

MIDWIFE LECTURERS' VIEWS OF THEIR
ROLE AND EXPERIENCES OF STATUTORY
SUPERVISION IN A UNIVERSITY SETTING

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ABSTRACT

Statutory supervision is a system established in 1902 to inspect and regulate midwives practise, in order to protect women. It has developed subsequently to support midwives' practice whilst simultaneously protecting women. Drawing on a range of literature sources and topics, the study critically analyses the context in which midwife lecturers practise and evaluates how they make sense of statutory supervision.

The theoretical framework for this qualitative study is based on social constructionism and relational autonomy. In order to analyse midwife lecturers' views of their role and experiences of statutory supervision in a University setting, the study is divided in two stages. The first stage is a questionnaire surveying the experiences of 254 midwife teachers and 11 Local Supervising Authority Midwifery Officers (LSAMO) in England. The second stage involved semi-structured interviews with a small sample of ten volunteers recruited from the survey. Results were analysed using voice centred relational analysis and framing analysis.

Based on the analyses of the sample of respondents' experiences, combining research, teaching and clinical practice within one role and merging an academic with a professional identity has created role strain. A model of spiralling support which 'nurtures the young' of the profession and creates a working environment built around interdependency is important. The respondents sought relationships which nurtured the growth of sense of coherence and self-efficacy, conflicting for some with the support available from statutory supervision: statutory supervision pre-defines who offers the support and cannot guarantee psychological safety. Conflicting constructions of the meaning of safety and the exclusion of service users challenge the effectiveness of the current model of self-regulation provided by statutory supervision.

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Throughout this text, the midwife is referred to as she. I have anonymised the names of all my respondents.

DEFINITIONS

ACCOUNTABILITY: ‘Accountable is being personally responsible for the outcome of your professional actions, and being able to justify what you have done, why you did it and what the results of your action were. This means that you need to understand not only how to perform a task but why it is appropriate to do so’ (NMC, 2002, module 3, p12).

BANK SHIFT: This refers to a temporary contractual arrangement whereby a midwife is required when there are inadequate numbers of permanent staff for that period of time or clinical shift. Maternity units did manage their own bank staff but this is now managed by the National Health Professionals organisation.

CASELOADING: This refers to a model of care in which a midwife on her own or in a small team provides continuity of care and carer during the antenatal, intranatal and postnatal periods. There is likely to be a higher rate of home births within this model although the midwife will attend wherever the woman chooses to give birth. Examples of this approach to care include the One-to-One project in Sheffield (Dorling, 2005),

CLINICAL LINK: An arrangement by which lecturers employed by a University are allocated to a clinical unit of care provision within the NHS, the independent or voluntary sectors. In this way, lecturers can support clinical staff with the assessment of practice documentation and the progress of students during periods of placement.

CLINICAL SUPERVISION: Clinical supervision became a popular activity in the nursing profession during the 1990's in the United Kingdom. Its widespread use was spearheaded by research reports and Department of Health strategy identifying the value and success in both developing practice and supporting practitioners (Butterworth and Faugier, 1994, Butterworth et al, 1998, Hallberg, 1994, DoH, 1993a). The Department of Health (1993a, page 15) defined clinical supervision as:

' a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume professional responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations ' (DoH, 1993a, page 15).

Moore (1994), the Chief Nursing Officer at the time, condensed and supported the DoH (1993a) definition by identifying how clinical supervision was ...

'... fundamental to safeguarding standards, the development of professional expertise and the delivery of quality care ' (CNO Professional Letter, 94(5)).

Clinical supervision provides therefore a framework for continuing development linked to improving the experience of care for members of the general public. This mirrors the modern aims of statutory supervision but without the responsibility of investigating a practitioner's fitness for practice. Unlike statutory supervision, a formal arrangement for the implementation of the concepts underpinning clinical supervision does not exist. Clinical supervision is optional; organised and developed locally in co-operation with the employing authority.

ENB: The English National Board was a professional body which issued standards and guidance concerning the education and training of midwives. There were four national boards representing each country in the UK. These were replaced in 2001 by the inauguration of the NMC.

FOUNDATION STATUS: In the drive to curb investment alone, the government maintained that investment had to be matched by reform of the organisation. The Health and Social Care Act (HMSO, 2003) established foundation status as a new type of organisation within the NHS. Foundation status trusts which include both acute and primary care are designed to provide, develop and manage services for NHS patients locally with local ownership and accountability rather than state ownership (DoH, 2002a). Waves of NHS Trusts will convert to NHS Foundation Trusts with the requirement to self-govern including budgetary management.

HEFCE: The Higher Education Funding Council distributes monies for research activity in Universities and Colleges based on the results of the RAE in England.

Bodies for the other UK countries are the Scottish Funding Council, the Higher Education Funding Council for Wales and the Department for Employment and Learning in Northern Ireland.

HONORARY CONTRACT: A contract provided by a NHS Trust legally allowing a midwife to practise within the unit but without payment. The Trust accepts liability for the midwife's practise.

INDEPENDENT MIDWIFE: A self-employed midwife who offers her services to individual women for a fee. She is governed by the same professional body and statutory framework as hospital employed midwives and is a member of the Independent Midwives Association. She is not bound by hospital policies unless she holds an honorary contract with local hospitals.

LECTURER: A midwifery lecturer is registered with the Nursing and Midwifery Council as a midwife and midwife teacher and contracted by a University to teach, develop and deliver midwifery educational programmes. In order to be eligible to practise as a midwife lecturer, the post holder must fulfil the requirements of a practising midwife (Rule 2, NMC, 2004b) and midwife teacher (NMC, 2002b, NMC, 2006). *'A variety of members of the teaching and health care team may contribute to the student's learning, but to enable the application of theory to practice, the majority of the teaching/academic input must be from a midwife teacher'* (NMC, 2004d, p25).

LSA: The Local Supervising Authority is the body designated in the Nursing and Midwifery Order (HMSO, 2001) as responsible for exercising general supervision over all midwives practising within its area. In England, the LSA's are Strategic Health Authorities, grouped together to form consortia. The responsibility of the LSA is delegated to the LSAMO (adapted from ENB, 1996a, p16).

LSAMO: The Local Supervising Authority Midwifery Officer is a midwifery officer appointed by the Local Supervising Authority in accordance with Rule 13 (1) of the Midwives Rules and Standards (NMC, 2004b). As a practising midwife, the LSAMO

carries out all the activities needed to ensure that the requirements relating to statutory supervision of midwives are in place and are monitored for the local supervising authority. This person can be contacted by women who need help or support in the way their pregnancy care is provided, or if they are worried about a midwife's practice. The LSAMO ensures that midwives follow the NMC Rules and Standards.

NAMED SUPERVISOR OF MIDWIVES: A supervisor of midwives allocated or chosen to supervise a number of midwives. The midwife can refer to the named supervisor for advice relating to practice (ENB, 1996a, p16).

NMC: The Nursing and Midwifery Council is the regulatory body for nurses and midwives.

PRACTISING MIDWIFE: The Nursing and Midwifery Council have issued rules and standards concerning eligibility to practise. Rule 2 (NMC, 2004b, p 8) states that a practising midwife means a registered midwife who notifies her intention to practise to a local supervising authority and who has updated her practice in accordance with the standards published by the Council, and who:

- a) is in attendance upon a woman and baby during the antenatal, intranatal or postnatal period; or
- b) holds a post for which a midwifery qualification is required.

Further guidance maintains that to be eligible as a midwife a person must hold a midwifery qualification, have current registration as a midwife with the NMC, and have met the NMC standards for updating her midwifery practice. In addition she must have given notice of her intention to practise to the local supervising authority in every area that she intends to practise in (NMC, 2004b, p8).

PREP REQUIREMENTS: This is developed further in Rules 2 & 4 (NMC, 2004b) and Post Registration Education and Practise (PREP) requirements. These state that a midwife must complete her annual intention to practise forms which she submits to the LSAMO, and fulfil her PREP requirements. PREP requirements identify a 750 hours per year of practise over a 5 year period (350 hours over a 3 year period from August 2006) and 35 hours of professional development over a 3 year period which

must be identified within a reflective portfolio. The NMC has stated that educational practice meets the practice standard (NMC, 2004).

PROFESSIONAL REGULATION: The statutory framework which regulates the professional education, practice and conduct of nurses and midwives for the purpose of protection of the public from harm which could be caused from the activities of an unregulated professional (adapted from ENB, 1999a, p17).

QAA: The Quality Assurance Agency works in partnership with the Department of Health, the Nursing and Midwifery Council, the Health Professions Council and Workforce Development Confederations (which were incorporated into Strategic Health Authorities on 1.4.04) to assure the quality of educational programmes involved in the preparation of health care practitioners.

RAE: The research assessment exercise is undertaken within Universities across the UK. The quality and volume of research is assessed against a scale of 1 – the lowest - to 5 * at the top. The top level is defined as research quality that equates to attainable levels of international excellence in most sub-areas of activity and attainable levels of national excellence in others (Tomlinson, 2000). In the revised criteria for RAE (RAE, 2006, Sinclair, 2004), the prominence of the promotion of teaching and learning as a basis for funding is re-orientating University organisational goals and highlighting the importance of teaching and learning alongside research.

STATUTORY SUPERVISION: ‘The mechanism designated by the Nursing and Midwifery Order (HMSO, 2001) and the Midwives Rules and Standards (NMC, 2004b), to promote safe standards of midwifery practice by providing professional support and guidance to all practising midwives for the purpose of protecting women and babies’ (adapted from ENB, 1999a, p17).

SUPERVISED PRACTICE: ‘A formal, assessed and evaluated period of clinical experience, agreed by either the LSAMO or the supervisor of midwives, arising from the investigation of an incident where the need to improve a midwife’s competence has been identified. Access to support from a mentor is arranged for the duration of the supervised practice period.’ (ENB, 1999a, p17)

SUPERVISOR OF MIDWIVES: As defined by Rule 1 in the Midwives Rules and Standards (NMC, 2004b, p8), a supervisor of midwives means a person appointed by a local supervising authority to exercise supervision over midwives practising in its area in accordance with rule 11(1):

'Supervisors are experienced midwives who have undergone additional education and training in the knowledge and skills needed to supervise midwives. Supervisors of midwives can only be appointed by a local supervising authority. By appointing supervisors of midwives the local supervising authority ensures that support, advice and guidance are available for midwives and women 24-hours a day, to increase public protection. A midwife who has completed a preparation of supervisor programme is not a supervisor of midwives until a local supervising authority appoint her. Supervisors of midwives must keep themselves up-to-date in supervision as well as in midwifery in order to remain as a supervisor' (NMC, 2004b, p8).

SUPERVISORY REVIEW: An activity undertaken between a midwife and supervisor on a regular basis to evaluate practice and identify areas for development (ENB, 1999a). This has become a mandatory annual activity in the latest edition of the Midwives Rules and Standards (NMC, 2004b).

TEACHER: Often used in conjunction with and synonymously with the term midwifery lecturer, a midwife teacher is employed by a University as a lecturer to teach, develop and deliver midwifery educational programmes on the basis of being a registered midwife and midwife teacher. A midwife teacher is registered with the Nursing and Midwifery Council as a practising midwife and midwife teacher.

UNIVERSITY GOVERNANCE: The internal structures of a University which support a framework of committee's and common procedures for managing staff and educational programmes. Governance structures vary between Universities.

1. INTRODUCTION

The topic for this research is midwife lecturers' view of their role and experiences of statutory supervision in a University setting. The general aim of the study is to develop a deep evaluative understanding of how midwives in an educational setting make sense of statutory supervision in their occupational roles. In achieving this aim, I also realised a significant personal journey of learning.

Midwife lecturers in England are employed by Universities to deliver midwifery education. This is a relatively new position for midwife lecturers and midwifery education. For many centuries, midwives were trained through experience by working alongside a familiar figure within a community (Marland, 1993, Evenden, 1993, Harley, 1993). However, with the growing institutionalisation of birth throughout the nineteenth and twentieth centuries (Loudon, 1992, Verluysen, 1981, HMSO, 1959, HMSO, 1970), hospitals provided a haven for medical dominance. Medical occupational closure strategies (Witz, 1992) either excluded women attendants or allowed them to train under the supervision of male doctors. Schools of midwifery existed next to wards and midwife teachers undertook the majority of teaching and assessment whilst also managing a ward or clinic (Allison, 1996): midwifery education, in common with nursing education, was managed and organised at the point of client contact in the National Health Service. Over the last ten to fifteen years, schools of midwifery across England have mostly merged with schools of nursing (Fraser and Peat, 1997) and mostly assimilated into University academic communities although there are variations in this pathway (Allen, 1997, Collington, 1997, Bazell, 1997). Economic reasons drove these organisational changes as well as the incentive of an increased academic standing and professional status of midwives associated with University based education.

Universities customarily employ a range of professionals for their role and expertise, i.e. civil engineers, dentists, physiotherapists, medical practitioners.

There is nothing unusual about the nature and function of the contractual arrangement for midwifery lecturers within a University although there are differences in comparison to medical practitioners¹. Working in a University organisation was new and uncharted ground for midwife teachers (Fraser, 1998) midwife teachers cultivated their midwifery and teaching knowledge and skills in the NHS². The significance of the new contractual arrangements, for the purposes of this study, surrounds the tensions that develop between organisational and professional requirements: a midwife teacher is a professional qualification which is recordable on the Nursing and Midwifery Council register; a midwifery lecturer holds an educational contract with a University and must be a registered midwife teacher³. All the respondents in the second stage of this study were midwife teachers in the NHS before employment as midwife lecturers in Universities.

Statutory supervision is legal requirement for all practising midwives because it secures:

'...public safety by supporting and enabling individual midwives to maintain and develop the competencies set by the Nursing and Midwifery Council (NMC) and by promoting practice environments which best meet the needs of mothers and babies' (NMC, 2002, p12).

In addition:

'Supervision is about the midwives themselves, the care they give and where they give it' (NMC, 2004b, p33).

It applies to all practising midwives whatever the area of practice, i.e. clinical or non-clinical. Practising midwives employed by Universities and based within an

¹ Medical careers are based on a model of joint contracts between the NHS and the University facilitating clinical practice, teaching and research (Pusey, 2002).

² Midwifery expertise can also be developed by independent practitioners working outside the NHS although this was not the case for any of the respondents in this study.

