental order of midwifery

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

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



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

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

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

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

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

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

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

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

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

#### **Identity work – attending to nurturance, growth and healing**

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



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

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

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

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

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

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

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

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

#### **Therapeutic midwifery: being a 'skilled companion'**

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

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

### **Midwives as ‘gravy’**

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

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



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

#### **The consequences of partnership....devolving power**

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

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<sup>32</sup> There are parallels here with the interviewing process that I discuss in Chapter 5.

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

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

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

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

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

#### **Key points emerging:**

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

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

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



## CHAPTER FOUR

### Clinical supervision – a potential source of support

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

from Miller Mair 1989

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

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

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

### Strengthening or 'policing' clinical practice?

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

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

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

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

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

### Learning lessons from other professions

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

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



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

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

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

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



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

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

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

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

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

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

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

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

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

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



### 'Big sister is watching you': supervision of midwives

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

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

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



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

### **The two hats – contradictions in midwifery supervision**

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

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

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

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

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

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

### **Challenging midwifery supervision**

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

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

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

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

### The nature and range of clinical supervision

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

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



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

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

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

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



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

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

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

### 'Doing' clinical supervision

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

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

### **Individual supervision**

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

### **Group supervision**

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

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

### **Peer supervision**

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



## **Frameworks for clinical supervision**

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

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

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

## **The focus of clinical supervision**

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

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

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

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

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

**TABLE 1: SCHOOLS OF PSYCHOTHERAPY OR COUNSELLING AS APPLIED TO CLINICAL SUPERVISION**

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

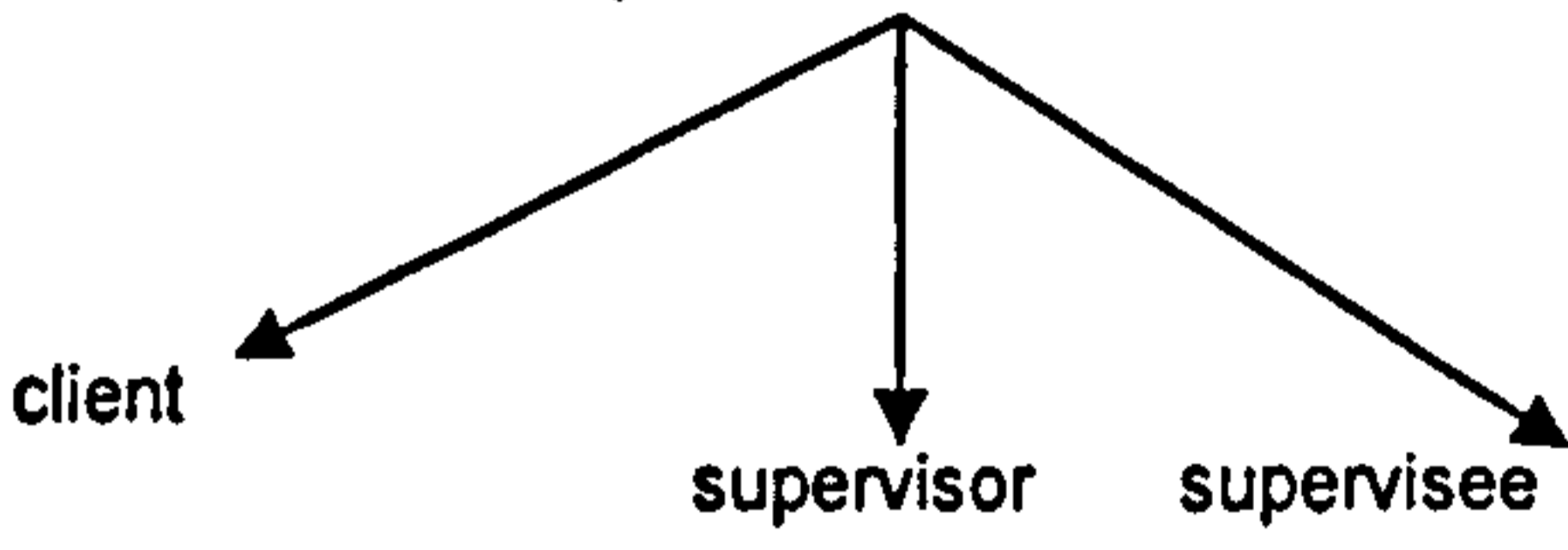
Clearly then, clinical supervision is not a singular concept and the 'model' initially chosen by the supervisor will depend on the school of counselling or psychotherapy to which the supervisor subscribes (Farrington, 1995). Whilst this is an important area within clinical supervision, Farrington (1995)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

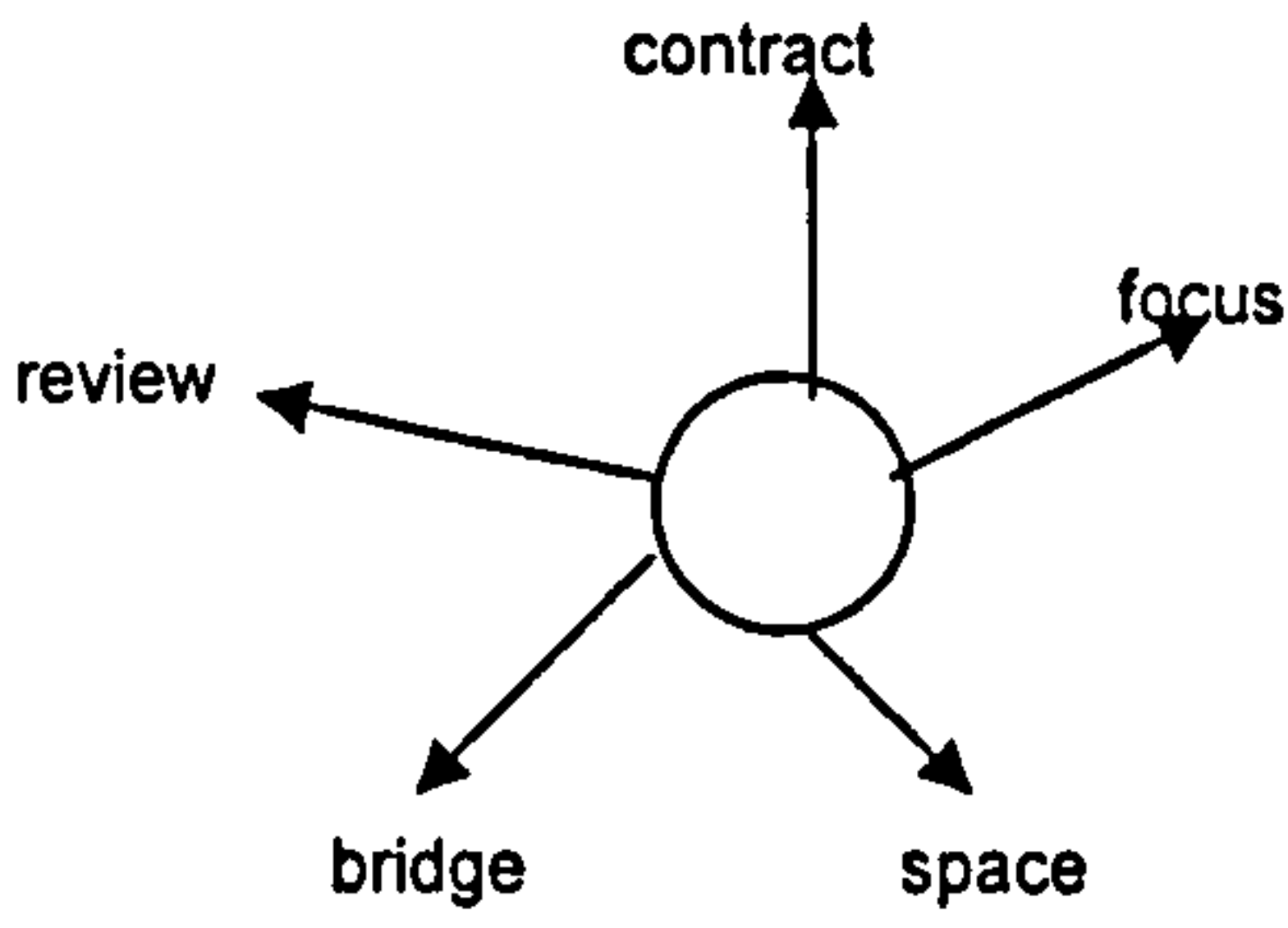
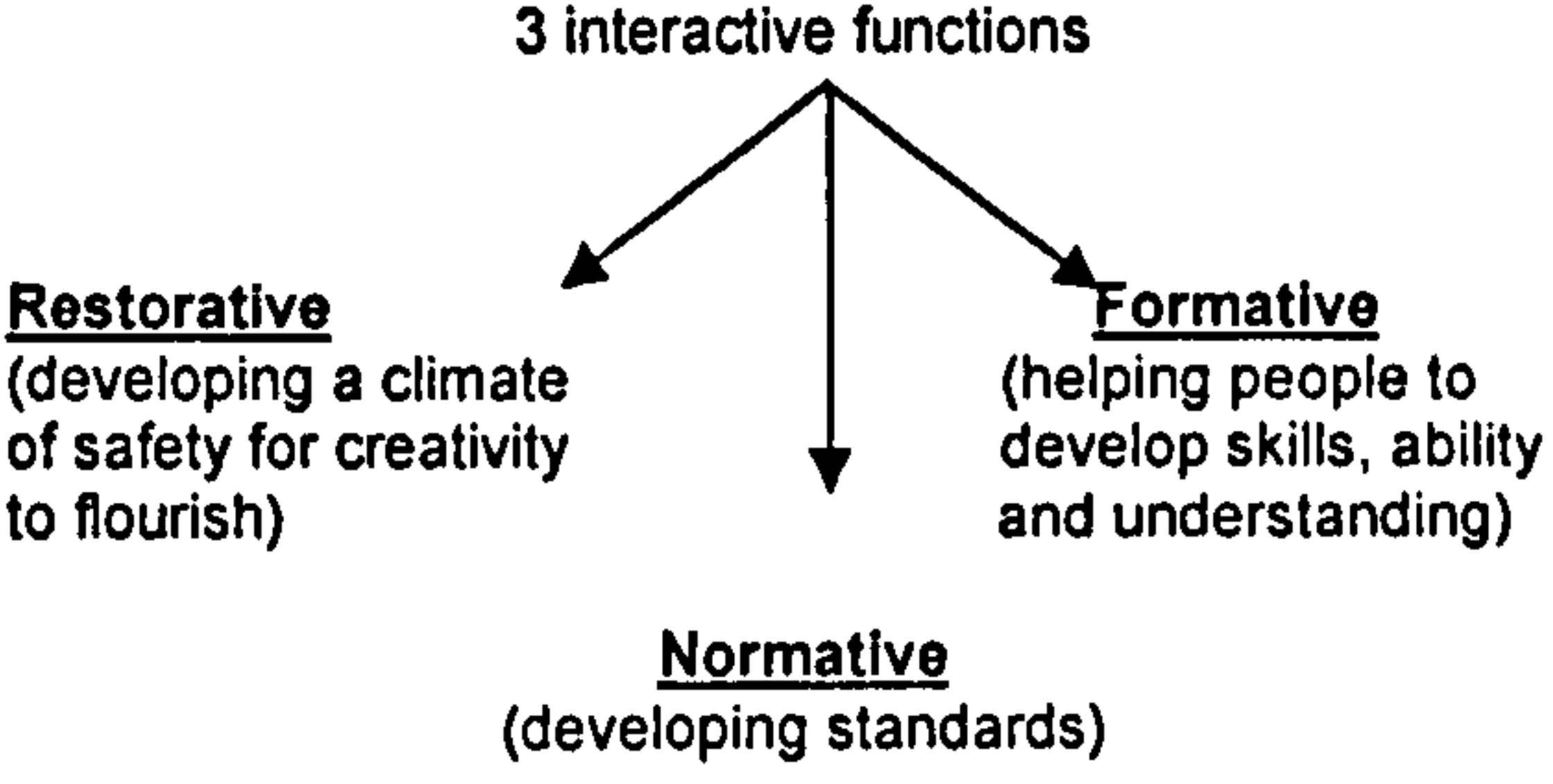


working although the models presented in Table 2 are often the ones currently employed in practice.