³ In order to retain registration as a midwife teacher, the postholder must be a practising midwife, have undergone a professionally recognised preparation programme and fulfil the role as laid out by the professional body (NMC, 2006). A midwife lecturer must be a midwife teacher. See definition section on page ii – iv for further clarification.

educational setting are not part of the clinical mainstream and face a differing set of work related issues to those employed to provide clinical care.

As a midwifery lecturer, I became increasingly aware of the need to utilise supervision but the organisational changes associated with transferring from a clinical to higher educational base minimised the ease by which this could occur. I had become a Supervisor of Midwives after nomination by my manager, successful completion of the preparation of supervisors of midwives programme and appointment by the LSAMO (Local Supervising Authority Midwifery Officer). My intended caseload included the midwives employed by the University. My experience had indicated that non clinically-orientated midwives do not experience statutory supervision in the same way as those based in clinical practice.

Although there is considerable information about the origins of statutory supervision and current issues within the supervision, only two main sources (Duerden, 1995, Stapleton et al, 1998) have considered the impact of supervision upon midwives. A literature search highlighted a lack of information about the implementation of statutory supervision for those midwives working outside the clinical mainstream.

My experiences and the lack of guidance from the literature highlighted a need to explore how statutory supervision translated in a non-clinical working environment. Identifying how midwives in education were supervised and their interpretation of its meaning and value would deepen my understanding of statutory supervision and assist me in developing the role of a supervisor of midwives within education. The respondents' comments challenged my thinking and understanding of statutory supervision. Once I realised how to embrace the challenge, their comments and my interpretation of them, led me on a path of personal and professional discovery.

I start with the explanation of my journey in and with the study. Professionalising Midwifery provides a review of the literature pertinent to this study and sets the context in which midwife lecturers practise. This is followed by the chapter on the Theoretical Framework in which I specify my theoretical location in designing and analysing the research to meet the research aims, so that the reader can understand my theoretical location. The Methods chapter connects my theoretical location with the choice of methods used to discover how individuals understand and make sense of statutory supervision. There are four Findings chapters: the first - chapter 6 - presents the results and findings from the questionnaire answered by midwife lecturers in England and the questionnaire answered Local Supervising Authority Midwifery Officer's⁴. Three chapters developed from the analysis of the second stage interviews: the first – chapter 7 - entitled 'The Role of the Midwife Lecturer' - explains how midwifery lecturers construct their role, thereby setting the scene for the following chapters; the second - chapter 8 - entitled 'Autonomy in Managing Midwifery Identity' - discusses how individuals manage the balance between personal, professional and organisational goals. The final chapter – chapter 9 - entitled 'Experiences of Statutory Supervision' - evaluates how individuals construct statutory supervision in relation to their role as midwife lecturers in higher education by examining the power and influence of statutory supervision within a higher educational and non-clinical setting. Themes from the study are drawn together in the final chapter: Discussion, Recommendations and Conclusions. Personal and professional learning and limitations with the study are integrated within the chapters.

⁴ See page iv for a definition of this term and appendix 11.12 pages 245 - 249 for an explanation of the role of the LSAMO.

2. MY JOURNEY IN AND WITH THE STUDY

Studying at PhD (Doctor of Philosophy) necessitated a deep questioning of personal assumptions and outlook. I have experienced highs and lows through my journey with the PhD. All my interactions with people, events and writers over the course of the PhD have influenced my thought-processes. My personal growth has evolved in parallel with my understanding of statutory supervision and its meaning in a non-clinical setting. There are several key stages which need discussion in order to clarify the nature of my growth.

I began the PhD in 1997 with what I now consider to be the naïve assumption that studying research theory, process and techniques would deepen my understanding and ability within a working environment where research monies and grants seemed a high priority. I had been appointed as a supervisor of midwives for midwives in educational practice 6 months earlier and was struggling to identify the meaning of statutory supervision of midwives in an educational setting. Some midwife lecturers had welcomed my new role whereas others resisted and informed me that there was no role for a supervisor of midwives within an educational setting. This challenged and shocked me as I had believed that as a group we needed a supervisor of midwives who could identify the needs of midwife lecturers from within and maintain links with midwives in other settings. Therefore commencing a PhD on statutory supervision served two purposes – to develop my role of a supervisor of midwives within education and to develop my research skills as required within a higher educational working environment. At that time, I believed that statutory supervision was a bonus for midwives so my perspective was ‘let’s make the best of it’.

The early years lacked focus because I did not fully appreciate the enormity of the journey before me, the extent of my own naivety and how embedded I had become in the systems of midwifery, midwifery education and statutory supervision. I had to delay the start by one year because I had created little time

for it and I thought it would be the same as other research projects that I had successfully undertaken. It was not a priority – I did not view or even respect it appropriately. With hindsight, I had classically identified with the minimisation stage of the transition model (Adams et al, 1976). Adams et al (1976) found that how individuals perceive a change event significantly affects the pattern of cognitive and behavioural adaptation to a new way of life in order to grow from the change and learn to cope from the passage of one phase of life. Minimising a change event helps to deny its influence or existence.

There were so many demands upon my energies at that time that I was unable to direct my study and produce analytical and insightful accounts. I concentrated on doing a good job and supporting others at work whilst struggling with being a supervisor. I – the ‘me’ - was lost in this situation. My own experiences mirrored those of other women who conform even when the environment is stressful and stifling (Belenky et al, 1997a). I perceived the PhD as a source of stress. My motivation to continue arose from my own need for help in being a supervisor in education, the people around me and the fortune of such an opportunity.

A series of events then occurred which triggered my realisation that finishing the PhD would be worthwhile. I had become programme leader for the supervisors of midwives preparation programme. I was developing more personal confidence in the role as a supervisor of midwives and I had become the link supervisor for the LSA of South Yorkshire, Trent, Leicester, Northampton and Rutland. Together, these events opened new doors for me as I experienced different working environments and met new people. My confidence grew as did my understanding of statutory supervision as I saw the difficulties others were having and how useful and how threatening statutory supervision could be in managing incidents from midwifery practice. Being part of a team which supported a midwife through a supervised practice programme showed me the benefit of having a system which supported the midwife without implementing performance management strategies. Equally, the midwife found the experience extremely stressful knowing that her livelihood could be

jeopardised should she fail to meet the requirements of the supervised practice programme.

At around the same time, I remember my excitement on hearing a research seminar given by a visiting lecturer from New Zealand as she discussed their newly developed Midwifery Standards Review (NZCOM, 2001) process. Midwifery Standards Review (MSR) presented an alternative way of supporting midwives to the model of statutory supervision in the UK. Shortly afterwards I had the opportunity to travel to New Zealand and speak to midwives and consumers involved in establishing and running MSR. I viewed my own PhD as an opportunity to examine the basis for and purpose of statutory supervision.

Becoming a Quality Assurance Agency (QAA)¹ reviewer opened my eyes regarding how a similar issue was approached differently within other organisations. Analysing the data from this study also revealed that individuals were dealing with similar supervisory issues, yet had developed differing responses.

I began to appreciate that my own story mirrored very closely those of the respondents: I could easily identify with their concerns and their issues. The strength and validity of the study lay in my ability to rationalise my decision-making. Thinking through the justification for the selection of appropriate methodology guided my development and personal questioning.

The combination of these realisations made me challenge the perceived wisdom behind statutory supervision and view the PhD differently and more positively. The process of challenging the perceived wisdom and ideology required appropriate triggers and guidance and a willingness to confront my perception of the world. My questioning changed from 'let's make the best of it' to 'what is this really all about?'

¹ Please turn to Page vi for the definition of QAA.

My heightened self-awareness and new understanding of statutory supervision is exciting as I realise that there may be other perceptions that need addressing. It is also daunting because I feel that I know very little now. The challenge for me is to continue seeing beyond the perceived truth and not regress as occurred before. I need to gather confidence that I have reached this point and recognise the structures and relationships that have helped me. I certainly feel this stage in my journey mirrors the final integration stage of the transition model (Adams et al, 1986): this involves thinking through how things are different and incorporating the new meanings into behaviour. The sense of seeing that life is different is now behaviourally acted out. I also feel my journey mirrors the fifth epistemological position of integration of voices as discussed by Belenky et al (1997a). A blend of my own subjective voice and objective principles of reason has created a contextual understanding where multiple views are recognised and valued. I feel different; I feel I can integrate the personal and intuitive with other sources of knowledge in order to see the world differently (Belenky et al, 1997a).

The guidance and relationship with my academic supervisor has been indispensable in my growth: she supported and waited for me to realise where I was going, for the chaos to end. This parallels one of the themes within the study that people develop a new sense of self given appropriate support and time. This has been the value of my PhD – it has allowed me to learn about me, chart my growth and give me confidence to see the world differently. I value relationships differently and changing through challenge is not threatening but liberating.

3. PROFESSIONALISING MIDWIFERY

This chapter critically examines the concept of a professional and the status of midwifery as a profession to review how this impacts upon the current organisation of midwifery education. It sets the context from which to critically examine midwife lecturers' views and experiences of statutory supervision in an educational setting.

3.1 The Meaning of a Profession

A profession can be broadly defined as doing a particular kind of work for reward and from which a living is gained (Freidson, 1994). The development and use of specialised knowledge and skills characterises professional work (Cruess et al, 2000). In addition, members of the profession internalise a set of values and practices acquired through a period of training (Jarvis, 1983, Freidson, 1994). Professionalisation refers to the process by which occupations seek to become a profession or achieve professional status (Jarvis, 1983).

Achieving professional status affords exclusive control over a defined area of work and protection from occupational competition (Abbott, 1988, Cruess, et al, 2000). In return for professional status, members are expected to develop and honour a trusting relationship with the client (Freidson, 1994).

Medicine and the development of obstetrics as a clinical specialty within medicine, provide a successful example of the professionalisation of an occupation. A profession's success in establishing its jurisdiction also reflects the situation of its competitors (Abbott, 1988). The group holding control over the technological and organisational elements of a role is able to construct those tasks which strengthen its professional position within society (Arney, 1982). This is particularly noticeable in obstetrics which has become the voice of authority on an aspect of life which had previously been synonymous with the female healer role (Oakley, 1976). The term midwife was not defined until 1902: before that time, the use of the term male midwives implied medical

practitioners whereas the term midwife implied the traditional female healer role of pre-industrial Europe (Oakley, 1976, Kirkham, 1996a). Medical ideology has come to dominate social policy and health care (Newburn and Hatton, 1996, Freidson, 1994). The Midwives Act in 1902 represents a significant reference point for the differentiation of roles for the birth attendant.

3.11 The Professionalisation of Obstetrics Pre 1902

Understanding how the occupational roles of the obstetrician and midwife have become differentiated and defined, helps to explain the sub-ordination of midwifery knowledge and skills during the nineteenth century and the increasing medicalisation of childbirth throughout the twentieth century.

Medicine has employed professionalising strategies since early in the nineteenth century gaining legitimacy and the beginnings of 'occupational imperialism' (Larkin, 1983) with the Medical Acts in 1858 and 1886 (IUP, 1900). Medical training had been established in elite Colleges of Medicine or Universities (Cowell and Wainwright, 1981) such that in the Victorian era, the occupations of medicine, law and the clergy were associated with high status¹. Members of these three occupational groups occupied positions of political and social authority (Elliott, 1972, Etzioni, 1967, Cowell and Wainwright, 1981).

Registration as a medical practitioner, after five years training, was dependent on qualification in medicine, surgery and midwifery (Cowell and Wainwright, 1981, Rentoul, 1892, Hewitt, 1892). Midwifery, i.e. attending a woman during childbirth, had only been included in the training of medical practitioners since 1886 as a consequence of the growth in scientific knowledge in Europe, espoused particularly by Devanter (Donnison, 1988, Wilson, 1995, Cowell and Wainwright, 1981). Theories and knowledge of tools and skills used to save

¹ The emerging medical profession was not a homogenous group. There were 2 main types of practitioner involved in attending a woman during childbirth – the hospital doctor and the general practitioner. Hospital doctors worked within a charity or poor law hospital (the Lying-In or Out-Patient Hospitals) where medical student training occurred. In 1870 general practitioners managed 90 - 95 % of births in small, non-manufacturing towns compared to 10 % in Coventry, a large industrial town (Loudon, 1992).

women's lives served as means of exerting control over the technical tasks, justifying exclusivity and professionalisation of medicine (Abbott, 1988, Cruess et al, 2000).

Whilst midwifery was becoming established as part of a doctor's role so occupational closure strategies were employed which undermined the involvement of the female midwife (Witz, 1992). The detrimental effect of industrialisation on women's health and rising maternal and neonatal mortality rates² were linked to lack of skill and unsafe practice of the female birth attendant (HMSO, 1892). Claiming a link between female birth attendants and unsafe practice served to establish a professional ideology that male medical practitioners were more knowledgeable and safer than female midwives (Larson, 1977): the power associated with professional status was used to claim jurisdiction and minimise occupational competition (Abbott, 1988).

Attitudes towards female midwives were changing considerably: where once female midwives were respected within a community (Wilson, 1995, Thompson, 1983), during the nineteenth century, the character of Sairey Gamp (*Martin Chuzzlewit*, Dickens) and 'churchyard luck' became associated with some female midwives³.

The period of industrialisation during the seventeenth and eighteenth centuries, also witnessed growing governmental and charitable involvement in the development of institution based maternity care⁴ as a way to bring about social reform. Combining self-interest and charitable motives, medical practitioners

² During the period of industrialisation, towns and cities were polluted with poor social and environmental conditions for health, i.e., damp, over-crowded and cold housing with inadequate sanitation (Wohl, 1984). According to Wohl (1984), more births occurred in the polluted and unhealthy towns than the healthier rural areas. The maternal mortality for women between the ages of 25 and 34 in 1890 exceeded the death rate from all other causes for women of that age range (Loudon, 1992). The infant mortality rate in 1891 was 229 per 1,000 births in the Strand in London compared to a rate of 115 deaths per 1,000 births in the middle class area of Plumstead and reached 200 per 1,000 births in large industrial towns, e.g. Birmingham, Manchester, Blackburn (Wohl, 1984).

³ Depicting the divisions that were appearing between those female midwives who practiced in rural and those in urban areas where the standard of hygiene and poverty were strikingly different, the image portrayed within the literature during the nineteenth century varied between being '*decent, intelligent, and clean in methods and very kind*' (Thompson, 1983, page 80) to one considered as a dubious occupation performed by incompetent women as characterised by Sairey Gamp in *Martin Chuzzlewit* (Dickens). Female midwives also became synonymous with the phrase 'churchyard luck' wherein women knowingly employed female midwives who had an unofficial reputation of being involved with the deaths of newborn infants (Donnison, 1988, Wilson, 1995).