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

**TABLE 2: MODELS OF CLINICAL SUPERVISION**

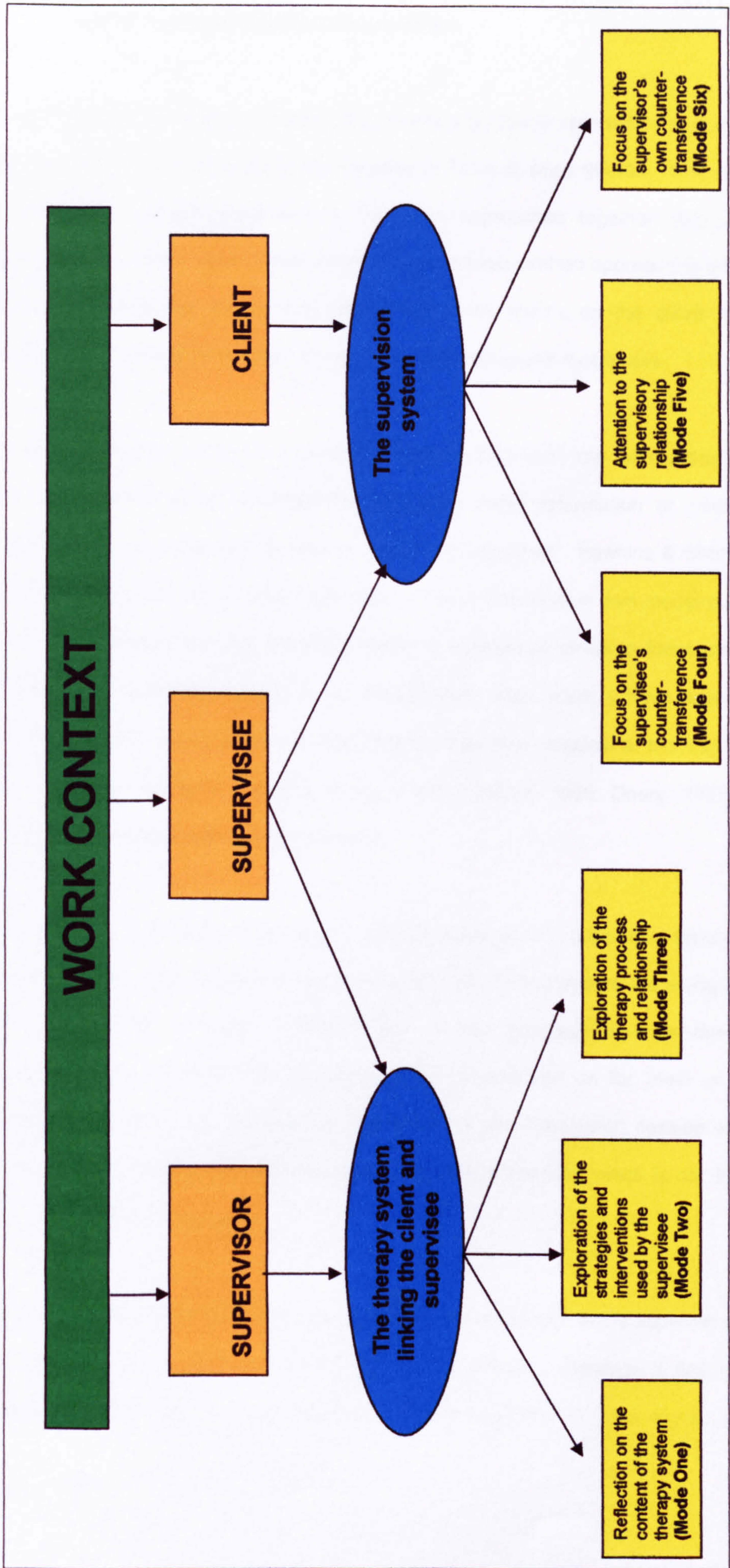
MODEL	FEATURES
Hunt (1986)	<p>Supervision styles are divided into 3 types;</p> <p>Case-centred approach which involves a discussion of the case 'out there'.</p> <p>Therapist centred approach that focuses on the behaviour, feelings and processes of the therapist.</p> <p>Interactive approach which focuses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

<p>Cyclical Model of Counsellor Supervision (Page &amp; Wosket, 1994)</p>	
<p>Growth and Support Model (Faugier, 1998)</p>	<p>Provides characteristics of the supervisory relationship that are seen as essential to good clinical supervision practice.</p>
<p>Interactive model (Proctor, 1991)</p>	
<p>Guided reflection (Johns, 1993, 1995)</p>	<p>Challenges, supports and helps the practitioner to unpack their practice. It differs from Proctor's model in that the emphasis is on enabling the practitioner to be 'caring' as a pre-requisite to achieving 'desirable work'</p>
<p>Six-category intervention analysis<sup>36</sup> (Heron, 1991)</p>	<p>6 styles of intervention (prescriptive, informative, confrontative, facilitative, cathartic, catalytic and supportive) are divided into 2 key areas; <b>Authoritative and Facilitative.</b></p>
<p>Problem-orientated supervision (Rogers &amp; Topping-Morris, 1997)</p>	<p>Addresses two main areas:</p> <ol style="list-style-type: none"> <li>1. problems the supervisee is having with the nurse-client relationship</li> <li>2. organisational difficulties.</li> </ol> <p>The main tools used are problem-solving strategies, for example defining the problem and brainstorming solutions.</p>
<p>Practice-centred, six-stage supervision cycle (Nicklin, 1997)</p>	<ol style="list-style-type: none"> <li>1. Objective practice analysis</li> <li>2. Problem identification</li> <li>3. Setting</li> <li>4. Planning</li> <li>5. Implementation</li> <li>6. Evaluation</li> </ol>

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



FIGURE 2: HAWKINS & SHOHEIT'S (1989) DOUBLE MATRIX MODEL OF SUPERVISION



Derived from: Hawkins, P. & Shohet, R. (1989) *Supervision in the Helping Professions*, Open University Press, Buckingham.



### Hunt's three approaches to supervision

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

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

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

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

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

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

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

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

*For the therapy system:*

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

*For the supervision system:*

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

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

### **Triadic model of supervision**

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



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

### **Six Category Intervention Analysis**

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

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

#### Authoritative

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

#### Facilitative

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

Interestingly the authoritative and facilitative interventions identified by Heron (1991) mirror the dilemmas posed for midwives within their work in that almost all care given by midwives appears prescribed or medically defined by doctors. In terms of facilitating care for clients problems arise because midwives are required to use skills that they have not had the opportunity to develop themselves

(Kirkham, 2000). As was seen in Chapter 2, midwives also seem to prefer to prescribe care for clients through the development of hierarchical relationships and the use of professional power, although this way of working mirrors the relationships to which midwives have always been exposed as well as a task-based approach to care. However, the facilitative aspect of Heron's model could go some way towards addressing this deficit in midwifery as words such as 'cathartic', 'catalytic' and 'supportive' lend themselves well to engaging emotionally with clients. Facilitating an approach to clinical supervision such as this in midwifery would require time and patience on the part of the supervisor and supervisee.

### **Cyclical Model of Counsellor Supervision**

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

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

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

supervision process rather than being static. Change is considered as fundamental both within the supervision process and within clinical practice. This model would be difficult to facilitate in midwifery because there is likely to be prolonged concentration on clinical material and self development which again some midwives have not been adequately prepared for. However the 'space' stage of this model might provide the time necessary to concentrate on these issues.

### **Growth and Support Model**

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

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



## Guided reflection or 'professional narcissism'

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

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

Gilmore (1999) supports this viewpoint stating that this model of structured reflection provides a guide for supervisees when they are preparing issues for discussion within supervision sessions. Rolfe et al. (2001) point out that clinical supervision should not be dominated by the use of a reflective model; rather clinical supervision involves critical reflection by the supervisee and the supervisor. Binnie & Titchen (1995) support this further by stating the tasks and functions of clinical supervision are inextricably linked to the development of critical reflection but stress that clinical supervision is a formalised structure in which reflection on clinical practice takes place. However, Fowler & Chevannes (1998) suggest that the use of reflection in clinical supervision is inappropriate for less experienced

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

practitioners because they may feel that they have a lack of clinical experience and knowledge upon which to draw in order to make sense of complex clinical practice issues. This then implies that the clinical supervisor must be from the same professional background as the supervisee rather than possessing the necessary skills to reflect on clinical practice constructively.

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

### **Interactive Model**

The interactive model (Proctor, 1991) is one of the most widely used and referred to models for supervision. This model has three facets, namely the normative, formative and restorative functions. The normative aspect of the model is concerned with maintaining standards of practice and quality control. The supervisor would ensure that the needs of the client are being met within a clearly defined framework of ethical and professional practice (UKCC, 1998). However when midwifery work is clearly defined in this manner (usually by guidelines and protocols) midwives cannot "see through and beyond the accepted ways of seeing and thinking" (Kirkham, 1997, p.259). As was seen in Chapter 2, and will be seen further in Chapter 5, midwifery work is complex and can be unpredictable involving "processes which are subtle and difficult to articulate" (Taylor, 2001, p.7). Therefore the normative aspect of Proctor's model creates a sense of

"[s]upervision and control [that] provide guidance toward bureaucratic goals" (Lipsky, 1980, p.40).

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

In theory, Proctor's model of supervision appears to address the necessary components of clinical practice in order to develop effective relationships with each other and clients. However, this model seems idealistic and does not mirror the current climate of change and disruption within the NHS. Like Faugier's model it is ill fitting and does not mirror the state of nursing and midwifery at this moment in time. Clinical supervision is aimed at the personal and professional development of individual practitioners. However the aims of the NHS as an organisation clash with this approach being more orientated towards "resource management – efficiency, productivity, and goal clarification" (Lipsky, 1980, p.125) highlighting a fundamental contradiction underpinning the NHS as an organisation. The normative aspect of this model also has aspects that are similar to the current model of midwifery supervision in that midwives may have to share elements of clinical practice with their supervisor that require investigation. They are then expected to utilise this same supervisor for support, counselling and friendship



which poses tensions and dilemmas for midwives (Deery & Corby, 1996; Stapleton et al. 1998).

### **Nicklin's six-stage supervision cycle**

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

Once this first stage has been analysed, problem areas are then clarified and objectives set to confirm "the expectations, obligations and aspirations of the organization, patients, the profession and the individual practitioner" (Nicklin, 1997). However, as was seen in Chapter 3, the values of the organisation often contradict the values held by grass root workers (Lipsky, 1980). This would make a realistic action plan, implementation of the agreed plan and evaluation of the outcome almost impossible within a midwifery setting where there was a clash of values between the organisation, managers and workers. Realistically therefore, this six-stage supervision cycle would only be feasible in "a street-level bureaucracy that has developed processes of staff growth and development...for small group decision making...making the most of the reality that street-level bureaucrats primarily determine policy implementation, not their superiors" (Lipsky, 1980, p.207).

### **Problem orientated supervision**

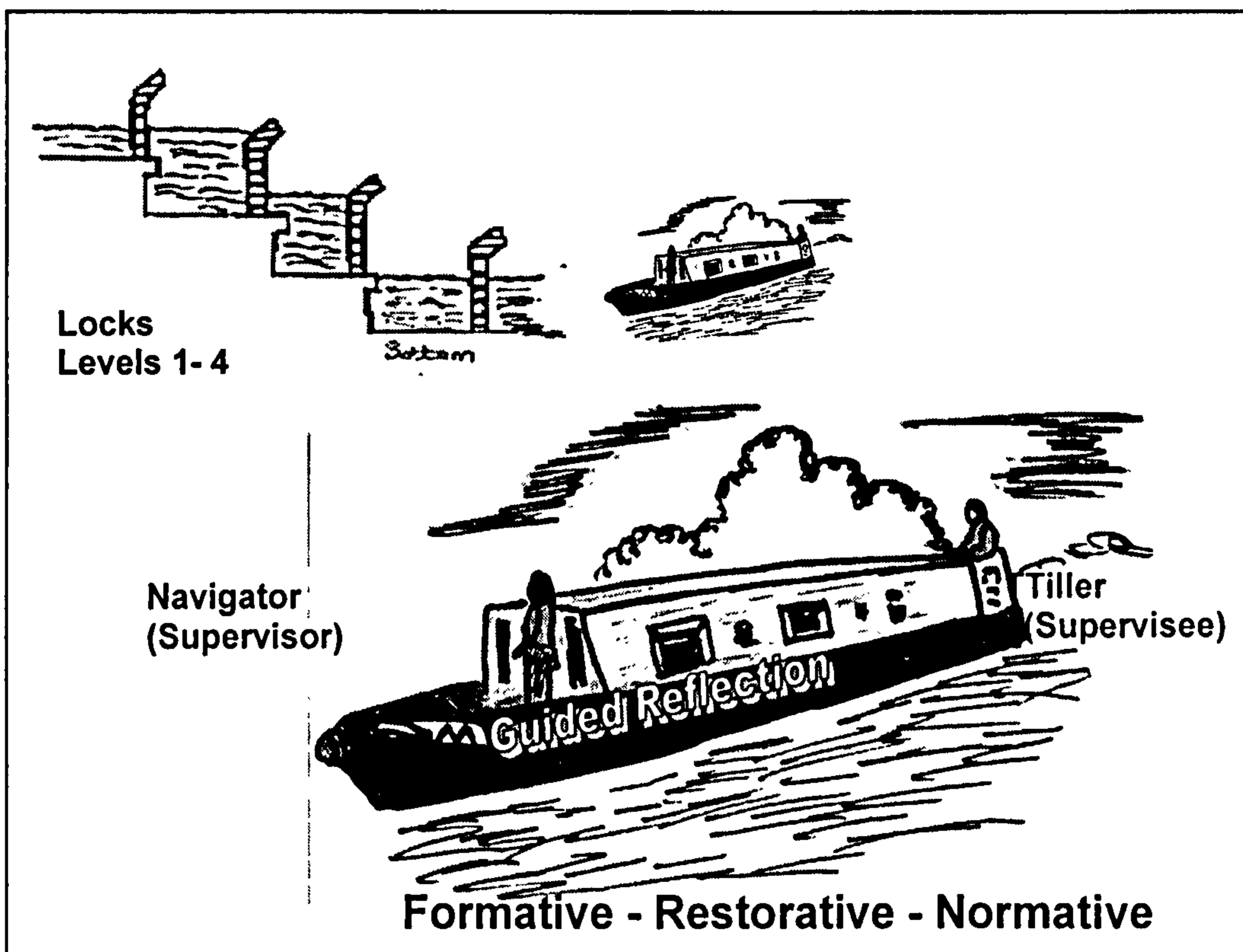
Similar difficulties identified above, in the six-stage supervision model (Nicklin, 1997), would also be encountered in the problem orientated supervision model proposed by Rogers & Topping-Morris (1997, p.14). Once again the focus is on working relationships (particularly interpersonal conflict) and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

### **A hybrid model of clinical supervision**

The clinical supervisor in this study drew on her own model of clinical supervision which is depicted (by Joss) in Figure 3, page 113.

This hybrid model of clinical supervision draws on and combines three different models of clinical supervision; Proctor's interactive model, Hawkins & Shohet's (1989) double matrix model and Johns (1993) guided reflection. Faugier's (1998) developmental model of the characteristics of a 'good supervisor' was also drawn on by Joss as a way of helping to keep her focused. The model devised by Hawkins & Shohet (1989) was only used in a clinical supervision session by Joss if found to be necessary and was not drawn on with the midwives participating in this study.

**Figure 3: Hybrid Model of Clinical Supervision**



This interaction model of clinical supervision views the processes within supervision as a journey in which the supervisor and the supervisee travel together. This journey was conceptualised and described by Joss as taking place on a canal. The journey has a navigator (the supervisor) whose role involves navigating through the twists and turns, problems and diversions. The navigator has to keep the boat on the canal, in good enough waters and ensures that any problems ahead are spotted and the correct actions taken. This process mirrors aspects of the supervisory relationship.

The depth of the water in the canal can vary as well as in width and can be interspersed with many challenges such as locks, swing bridges, fishermen, aqueducts, via ducts, other narrow boats. There are specific 'passing places', turning places, and stopping or mooring places. The ground rules are very clear as



in any supervisory relationship that has had a contract set at the outset. The navigator of the boat has to traverse the canal so as to keep the boat, the crew and the passengers safe.

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

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

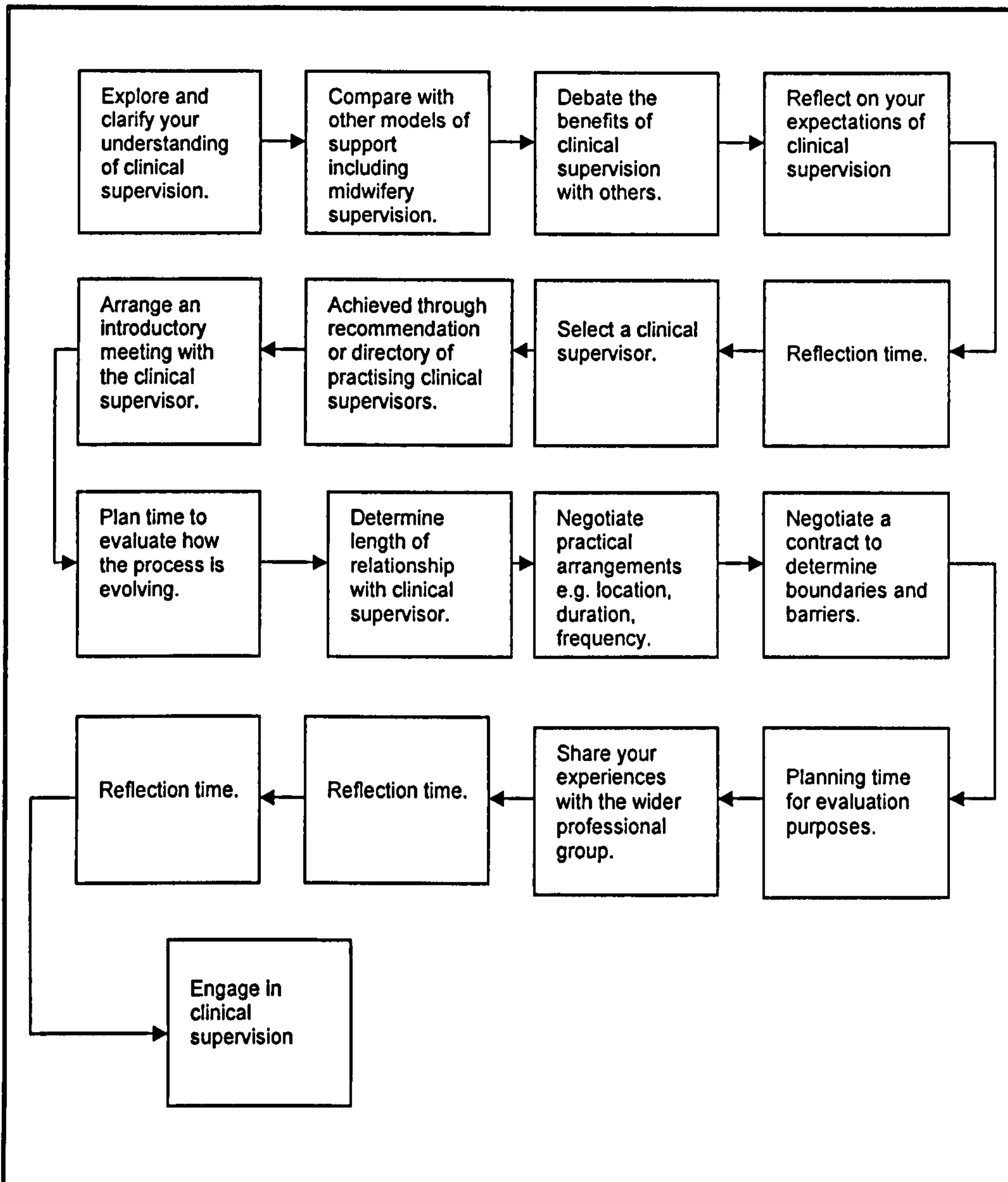
No journey is ever the same or straight and the locks are seen as a necessary challenge to navigate in order to move up and down hills. Some locks are single, some are in pairs and others are in sets as depicted in Figure 3. Some are set

apart with only a distance of half a mile and others are set apart by one or two miles. This illustrates the uniqueness of each clinical supervision session and how supervisees will reach different points of learning within their sessions. Joss believed that the process of learning, reassessment of that learning and the skills they possess is a never ending process and that supervisees will travel up and down the locks of continuing professional development.

### **Practical route to successful clinical supervision**

Several practical routes for clinical supervision are offered in the literature (Bond & Holland, 1998; Faugier, 1998; Bishop, 1998; Wilkins, 1998). It is not my intention to exhaust these within the thesis as individual supervisees and clinical supervisors will select the route that suits them best. However I have previously devised a practical route to obtaining successful and effective clinical supervision for midwives (Deery & Corby, 1996, p.205) and although not drawn on by Joss in this study, aspects of the process used by Joss are similar to the route I have devised. Figure 4, on page 116, represents the route derived from earlier suggestions.