⁴ Mathers and McIntosh (2000) provide an account of the development of local government hospital services in response to the series of Poor Laws.

had lobbied philanthropists for funding to develop institutions (Cowell and Wainwright, 1981). The institutions provided the breeding ground for medical training and development of clinical knowledge and skills. Although less than 2 % of women gave birth in these institutions in the 1880's (Loudon, 1992), medical control excluded female midwives unless working under the direction of a doctor. Gendered dimensions⁵ of closure practices in professionalising midwifery within medicine involved the creation and control of boundaries between male and female involvement in childbirth (Witz, 1992).

The majority of female midwives were working class and uneducated (Heagarty, 1990). They lacked sufficient power or influence to counteract the social changes occurring. The midwifery leadership, represented by the Midwives Institute⁶, hoped to raise the status of midwifery by attracting the educated classes and thereby excluding working class and uneducated women. The ideology which supported the limitation of female midwives practice (Paget, 1892, Cowell and Wainwright, 1981, Heagarty, 1990) demonstrates the acceptability of the prevailing patriarchal doctrine that medical practitioners dealt with emergencies in childbirth.

The female midwife was effectively being stripped of complex skills by restricting the scope of practice and de-skilling the sphere of competence (Witz, 1992). The first Midwives Act (HMSO, 1902) legalised the domination of male doctors and the limitation of female midwives involvement in childbirth⁷. The

⁵ The social patriarchal structuring of relations supporting male dominance and female inferiority provided men with privileges (Witz, 1992). Exclusionary forms of patriarchal control existed in the prevention of women entering certain spheres of employment (Witz, 1992) and nationally, women were unable to vote and barred from England's Universities (Banks, 1999). The inclusionary form of patriarchal control of women became evident as the labour of women and children came under the control of the male head of the household (Witz, 1992).

⁶ The Midwives Institute was a group of Victorian ladies who sought to improve the reputation and training of midwives. As trained nurses and midwives, in reality they represented a small minority of midwives. Their values and outlook reflected those of their class rather than the working class values of the majority of unqualified midwives (Davies, 1996). Their attraction to midwifery resulted from involvement with social and professional reform activists (Heagarty, 1990). Having trained as a nurse and midwife, Rosalind Paget led and funded the Midwives Institute rather than working as a midwife. Rosalind Paget, whose family wealth was derived from shipbuilding in Liverpool, was also the niece of William Rathbone the philanthropist and MP (Kirkham, 1996a). Members of the Midwives Institute, whose husbands and relatives occupied powerful positions, used their social status and connections to bring about social changes (Cowell and Wainwright, 1981).

⁷ See appendix 11.11 pages 241 – 244 which summarises the 1902 Midwives Act.

Act established the template for the implementation of a regulatory mechanism: sanctioning those who could legally practise using the title of midwife⁸, implementing a mandatory requirement for training to become a certified midwife, establishing a register or Roll to record those certified as midwives, establishing the professional regulatory body named as the Central Midwives Board (CMB) and a system of national statutory supervision of certified midwives (HMSO, 1902). The implementation of the strong regulatory mechanism was based on the assumption that registration and training would reduce the high maternal and infant mortality. Previously, there had been no authority over a midwife unless she worked in an institution which was under the control of the medical profession.

The Act, which arose from the social mood and events at that time, effectively restrained the role of the female midwife and initiated 'occupational imperialism' (Larkin, 1983) for medical involvement in childbirth.

3.2 Ideological Dominance in Childbirth in the Twentieth and Twenty-First Centuries

The management of childbirth, particularly the choice of place of birth, has changed considerably since 1902. Modern maternity care within the NHS today, is dominated by the medical model: the centralisation of hierarchical maternity services which has occurred throughout the twentieth century⁹, has effectively

⁸ The Act did not clearly define the meaning of a 'midwife'. It did assert that there was a clear distinction between the title of midwife and the title of a medical practitioner. In so doing, the definition of a midwife becomes more what she should not do: 'The certificate under this Act shall not confer upon any woman any right or title to be registered under the Medical Acts or to assume any name, title, or designation implying that she is by law recognised as a medical practitioner, or that she is authorised to grant any medical certificate, or any certificate of death or of still-birth, or to undertake the charge of cases of abnormality or any disease in connection with parturition' (Midwives Act 1902, section 1:5). It also states, again in a negative sense that .. 'No woman shall habitually and for gain attend women in childbirth otherwise than under the direction of a qualified medical practitioner unless she be certified under this Act' (Midwives Act 1902, section 1:2).

⁹ During the twentieth century, a number of NHS re-organisations permitted the ascendancy of medical values in determining the development of some specialisms at the expense of others (Wall & Owen, 2002). Two reports advocated an increase in institutional confinement for births from 70% in 1959 to 100% in 1970 on the grounds of safety as medically defined (HMSO, 1959, HMSO, 1970). The organisation of maternity services in this way has occurred without substantial supporting evidence and contrary to womens needs (Allison, 1996, Tew, 1998, Edwards, 2005, Robinson, 1990, Newburn and Hatton, 1996).

given control of childbirth to the medical profession. Central to the success of the medical model in obstetrics is the control of uncertainty in childbirth (Oakley and Houd, 1990). Controlling uncertainty and risk in maternal and perinatal health is linked with an assumed reduction in the likelihood of unpredictable events (DoH, 2003, DoH, 2004).

The authority to determine 'risk' is based on an epidemiological perspective and orthodoxy which is 'wedded' to a biomedical approach (Saks, 1999).

Underpinned by a mechanistic and technocratic view of human beings, the understanding of disease separates the human being from the environment and social context (Bryar, 1995, Davis-Floyd, 1992). Drawing on knowledge derived from anatomy, physiology and biochemistry (Bryar, 1995), scientific and propositional knowledge is applied in diagnosing and solving problems (Rowland, 1993, Bryar, 1995). The prevalence of disorders and conditions in the human population are identified as a means of determining the risk factor for an individual (Bowling, 1999).

Theoretical scoring systems have been developed to predict, detect and manage problems or factors that may adversely affect the health of the mother and/or baby (James and Smolienic, 1992). James and Smolienic (1992, p 885) define the 'at-risk' obstetric patient as....

'...a woman in whom the chance of an adverse outcome to herself and/or to the baby is greater than the incidence of that outcome in the general pregnant population'.

The UK National Screening Committee addresses all aspects of antenatal, newborn and child health screening programmes having developed a policy framework applicable to all pregnant women and children (NSC, 2006).

Scoring systems or a set of risk factors, do not however value the social and cultural circumstances of individual women (Edwards, 2005) or the added value of supportive relationships (Kirkham, 2000). Instead the scoring systems serve to generalise when there is insufficient evidence concerning individual health

and well-being (Oakley & Houd, 1990, Bowling, 1999). Women experience this mass screening for risk factors as routinised and fragmented care (Newburn and Hatton, 1996). The scoring systems lack specificity, exposing women, categorised as high risk, to iatrogenic risks of interventions (Quilliam, 1999). Thomas (1999) comments how a grey area develops between the potential for a complication to arise and its actual presence. Mander (2002) argues that the dominant ideology of the medical profession has undermined a woman's confidence in her ability to give birth without anaesthesia and intervention, thereby supporting the medical belief that childbirth is only normal in retrospect.

Alternative and competing ideologies do challenge the authority of the bio-medical model. The changing socio-political context has witnessed the emergence of the social model of health, consumerism and the growth of managerial and bureaucratic control in the NHS.

3.21 Social Model of Health

The social model of health is an alternative ideology surrounding childbirth. Clients are viewed as consumers and alternative sources of knowledge and non-medical aspects of care are welcomed (Katz Rothman, 1991, Colyer, 2004, Downe and McCourt, 2004). It uses a different knowledge base and set of skills to those necessary from a biomedical approach. In line with the principles of qualitative research, the nature of this knowledge is inductive, intuitive and interactional. The tacit, insider and contextual knowledge as discussed by Benner (1984) and Schon (1983) is reminiscent of Polanyi's (1958) analogy of not really knowing how the cyclist keeps his balance.

Davis-Floyd (1992) describes a holistic and social model of health in relation to childbirth where the woman is seen as the expert: her well-being and her ability to reproduce are valued and developed through relationships of trust with her care-givers. Leap (2000) explains how midwives can draw on the social model of health to engage with women during their pregnancy and childbirth. Rather than attempting to control uncertainty, the midwife is a point of reference acting as a safety net and working with the woman to understand the effects of

pregnancy and childbirth in her particular circumstances. Using skills of watching and listening, the midwife develops 'cluefulness', knowing when to withdraw and when to suggest or inform (Leap, 2000). A midwife can develop her 'practice theory' through developing relationships with women during their pregnancy and childbirth experiences (Bryar, 1995).

There are examples of the social model of health operating currently within the UK. Within the NHS, there are examples of packages of care, i.e. caseloading, which demonstrate evidence of the benefits of individualised and continuous care despite the presence of risk factors (Hodnett, 2003, Dorling, 2005, Newborn and Hatton, 1996, McCourt and Page, 1996, Leap, 2000, Pairman, 2000, DoH, 2004). Although small in numbers and marginalised in relation to the NHS, independent midwives provide one-to-one care, described by Leap (2000), often with women who present with numerous obstetric 'risk factors'. The collated statistics demonstrate favourable physical outcomes for mother and baby in comparison with national birth statistics (IMA, 2005)¹⁰. There is mounting evidence of the value of the midwife-mother relationship on childbirth outcomes and experiences particularly where women are cared for in their own social context in community (Hodnett, 2003, Kirkham, 2000). It is also the approach that many women have requested (Newburn and Hatton, 1996).

3.22 Consumerism

Current political directives support the growth of the consumer model of health care by recommending widening access for all to information previously and exclusively held by professionals (DoH, 1998). Consumerism favours personal autonomy, empowerment and subjectivity. Not only does this encourage a narrowing of the gap between the expert and clients/patients but it also indicates the displacement of one ideology for another (Parkin, 1995, Colyer, 2004, DoH, 1993b, DoH, 2004, RCM, 2001).

¹⁰ In comparison to statistics released by the Department of Health, inductions, caesarean sections and episiotomies are significantly reduced whilst achieving high home delivery rates (IMA, 2005).

In the childbirth movement¹¹, consumerism is transforming women's rights and expectations of childbirth with rejection of the paternalistic approach and for some, professional advice (Hewson, 2004, Newburn and Hatton, 1996). The consumer voice has lobbied for an improvement in care as maternity pressure groups (Association of Radical Midwives, Association for the Improvement in Maternity Services, National Childbirth Trust) throughout the 1980's and 1990's campaigned for greater information, continuity of care and kindness in maternity services (Reid & Garcia, 1989). Women have increasingly expressed their dissatisfaction with the power and hegemony of obstetrics within maternity services (DoH, 1993b, Newburn and Hatton, 1996, The Commission for Healthcare Audit, 2000). The childbirth movement has questioned in whose interests the professional serves by challenging the underpinning philosophy of medicalisation and centralisation of maternity services (Newburn and Hatton, 1996).

Promoting partnership between professionals and consumers is complex. Home birth provides an example where professional and consumer ideologies of health and safety in childbirth can conflict. For the majority of women birthing in a bureaucratic hospital remains the norm (Healthcare Commission, 2005). Despite the government and professional ideology encouraging women to give birth at home (DoH, 2004), the number of women who do so is estimated as 2 per cent in England (www.BirthChoiceUK.com). Both Edwards (2005) and Simpson (2004) comment on how the distinction between safety and danger in childbirth has been culturally and socially constructed by the medical profession¹².

Women, in Edwards's (2005) study, accepted that safety was an on-going process and that the application of obstetric knowledge on the basis of

¹¹ The childbirth movement is a collective term referring to maternity groups such as NCT or AIMS as well as individuals, women, parents, midwives and some obstetricians. The movement seeks to challenge the increasingly medicalised approach to childbirth favouring a more holistic approach. United in their concerns, the movement grew during the 1950's and 1960's, reaching sufficient numbers to exert influence when the forces of feminism and consumerism combined in the 1970's (Newburn and Hutton, 1996).

¹² Edwards (2005) found that giving birth at home was viewed as unsafe by those who support the obstetric concept of safety, due to the belief in the unpredictable nature of childbirth and the need to guard against all potential complications. As the authoritative professional voice, refusal to accept the medical construction of safety equated to irresponsible behaviour by 'threatening the life of the unborn child' (UKCC, 1998, RCOG, 1982, Hosmer, 2001). Simpson (2004) also found that the medically constructed definition of risk was used with women to persuade the client to follow medical decision-making and support medical authority in discussions.

minimising danger, could not ensure safety or eliminate risk. Their experiences of maintaining this view brought them into conflict with medical and midwifery professionals, highlighting the disempowering effect of the professional paradigm (Wilkins, 2000, Hoyle, 2001, Illich et al (1977): their needs seemed secondary to the medical ideology of epidemiological surveillance, development of intrusive technology and the booming business of birth technology. Giving birth at home does not fit the mould of the way to give birth with claims of lack of resources to 'cover' home births (Harrison, 2003, Edwards, 2005).

The new National Service Framework for Children's and Women's Services (DoH, 2004)¹³ advocates woman centred, supportive and individualised care providing further opportunities to promote consumerism within the maternity services. A re-organisation of the maternity services to place women at the centre of care challenges professional roles and opposes both medical and managerial ideology (DoH, 2004, Demilew, 2005). There are moves to involve women as users of the service within statutory supervision¹⁴: the 2004 (NMC, 2004b) edition of the Midwives Rules and Standards introduced the need to involve service users in the audit of maternity services and recently the LSAMO's have collectively developed a guideline which suggests involving users in the selection of prospective supervisors. The adoption of consumerism requires a shift in thinking by professionals. As Bradshaw & Bradshaw (2004) identify 'expert-driven' care remains the norm and 'doing with' patients requires a new breed of professional in order to sustain consumer and public involvement.

¹³ The National Service Framework (NSF) for Young Children, Families and Maternity Services (DoH, 2004) is a policy directive regarded as the blueprint for the development of services over the following ten years.

¹⁴ See section 3.3 page 21 for an explanation of statutory supervision.

3.23 Managerial and Bureaucratic Control

The NHS, as a hierarchical organisation (Fairtlough, 2005), is a blend of both role and existential culture and style¹⁵ (Handy, 1985). Fundamental reform in the NHS is breaking down traditional patterns of working and beliefs which support hierarchy (DOH, 1998, 2002c): the vision for the NHS entails devolved decision making and networks of care with the drive toward foundation status¹⁶; empowering front line staff to develop the skills and abilities needed for innovative care delivery; empowering patients by increasing the information available to them; and encouraging patient involvement in the delivery and development of local services. Primary Care Trusts (DOH, 2002) have been given new powers to control resources and commission services across hospital, community and primary services for a local area and to respond to local health needs. Improved health and social care will be achieved by the creation of smaller autonomous sub-units in community based buildings and areas with accountability to the local community (DoH, 2006). Further evidence of decentralisation of decision-making arises from the devolvement of Department of Health responsibilities to smaller and Strategic Health Authorities which will performance manage the NHS at regional level and determine the criteria for success or failure.

¹⁵ Within a role culture, power is associated with the role (Handy, 1985). Typical of hierarchical and bureaucratic organisations, power is invested in responsibilities associated with the role which are defined in job descriptions. Jobs are predictable and standardised with clear career pathways and pension schemes. As Hochschild (1983) and Kirkham (2005) discuss, the standardisation helps to identify occupational role but also ensures a highly controlled performance. This style of organisation can be less reactive to changes in the external environment and ineffective in developing staff and organisational growth as the rules and procedures introduced can stifle innovation (Powell, 2002, Mintzberg, 1979). The existential style is characterised by individual talent and relates to specific roles within the NHS where managerial and administrative roles support the prized individuals. Handy (1985) maintains that this style is beloved of professionals who can exert their personal and professional freedom and create their own identity, e.g. academics within Universities or Consultants within hospitals.

¹⁶ Foundation status was established from the Health and Social Care Act (HMSO, 2003) and refers to independent public benefit corporations within the NHS. Through a ten year plan, waves of NHS Trust organisations providing health care will convert to NHS Foundation Trusts. The new Foundation Trusts are self-governing (which includes budgetary management) with lines of local public accountability as opposed to state accountability. Foundation status Trusts remain part of the NHS and are subject to national inspection, policies and frameworks but controlled and run locally (see glossary for further information).

In order to steer the NHS in the direction of the policies and develop consistency in the quality of care provision across the UK, a range of national bodies have been established: the National Institute for Clinical Excellence (NICE) sets standards across the NHS and the Healthcare Commission (formerly Commission for Health Improvement)¹⁷ inspects and awards performance ratings by way of external audit (Freeman and Walshe, 2004). The star rating system was abolished in 2006 in favour of a new set of generic indicators (Bradshaw & Bradshaw, 2004).

Reform of the NHS has altered the underpinning philosophies of health care and its micromanagement (Bradshaw & Bradshaw, 2004). The prioritisation of principles of business management (DoH, 2002c) conflicts with the professional interests of the differing professional groups particularly the powerful medical profession. Bureaucracies and managers now determine which staff is needed for specific roles: a strategy of employing cheaper and unqualified health care workers in aspects of care is well established where this was previously the jurisdiction of the health care professional (RCM, 1999, Spiby & Crowther, 1999, DoH, 2004). Clinical governance was introduced as a framework through which NHS organisations are accountable for safeguarding high standards of care and promoting quality (NMC, 2002). Its introduction emphasises managerial control over professional activity. The Clinical Negligence Scheme for Trusts (CNST)¹⁸ is another example of the battle for control of clinical practice and increasing managerial domination over professional ideology (Abbott, 1988, Edwards, 2005). The prominence of litigation, particularly in the maternity services, has led to the development of a policies and standards across the NHS which are subject to national audit. Clinical guidelines and protocols

¹⁷ The Healthcare Commission developed from the Commission for Health Improvement which was initially concerned with implementing clinical governance reviews. Established in 2004, it is a super-regulator improving the quality of care, judging performance and co-ordinating the work of six national bodies (Bradshaw & Bradshaw, 2004).

¹⁸ CNST is the Clinical Negligence Scheme for Trusts managed by the NHS Litigation Authority. Monies incurred from a successful litigation claim against the NHS are paid by the NHSLA. To reduce the litigation risk, national standards have been set against which every maternity service is assessed and graded. Compliance with the highest level of 3 signifies a significant reduction in the Trusts' financial contribution to the clinical negligence scheme (NHSLA 1999).

diminish opportunities for clinical freedom and individual variation (Colyer, 2004, Parkin 1995).

Working in the NHS at grass roots level seems different to the vision laid down in the principles of a First Class Service (DoH, 1998) and the NHS Plan (DoH, 2002c). Evidence from some midwives, including midwifery managers, suggests that the lack of professional autonomy is affecting their experience and satisfaction with their role. Some midwives discuss their experiences of powerlessness, vulnerability, divisions within midwifery, fear of litigation and lack of resources (Ball et al, 2002, 2003, Kirkham and Stapleton, 2000). Based on data from those midwives who chose to leave midwifery, Curtis et al (2006a) found that the biggest reason for finding alternative employment was dissatisfaction with the system of care which contradicted their own philosophical values about the most appropriate way of providing midwifery care. From their findings, Curtis et al (2006b) point to an organisational culture¹⁹ and dysfunctional social system which fails to challenge unacceptable norms of behaviour resulting in lack of support and respect. The absence of 'supportive collegiality' hinders attempts to develop new ways of working (Curtis et al, 2006c).

Competing ideologies provide differing perspectives on how best pregnancy and childbirth can and should be experienced in the twenty-first century: which ideology an individual favours greatly affects their outlook and evaluation of the maternity services. Ideological dominance is reflected in the strength of social position and level of authority. Presently, the range of ideologies challenges professional status in obstetrics and midwifery.

¹⁹ There is a link between organizational culture and individual satisfaction at work. Fairtlough (2005) identifies the existence of enabling or coercive cultures and their impact upon the employee. An enabling culture demonstrates '*... frankness, mutual respect, shared commitment to goals, loyalty and fun*' (Fairtlough, 2005, p22), suggesting an enjoyable working atmosphere. Constructive leadership, respect for others, self-discipline and a commitment towards the generation and sharing of knowledge contribute to an enabling culture. Conversely, a coercive culture demonstrates '*... an ambiance of fear, favouritism, malicious gossip and dishonesty*' (Fairtlough, 2005, p22), and therefore an unsupportive and tense working atmosphere.

3.3 Self-Regulation and Statutory Supervision

Self-regulation is one of the cornerstones of professional status affording the exclusive privilege of determining control of the profession by the profession (Cruess et al, 2000, Styles, 2005). An internally managed process appoints a governing body to establish the standards and rules by which to regulate the conduct and behaviour of its members (Norman, 1999).

Midwifery, nursing and community specialist public health nursing registrants are regulated by the Nursing and Midwifery Council (NMC). The NMC arose from an independent review body commissioned by the Department of Health to investigate the effectiveness of the then regulatory framework and improve public accountability and responsiveness to stakeholders (JMConsulting, 1999, UK, 1999)²⁰. Reflecting changes in socio-political attitude to the principle of professional self-regulation, the primary function of the NMC is public protection and accountability. Public participation and representation with faster and transparent procedures are key principles in the constitution of the NMC (NMC, 2002a, 2004h, 2004j, 2004e). The implementation of the new Fitness to Practise Rules and procedures from 01 August 2004, as required by the Nursing and Midwifery Order (NMC, 2004 a & h, HMSO, 2001), demonstrate greater control over the conduct, performance and behaviour of all registrants than previously²¹.

Statutory supervision operates within the framework which is defined by the Midwives Rules and Standards (NMC, 2004b) and Fitness to Practise Rules (NMC, 2004j & h) and from which statutory supervision regulates the practice of midwives in the UK (NMC, 2004b). Statutory supervision presents a unique

²⁰ The first governing body, the Central Midwives Board (CMB), was formed from the 1902 Midwives Act. Medical and male membership (Cowell and Wainwright, 1981) shaped the new midwife in the early twentieth century effectively blocking self-regulation. This was replaced by the United Kingdom Central Council (UKCC) in 1979 when nursing and midwifery combined to form one instead of two separate governing bodies, following recommendations from the Briggs Committee (HMSO, 1972). A midwifery committee was formed to promote the interests of midwifery due to publicly voiced concerns that midwifery would be misrepresented (Robinson, 1990, Dimond, 1994).

²¹ The new powers include the introduction of competence as a standard by which practitioners can be judged and a greater range of sanctions available for the panel of the Conduct and Competence Committee (NMC, 2004 a&h).

situation in professional work by claiming territorial and professional control over the regulation of midwifery practice (NMC, 2004b). Initiated in 1902 (HMSO, 1902), statutory supervision served as a system for inspecting midwives practice when the majority of midwives practised independently²². Today, the purpose of statutory supervision, as a self-regulatory system, is both public protection and support for women and midwives (NMC, 2004). As the NMC states:

'The role of a supervisor of midwives is to protect the public by empowering midwives and midwifery students to practise safely and effectively' (NMC, 2004, b, p26)

Networks of trained supervisors of midwives respond to local needs and are managed by regional LSAMO on behalf of the Local Supervising Authority (NMC, 2004b)²³. Currently, in most parts of the UK, a midwife is selected to become a supervisor of midwives by peers and the LSAMO before commencing the statutory preparation programme (Rule 11, NMC, 2004b). The preparation programme is supported by material published by the NMC: publications are updated as the regulatory framework changes (ENB, 1997, 2000, NMC, 2002) with the latest edition expected in December 2006. The relationship between the supervisor and supervisee is the main vehicle for undertaking supervisory activities. The size of a supervisory caseload has changed dramatically recently: at one time a ratio of 1 supervisor to 117 midwives existed (Murphy-Black and Mannion, 2000) whereas the current Midwives Rules and Standards (NMC, 2004b) state that the ratio should reflect local needs and circumstances and not normally exceed 1 supervisor to 15 midwives (Rule 12). The responsibilities are now acknowledged in the pay framework (DoH, 2004a) as clinically based supervisors of midwives receive payment of between £500 and £2000 per year nationally in undertaking what was previously a voluntary role.

²² Appendix 11.11 pages 241 – 244 summarises the 1902 Midwives Act.

²³ Appendix 11.12 pages 245 – 249 describes the organisation of statutory supervision and explains the differing responsibilities and duties of the Local Supervising Authority, Local Supervising Authority Midwifery Officer and a supervisor of midwives.

The public protection function primarily involves investigating an incident where a midwife's fitness to practise is questioned (NMC, 2004a, b & h)²⁴. The preparation undertaken to become a supervisor of midwives addresses this aspect in detail. In the case of proven unsafe practice or lack of competence or confidence, a supervisor of midwives will liaise with the LSAMO to determine the most appropriate action to protect the public. The LSAMO can suspend the midwife from practice if continued practise threatens the safety of women whilst pregnant (LSA, 2005, c). Alternatively, supported and supervised practice programmes can be developed locally to support a midwife to improve her confidence or competence²⁵.

Duerden (2002) maintains that the small number of midwives referred to the NMC for impaired fitness to practise supports the activities of supervisors of midwives and the LSAMO thereby valuing statutory supervision as a self-regulatory mechanism. Using the nursing profession for comparison, figures published in 2006, identify that 2.9% of the total number of fitness to practise cases related to midwifery (Keat, 2006).

The assumption that statutory supervision, as a form of self-regulation, protects women from unsafe practitioners can be challenged. Using evidence from cases presented before the Professional Conduct Committee (PCC) in 2003 – 2004, the numbers of nursing, midwifery or community specialist public health nurses practitioners placing the public at risk was relatively small: 301 from a total of 644,000 on the register (NMC, 2005, Asbridge, 2003). Of these 127 practitioners were removed from the register and 45 cautioned for failing to attend to basic needs, unsafe clinical practice or abuse. Only 3% of cases were

²⁴ Fitness to practise is defined as: '*being impaired by misconduct, lack of competence, a conviction or caution, physical or mental ill health, a finding from another health or social care regulator, or fraudulent or incorrect entry in the NMC's register*' (NMC, 2004j, p2). Lack of competence is defined as: '*a lack of knowledge, skill or judgement of such a nature that the registrant is unfit to practice safely and effectively in any field in which the registrant claims to be qualified, or seeks to practice*' (NMC, 2004h, p2).

²⁵ A supported practice programme involves a set period during which the midwife will be supported to improve her confidence or competence in a defined area. A supervised practice programme arises when a midwife has breached the NMC Rules and Standards and requires a set period of time for training after which the midwife must demonstrate competence and conduct. Failure to pass a period of supervised practice can lead to referral to the NMC for further investigation and possibly removal from the register (LSA, 2005b).

non practice-related. As at 04 November 2005 (Personal Discussion with a member of staff within the Fitness to Practise Section of the NMC) there were 34 midwives being investigated by the Investigating Committee²⁶ of the NMC which represents 0.1% of the total midwifery population on the register. Five midwifery registrants have been referred to the Conduct and Competence Committee²⁷ (CCC) by the Investigating Committee representing 0.015% of the total midwifery population on the register (NMCd, 2005). For nursing and community specialist public health nursing registrants, 1164 are being investigated (0.185% of the total nursing population on the register) and 69 have been referred to the CCC (0.011% of the total nursing population on the register). The NMC register only accounts for 4.9% of practising midwives (Keat, 2006) hence although there are fewer midwifery cases referred to the CCC, the population from which the cases are drawn is smaller so the actual numbers of cases presented before the NMC is higher.

A crude survey of 9 of the 11 LSAMO in England for the year 2004 – 5 also questions the assumption that statutory supervision protects women and their families. The survey identified that 65 midwives had undergone either supported or supervised practice programmes as a result of a supervisory investigation or recognition of the need to improve areas of care provision (Wilkins, 2005). The figure of 65 presents two arguments: the number of cases highlights the volume and value of work undertaken by supervisors of midwives once an incident has been identified; they also indicate a level of poor practice where statutory supervision is responding and reacting to incidents once they have occurred and where confidence or competence has already detrimentally affected a woman's experience of midwifery care.