**Figure 4: The route to successful and effective clinical supervision**



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

### Key points emerging

There are many different models of clinical supervision to be found within the nursing literature. Given the diversity of nursing practice, this should probably come as no surprise, as the availability of numerous models provides practitioners with the opportunity to choose their preferred approach. However, in its eagerness to adopt the concept of clinical supervision, nursing may have misconceived its original intention. When the usefulness of clinical supervision was highlighted



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

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

## CHAPTER FIVE

### Action research: opening new dialogues for enquiry

No academic solution  
is satisfactory  
It has to be  
a lived posture

That's why  
I can't get away  
with saying one thing  
and doing another  
or with preaching  
and not practising

Everything has somehow  
to exemplify  
and be itself

from Miller Mair 1989

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

## The beginnings.....action research in the making

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

During the 1950s Lewin's ideas about social and educational issues were influential in the USA especially with regard to action research. Lewin's view was that social science should be able to improve conditions for people. However after a decade of growth Lewin's ideas fell into decline in America and "a hegemonic emphasis on knowledge that is externally obtained" (Davis-Floyd & Davies, 1997, p.145) became evident with positivist approaches to research taking precedence (McNiff, 1988). According to Carr & Kemmis (1986) this resulted in the separation of research and action and theory and practice. However with the help of Lawrence Stenhouse action research in the UK continued to grow and develop, especially in education and the teaching profession (McNiff, 2002).

In 1988, McNiff traced action research in teacher education and in later work she identified key action research theorists (McNiff, 2002). Both Somekh (1994) and McNiff (2002) agree that John Elliot, an educationalist, had an influence on Stenhouse's (1975) thinking around curriculum development within the teaching



profession. Kemmis & McTaggart (1988) encouraged use of the term 'educational action research' because they wanted to understand "the social and politically constructed nature of educational practice" (McNiff, 2002, p.45). They were influenced by the origins of Kurt Lewin's work as well as Lawrence Stenhouse's work on curriculum development. The work of Kemmis & McTaggart (1988) also demonstrates the influence of critical social science and the belief that research methodologies during the 1930s did not recognise "the historical, cultural and social situatedness of researchers" (McNiff, 2002, p.33).

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

### Valuing process and outcomes

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

believe that this action research study was unique and individual and did not subscribe to a pre-ordained formula.

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

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

### **Contextualising 'real world practice'**

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

research. My interpretation is that action researchers carry out research on their own professional job and refer to this as 'practice' in their reports of action research.

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

### **Defining action research**

Action research is now reported globally. It is carried out in a variety of contexts and has moved beyond the teaching profession where it developed (McNiff, 1988) to include many other professions, including nursing (e.g. Meyer, 1993; Coghlan & Casey, 2001; Binnie & Titchen, 2002; Waterman, Tillen, Dickson & de Koning, 2001) and midwifery (e.g. Fraser, 2000; Munro, Ford, Scott, Furnival, Andrews & Grayson, 2002). Although action research is now employed in many health care settings in the UK "its scope and role in this context is not clear" (Waterman et al. 2001, p.iii) and it continues to be utilised under a variety of names. This has meant that many varieties of action research have been developed and these can all be interpreted in different ways usually according to the varying perspectives of those undertaking the action research. In the early stages of planning this action research study these varying perspectives caused a great deal of confusion as I grappled with the different types of action research emerging within the literature.



This was further complicated by a paucity of action research within midwifery to support my inquiry. However, it is important that definitions and descriptions have changed over time because the purpose of action research is for the researcher and the participants to engage in a dynamic relationship with constantly changing situations. This is pertinent to midwifery where action research can help respond to the complexities and radical changes of clinical practice in a constantly evolving profession.

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

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

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

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

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

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

Reed & Procter (1995) have written about practitioner research stating that they believe it is the focus or concern on clinical practice and the aim to bring about change that differentiates action research from other approaches. They state that

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

<sup>39</sup> I provide a discussion of ways to ensure rigour in action research in Chapter 6.



"the primary aim of practitioner research is usually to solve a critical problem or to develop an understanding about the nature of practice, and ultimately to contribute to the body of knowledge" (Reed & Procter, 1995, p.11). This attempt by Reed & Proctor (1995) to define practitioner research still does not make clear the nature of 'practice' and what actually differentiates practice-focused research from other approaches. This is probably because most research can lay claims to being concerned with changing practice. Waterman et al. (2001) state that healthcare action research has "a different context to educational action research, with consequently, differing practical issues and concerns" (p.2). However, much research that has been undertaken within midwifery (and nursing) makes "recommendations for practice" rather than being concerned with bringing about change<sup>40</sup>. Schön's (1983) analysis of 'practice' might help here as I could recognise its application to my midwifery work and also to action research:

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

This 'certain kind of work' referred to by Schön (1983) is analogous with my understanding of the nature of action research and coming to terms with, and understanding that nothing in clinical practice is a 'given'. Indeed, midwives do "frame" (Goffman, 1974) their interpretation of some situations in order to carry out this 'certain kind of work' (see Chapter 8, p.245). For example, the dominance of obstetrics in midwifery and working in a bureaucratic setting means that midwives have to resort to certain behaviours (or performances<sup>41</sup>) in order to 'frame' their problems. The power of the system therefore becomes a 'given' because midwives are preoccupied with meeting organisational demands and are unable to

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<sup>40</sup> Furthermore, whilst research can eventually lead to improved practice, it is a considerable time before the findings get implemented in practice (Foote-Whyte, 1991).

<sup>41</sup> Chapter 8 addresses midwifery performances further.



consider alternative ways of working within the system. As Winter & Munn-Giddings (2001) and Lloyd & Hawe (2003) suggest, re-framing may be the solution whereby health practitioners can identify more effective solutions to problems. As will be seen in Chapters 9 and 10 this action research study was fraught with challenges (some of them unexpected), especially in terms of the degree of collaboration from the participating midwives and also my position as a researcher<sup>42</sup>. This meant I constantly had to re-frame the way forward for the study.

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

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

### The nature of reality

Guba & Lincoln (1989) and Patton (2002) provide frameworks that claim to help researchers make decisions about their choice of methodology. These authors agree that ontological and epistemological assumptions are the first stages in

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<sup>42</sup> I explore and discuss my position as a researcher more fully later in this chapter.

determining choices that are available when choosing a methodology. Ontological debates concern the nature of reality and the way people view themselves. Patton (2002) offers two perspectives here; firstly, that there is a singular reality and secondly, that socially constructed multiple realities are inevitable. However, the nature of human culture is such that:

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

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

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

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

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

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



### 'Learning is rooted in experience'

Epistemological debates concern how people understand knowledge, including how knowledge is acquired. Guba & Lincoln (1989) and Patton (2002) suggest that epistemological assumptions stem from accepting that knowledge can either be objectively knowable (propositional logic) or subjectively knowable (dialectical logic). The epistemological tradition of propositional logic regards theories as static models of reality that are understood intellectually. This form of logic is often most valued by Western tradition because it attempts to "eliminate contradiction from rational thought" (McNiff, 2000, p.29). Positivist researchers, and to a certain extent interpretative researchers, often work with propositional logic (Patton, 2002) although clearly propositional logic would not have benefited this study where there was a plethora of contradictions and the reactions of the midwives meant that the research had its own momentum.

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

Dialectics are often the result of asking questions and finding answers; answers then generate new questions and contradictions are a valued part of this process. This cyclical process parallels an action research approach. The complexity and unpredictability of midwifery practice means that knowledge resulting from dialectical logic is "never static or complete; it is in a constant process of development as new understandings emerge" (McNiff, 2002, p.18). Likewise, it

was possible that the participating midwives could generate their own knowledge through clinical practice by collaborating in this action research study although, as will be seen in Chapters 9 and 10 they appeared to resist this opportunity.

Whilst knowledge can be gained from others, tacit knowledge is generated where it is experienced and valued. Within midwifery, learning in this respect is derived from clinical experience and involves reflecting on practice to consider how this can be improved. Reason (1994) supports this stating that "critical self-reflective inquiry and openness to public scrutiny, the practices of human inquiry engage deeply and sensitively with experience, are participative, and aim to integrate action with reflection" (p.10).

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

### **Rejecting the search for 'truth'**

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

attempt to bring the world under scientific control through the measurement of quantities:

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

**(Ellis and Crookes, 1998, p.88)**

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

### **Prescription and the imposition of control**

Over time positivist research has developed certain principles to guide its conduct. These principles establish a theory to identify all constructs, concepts and hypotheses while a research proposal is being prepared and before data collection commences (Morse & Field, 1996). Cohen & Manion (1994) refer to positivist research as "the systematic, controlled, empirical and critical investigation of hypothetical propositions about the presumed relations among natural phenomena" (p.4). Hypotheses are suggested in the above definition as a way of looking for relationships between variables so that causality can be explained along with accurate prediction (Morse & Field, 1996). The researcher proceeds to examine



experimental variables in order to impose some degree of control over the research. By imposing this control the positivist researcher believes that relationships between variables will be generalisable and predictive in all settings and at all times (Morse & Field, 1996). Hypotheses are tested using systematic and controlled methods and are either rejected or accepted by the researcher according to the probability values they generate. The research becomes empirical because it is validated by observation, evidence, experimentation and testing. Cohen & Manion (1994) refer to Comte who believed that "all genuine knowledge is based on sense experience and can only be advanced by means of observation and experiment" (p.11).

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

Clearly, a positivist approach to the study would have been unsuitable because of the principles used to guide the conduct of the research. Objectivity such as non-involvement and non-participation as well as a non-dynamic, fixed and planned research design are common ideals when the above principles have been adhered to (Leininger, 1985). Positivist approaches are therefore inappropriate for research that involves people interacting in complicated and unpredictable situations where there may be multiple variables present. Under these circumstances participants

cannot be measured and quantified as if they are entirely predictable (Winter & Munn-Giddings, 2001; Patton, 2002).

### **What about complex, messy clinical practice situations...?**

This action research study explores midwives' support needs and working relationships. Therefore a paradigm in which dynamism and mutation are not core values would be unsuitable and could actually inhibit the process of change necessary within the study. Within traditional research thinking, messiness or lack of control are all seen as negative qualities (Morrison & Lilford, 2001), indicative of weaknesses in a methodology or study, and therefore can cause confusion, angst and/or doubt, especially in novice action researchers.

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

### **Naturalistic research: Subjectivity and shedding light on complex problems.**

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

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

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

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

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



## **Whose knowledge.....whose practice counts?**

A researcher from the interpretist tradition is therefore still viewed as an outsider who "speaks on behalf of other people" (McNiff, 2002, p.33) and "generates a theory about an external situation" (ibid. p.33). In effect this means that power differentials exist between researcher and participants as to "who is regarded as a legitimate knower, whose practice is to be studied, and whose knowledge counts" (McNiff, 2002, p.33). As I have discussed in Chapter 2 there are close parallels here with women's ways of knowing (Belenky et al. 1986) and the degree to which individuals value each other's knowledge. The naturalistic paradigm therefore, still did not seem to address the importance I placed on the collaborative, participatory and reflective aspects of my clinical work.