Statutory supervision is a mechanism for managing midwifery practice when fitness to practise is questioned: it provides swift and local action to prevent re-occurrence. This is positive and acts to protect the public whilst also

²⁶ The Investigating Committee gathers information concerning a case and whether there is a case to answer. If the facts of the allegation are capable of being proven, the case will be referred to the Conduct and Competence Committee (NMC, 2004a)

²⁷ The Conduct and Competence Committee is a public hearing to determine whether a registrant's fitness to practise is impaired and whether the registrant is safe to remain on the register (NMC, 2004a).

highlighting the difficulty of preventing poor professional practice. Crossley et al (2002) maintain that good professional regulation depends on the quality by which professional performance is assessed and the effectiveness in evaluating professional competence. Defining and measuring competence is acknowledged (Fraser, 1998, Minarik et al, 2005, Roberts et al, 2005). The organisation of statutory supervision facilitates opportunities to discuss issues from practice and developmental needs through the annual supervisory review between the supervisor and each supervisee on her/his caseload (NMC, 2004b). The annual review, together with the Post Registration Education and Practice (PREP) arrangements adopted by the NMC (2004f)²⁸, do not however measure or guarantee competence or safety (Norman, 1999) and cannot therefore claim to fully protect the public from unsafe practice.

3.31 Other Sources of Tension within Statutory Supervision

There are number of other tensions which question the assumptions behind statutory supervision.

In the present socio-political context, advocating self-regulation contradicts the principles of public involvement and consumerism²⁹. Baker (2005) argues that a supervisor of midwives can have her own interpretation of safety which is contrary to that of the woman and the midwife she is intending to support. She demonstrates that although statutory supervision claims to represent and protect the interests of women, it imposes a construction of safety which can differ from that of the woman and the midwife. This would be most notable when a supervisor of midwives judges the practice of an independent midwife who traditionally is more likely to hold an alternative view of pregnancy and childbirth to a midwife trained and practising within a hospital setting (IMA, 2005a). Judging safety of a peer permits the dominance of one ideology over another.

²⁸ Please see the definition section for explanation of PREP.

²⁹ See section 3.2.2 pages 16 -18 In this chapter for further explanation of the importance of consumerism in maternity care.

Statutory supervision can be viewed as an organisational tool rather than a mechanism for self-regulation or professional leadership. Flint & Fraser (2002) point out that the growth in the number of appointments of supervisors of midwives who are involved in monitoring the quality of the organisation, serves to emphasise how statutory supervision is a tool used by others to control the practise of midwives. Duerden (2002) comments on how the new model of supervision which has developed in the last 10 years provides a firm foundation for clinical governance thereby contributing to organisational effectiveness within the NHS. Similarly, Hawkins (2002) identifies how the role of the supervisor of midwives includes implementing findings from the confidential enquiries and supports the achievement of the standards set by the Clinical Negligence Schemes for Trusts (CNST)³⁰ within the NHS. Modern statutory supervision is aligned with supporting the implementation of current social and health policy and underpinning ideological values within the NHS. In so doing, there is the suggestion that statutory supervision can be viewed as a mechanism for maintaining the patriarchal control of childbirth and supporting hospital culture and hierarchies (Silverton, 2000, Cruess et al, 2000, Kirkham, 1996). Stapelton et al (1998) identify how statutory supervision is too closely aligned to the organisational power structures for it to fulfil its supportive function for midwives and women.

Recent investigations by the Healthcare Commission have identified failings in the system of statutory supervision in fulfilling its regulatory and self-designated organisational role (Healthcare Commission 2004, Healthcare Commission, 2005, CHI, 2003). The results of three investigations in maternity services over the last two years have identified that the overall root cause for poor performance is weak managerial or clinical leadership (Healthcare Commission Press Release, 2005a). The culture was non-supportive, guidelines were not evidence based, team working was ineffective and staffing levels were low. Statutory supervision with its focus on safety and standards in practice, operated in all of these units demonstrating how as a system it failed to make an impact in

³⁰ CNST is referred to and defined in section 3.2 3 page 20.

the effectiveness of the organisation even though it claims this area as legitimate activity.

Individuals' experiences of supervision vary and can be limited by the conflicting statutory responsibilities and the hegemony of hierarchy (Flint, 1987, Flint and Fraser, 2002, Beech, 1993, Seaman, 1995, Williams, 1996). Stapleton et al (1998) in an ENB funded study on the evaluation of the impact of statutory supervision on midwives identified that supervision has positive effects on midwives' practice but there were also less desirable consequences. These weaknesses included lack of confidence in a supervisor which undermined the supervisee's ability to receive support from her supervisor, the creation of dependency and lack of control within the supervisor-supervisee relationship. Whilst some midwives identify the importance of empathy and support from their supervisors of midwives, others find that breaches in confidentiality detrimentally impact upon their confidence in developing a trusting relationship with their supervisor of midwives (Stapleton et al, 1998). The duty of public protection works against the development of relationships between supervisors and supervisees which value '*openness, trust, negotiation and empowerment*' (Stapleton et al, 1998, p213). Dissatisfaction with statutory supervision also arises when the supervisor, who is also a manager, confuses the roles (Seaman, 1995, Walton, 1995, Williams, 1996).

Self-regulation and the systems of medical and non-medical regulation have been under review (DOH, 2005, Walshe and Benson, 2005) in response to high profile misconduct cases (Kennedy, 2001, Smith, 2004, NMC, 2005b). The governmental review highlights the tension between current arrangements for self-regulation and the demands of consumerism and managerialism within the current political and societal climate (Allsop and Saks, 2003) and challenges the strength of the professional power base. Published in July 2006, the review (DoH, 2006a) which is subject to consultation, recommends co-ordination of regulation between the health service and professions so that one integrated and consistent framework of regulation across the different professions exists. Re-validation processes should dovetail with the systems established within the

NHS, i.e. the Knowledge and Skills Framework³¹, and strengthened by the implementation of a risk analysis for those professionals whose practice places the public at greatest risk of harm. Statutory supervision is absent from the report: even where it is acknowledged that legislation designed to protect the public exists, the Report (DoH, 2006a, p8) suggests that changes should bring *'regulation of these professions into line with the majority'*.

As a system for self-regulation, statutory supervision has undergone evolutionary steps throughout the twentieth and twenty-first centuries. Assumptions surrounding the effectiveness of statutory supervision are beginning to be challenged within midwifery and nationally with the publication of the Foster Review (DoH, 2006a). It is difficult to establish how effective statutory supervision is because success and individual perception rests on the interactional nature of the supervisor-supervisee relationship. As the NMC states:

'The success of supervision reflects the ability of those who do it and it is, therefore, important to get the right person into the role' (NMC, 2004b, p26).

3.4 Midwifery Knowledge Base

The assimilation of Colleges of Nursing and Midwifery with higher educational establishments has heightened the drive towards graduate status programmes (Allen, 1997, Collington, 1997, Bazell, 1997). Enhanced academic achievement is thought to enable a deeper and broader understanding of client health needs (Larcombe and Maggs, 1991) and act as a way of increasing professional standing by claiming a midwifery knowledge base.

The development and use of specialised knowledge and skills is central to defining professional work (Cruss et al, 2000) and characterise a curriculum: a curriculum is the framework and pathway for internalising a set of values and

³¹ See section 3.4 page 30 for further explanation of the Knowledge and Skills Framework (DoH, 2004b)

practices acquired through a period of training (Jarvis, 1983, Freidson, 1994). In order to gain registration as a midwife with the NMC, the framework for midwifery knowledge and proficiency is defined by Article 4 of the Second Midwifery Directive 80/155/EEC, the Standards of Proficiency for Midwifery Education (NMC, 2004d) and the Midwives Rules and Standards (NMC, 2004b). The EU Directive and NMC publications form the professional and statutory basis for a curriculum and are exclusive to midwifery. There are other influences upon the development of a midwifery curriculum which are not necessarily uni-professional. Each academic organisation has a set of criteria which stipulate the requirements for students to achieve an academic award. Some Department of Health initiatives relate specifically to the role of a midwife in health care³². Other Department of Health directives, such as the Knowledge and Skills Framework (DoH, 2004b) and Agenda for Change (DoH, 2004a) as well the emerging influence from the Skills for Health (DfES, 2005) group³³, are influencing the content and outcomes required for all pre-registration programmes for health care practitioners.

The growing number of influences upon midwifery curriculae and health care practitioners challenges the notion of a specialised knowledge base and skills. Greater moves towards shared and interprofessional learning (Bower, 2002, HEFCE, 2005³⁴) is also emphasising an identification and harmonisation of those elements which are generic between different professional groups. Both Kirkham (1996) and Draper (1991) identify how propositional theory such as medical physiology, sociology, psychology and ethics can be borrowed from other disciplines rather than the development of holistic midwifery knowledge. The concern surrounds how easily knowledge can, when learnt in a piecemeal

³² Standard 11 of The National Service Framework for Young Children, Families and Maternity Services (DoH, 2004) contains a blueprint for the development of maternity services by 2014 with key objectives for 2009. This replaced the priorities outlined within the earlier Changing Childbirth Report (DoH, 1993b).

³³ The Knowledge and Skills Framework (DoH, 2004b) defines the knowledge and skills that NHS staff require to deliver quality services. It is linked closely to the Agenda for Change (DoH, 2004a) which identified the basis for career terms and conditions as well as progression within the NHS. The Skills for Health (DfES, 2005) group is the Sector Skills Council for the UK health sector licensed by the Department for Education and Skills. It is tasked with defining generic competences, transferable skills and portage of occupational roles.

³⁴ HEFCE created Centres for Excellence in Teaching and Learning in several Universities running interprofessional learning programmes in order to increase and deepen its impact across the teaching and learning community.

way, be transferred to the clinical setting when as Schon (1983) and Benner (1984) discuss, a practitioner particularly the expert one, requires the ability to distill and apply knowledge in clinical scenarios. The current popularity of problem based learning as a means of validating contextualised knowledge and clinical reasoning processes (Boud & Feletti, 1997, Glen and Wilkie, 2000) within midwifery academic programmes suggests an acknowledgement and rebalancing of this situation (Thomas and Cooke, 1999, Thomas et al, 1998)³⁵.

Universities are changing. Still characterised by a heterarchical structure³⁶, the socio-political context in which Universities operate has stimulated changing organisational goals (Dearing Report, 1997, DoES, 2003). Organisational goals until recently related to the research activity undertaken: the volume and quality of research in Universities in England was assessed by the Higher Education Funding Council (HEFCE) through the research assessment exercise (RAE) (Tomlinson, 2000)³⁷. Quality related research funding provided not only kudos but core funding for a University's research base covering staff, premises and computing (Tomlinson, 2000). In 2003, the Department of Education and Skills identified national strategic priorities for learning and teaching in Higher Education identifying embedding excellence, innovation and professional development as the cornerstones for activity. This led to the creation of an additional funding stream: HEFCE invited bids for Centres for Excellence in

³⁵ There is no clear indication of the numbers of midwifery programmes using PBL. However this comment arises from discussion with Lead Midwives in Education and from local contacts in Yorkshire and the Midlands.

³⁶ Heterarchy describes the separation of power and control from one individual towards a de-centralised and distributed approach (Fairtlough, 2005). Co-operation, team working and consensual decision making is central to the success of this style or a hidden hierarchy can develop. Diversity and job rotation are valued in order to foster organisational growth and develop an awareness and understanding of organisational purpose and function. In so doing, all employees have a personal responsibility towards achieving the organisational goal. University Charters divide power and decision-making between chancellor and vice chancellor roles and councils include staff representatives (Brown, 1992, Fairtlough, 2005). The style of organisation is complex with diverse professional groups each with their own cultural background (Brown, 1995). As an organisation, Universities adopt a blend of task and existential styles fostering the development of academics whose individual skills give credence to the organisation (Becher, 1989). In return, academics are not highly controlled and are valued for the expertise, personal drive and charisma.

³⁷ Each higher education institution is allocated a block grant by HEFCE, additional monies are linked to the graded results from the RAE. Seventy subject areas including medicine and nursing (which includes midwifery) were considered in the last RAE with the subsequent allocation of monies. RAE is UK-wide with support from HEFCE in England, the Scottish Funding Council, Higher Education Funding Council for Wales and the Department for Employment and Learning.

Teaching and Learning (HEFCE, 2005b) in 2004 with significant funding until 2009 (HEFCE, 2006a). Seventy-four centres in Universities were established in 2005 creating access to extra revenue and a national and international reputation as a centre of excellence for teaching and learning. The funding has arisen from a newly developed element within the Teaching Quality Enhancement Fund (HEFCE, 2006b). The prominence of the promotion of teaching and learning as a basis for funding re-orientates University organisational goals: TQEF and CETL's together with the revised criteria for RAE (RAE, 2006, Sinclair, 2004) highlights the importance of teaching and learning alongside research. The award of doctoral studies was more highly valued over teaching qualifications; some Universities are now introducing teaching fellow posts to enhance the status of teaching and learning (Lomas, 2004, Times Education Supplement, 2002).

External bodies are critiquing and influencing University organisational goals. The Quality Assurance Agency (QAA)³⁸ assesses the quality of programmes and their ability to link aims, learning outcomes, teaching methods and assessments. The QAA is embedding a new set of cultural values of continuous quality improvement, effectiveness and to a degree, standardisation (QAAHE, 2000) in organisations which previously experienced considerable autonomy. Barrett (1998) maintains that the ivory tower concept associated with Universities is out-dated as teaching and learning strategies, profile of the student body and nature of teaching has changed. Universities are required to prepare individuals for the new world of working life rather than the development of pure academic skills (Schabarcq & Cooper, 2000, Rowley, 1998, DoES, 2003).

The experience of working in an organisation, whilst being in part responsible for establishing and delivering professionalising activities, highlights some tensions. Day et al (1998) comment on how the changes in the content and structure of University based educational programmes has created competing demands on the role of the lecturer. Silverton (1996) indicates that the source of

³⁸ After a tendering process, the QAA was replaced by the HLSP in 2006. The HLSP will coordinate reviews on behalf of the NMC.

the competing demands stem from the prioritisation of research and postgraduate studies over clinical practice and working alongside students and mentors in the clinical learning environment. Referring to the potential theory-practice gap, Silverton (1996) continues by identifying how lecturers' lack of clinical involvement can highlight how the rhetoric and reality of clinical care can create difficulties for the students in placement areas (Silverton, 1996). Fairbrother and Ford (1997) discuss how lecturers are stretched by the competing requirements of university life and supporting students in clinical practice. The changing organisational direction of Universities may address some of these tensions although the Report of the Education and Development Group of the National Midwifery Recruitment and Retention Six Point Action Plan (EESHA, 2006) has spotlighted the role of the midwife lecturer. Recommendations from the Group (EESHA, 2006) include establishing a system which allows midwife lecturers to work in both practice and education and promote research and scholarship whilst enhancing practice and education.

Gaining access to a University based education represents steps towards achieving professional standing. Claiming an exclusive knowledge base is diminishing as external demands influence the future direction of higher education and the education of healthcare professionals generally.