### **Critical theory research: challenging politically constructed situations**

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

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

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

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

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

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

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

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

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

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

Kemmis (2001) has developed the above criticisms further, particularly the “notion that truth could only emerge in settings where all assertions are equally open to critical scrutiny, without fear or favour” (p.93). In further developing Habermas’ views and critical social science, Kemmis (2001) emphasises a need to take account of communicative action and the two levels at which society can be



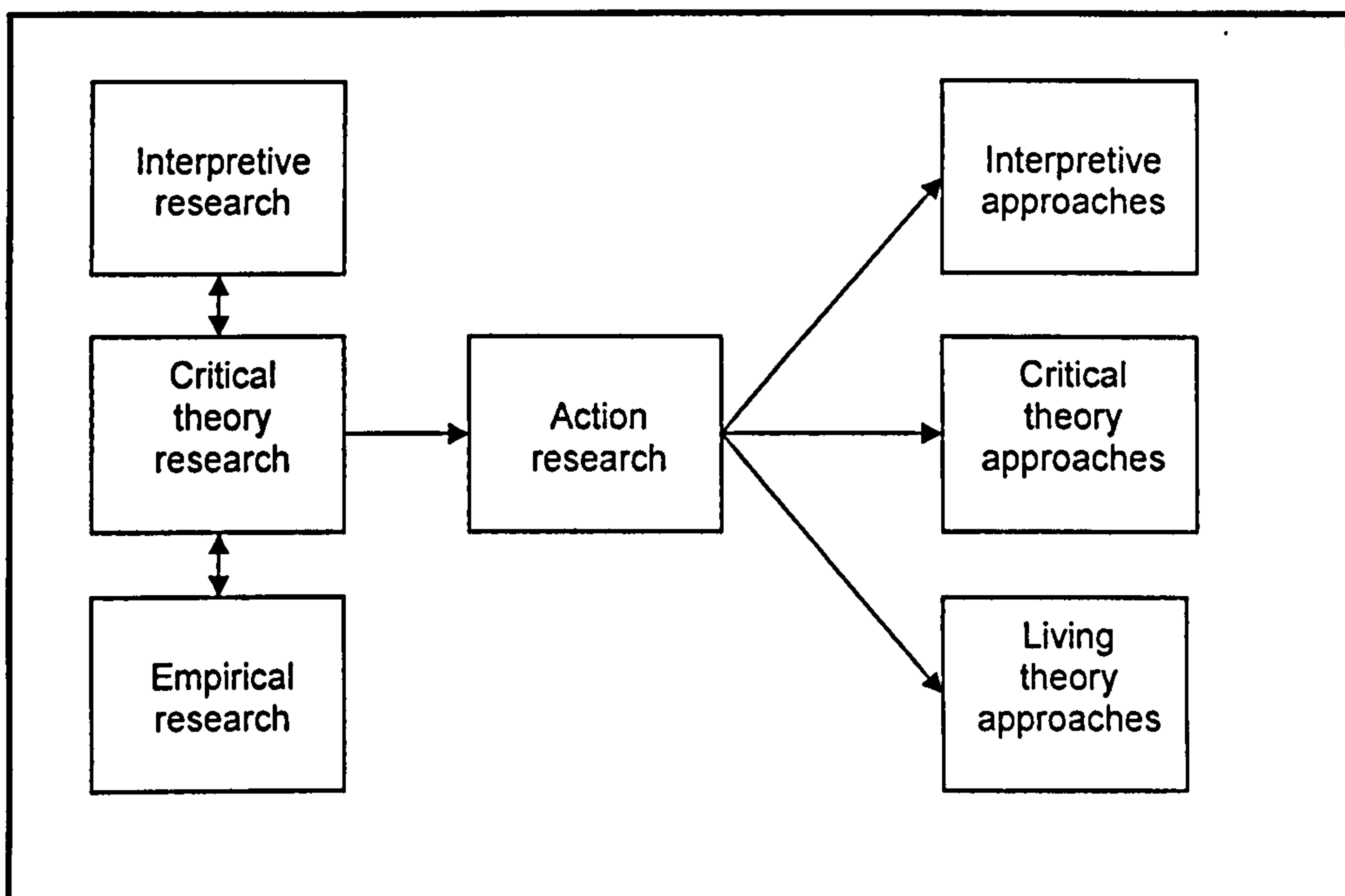
viewed; the system's view and the life-world view. The system's view sees society encompassed by organisational and bureaucratic structures where there is a pressure to meet targets (see also Lipsky, 1980). The lifeworld perspective views society as encompassed by culture, social order and individual identity and according to Kemmis (2001):

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

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

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

**Figure 5: Different approaches to action research in critical theory paradigm**



(Derived from McNiff, 2002, p.58)

### Models...approaches...typologies...traditions?

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

Action research is, on one hand, not prescriptive; it merely offers a range of models, for example McNiff's three-dimensional spiral model, Hart & Bond's four typologies, Holter & Schwartz-Barcott's three approaches and Zuber-Skerritt's

CRASP model (McNiff, 1988; Hart & Bond, 1995; Holter & Schwartz-Barcott, 1993; Zuber-Skerritt, 1992). On the other hand, this range of models can have the effect of implying that some form of order needs to be placed on action research<sup>43</sup>. Thus, the implication that models impose some form of order does not help with the "terminological anarchism" (Kalleburg, 1990) within action research.

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

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

Rather than presenting varieties and different types of action research Winter & Munn-Giddings (2001) present a set of contributory traditions that have developed in different contexts. 'Service user research' (p.28), 'community development'

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<sup>43</sup> See Chapter 2 for similar imposition of models within midwifery.



(p.33), action research as management or organisational learning (p.37), action research as 'responsive evaluation' (p.45) and feminism and action research (p.55) are some of the traditions identified by Winter & Munn-Giddings (2001). However there are still many overlapping, common themes within these traditions.

### **Cycles and steps as repressive and mechanical**

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

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

Elliot (1991) also notes that implementing action steps is not without its difficulties and that the effects of such action should not be evaluated until the extent to which the action that has been implemented has been monitored. Atkinson (1994)

agrees with Elliot (1991) arguing that an "observe, plan, act, reflect cycle" (p.397) does not demonstrate complex, messy real life situations when in fact all four of these components could be in action at any one time. Somekh (1994) is also critical that models can be interpreted too literally and hamper less experienced researchers.

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

Whitehead (1994) reinforces the imposition of models when emphasising the need for originality. He states that describing action research as a logical, technical approach can inhibit those participating in action research from analysing and synthesising. The variety of interpretations can be experienced by action researchers as restrictive and in opposition to their reasons for choosing action research as an approach. One of the reasons I chose action research was because the research would become accessible to the midwives participating in the study and help them to close the gap between theory, practice and research (Somekh, 1994). Naively, at the outset of the study, I felt that the midwives would be able to participate in action research and create their own midwifery theory whilst undertaking clinical practice at the same time. This would enable them to facilitate change in the clinical area 'on the job' rather than wait for the findings of

the research to be published and then incorporating the findings into practice. Further complicating action research through the imposition of theoretical categorisations could have been disabling for the participating midwives. However I could also be accused here of protecting the midwives from the complexity brought about by action research. As will be seen in Chapter 10 their reluctance to engage in personal and professional development meant that I may well have been protecting them from such complexity in order to maintain their interest, for my benefit, in the study.

### **Struggling in the swampy lowlands**

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

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

Mellor (1999) also states that he "eventually came to accept that [his] struggle in the swamp was the method, not a path to find a better method" (p.100). I found Mellor's words reassuring and helpful as I came to understand and accept

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



complexity and uncertainty within the study as part of the “swamp” and central to the process of undertaking action research.

### Accepting certainty and valuing uncertainty

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

Davis-Floyd (1992) also refers to the “technocratic model” of birth as that which values contemporary obstetric practices as well as the hegemonising influence of “diagnostic technologies” (Davis-Floyd & Davies, 1997, p.147). For example in obstetrics continuous electronic fetal monitoring during the labour process may create an illusion that a baby's chances of a healthy outcome are greatly improved when in fact the uncertainty surrounding the baby's well-being becomes less apparent when the situation is “technologically controlled” (Harvey, 1996, p.86). This is because medical technology serves to mask uncertain outcomes. This is referred to by Harvey (1996) as achieved certainty “whereby an appearance of medical control may be accomplished in a situation that may remain riven with uncertainty” (Harvey, 1996, p.89).

However uncertainty also appears to have become a strength in obstetrics in that obstetricians believe that they “cannot know for certain who will be overtaken by ‘potential pathology’” (Harvey, 1996, p.90). All childbearing women therefore have

to comply with obstetric protocols and guidelines so that high mortality/morbidity outcomes can be avoided (Tew, 1990). As Taylor (2001) states:

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

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

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

Leap (2000) suggests that midwives and clients should embrace uncertainty together. This might be uncomfortable for some midwives who depend on the achieved certainty (Harvey, 1996) of their clinical practice in order to predict events within the childbearing process. Several examples are noteworthy here, for example the date of the baby's birth is predicted through mathematical calculation or ultrasound scan, and some midwives measure the growth of the uterus with a tape measure in order to assess fetal growth (Neilson, 2000). The length of a woman's labour is also estimated and the time of birth predicted on a partogram<sup>45</sup> and dilatation of the cervix is measured by vaginal examinations. These interventions provide good examples of the ways in which midwives attempt to control and predict their practice through achieved certainty (Harvey, 1996) in order to be certain of events. Rather than trusting the physiological process of 'normal'

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

childbirth and the woman's body, midwives use these varied interventions to help them feel comfortable within their sphere of practice:

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

Lipsky (1980), when addressing the different ways in which street-level bureaucrats have to work with conflicting and ambiguous values in their employing organisations, states that:

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

Like Leap (2000), Lipsky (1980) is suggesting embracing uncertainty in the work environment although he also acknowledges that this can be organisationally inhibited. Lipsky's words also hold true for an action research approach where the dynamic, flexible nature of the approach lends itself to discovering new and different ways of working. As will be seen in Chapter 7 the "hunger" that Lipsky refers to was demonstrated in the midwives' articulated need for support. However, their willingness to change was impeded by the fact that "they operate in an environment that conditions the way they perceive problems and frame solutions to them" (Lipsky, 1980, p.27) (see also pages 126 and 246). This means that the midwives probably had no option but to resist suggested changes to their



ways of working. However I did remain convinced that midwives might enjoy richer, more rewarding experiences within clinical practice if they reflected on and examined their values and then used this critical reflection as a way of guiding or "re-framing" (Winter & Munn-Giddings, 2001, p.52) (see also p.126) their practice. As will be seen in Chapters 9 and 10, the midwives were offered the opportunity to examine their values, reflect on practice and embrace the uncertainty of clinical practice through the process of clinical supervision.

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

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

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

- Identifying a practical problem and/or need for change.
- Establishing participation/collaboration between all those involved.
- Selecting methods of data collection appropriate to the purpose of the study.
- Participating in change based on analysis of and reflection on the data.
- Repeating the above until practice is developed to a point that is mutually agreed to be a point of sustainable improvement or change.
- Reflecting on the experience of the action research to build knowledge and disseminating the findings.  
(Derived from Deery & Hughes, 2002, p.1)

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

### **Feminisms and action research**

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

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

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

### **The living theory approach**

Most action researchers would take the stance that reflexivity and dialectical critique in a democracy are important factors (Winter & Munn-Giddings, 2001) with Whitehead (2000), McNiff (2002) and Lomax (1995) viewing self-reflective



enquiry as an important aspect of critiquing the researcher's own values. McNiff (1988) criticises Elliot (1981), Kemmis & McTaggart (1982) and Ebbutt (1985) for not mapping "their own imagined frameworks" (p.34) onto their own practice. She states that these action researchers do not explain the educational phenomena that they are dealing with and fail "to demonstrate the marriage of their own theory and practice" (p.34).

As an academic and a clinical midwife I am encouraged to reflect 'on' and 'in' practice. However, neither role allows time for this and the culture of both professions merely pays lip service. Action research therefore can become accessible to researchers because of its ability to work and reflect on a clinical situation or otherwise whilst still engaged in the research process<sup>46</sup>. Critical reflection lies at the heart of action research as it enables analysis of the researcher's actions and the potential for improvement and understanding of the situation (Winter & Munn-Giddings, 2001).