3.5 Summary

Reviewing the pillars of professional status - ideological strength and values, self-regulation and a defined knowledge base - has challenged the concept of a professional in the twenty-first century. Midwifery has striven for professional status but the socio-political context is affecting how a midwife works in the NHS and the development and management of midwifery educational programmes in Universities. The role of a professional in health care is subject to shifting philosophical influences and requires a paradigmatic shift in thinking to determine how midwives will be trained and work in the future.

4. THEORETICAL FRAMEWORK

In this chapter, the aims and design for the study are presented to demonstrate what and how I was intending to achieve. I follow by explaining my perspective in designing and analysing the research to meet the research aims. In so doing the reader can understand the basis for my decision making throughout this study. My perspective has been influenced by social constructionism from the qualitative paradigm and relational autonomy as a development of the theory of relationality.

Oppression and patriarchy have affected the occupational role of a female midwife and women's experiences of childbirth¹. Despite the centrality of oppression and patriarchy in feminist epistemology, this research has not been taken as a feminist project per se and I am not a feminist. I do recognise how interactions and responses to events can be influenced by gender differences: '*cultural templates*' which fail to acknowledge gender differences undermine the '*connected way of conceptualising the self-world relationship*' (Belenky et al 1997b, p50). This chapter explains this stance.

4.1 Aims of the Study

At the beginning I stated my aims for the study as:

- To establish a national picture regarding the present statutory supervisory arrangements for midwifery lecturers/lecturers;
- To explore the relationship between supervision and midwives' practice within higher education;
- To determine the role and meaning of supervision for midwives within a higher educational settings.

¹ Section 3.1.1 page 10 in the chapter on Professionalising Midwifery examines how the growth of obstetrics and the medicalisation of childbirth during the nineteenth and twentieth centuries affected both the role and autonomy of the female midwife and women's experiences of childbirth.

Although acceptable, the simplistic manner in which I stated the three aims demonstrates my naivety and lack of awareness at that time. The shape of the study formed through a complex process of peeling away assumptions and building layers and spirals of understanding over time. As I analysed the findings from the first stage and realised my own values in designing and undertaking the study, my perspective changed² and a clearer and more appropriate theoretical framework emerged. My analytical choices reflect my theoretical location. With hindsight I would now state my aims as:

- To critically analyse the context in which midwives in education practise;
- To critically evaluate the system of statutory supervision of midwives and its relevance in the modern and future context of midwifery practice;
- To develop a deep evaluative understanding of how midwives in an educational setting make sense of statutory supervision;
- To realise a significant personal journey of learning.

4.2 Study Design

The initial aims suggested two distinct approaches: how midwifery lecturers were being supervised and how they experienced statutory supervision. This divided the study in two stages. The first stage of the study involved establishing existing patterns and relationships as the literature review had identified a limited existing knowledge base regarding the organisation and implementation of statutory supervision for those midwives working in an educational setting. This orientated the second stage towards a focused and deep exploration of experiences based upon the issues arising from the first stage, my personal experience and the literature review. The choices of method within the design were influenced by my changing theoretical location as I explain in these next sections.

² See section 4.3 page 35 – 39 in this chapter for greater explanation of my changing perspective through the course of the study.

4.3 Paradigm Change

I started with quantitative assumptions. A quantitative perspective is underpinned by a positivist paradigm wherein knowledge is observable and subject to prediction and control (Ellis and Crookes, 1998, Burns and Grove, 1997). The researcher applies standardised instruments to minimise variation and bias in the findings (Crookes and Davies, 1998, Dyson and Brown, 2005). The influence of the researcher upon the research is minimised so that studies can be replicated by different researchers to prove their validity (Carter, 2000).

The first stage of the study and the development of the questionnaires were influenced by this positivistic paradigm. As I progressed with the first stage of the study several limitations associated with a positivistic stance surfaced in relation to my topic. The emerging diversity of responses to the questions from the questionnaires challenged the design of the questionnaire and my understanding of statutory supervision. I had assumed that 'statutory' supervision was one reality which individuals shared when the evidence was suggesting that others held a very differing view. Some of these views reflected the sentiments of those who criticised statutory supervision (Seaman, 1995, Flint and Fraser, 2002).

I began to question the meaning of objectivity as required within the positivistic paradigm when, as a supervisor of midwives and midwifery lecturer, my own views were deeply embedded in my rationale for choosing the research topic and designing the questionnaire. My 'insider' knowledge, as Silverman (1985) calls it, challenged the positivistic meaning of objectivity by blurring the boundaries between myself and the respondents. Edwards and Ribbens (1998) reference to 'a way of being in the world' matched my location: my insider knowledge, both public and private, affected my actions and connectedness with people and therefore my role as a researcher. My need to lose any commitment to a positivistic objectivity was confirmed by Packer and Addison (1989, p12):

'Detachment is not an essential prerequisite to objective, undistorted description and explanation. On the contrary, it is a distorting move that

removes or covers up the practical involvements - cultural, social or personal – that enable us to understand other people in the first place’.

Maintaining a positivist paradigm was incompatible with the aims of the study.

The qualitative paradigm, as an alternative to positivism, aims to describe and promote the understanding of human experiences (Polit and Hungler, 1997, Ellis and Crookes, 1998). Covering a large and diverse body of thinking, generally, the qualitative paradigm explores how individuals make sense of and construct their social world (Silverman, 1985). Qualitative research seeks to examine the process by which the researcher influences the research (Porter, 2000).

Standardisation and generalisation as measures of validity and reliability within a quantitative perspective are replaced by the demonstration of credibility, transferability, dependability and confirmability (Dyson and Brown, 2005, Guba 1981). The involvement and participation of the researcher is acknowledged through the process of reflexivity (Ellis and Crookes, 1998, Cluett and Bluff, 2000): the values and commitments of the researcher and the context within which the research is conducted, contributes to the process of reflexivity (Hammersley and Atkinson, 1995, Silverman, 1985, Mauthner and Doucet, 1998, Edwards and Ribbens, 1998).

Social constructionism is a theoretical stance within the qualitative paradigm. It recognises that concepts such as perceptions, meanings, motives and feelings help individuals make sense of the world and that there is not a single unitary reality (Dyson and Brown, 2005). It is founded on four assumptions (Burr, 2003). Firstly, taken-for-granted ways of understanding the world have to be critically examined in order to generate differing accounts of social phenomena. Secondly, ways of understanding are historically and culturally relative, and therefore dependent upon prevailing economic and social arrangements at the time. Thirdly, knowledge or a way of understanding the world is negotiated through social processes and interactions. Burr (2003, p4) summarises this by stating how:

‘It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated....The

goings-on between people in the course of their everyday lives are seen as practices during which our shared versions of knowledge are constructed. (Burr, 2003, p4)

This stance allows for numerous social constructions of the world without making the assumption that one construction is any better than another. The final assumption within social constructionism is that differing constructions invite different kinds of action (Burr, 2003). There is a strong link between the way of understanding the world and the way of responding to it.

Transformational moments occur from which individuals interpret and make judgements about their own and others behaviours and experiences (Denzin and Lincoln, 1998).

Social constructionism influenced my orientation towards the study as I realised how the respondents and I had constructed differing understandings of statutory supervision based on experiences and contexts. Gergen (1999) identifies how multiple realities can lead to a mutual understanding. My journey and particular social location as the researcher and the location of the respondents, cannot be transferred to another setting. The study represents a moment in time, from which the educational and supervisory landscape has changed since. The understanding that emerged is contextualised and the interviews are dependent on the relationship and context between the interviewee and me at that time³. As Mauthner and Doucet (2003) explain it is with the benefit of hindsight that the extent of the range of influences that shaped the research is recognised:

'....some influences are easier to identify and articulate at the time of our work while others may take time, distance and detachment from the research' (Mauthner and Doucet, 2003, p435).

Identifying error can be symptomatic of 'good' research (Oakley, 2000). I had already collected data from the questionnaires and commenced interviewing before clarifying my paradigm. If I had been more sensitive towards the values influencing my perceptions then I may have I asked different questions or

³ Appendix 11.7 page 218 provides details of the interview plan. These topics were discussed in each interview but the manner and format changed between the interviews due to the flow of the conversation and the sensitivity I demonstrated in responding to their comments.

responded in different ways. The methods of analysis reflect however both social constructionism and relational autonomy.

4.4 Relational Autonomy

Relational autonomy refers to a range of perspectives which share recognition that persons are socially embedded. Identities are shaped and formed within the context of relationships as individuals respond to their social location (Mackenzie and Stoljar, 2000). A range of factors, i.e. gender and race, can influence experiences although Meyers (2000) argues that agents are capable of partial autonomy or autonomy in certain domains of their lives. Skills of self-discovery, self-direction and self-definition allow an integrated and dynamic self. Mackenzie and Stoljar (2000 p13) explain this further:

'From both a feminist perspective and that of mainstream theories, oppressive socialisation often seems inimical to agents' autonomy. Contemporary accounts of individual autonomy hold that autonomy, or self determination, involves, at the very least, the capacity for reflection on one's motivational structure and the capacity to change in response to reflection.'

This mirrors Freire's (1996, p31) comments regarding transformation and social change:

'In order for the oppressed to be able to wage the struggle for their liberation, they must perceive the reality of oppression not as a closed world from which there is no exit but as a limiting situation which they can transform'.

The fluidity of power as described by Freire (1996) and Mackenzie and Stoljar (2000) highlights the importance of individual agency in overcoming barriers or difficulties. Whilst being subject to the socialising processes of patriarchy and obstetrics, the respondents were advantaged in many ways - educated, waged and articulate - and made powerful decisions to improve their working lives through their efforts to manage and sustain relationships⁴.

⁴ See section 7.1 pages 85 – 94 in 'The Role Of A Midwife Lecturer' for a fuller discussion on the web of relationships involved in being a midwife lecturer.

The theory of relationality, which underpins relational autonomy, has its roots in feminist epistemology. Feminist epistemology represents a broad and diverse range of perspectives sharing a commitment towards making visible women's experiences with a view to improving their lives in some way (Maynard and Purvis, 1994, Harding, 1987). A feminist theoretical framework examines the world through the experiences of women, taking into account the impact of gender differences, women's oppression and patriarchal control (Maynard and Purvis, 1994, Gilligan, 1993, Belenky et al 1997a, Harding 1987). Oppression and patriarchy are multi-faceted and affect women in different ways, some of which are shared by men, i.e. the effect of class, race (Haralambos and Holborn, 2004, Ramazonglu, 1989).

Developed by Gilligan (1982, 1993), the theory of relationality is the cornerstone of this study and relational autonomy because it raises the importance of different modes of social experience (Nicholson, 1999). The writings of Gilligan (1982, 1993) and Belenky et al (1997a) informed my understanding of how gender differences can shape identity formation and how women can, at times, view and respond to the world differently to men. It is not a polarisation of male and female experience rather a convergence of differing perspectives to provide a new understanding.

Gilligan (1982, 1993) identified how more women than men would define themselves in terms of their relationships and connections with others. Women are more likely to resolve moral conflicts through dialogue and by listening and responding to everyone's concerns (Belenky et al, 1997b). Gilligan (1982, p62) writes how:

'...the images of hierarchy and web inform different modes of assertion and response: the wish to be alone at the top and the consequent fear that others will get too close; the wish to be at the centre of connection and the consequent fear of being too far out the edge. These disparate fears of being stranded and being caught give rise to different portrayals of achievement and affiliation, leading to different modes of action and different ways of assessing the consequences of choice.'

Belenky et al (1997b) explain how women tend to develop a sense of identity through relationships whereas the male identity is more likely to be based on

separation and autonomy. In society, the conception of masculinity as rational, separate and detached is valued more highly and opposes those qualities associated with femininity such as care, emotion and friendship (Mackenzie and Stoljar, 2000).

Nicholson (1999) particularly comments that Gilligan's (1982, 1993) theory of relationality reflects the kinds of lives typical of western and professional women. DeBold et al (1996), Edwards (2005) and Nicholson (1999) highlight the diversity of women's experiences and the difficulties associated with maintaining some relationships. However the theory resonated with my own experiences and those of the respondents: the connection and relatedness with others figured prominently in the respondents interviews as each described a network of relationships which contributed to their sense of identity and which prevented the feeling of being 'out on the edge'.

Mary Field Belenky, Blythe McVicker Clinchy, Nancy Rule Goldberger and Jill Mattuck Tarule developed Gilligan's (1982, 1993) theme of the importance of relationality. The shifting and dynamic nature of power within relationships is reflected in the five epistemological perspectives developed by Belenky et al (1997a) and referred to as 'Ways of Knowing'. Harding (1996) highlights three key aspects of this work: the importance of locating women's ways of knowing and differences between them; how conditions in lives can place limitations upon the development of self, voice and mind; and lastly how:

'In the case of gender relations, knowledge possibilities are shaped not only by the activities in which men and women characteristically engage, but the positions they are assigned in power relations' (Nicholson, 1996, p432).

Using a phenomenological approach, 135 interviews were undertaken with women from differing class, ethnic and academic backgrounds. The five epistemological perspectives are named as silence, received knowledge, subjective knowledge, procedural and constructed knowledge (Belenky et al,

1997a)⁵. Their findings highlight how relationships and the circulating nature of power can both enable and disable women's sense of identity. Although not dissimilar to the way that men develop, Goldberger (1996) points out that Belenky et al (1997a) uncovered themes, such as the experiencing of silence and the importance of personal knowing, which validated 'genderised' knowledge. In response to the debate surrounding the contribution of this theory to gender differences, Goldberger (1996) stresses how the uncovered themes identify how women respond to socialising forces rather than contributing to divisions between men and women.

Oakley (2000) questions the methodology by pointing out that there is little information on how the sample had been recruited or their social backgrounds. Equally, women's position in society is not as simple as perhaps suggested by the five epistemological perspectives (DeBold et al, 1996). Explanation of movement between the perspectives is limited which Belenky et al (1997a) do acknowledge. Despite these criticisms, Belenky et al (1997a) demonstrate the significance of supportive relationships in developing the voice and mind of another. Support from others is valuable in developing a stronger sense of coherence and boosting personal confidence in one's own abilities and competence (Antonovsky, 1988).

Bluckert (2005) discusses how the ability to support another to grow is very skilled and may only occur when a cognitive connection exists. Pedler et al (1986, p235) maintain that within a supportive relationship:

⁵ The perspective 'silence' represents those women who have little confidence in their own abilities or concept of self and are dependent on others. Received knowledge refers to a group of women who have little confidence in their own voice but listen and learn from others. This favoured a sub-ordinated role within relationships and conformist thinking. Women with a subjective knowledge perspective, which represented half of the sample, lose the awe of external authority and replace it with personal feelings and experiences. A procedural knowledge perspective identifies how women can draw on their subjectivity and knowledge from external authorities. Belenky et al (1997a) comment how this perspective is not unique to women. It does hold two sub-categories: separate and connected knowing. Separate knowing is represented as impersonal reasoning whereas connected knowing is represented as reasoning through relationships with other people. Women tend to 'tip' towards connected knowing. Finally, in a constructed knowledge perspective, women develop a way of knowing which blends their own subjective voice with the objective principles of reason to create contextual and integrated understanding. Responsibility, commitment and nurturing others characterised this group.

'Self-development is bound to be a risky business, involving... facing up to one's own weaknesses and trying to work on them.... This requires a high level of trust, mutual understanding and respect'

Goldberger et al (1996) apply the perspectives in educational practice to facilitate discussion and support individual voice in conversations. Likewise, in the Edgware birth centre, the supervisor facilitated peer support rather than dependency on her as a means by which midwives could develop their confidence (Jones, 2000). Only when individuals feel truly supported, can the process of empowerment begin (Kirkham, 2003).

Support is offered within the supervisory relationship yet respondents in the first and second stage of the study highlighted lack of trust as a significant reason for not engaging with statutory supervision. Stapleton et al (1998) found that not all midwives experienced statutory supervision as enabling and empowering. The report identifies how statutory supervision ...

'...can be for good or ill' (Stapleton et al, 1998, p213).

The literature review and responses from the first stage of the study highlighted the dual and dynamic nature of power within statutory supervision: it seemed a system through which discourse can powerfully silence a midwife and, as some of the respondents demonstrated, also powerfully develop the thinking of others. As the researcher, the importance of the power differential within the supervisory relationship as enabling or disabling personal and professional autonomy grew as I analysed the respondent's comments in their interviews. The respondents in the study, as women, mothers and workers were juggling and balancing relationships whilst making decisions and exercising personal power about what was best for them.

The significance of relationships in the respondents' comments and the offer of support from the supervisory relationship links the theory of relationality to the development of the theoretical framework. Relational autonomy challenges the feminist rejection of the term autonomy and its association with masculinity and selfhood, by emphasising instead the dynamic nature of autonomy in

relationships which is relevant to both men and women. This position mirrors the comments of Foucault (1976 in Gordon, 1980) who describes power as circulating:

'Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power... individuals are elements of power' (Foucault, 1976 in Gordon, 1980, p98).

Within relational autonomy, the individual has the power to determine personal behaviour and response.

4.5 Methodological Choice

A range of methodological options were available to me given the epistemological elements that had influenced my thinking and interpretation and which matched the respondents' comments. These included, among others, grounded theory, phenomenology, ethnography, feminist methodology and social constructionism (Strauss and Corbin, 1998, Holloway and Wheeler, 1996, Silverman, 2001, Goodman and Strange, 1997, Cameron, 2001). Even though I valued the contribution of social constructionism in my theoretical orientation I rejected it as a specific methodology. Burr (2003) maintains that the importance in adopting social constructionism is a commitment towards understanding differing negotiated meanings. As a loose collection of perspectives, adopting a social constructionist methodology alone would have ignored the contribution of relationality.

Differentiating between the remaining diverse philosophical views embraced by qualitative research was problematic because many share core themes. This added to the difficulty of unravelling the distinctiveness of each option and recognising what each might contribute to the study. All but the feminist methodology were rejected after I realised how closely the values within a feminist approach could shed light on the experiences of midwifery lecturers.

Phenomenology seeks to understand the way individuals exist in the world and the significance of everyday things and events to that individual (Stephenson and Corben, 1997). The purpose is to understand the meaning of phenomena rather than explain behaviour which Strausser (1963) described as intuitive primary perception. Individuals organise their contact with the outside world and classify their experiences in order make sense of it. Benner (1984) provides an example of phenomenological approach when exploring the concept of expertise in nursing as do Belenky et al (1997a) in exploring women's ways of knowing. Statutory supervision is not a way of being however: I needed to understand how and why individuals respond and negotiate meaning.

Ethnography alternatively, is a collective term for varying approaches: cognitive anthropology, social interactionism and ethnomethodology (Silverman, 1985). Each concerns the replication of routine events, the creation and exchange of symbolic orders or everyday encounters in order to give meaning in the social world (Silverman, 1985, Field and Morse, 1985). Each seeks to explain acceptable and conforming behaviour (Dingwall, 1981). However, individual responses to the system of statutory supervision were revealing complexity and contradictions. Further the collection of data using an ethnographic approach would have proven difficult and time consuming as well as jeopardised the guarantee of confidentiality. I required an approach that sought to understand these responses rather than clarify norms governing conforming behaviour (Haralambos and Holborn, 2004).

The significance of relationships and relational autonomy justified adoption of a feminist methodology. Recognising individual responses to socialising forces corresponded with the topic, the literature review, the respondent's comments and my journey as the researcher.

4.6 Summary

In this chapter I have explained my location with respect to theoretical and methodological decisions. My location recognises that the respondents and I held differing constructions of statutory supervision. I have partially adopted the feminist theory of relationality (Gilligan, 1982, 1993) and 'Women's Ways of

Knowing' (Belenky et al, 1997a) in so far as these identify the value of a supportive web of relationships and how gendered responses to socialising forces can emphasise the disabling and enabling effects of power within relationships. I have located myself with relational autonomy as this provides a theoretical foundation from which to examine how the respondents have taken control of their situation and used personal power as tools for self-determination.

In this next chapter, I present the selected methods based on the values and assumptions presented in this chapter.

5. METHODS

In this chapter, I explain how my theoretical location and social context influenced my choice of methods so that the reader can assess the consistency between my theoretical framework, decisions and analysis.

5.1 The Influence from Other Studies

Searching the literature base was extensive and on-going. The library at the NMC, the Public Records Office at Kew, Reports of the Commons Health Select Committee's during the 1890's and subsequent Government papers provided a useful historical review of the development surrounding the regulatory framework. The OVID and EMERALD databases provided relevant articles from midwifery, nursing, medicine, management and organisational psychology. Two local University libraries offered excellent reference material on women's studies, politics and research methodology.

Other studies conducted in the same field provided insights concerning the design rationale, obstacles faced and limitations identified. I was influenced particularly by the work of Jean Duerden (1995) and Stapleton, Duerden and Kirkham (1998). Both these studies provided the basis for the development of the questionnaire in the first stage of the study.

Duerden (1995) audited statutory supervision by interviewing 91 per cent of supervisors of midwives and 15 per cent of midwives and midwife lecturers within a defined area of England using a questionnaire as the audit tool. With Jean Duerden's consent, I used her questionnaire in developing my own¹. Using a qualitative ethnographic approach, Stapleton, et al (1998) study examined how midwives and childbearing women experienced supervision and how it influenced them. Stapleton et al (1998) stressed the significance of assuring

¹ As you will read later, this was a help and a hindrance as I tended to follow the questions created by Jean rather than develop my own. This was due to my own lack of clarity and uncertain theoretical location at the time.

confidentiality and anonymity when interviewing participants concerning personal professional practice. The team also recognised the omission of managers of midwives when defining the intended sample population.

5.2 The Sample Population

Porter and Carter (2000) refer to the sample as a proportion of a defined population, in whom the researcher has an interest, and which reflect the total population. The strength of the sample arises from the evidence concerning where the sample has arisen from and characteristics of that sample (Bond, 2000). Selection of the appropriate sample was significant, particularly in relation to the omission identified within the sampling techniques in the Stapleton et al (1998) study.

Based on my knowledge of the role of the midwife lecturer, I defined the target population as all midwives who taught students on pre-registration and post-registration midwifery education programmes and who held a substantive post within a University. Taken from the Notification of Intention to Practise forms, the total population of registered midwife lecturers at the time was 650 in the United Kingdom with 553 in England (UKCC, 1998). This figure included Heads of Midwifery in Education, i.e. managers, midwife teachers/lecturers and lecturer-practitioners².

As each midwife, in whatever setting, legally requires a nominated supervisor (NMC, 2004b), supervisors of midwives were considered but subsequently excluded from the sample: heeding the advice from Stapleton et al (1998), the inclusion of supervisors could have interfered with individuals' confidence in the assurance of anonymity and confidentiality. Further, given the confidential nature of the relationship between the supervisor and supervisee (NMC, 2004b), contacting the supervisors of midwives who supervised midwifery lecturers posed ethical and administrative problems.

² Lecturer-practitioners are joint appointments between an NHS Trust and a University (Lessing-Turner, 1997).

Local Supervising Authority Midwifery Officers (LSAMO) statutorily provide advice and support to supervisors and midwives within a defined Local Supervising Authority³. Including this group, which totalled 13 (one other was on long-term sick leave), provided a valuable dimension concerning guidance on the supervision of teachers/lecturers⁴ in education.

The national supervisory arrangements also had to be taken into account when defining the sample, as the arrangements varied slightly between England, Scotland, Wales and Northern Ireland. Given the differences, addressing the needs of midwives in education in each country suggested collecting data separately. To minimise confusion with the collection and analysis of results the population was confined to England, which also represented the largest population.

The total potential population was 553 registered midwife lecturers and 13 LSAMO. A larger sample is more likely to be representative and more likely to identify a range of experiences which I required in order to determine patterns and establish a picture (Pontin, 2000, Hicks, 1996). The sampling technique was therefore purposive and convenient (Bowling, 1999), in that only the potential respondents in England were targeted. The total potential population was necessary to establish a national picture regarding the present statutory supervisory arrangements for midwifery teachers/lecturers and fulfil the first aim of the study.

A means of confirming the findings from this study, further research could contrast the views of midwife lecturers with other midwifery groups, e.g. independent midwives, midwives supporting women who have home births to discuss their experiences of statutory supervision and whether their experiences supported or disproved the experiences of midwife lecturers. This would have

³ Appendix 11.12, pp245 – 249, explains the organisation of statutory supervision, clarifying and distinguishing between the role of the LSAMO and a supervisor of midwives.

⁴ I use the term lecturer/teacher as terminology varies nationally but it refers to either a midwife lecturer or midwife teacher. See the definition section, pages ii – vii for further explanation.

provided a useful mechanism to compare similarities and differences and enhance understanding of the socially constructed nature of statutory supervision.

5.3 Data Collection Tools

5.31 Choosing a Survey Approach for the First Stage

I needed to establish how midwife lecturers were being supervised in order to fulfil the aims of the study. Although there is debate within the literature concerning the nature and purpose of survey research (Rees, 1997, Abbott and Sapsford, 1997, Polit and Hungler, 1997), the definition provided by Atkinson (2000) that descriptive surveys make descriptive statements about a population, matched my rationale. This method allows an account of the characteristics of a particular individual, group or situation (Carter, 2000, Burns and Grove, 1997).

In addition, a survey offers flexibility and scope. It generates information and provides the basis for further research from its findings (Polit and Hungler, 1997, Daly et al, 1992). Silverman (1985), Polit & Hungler (1989) and Atkinson and Hammersley (1998) identify that surveys offer extensive rather than intensive analysis, as findings tend to represent the ideal account of attitudes and behaviour with an uncertain relationship to reality. The emergence of general issues forms the basis for further examination during the second stage of the study (Daly et al, 1992).

5.3.11 Choosing a Questionnaire and its Design

Options within data collection when using descriptive survey studies include the use of interviews, questionnaires or observation techniques (Carter, 2000, Burns and Grove, 1997). Given the sample size of 567 respondents, a questionnaire approach seemed most appropriate for the first stage of the study. Considering the size of the proposed sample, a self-administered postal questionnaire appeared to be the most economical, effective and manageable

means of collecting data (Oppenheim, 1992, Silverman, 1985, Polit & Hungler, 1997).

Two separate questionnaires were developed to reflect the different experiences of midwives in education who experience statutory supervision and those of the LSAMO who offer advice and guidance. The topics for inclusion in both questionnaires⁵ was guided initially by issues raised from the literature, particularly the work of Duerden (1995) and Stapleton et al (1998), together with my own experience and discussions with other supervisors and midwives. Using Hicks' (1996) framework to generate the questions, the key concern was making the questions clear to the respondents (Barker, 1989).

Questions were arranged in modules, each covering an identified theme. Factual data was placed at the end within the build-up and ordering of the questions in order to minimise incompleteness of the questionnaire through loss of interest on the part of the respondent (Oppenheim, 1992). I chose to use the SPSS package to manage and analyse the responses using percentage calculation. Using this package proved to be a valuable method of learning concerning developing graphs and charts using statistical information although not all the charts proved useful in clarifying the diversity of responses⁶.

The value of the survey findings depended on my skill in designing a questionnaire that adequately addressed the research question, attempted to reduce potential bias and avoid misleading the respondents (Polit & Hungler, 1997). Heeding advice from Oppenheim (1992) who warns against the perils of poorly designed questionnaires, re-framing and re-organisation of the questions occurred after feedback from three critical reviewers and a pilot undertaken in Wales.

⁵ See appendices 11.4, pp 196 - 202, and 11.5, pp 203 - 207, for the final questionnaires distributed and 11.3, pages 187 - 195 for the rationale for the questions posed.

⁶ I use some of the charts developed using the SPSS package to aid the explanation of the findings from the first stage of the study in Appendix 11.6, pages 208 - 217.

5.3.12 Recruitment to the First Stage

The process of recruiting the population sample was governed by the need to self-select rather than the application of techniques for selection (Atkinson, 2000). The response rate with a self-administered postal questionnaire is known to be low, usually around 30% (Oppenheim, 1992). To minimise the possibility of a low return, efforts were taken to ensure the appearance seemed professional and each questionnaire was accompanied by a stamped return envelope (Oppenheim, 1992). Compliance with ethical principles was essential (McHaffie, 1996, McHaffie, 2000)⁷. Confidentiality and anonymity were guaranteed together with an estimation of the time required to complete it.

Given the small numbers and their national prominence, accessing the LSAMO was straightforward. Accessing midwives in education was more complex⁸. A database containing the name of each midwife lecturer or lecturer/practitioner did not exist. A letter was sent to the Head of Midwifery in Education in 51 organisations throughout England, requesting the participation of those employed in a substantive post and employed by the University. Over a six month period and after seeking ethical approval in two organisations, I collated the names of 434 midwife lecturers or lecturer-practitioners. A copy of the questionnaire with a stamped return envelope was sent to each midwife lecturer / lecturer-practitioner. A green sheet was attached at the end of the questionnaire requesting contact details for those prepared to volunteer for the second stage of the study.