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

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<sup>46</sup> I am reminded of the proverb "killing two birds with one stone" at this point.

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

### **'Mapping imagined frameworks' onto clinical practice**

As my understanding of action research developed I began to understand more fully that the values I espoused were not being evidenced in my research. After reading work written by Jack Whitehead at the University of Bath and Jean McNiff I have been particularly influenced in the living out of my values in practice and further exploration of these values as a way to shape my action research practices. It is important to point out here that both these action researchers take a different stance from interpretivist and critical theory action researchers where the issue of values is not made explicit.

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

### **Putting values 'up-front'**

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

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

**"Street-level bureaucracies encounter conflict and ambiguity in the tensions between client-centered goals and organizational goals. The ability of street-level bureaucrats to treat people as individuals is significantly compromised by the needs of the organization to process work quickly using the resources at its disposal...typical conflicts here are individual client treatment versus routinization and**



mass processing, and response to the needs of individual clients versus efficient agency performances".  
(Lipsky, 1980, p.44-45)

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

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

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

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

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

Winter & Munn-Giddings (2001) are critical of Whitehead's interpretation of examining the contradictions between the researcher's professional values and current practice. These authors believe that "values represent ideals, and ideals are by definition never fully realisable in practice" (p.52). Therefore the relationship

that Whitehead (1985) claims to exist between values and practice is not merely a contradiction that can be resolved (Winter & Munn-Giddings, 2001) because contradictions exist between competing values. McNiff (2002) acknowledges the difficulties of working with "multiple values perspectives" (p.17) and the challenges this presents for the action researcher in terms of "recognising and suspending their own prejudices" (p.17). She argues that this requires personal commitment to action and working in ways that are often not challenged.

Winter & Munn-Giddings (2001, p.52) also criticise Whitehead for suggesting that the critical dimension of action research involves a personal "confession" of the failure to enact values in practice. Neither should action research end with "self righteous claims" (Winter & Munn-Giddings, 2001, p.52) to have removed contradictions between values and practice. Whitehead's (1985) interpretation of creating an epistemology of practice does not claim to remove contradictions from practice. Indeed Whitehead (2000) states that the living contradiction is "the experience of holding together two mutually exclusive opposite values" (p.93) thereby refuting Winter & Munn-Giddings (2001) suggestion that contradictions can be resolved. However this "holding together" of competing values is not easy because:

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

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



## Active versus passive participation

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

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

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

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

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

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

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

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

Whilst participation in most action research studies is central to the dynamic of change, the converse can also be true in that participants can use their "power" to constrain and limit the progress and scope of that study. In this study for example the midwives chose to limit their involvement and the scope of the enquiry by establishing some very constraining ground-rules at the outset. These were that they did not wish to undertake anything that was outside of their work schedule. This sort of imposition of boundaries within the study ultimately limited its scope and was disappointing as one of the aims of the study was to plan a means of gaining support with the midwives through mutual collaboration.

### **The balance of power...**

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

This is an important quotation from Ellis & Crookes (1998) because despite the fact that I wanted an equal power base between myself and the participating midwives, at times they were insistent that I was the only person that held any power to enact change within the study. As will be seen in Chapter 9, the midwives became disempowered with regard to the study although it could also be argued that they powerfully resisted my imposing change upon them. Initially they had seized the opportunity to participate in the study but when their involvement became



uncomfortable and did not produce “answers” or even mask their difficulties, they became reluctant to participate.

### **Becoming a political entrepreneur!**

My difficult, but rewarding experiences, as an action researcher have resonance with the words of McNiff (2002) when she describes action researchers as often facing “entrenched hostile attitudes” (p.x) as they wade their way through the “complexities of institutional power-constituted epistemologies” (p.x). Coghlan & Brannick (2001) discuss the political implications for action researchers working in their own organisations and ways in which political forces can undermine the endeavours of researchers and eventually lead to resistance to change. Coghlan & Brannick (2001) view the management of political relationships as key to “ensuring the legitimacy” (p.65) of the study.

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

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

Reed & Proctor (1995) suggest three researcher positions or relationships along a continuum (see Table 3). I found myself sitting comfortably within the "insider" position and moving into the "hybrid" position at times. I had worked as a hybrid researcher when undertaking research within the department in which I work as an academic. This involved action research with clinical practitioners other than midwives. However, there was no getting away from the fact that I had a history and a future in midwifery. My position as a researcher became that of an "insider" (Reed & Proctor, 1995), aiming to improve or change practice and contribute to the body of professional midwifery knowledge with the help of the midwives taking part in the study. At times, my previous work as a midwife and current work as a bank midwife did not serve me well as I lapsed into "old ways" of behaving and thinking.

**Table 3: The position of the researcher**

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

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

Williamson & Prosser (2002) discuss the roles of 'insider', 'outsider' and 'insider/outsider' action researchers working in their own organisations although they state that these roles are contextualised differently in each action research report. According to Williamson & Prosser (2002) an 'insider' action researcher can experience role duality in that the demands of the organisation in which they

work can conflict with the research role. This can then lead to role conflict (Holian, 1999). Although I had considered myself an 'insider' action researcher in view of my previous working relationship with the participating midwives and my bank midwife role, on reflection, my full time role was that of an academic and I was not working with the participating midwives on a daily basis.

### **Blurred boundaries – dealing with political behaviour**

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

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



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

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

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

### Key points emerging:

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

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

In the next chapter I explain the methods I used to generate and analyse the data.  
Again my epistemological and ontological assumptions underpin this chapter.



## CHAPTER SIX

### Methods

Understanding requires  
putting yourself in a position  
to be taught by  
to learn from  
to experience  
to be affected and changed  
to be humble  
to stand under

It is to care enough  
to give the other  
power

from Miller Mair 1989

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

#### Placing 'the self' at the centre of the inquiry

##### Shaping the research with social, political and critical insight

My experiences, values, feelings, knowledge, interpretations and responses, as well as the way events influenced me, were all part of the data I gathered during individual interviews and focus groups. Immediately after the interviews and focus groups I made methodological and reflective notes in my research diary which I often referred to when re-reading the transcript. This enabled me to question what was going on (Koch & Harrington, 1998) and to check that what I was doing and

saying corresponded. I documented my personal and professional prejudices and how these might influence what was happening in the study. All this was recorded and reflected upon in my research diary. As an action researcher this meant that I was contributing to the data by reflecting upon, and being critical of, my actions.

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

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

### **A story of myself (6.12.00)**

I decided in the fourth year of my PhD studies that I wanted to include a personal account in my thesis in order to provide the reader with some insight into my

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

#### Childhood lasts a lifetime

I was born in Preston, Lancashire, the eldest of five children. I have two brothers and two sisters. My mother was a teacher and my father a draughtsman. My father was also a brilliant artist. He passed these skills on to me. When I was born my mother went back to work when I was six weeks old in order to help make ends meet. I went to the local village primary school and was considered a 'bright child'. I took my eleven plus a year earlier than every one else and passed. I used to walk to and from school (about two miles) and on the way home my cousins, who lived next door to us, would wait in the bushes and throw stones at me and "call me names". I used to dread the walk home and the look on my mother's face when she saw I had been crying.



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

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

Life at home deteriorated. My parents separated and this had devastating effects on my emotional wellbeing and schoolwork (see attachment on page 54). I failed one of my A levels. I needed to feel needed (see page 282). I decided to become a nurse where I felt others might need me. I left home and went to live in the city. I missed my brothers and sisters and worried about them. Nurse training was different and there were lots of parties and socialising and I made some lasting relationships. Only some of my inner desires were satisfied. The training was disappointingly authoritarian; we learned by rote and were not allowed to speak to senior students or senior members of staff. We were kept firmly in our places and not allowed to express ourselves. There were 120 students in my group. I could easily lose myself, keep silent and hide behind the others. I imagined what it would be like to be humiliated in front of 120 peers.

I went on to pass my State Registered Nurse finals (first time). My first post was on the Intensive Care Unit (ICU). There was no need to communicate with the

patients on ICU. Most of them were artificially ventilated and could not speak; others were so critically ill that talking was the last thing on their mind. The doctors all seemed so knowledgeable, yet so detached. I decided to apply for midwifery training. Somebody told me a second qualification was good if you wanted to work abroad.

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

I had easily become an 'accepting' midwife because my past career as a nurse was undertaken when 'doctor knew best' and nurses were doctors' handmaidens. I had never seen or practised midwifery differently and as a result of being 'accepting' I became socialised into ways of working that dominated my entire working life. As a group of midwives we moaned about our excessive workloads, complained about many of the clients (especially the more demanding women), blamed our misery on midwifery managers and constant change in the NHS and talked about each other inappropriately all the time. I used to feel that I gave the

women so much of myself and never got anything in return. I used to feel 'drained' and began questioning this feeling (see Chapter 8). I used to dream about how midwifery might be but never dared to articulate my thoughts because I was frightened of reprisal and being humiliated in front of my peers.

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

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

I set off on a journey that took me through university education, becoming a teacher and then being employed in a higher education institution. I understood more about oppression, power relations and research and I was able to understand and articulate my value position more clearly. However I became more and more aware that I was still not "living out" (Whitehead, 1993) my values as I remained



muted in the institution in which I worked. This worried me and I became immensely frustrated at times as I struggled to make my voice heard. At the time I never imagined that these very same issues would emerge as methodological issues within my study.

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

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

## **PHASE ONE**

### **Gaining access**

I returned to Glendale NHS Trust in 1996 as a researcher seeking access to undertake this study within the maternity unit where I used to work. As the midwifery managers and midwives knew me from a previous "working life" I felt that gaining access would be somewhat easier to achieve although it was never my intention to avoid going through the correct formal procedures. In fact, getting access was tough as I battled my way through layers of hierarchy. The Head of

Midwifery at the time had suggested that I attend a supervisor of midwives meeting in order to "get approval" for the study. Apart from seeking ethical approval, this was my first encounter with gatekeepers.

### **Gatekeeping access**

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

On the day I attended the meeting I waited in the midwifery manager's office to be "summoned". I wrote in my research diary that "I felt like a lamb going to the slaughter" (Research Diary, March 1997) and that the supervisors kept me waiting 30 minutes before they invited me into their meeting room. I realised whilst I was waiting that I had become a powerless, muted midwife again. I felt myself dithering, my mouth became dry and an overall feeling of anxiety began to wash over me. I felt helpless and cornered as I waited to present my work to a group of midwives that I perceived to be more knowledgeable, powerful and better than me. I felt ashamed, and angry with myself, that despite many years since leaving the NHS, and making a conscious decision to try and leave old ways of working and socialisation behind, I was overcome with a kind of hysterical nausea that paralysed me. Wilkins (1993) reports much the same when she conducted research on childbirth. She refers to experiencing "acute anxiety" and resorted to carrying a "panic pack" (p.95) especially when she knew that she was going to be

encountering "gatekeepers". The sweating and dry mouth that she refers to certainly had resonance with my experiences in the field.

### Old habits die hard

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

### **Silencing mechanisms at play**

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



's". At the time this choice of words indicated to me the powerful and hierarchical nature of statutory supervision as undertaken in the maternity unit.

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

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

### **Recruitment to the study**

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

The midwives were questioning about their role and asked questions like "what will it involve?" and made comments like "I'm too old for this sort of thing" and "I'm not

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

At times, however I was disappointed that the midwives seemed to persist in denigrating their capability and that they appeared unable to recognise or visualise the potential personal and professional development that was inherent within the study. On reflection, I was thinking naively because the midwives were beginning to highlight that participation was going to become a constraining factor for them. Whilst I tried to bolster their confidence in terms of their pending contributions, I began to question their commitment to the study on the level I had imagined.

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

## **Excluding 'others' from the research**

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

## **PHASES ONE, TWO AND THREE**

### **Interviews as complex, social interactions**

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



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

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

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

Arksey & Knight (1999) refer to in-depth interviews as 'unstructured' and the way in which they can offer flexibility in gathering information for those participating in the research. Bearing in mind that action research involves working collaboratively with others and in a non-hierarchical manner, these are important points to

consider when choosing interviews as a method of data gathering. Kvale (1996) has stressed the importance of the conversational nature of interviews stating that they are "literally an inter view, an interchange of views between two persons conversing about a common theme" (p.44).

### **The influence of reciprocity**

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

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

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

However there were difficulties I encountered with this intimate/reciprocal approach which Oakley (1981) does not seem to address in her work. One of these difficulties was around issues relating to power within the research relationship and the ways in which participants can become "politically motivated actors" (Alvesson, 2002, p.113). As will be seen later the participants could well have had their own agendas during the research process and thus tried to influence the way I represented certain issues within the research and to midwifery managers<sup>49</sup>.

### Listening to midwives' voices

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

I had decided to interview the midwives twice, initially to capture life as a community midwife and hopefully identify a need for change, and also at the end of the study in order to evaluate their experience. However as this was an action research study I had to remember that I really wanted the participants to shape the progress of the study and that a need may arise during the course of the research to alter this initial 'plan'. All the interviews were audio-taped and transcribed in full. The typed transcripts were returned to the midwives within one month of the interview and prior to our next meeting, to check for accuracy and to invite further

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<sup>49</sup> Once again there are parallels here with clinical practice and the rhetoric of policy documents. Midwives are encouraged to work in ways espoused within these documents but the reality of their practice (i.e. organisational constraints) means that this is often impossible.

<sup>50</sup> I did, however use interview schedules to guide my approach to questioning (see Appendices 2 and 5) although I very rarely needed to refer to these because the midwives talked at great length.



comments. I also re-read the transcripts myself and checked them whilst listening to the tape recording. The interviews were conducted at a time convenient to the midwives. This usually meant that I was conducting an interview following an antenatal clinic in one of the health centres or during a lunch break. We tried to ensure that we were not disturbed and only were on two occasions.

### **Listening to the voices of Susan, Sarah and Stella**

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

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

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

### Seeking 'spontaneous story-telling'

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

As the interviews progressed I tried to move the midwives into more reflective thinking by asking questions which focused more directly on aspects of their clinical practice. As was seen in Chapter 4, there are parallels here with clinical supervision and reflective practice (Bond & Holland, 1998; Rolfe et al. 2001). I asked them about their working relationships and to elaborate on particular situations which they were relating in their stories. I asked them to describe what had been going on, why and how they did things and what their logic was behind some of their behaviour and thinking. As well as using open questions I used techniques for probing and clarification, for example, "could you tell me more about that?" or "could you explain that further?" I also included *résumé* or summary questions (Grbich, 1999) to help me clarify and sequence events in their stories, for

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

example "so...is what you are saying...?" and "so the first thing that happened was...and then this happened..."

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

#### The interviewer as a therapeutic resource

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

Jane, for example who I interviewed in a bathroom at one of the health centres, did not sob but was clearly distressed as she vigorously stirred her cup of soup, clattering the spoon against the side of the cup. Initially I was concerned that I would not be able to hear her words over the clattering noise she was making when I transcribed the tape but then I realised that this body language was data



and she was trying to tell me that remembering these stories was painful for her. My language changed too, as I resorted to using words that I knew would let the midwives know I was prepared to listen to them (for example, "Tell me more about those feelings" or "I can see that this is very painful for you").

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

#### **Is it necessary to draw a line in the sand?**

Following the interviews I struggled with issues relating to whether I had drawn an appropriate "line in the sand" between being a researcher holding feminist values of women supporting women and entering into a therapeutic relationship. I did not want the midwives to feel that I had manipulated my relationship with them in order to elicit data for my research. Although I had invited the midwives to indicate to me if they wanted the tape turning off during the interview none of them did this. In fact when two of the midwives became distressed during their interview they were adamant that the tape recorder had to be left switched on despite my attempts to stop the tape running. Likewise this could be likened to the midwives using the interview for their own political purposes where they tell the truth as they know it "but in ways that are favourable to them, and not disclose truths unfavourable to them and their group" (Alvesson, 2002, p.114).

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

### **Choosing the venue...feeling safer on your own patch**

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

### **Coping with distractions and interruptions**

Phillips & Davies (1995) have stated that taking a lead from the research participants for the interview venue may mean being prepared to undertake an interview in an unusual place (e.g. the sluice in a hospital ward or the kitchen area in someone's home). During one of the interviews I undertook on health centre premises I had to change venues twice within the same interview eventually conducting the interview screened off, in the corner of a large room where a baby

clinic was being held. Morse & Field (1996) identify interruptions and competing distractions as two pitfalls that can be encountered when conducting interviews. In this particular interview the distractions comprised being interrupted firstly by a health visitor requiring the room to see a mother and baby and then by a practice nurse requiring the room to see a patient. The competing distraction in this instance was that the midwife being interviewed had set a time limit to the interview as she had a long journey home. Unfortunately interruptions and distractions were outside of my control as I had given the midwives the flexibility to identify the time and place of the interview.

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

Cotterill (1992) refers to interviewees obliging the researcher by providing what the interviewees perceive to be the correct answer to questions posed. This type of 'appropriate' behaviour would conceal views that might be unacceptable to others<sup>53</sup> (Cotterill, 1992). Until trust had been established between the research participants and myself I was not expecting any revelations about personal feelings<sup>54</sup>.

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<sup>53</sup> As was seen in Chapter 4 there is also the possibility of this happening within the process of clinical supervision whereby supervisees will not discuss or highlight pertinent issues relating to clinical practice for fear of reprisal or disciplinary action from managers (Butterworth, 1998).

<sup>54</sup> There are close parallels here to establishing trust with clients in the clinical setting (Kirkham, 2000; Stapleton et al. 2002a). "In such situations, the midwife, if she trusts the mother, becomes involved with attitudes and values that are deeply threatening in the context of her relationships as a professional and an employee. In such circumstances, relationships are negotiated and renegotiated, and trust has to be reconstituted (Levy 1998) or replaced by mistrust" (Kirkham, 2000, p.240).



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

### Articulating 'unarticulated experience': helping each other out

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

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

As I wanted to focus on the conversational nature of interviewing and thus encourage the midwives to "tell their stories" in a safe environment this meant leaving technical issues on one side so that the linguistic style of the interview would not become masked (Mishler, 1991).

Morse & Field (1996) state that "good interviews can be detected as soon as they are transcribed. The page appears a solid block of text" (p.75). If I were to use this gauge as a measure of success in some of my transcripts then the interviews I held with some of the midwives would have been described as deficient in terms of "unarticulated experience" (DeVault, 1990, p.101). When interviewing Gemma I often offered assistance in terms of "let me help you" when I saw, what I perceived

to be, her struggling to answer or understand the question I had asked. When reviewing my transcripts there were many one-line responses or even one-word responses within the data leading to copious amounts of white paper being visible. I became aware that some of my transcripts were filled with the words "you know". At first I viewed this as "stumbling inarticulateness" on the part of the midwives (DeVault, 1990, p.103) yet on reflection this seemed rather a harsh stance to take. Like DeVault (1990) I began to think that "the phrase is not so empty as it seems" (p.103) and means "something like, 'OK, this next bit is going to be a little tricky. I can't say it quite right, but help me out a little; meet me halfway and you'll understand what I mean'" (Devault, 1990, p.103).

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

### **The co-production of data within interviews**

Although not specifically referring to interviewing Peshkin (1988) states that subjectivity is a virtue that pervades the entire research process. He views this as advantageous and explains how he decided to "actively seek out" his subjectivity in research by noting down when different feelings were aroused. Peshkin believes that " [subjectivity] is the basis of researchers making a distinctive contribution, one

that results from the unique configuration of their personal qualities joined to the data they have collected" (Peshkin, 1988, p.18). Therefore, the importance of the researcher discussing thoughts of "this is me" or intersubjectivity (Klein, 1983) with the interviewee can help to make the research relationship more equal. Oakley (1981) has also identified this as the researcher "investing his or her own personal identity in the relationship" (p.41).

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

Scheurich (1997) agrees with this point stating that "the researcher has multiple intentions and desires, some of which are consciously known and some of which are not" (p.62). Scheurich goes on further to state that "the same is true of the interviewee" (p.62). Bion (1984) states, that when emotions are being passed unconsciously from one to the other, feelings can sometimes become too uncomfortable because of past associations. Therefore, within the dynamics of the interviewing process, the defence of projection could be used to get rid of the feeling by placing it into the interviewer or the interviewee (see footnote 56). As Hollway and Jefferson (2002) state there is the possibility that the projection can be experienced as empathy or if the other person denies the feeling, reassurance often comes into play<sup>55</sup>. Alternatively, "the other person can contain the pain, [and]

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



it can be returned 'detoxified' and faced as an aspect of reality" (Hollway & Jefferson, 2002, p.50)<sup>56</sup>.

## **PHASE TWO**

### **Hearing Joss' voice**

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

### **Focus groups as 'natural social networks'**

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

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

<sup>57</sup> The data from this interview is reported in Chapter 10 and combined with the midwives' evaluation of the process of clinical supervision.

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

### **Interaction as synergism**

Kitzinger (1994) states that it is useful to work with pre-existing groups as they provide social contexts in which ideas are already being formulated. However Kreuger (1994) warns about working with groups that are already established as this may inhibit disclosure<sup>59</sup> and encourage diversification from the topic area. As one of the aims of this study was to explore midwives' working relationships it was important that I was able to observe them together as a group albeit out of the work context. The midwives who took part in this study already knew each other through working and socialising together. This would hopefully enhance what Twinn (2000, p.18) refers to as the "synergism" of the focus group and provide a "natural social network" (Kitzinger, 1994, p.106).

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

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<sup>58</sup> I had a series of pre-devised questions in the form of a focus group schedule (see appendices 3 and 4) in order to guide the focus group but found that I rarely needed this because discussion often "took off" without me needing to refer to the schedule.

<sup>59</sup> See Chapter 9 for further exploration of ways in which midwives can become silenced during focus groups.

needs and a way forward during the change process. Focus groups are therefore different to interviews in that participants engage with each other as well as the researcher (Agar & MacDonald, 1995).

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

#### **Focus groups equate with 'time-efficiency'**

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

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



be seen in Chapter 9, where there is an existing hierarchy within a work team this becomes difficult.

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

### **Silent voices...remaining an outsider**

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

Thus, despite my eagerness to facilitate a collaborative, non-hierarchical, participatory approach (as enthused by action research and feminist approaches) by encouraging the midwives to talk freely to each other, ask questions and

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

express their opinions and anxieties, full participation from all focus group members was not always possible. Eventually this turned out to be a reflection of the way in which the work team functioned and communicated to me as a researcher "the social pressures and the construction and the communication of knowledge" (Kitzinger, 1994, p.113) that was at play within the work team.

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

#### Focus groups as a forum for change

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

### **Facilitating focus groups**

Morgan & Kreuger (1998) recommend that focus groups are conducted with a facilitator and an observer. The facilitator would normally ask questions and guide discussion whilst the observer would provide technical support and take notes that supported data analysis. I have previously conducted focus groups in this way with me facilitating the focus group and a co-researcher taking notes on a lap top computer (Deery et al. 1999; Deery et al. 2000). However, the lap top proved to be more of a hindrance than helpful and my co-researcher found that writing notes to support the data was far easier. In the focus groups in this study I undertook both roles. I was reluctant to invite another person to take on the role of observer because of the sensitive nature of the data already obtained in interviews which I thought would spill over into the focus groups and that the midwives would be reluctant to share this with another person. I never asked the midwives if they would be willing to agree to another person assisting me in the focus groups.

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

### **Observing interactions within focus groups**

As seen in this chapter, the group processes and interactions of group members in a focus group are seen by a number of authors as a key advantage to their



functioning (Morgan, 1997; Greenbaum, 1998; Barbour & Kitzinger 1999; Twinn, 2000). Individuals are brought together by a researcher in order to reflect on a specific topic (hence the word 'focused') in order to stimulate new ideas and build on existing ideas. Morgan (1997) and Barbour & Kitzinger (1999) identify group interaction as one of the important criteria that distinguish focus groups from other methods of data collection. Despite the importance placed on the interactive nature of these groups, Webb & Kevern (2001) have criticised researchers for their naïve use of the method in terms of data analysis and social interaction within focus groups. These authors state that group interaction has rarely been reported on or discussed in the articles that they reviewed for their critique.

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

### **Issues of ethics and rigour**

I sought ethical approval for my study in the early planning stages of the study and permission was granted by the Local Research Ethics Committee (LREC). The

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<sup>61</sup> My observations of the work team during both focus groups are explored more fully in Chapter 9.

Chairperson of this committee was keen for me to convince him that I was not placing the midwives under any undue pressure by taking part in the study. I was not requested to attend the LREC but instead communicated by letter and spoke at length on the telephone regarding the midwives' participation until he was fully satisfied that I was not pressurising the midwives in any way.

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

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

I also reassured the midwives that their data would be treated confidentially and anonymously and that no-one would be able to trace information back to them although midwifery managers knew that they were participating in the research. I

asked their midwifery manager to reinforce the nature of confidentiality and anonymity with other managers. I reassured the midwives that when I used quotations from their interviews I would use pseudonyms so that no-one would know whose words I was using. I also informed the midwives that they could withdraw from the study at any time and without prejudice although we also discussed how their withdrawal might affect the dynamics of the work team and clinical supervision group. No-one withdrew from the study.

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

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

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<sup>62</sup> I am also reminded of "politically motivated actors" (Alvesson, 2002) as discussed on page 179.



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

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

### **The appropriateness of reliability and validity in action research**

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

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

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

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

### **Exercising professional imagination**

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

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

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

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

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



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

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

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

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

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

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

## **PHASE THREE**

### **Analysing the midwives' accounts**

The data gathering procedures within the study extended over nearly three years according to the cyclical nature of action research and the needs and requirements of the midwives participating in the study. All interview and focus group data<sup>63</sup> were transcribed verbatim and then checked against the actual tape recordings. The transcripts were then anonymised by removing the names and places and the participants were given code names that only I would recognise. This coding also enabled me, during the course of the study, to compare individual midwives' words and how these changed, if at all, during the course of the study<sup>64</sup>.

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

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

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

#### **'Starting up terror' – leaping into the unknown**

I was initially overwhelmed by the amount of data that I had to analyse and related to the "internal chaos" described by Ely, Anzul, Friedman, Garner & Steinmetz (1991, p.141) as I began searching for answers of "how to do data analysis" in the proliferation of texts that have arisen within the area of qualitative research. This "internal chaos" often converted to "external chaos" (Ely et al. p.141) as I resorted to doing anything except analysing data. Mellor (1999) refers to this as "normal starting up terror, the leap into the unknown" (p.118). During times that I did manage to feel comfortable with the chaos, I realised that the detailed processes of data analysis have received very little attention in the literature. Whilst there are several important books that discuss data analysis (for example, Coffey & Atkinson, 1996; Wolcott, 1994; Silverman, 1993), and some that discuss and outline templates for data analysis (for example, Glaser & Strauss, 1967; Miles & Huberman, 1994; Wolcott, 1994; Strauss & Corbin, 1998), there is very little attention given to the tensions and dilemmas within data analysis. For example, I had to resist an urge to "clean up" the data because of its sensitive nature.



Riessman (1987) provided useful insights here stating that "narratives are laced with social discourses and power relations" (p.65) that must be preserved otherwise important information will be lost.

### **The process of making sense**

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

As I have already discussed in Chapter 5 it was important that my philosophical approach to the way in which I gathered data demonstrated the way in which I had been influenced by feminist writers (for example, Maguire, 2001) and the ways in which women's voices had remained unheard (Belenky et al. 1986). Equally important was the way in which I analysed the data, in order that I gave the participating midwives an opportunity to have their voices heard and kept alive by listening, interpreting and presenting their perspectives accurately. Mauthner & Doucet (1998, p.120) have pointed out that "the issue of listening to women, and understanding their lives 'in and on their own terms', has been a long-standing and pivotal concern amongst feminist researchers".

Although I knew that data analysis comprised trying to make sense out of the data, I struggled with having to find what I thought was a ready made solution to the process because, like Miles & Huberman (1994) I felt that "no study conforms

exactly to a standard methodology" (p.4). This is especially the case for action research where the participants guide the path of the research and data analysis takes place according to those participating in change although the midwives taking part in this study did not interpret their own data.

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

### Facing myself.....again

Just as I have discussed "intersubjectivity" during the interview process earlier in this chapter, and how I was confronted with 'myself' during conversations with the midwives, I was now confronted with myself again when analysing the data. Some of the anxieties I experienced at this stage were also related to insecurities I experienced as a nurse and a midwife in earlier years and the comfort of wanting to take and know the 'right approach' for fear of criticism, even reprisal.

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

where I was located in relation to the midwives participating in the study, I also had to "acknowledge the critical role...play[ed] in creating, interpreting and theorising research data" (Mauthner & Doucet, 1998, p.121).

### The principles of voice-centred relational methodology

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

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



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

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

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

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

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

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

### **Second reading: Being with midwives**

The second reading of the transcript followed on from the first and focused particularly on listening to how the midwives related their experiences, thoughts and feelings about themselves and clients. This second reading was cathartic as I realised how unsupported, stressed and angry the midwives were feeling. As suggested by Mauthner & Doucet (1998) I traced 'I', 'we' and 'you' through the midwives' narratives in order that I could concentrate on their stories. I then found I was able to build a picture of where the midwives saw themselves, whether they were struggling with words and how they perceived and experienced themselves. As will be seen in Chapter 9 I discuss this more fully when I analysed the narratives of the midwives at the second focus group. This second reading then enabled me to discover how the midwives spoke of themselves before I spoke on their behalf (Mauthner & Doucet, 1998, p.128).

Focusing on 'I', 'me', 'them', 'we' and 'you' helped me to become more aware of how the midwives were struggling with the competing demands of working within a complex organisation and developing and facilitating the supportive relationships that were expected of them as midwives. 'Them' became structures, organisations and midwifery managers and 'I', 'me' and 'we' became the oppressed, marginalised grass root workers. I became more aware of their anger and tried to stay with their "multi-layered voices, views and perspectives" (Mauthner & Doucet,

1998) rather than becoming too embroiled in my own anxiety and the way in which I felt the midwives had intimidated me at times (see page 312). I developed a much better sense of the processes at play in their working relationships and the contradictions which were central to their roles as midwives and often used as coping mechanisms.

### **Third reading: Achieving a sense of balance in relationships**

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

I began to see how increasing demands placed on the midwives within the maternity service meant that their lives both at home and at work became intertwined and usually not to their advantage. I became more empathetic towards the midwives as I realised that the organisation of the maternity service appeared insensitive to their needs both as women and as midwives. Just as I have suggested in Chapter 3 that emotional and psychological difficulties can become apparent within relationships as a result of earlier, less successful relationships, I now concentrated on how the relational difficulties the midwives seemed to have experienced in this study could have been similarly linked.

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



unsupportive, constraining and intimidating, in which their voices were silenced or rejected.

#### **Fourth reading: Some voices are louder than others**

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

I also concentrated on how some of the midwives' voices were louder than others in the work team. As will be seen in Chapter 10 complex silencing mechanisms appeared to be at play within the work team. When I concentrated on the voices of the midwives I realised that the dominant voices often highlighted the complex relationship between power and knowledge. Listening to the way the midwives spoke to and about each other enabled me to make links between the way in which they experienced their work and their relationships with each other. The way in which the midwives spoke about their experiences in the particular social context of the NHS linked to issues of oppression, power and resistance to change.

#### **Fifth reading: expressing emotion through metaphors**

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

“right” response from the midwives. I did not understand metaphors and felt that they were using colloquialisms.

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

### **Metaphors as a form of expression**

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

performance of midwifery work that would be difficult using more literal language (Lakoff & Johnson, 1980).

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

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

Structural metaphors move beyond naming and quantifying concepts and build meaning of one concept in terms of another (Krone & Morgan, 2000) (e.g. 'time is money' – see Chapter 10). Lakoff & Johnson (1980) provide examples of "argument" in order to demonstrate what it means for a concept to be metaphorical



and how the conceptual metaphor "argument is war" (e.g. 'I've never won an argument with him' or 'He shot down all of my arguments', p.4) is reflected in our everyday language through a range of expressions. As Savage (1995) states "[i]n arguments 'opponents' take 'positions', which are 'attacked' or 'defended'; arguments are 'lost' or 'won'" (p.80).

Furthermore, this conceptualisation of "argument" may then inform the way in which we argue and the actions we perform while we argue (Savage, 1995). Within the culture of midwifery this metaphorical concept of argument has already become evident in the work of Kirkham (1999), Stapleton et al. (1998) and Hughes et al. (2002), where arguments are seen in terms of war within midwifery work. Although these studies do not adopt a narrative discourse analysis approach there is evidence in them that midwives talk about and understand their work as midwives in terms of 'war'. Both Stapleton et al. (1998) & Kirkham (1999), in work examining the culture of midwifery, cite one of the participating midwives reporting her feelings about routine updating as feeling like "a lioness coming into a different pack...and they're all just sitting waiting to attack...it felt like they were breathing down my neck the whole time" (Kirkham, 1999, p.736). Hughes et al. (2002) report midwives talking about a culture of blame compounded by a lack of support at times of crisis in their focus groups, with one of the midwives stating, "[i]f something goes wrong, how many people are going to jump on your back? Everybody" (Focus group B, p.49).

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

the midwives, can reveal the values and assumptions underpinning the culture of midwifery within the NHS and the wider culture of their lives.

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

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

Voice-centred relational methodology and metaphor analysis provided me with the opportunity to listen to and interpret the midwives' narratives by being as true to their words as I possibly could. Metaphor analysis provided particularly valuable insights into associated emotion work in midwifery. In earlier readings of the transcripts I felt that I was being too hard on the midwives and that my

interpretations were not respecting their voices. As I grew more familiar with their voices and I listened more intently and deeply, I heard them and was then able to take account of and analyse their different voices, especially through the use of metaphors.

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