From the total of 434 questionnaires sent to midwife lecturers throughout England, 254 returned a completed questionnaire, providing a response rate of 58.5%. From

⁷ See section 5.5 page 63 in this chapter for an explanation of the ethical principles guiding this study.

⁸ See appendices 11.1, pp 184 - 185, & 11.2, p 186, for a copy of these letters.

the total of 13 LSAMO in England, 11 responded by returning a completed questionnaire, representing a response rate of 84.6%.

Whilst collating the results from the pilot and whilst re-visiting the literature on statutory supervision and research design, my concerns surrounding the underpinning quantitative perspective ignited. I began to realise how this perspective ignored the socially constructed nature of statutory supervision⁹. My altered world view automatically affected my research design. At the time I chose focus groups as the most appropriate means of data collection for the second stage of the study. However as the next section explains, this decision was ultimately affected by my recruitment strategy.

5.32 Deciding to Interview in the Second Stage

My changing philosophical perspective, which occurred during the development of the questionnaire, does not discount the findings. Indeed as Lincoln & Guba (1987) and Polit & Hungler (1997) maintain, the first phase of a qualitative study involves the implementation of strategies designed to facilitate understanding of the key elements in the area of interest as these go on to form the basis for further deeper exploration. The second stage was dedicated to exploring individuals' experiences of statutory supervision. This fulfilled the two aims of the study which concerned the needs and attitudes of midwifery lecturers.

Choices within a qualitative and feminist approach which allow exploration of women's experiences tend to focus on observational studies or variations of an interview technique (Bowling, 1999). Observational studies are more suited to an ethnographic approach where the direct gathering of information uses all senses to observe behaviours and establish the meaning attached to everyday events (Bowling, 1999, Polit and Hungler, 1997, Pontin, 2000). Observing

⁹ See section 4.3, pp 36 - 39, on Paradigm Change within the Theoretical Framework chapter for greater explanation of the factors contributing to my change in philosophical perspective.

supervisory meetings between midwives in education and their supervisors of midwives raised ethical issues concerning confidentiality and anonymity as discussed earlier. Interviews allow delving beneath the surface of superficiality to find meaning and to understand the social world (Bowling, 1999, Pontin, 2000a, Gilligan, 1993, Belenky et al, 1997a). Using clarification and paraphrasing, interviewing allows a deepening exploration and understanding of the assumptions of others and my own. Interviewing more closely aligned with the intentions and theoretical location of the study.

The interview in qualitative research, unlike the interview in a quantitative design, is seen as a dynamic interaction connected to the time and place in which it takes place (Pontin, 2000). It provides a forum for sharing information which necessarily involves the researcher and all she brings to the interview (Maynard, 1994). The opportunity for dialogue is fundamental in enabling the respondents' voice to be heard (Maynard, 1994, Parr, 1998, Edwards and Ribbens, 1998)¹⁰.

An individual face-to-face interview can be unstructured or semi-structured. Unstructured interviews provide an opportunity for respondents to tell their own story and would be in keeping with feminist methodological intentions (Pontin, 2000a, Bowling, 1999, Brown et al 1989). Semi-structured interviews rest upon the use of specific open-ended questions which is useful when specific points need raising (Polit and Hungler, 1997, Silverman, 1985). The interview plan developed from the first stage findings indicating the need for semi-structured interviews. Respondents were still able to speak freely (Mannion and Cohen, 1980) as the interview plan provided topics or triggers within the interviews which needed greater explanation¹¹. I now feel that this demonstrated my lack of confidence: it felt comfortable to have an interview plan.

¹⁰ Section 4.4, pages 39 - 44 in the Theoretical Framework chapter provides an explanation of the importance of allowing expression in order to understand the respondents understanding and construction of her world.

¹¹ See appendix 11.7, p218, for the interview plan and scenario's used.

The content of an interview can be different on another day and with another interviewer (Haralambos and Holborn, 2005). As Maynard (1994) discussed, an interview is about sharing information and acknowledging that a relationship exists and develops during the interview. The process of interviewing rested upon my ability and skills to communicate effectively. I found that during the interviews some individuals were having difficulty thinking about statutory supervision: they had determined how they managed their role and midwifery identity and seemed to resist suggestions of alternative approaches. Intuitively, I added some scenarios, i.e. an example of a poorly performing student, as recommended by Cormack (2000) and Benner (1984) to stimulate thought and discussion. My decision to add scenario's within the interview was spontaneous, an effort to maintain discussion, support the respondent and continue the interview.

5.3.21 Recruitment to the Second Stage

I contacted each respondent regarding the possibility of organising an interview whilst assuring anonymity and confidentiality. Interviewing facilitates clarity and sensitivity although it raises issues of time and expense for the researcher and respondents. Smaller samples are more likely due to the in depth nature of the analysis (Bowling, 1999, Polit and Hungler, 1997, Pontin, 2000a). This sample only contained midwives in education because I wanted to learn more about experiences rather than the advice given by the LSAMO. Forty people volunteered from different geographical areas of England and none were from the same University. From the original forty volunteers only ten individuals actually agreed to be interviewed. The interviews were not time - limited and lasted between one hour and three at a local venue chosen by the respondent. Each was tape recorded and subsequently transcribed.

5.33 Limitations with the Data Collection Phase

There are several elements within the data collection phase which limited the usefulness of the information gained. Firstly, the value of all the questions within the questionnaire is restricted. I learnt a lot about designing and administering a questionnaire and using SPSS but actually the findings did not really give me many answers. This was primarily due to inappropriately worded questions: naively, I had expected straightforward answers when instead variable patterns emerged. Question 13, for example, concerned an individual's professional network. I had expected a few responses rather than vast number which did emerge¹². This frustrated me and in an attempt to use the information I used areas where there was greatest deviation as props for the interview. Now I see that this variety was symptomatic of feminist theories based on multiplicity and difference that Edwards (2005) refers to. I was however having difficulty coping with unexpected vastness of the variety – I had not anticipated and therefore not developed means of analysing the data.

Secondly, although I used critical reviewers and piloted the questionnaire in Wales, this approach only partially enabled the process. The reviewers were deeply embedded within statutory supervision: this step checked the question format rather than the rationale for the question. Further, the pilot study highlighted the need to re-phrase several questions. The respondents found questions on clinical activity too sensitive and I withdrew those questions. Rather than generating a questionnaire sourced from the literature and drawn from my own experiences, I would now develop a questionnaire from focus groups using topics which the participants identified as significant.

Thirdly, there was a period of three years between conducting the survey and undertaking the interviews. Events at home had overtaken my ability to concentrate on the study but equally I was floundering with it. Subconsciously I believe I had realised that taking the study further meant changing my thinking

¹² Section 6.1.33, page 71, in the Findings from Stage One chapter explains how individuals identified support from local, national and international sources.

and threatened my comfort zone. This seriously impacted on my enthusiasm for starting the second stage interviews. By the time I contacted those who had expressed an interest in becoming involved, several had changed jobs etc. I had originally intended to use focus groups following the design of Stapleton et al (1998). The different dynamics within the focus groups challenge and deepen the researcher's understanding of the emerging issues by stimulating discussion and providing greater insight (Bowling, 1999, Pontin, 2000a). However, this was before I had collated the responses from the first stage questionnaires and, significantly, before I was certain how many people would volunteer for the second stage of the study. The practicalities associated with bringing the forty volunteers together negated the possibility of using focus groups. The intention to use focus groups as a data collecting tool in the second stage was inappropriate due to insufficient numbers of respondents who replied after the lapse of such an extent of time. Although in reality, lack of time and resources would have hampered the practical implementation of this intention, my recruitment strategy was weak.

Thirdly, I omitted to collect data during the interviews which would have enhanced my contextualised knowledge of the respondent's situation. I failed to find out about the respondents sufficiently, i.e. a short biographical profile, an overview of their working environment, how long each respondent had been practising as a midwife lecturer and when respondents became employees of a University. It would have been useful to profile each University to establish some cultural principles. This limited my ability to contextualise their comments although prior relationships and meeting the respondents in their working environment did compensate to some degree. However, the lack of attention to this aspect also limited my ability to let their stories be told and reflect the complexities of their lives true to a feminist perspective (Edwards, 2005). Relational analysis was a mechanism for rectifying this situation.

5.4 Analysis Methods in the Second Stage

5.41 Choosing Voice-Centred Relational Analysis

Voice centred relational analysis signified a practical way of addressing and legitimising my social location whilst listening and representing the views and lives of the respondents. Mauthner and Doucet (1998, page 119) refer to voice-centred relational analysis as one which keeps...

'...respondents' voices and perspectives alive, while at the same time recognising the researcher's role in shaping the research process and product'.

Voice centred relational analysis acknowledges the relationship between the researcher and researched in shaping the construction of knowledge (Mauthner and Doucet, 2003). Anchored within a feminist methodological standpoint, Mauthner and Doucet (1998) adapted the technique developed by Brown and Gilligan (1992): their work on relational ontology forms the core of their technique¹³. It is a means of exploring narrative accounts in a number of contexts and involves four stages.

The first stage refers to reading the transcript for the plot and for the researcher's response to the narrative. This involves reading for the overall plot, the main characters and subplots and identifying the researcher's response to the narrative, its context and the person narrating. The first step is common to other qualitative approaches (Mauthner and Doucet, 1998) but the second step aims to bring to light the researcher's theoretical location and ideas. Repeating the statement by Brown and Gilligan (1992, p 27) that considering ...

'...how our thought and feelings affect our understanding, our interpretation, and the way we write about that person',

¹³ The section 4.4, pages 39 - 44, in the Theoretical Framework chapter for a review of how women develop their voice, mind and self through relationships.

Mauthner and Doucet (1998, 2003) are keen to emphasise how this step enables reflexivity. This technique involves socially locating the researcher in relation to the respondent, attending to the emotional responses of the researcher, examining how the theoretical interpretations of the respondent's narrative are made and documenting these processes. Stage one is concerned with identifying the emotional and intellectual responses of the researcher, the 'unconscious filters' (Mauthner and Doucet, 1998, page 121) in order to become familiar with the respondent and the way the respondent reacts to her and vice versa.

Stage two concentrates on how the respondent speaks and refers to herself. The significant areas are those where the respondent changes from the use of 'I' to 'we' or 'you'. This change denotes a shift in thinking and conceptualising of the self. This draws specifically on the work of Brown and Gilligan (1982) and the way that women perceive themselves and their self-esteem. Mauthner and Doucet (1998) found that this stage became instrumental in exploring relationships and meanings central to the women's lives.

Stage three determines how the respondent views relationships and which relationships she refers to. This places her within the context of her world and social networks. Finally, stage four of the relational analysis technique places people within their cultural and social contexts.

This technique resonated with and liberated me. My concern had been that my interpretations would dominate the analysis and the respondent's voices would become silent given my social, organisational and personal biography. It did give my own feelings greater legitimacy whilst respecting and valuing the views of the respondents in the context of the pressures they were under. As Mauthner and Doucet (2003) discuss, the concept of the subject as constructed by the researcher influences the analysis. I perceived the subjects, within this technique, as sources of self-reflective accounts locating themselves to a context and time. It was a practical method which matched my theoretical framework.

5.42 Using Voice Centred Relational Analysis

Using this technique, I read each transcript at least 4 times or as many as necessary to gather the information for each stage. In practice and in agreement with Mauthner and Doucet (1998), I experienced the data analysis as an on-going process rather than clearly defined stages. Compared to previous data analysis techniques I had used, this method shed new light on the lives of the respondents and my own role and reactions. As Mauthner and Doucet (1998) advise I used different coloured pencils to distinguish between each stage. It was remarkable how this technique clearly showed how the respondents viewed themselves and the world in which they lived as well as my own reactions to their comments. This was fascinating and changed the way I listened to others in my life outside the research. I felt that the relationship developed from the interview continued through the successive readings. I also felt that reading each respondent's data so thoroughly ensured the individual was not lost: the Findings Chapters arose from my reaction to their comments. The reflexivity Mauthner and Doucet (2003) discuss continued beyond the stage of voice centred relational analysis: their voices challenged my thoughts as I developed the findings chapters and recommendations. I also became acutely aware of the differences and similarities between the respondents rather than focusing on a series of common codes. This method allowed me to acknowledge how these relationships had influenced my perceptions.

5.43 Framing Analysis

Having become familiar with the respondents and my own responses to them, I needed a method which gathered the data in a productive and manageable way. Framing analysis provided this by helping to identify commonly referred to issues yet acknowledging differing perspectives (Lloyd and Hawe, 2003). As Lloyd and Hawe (2003, p1783) state framing refers to...

'...the way particular causalities and moralities are contained within the ways in which people communicate concepts, in particular in language and metaphor'

Schon (1983) identified that individuals may frame the same problem in different ways and in so doing highlight different features. As an analytical method, framing technique involves applying four elements in order to identify key features and connections. The first element involves identifying and naming a frame. Lloyd and Hawe (2003) refer to a frame as a problem. I interpreted this as a concept which respondents referred to albeit it in different ways.

After naming the frame, the researcher must consider the nature and source of the concept (Lloyd and Hawe, 2003). This forced me to consider why individuals held differing or similar views. The third element involves evaluating the concept, i.e how this has affected the respondents, whilst the fourth concerns identifying solutions, i.e. what would need to happen to improve the concept.

Voice centred relational analysis contextualised respondents' comments and demonstrated how each responded to influences and relationships within that context.

I summarised each respondents' comments in the stages identified by Mauthner and Doucet (2003)¹⁴.

Having completed the voice centred relational analysis for each respondent I summarised each respondents' comments by identifying what seemed important in each section of the interview. The summaries were numbered as a means of cross referencing for further and full use in the thesis. I then began the framing analysis by looking for similarities and differences between the respondents. The respondents' comments challenged my thinking and assumptions as I sought to understand individuals negotiated meanings. Naming the frame arose from my consideration of how the similarities and differences manifested. The frame 'Tensions within the Educational Role'¹⁵ for example, developed

¹⁴ An example of the summary of voice centred relational analysis is provided in appendix 11.9, pages 233 - 235.

¹⁵ The table of frames with the related themes plus an example of a framing analysis for the frame 'Tensions within the Educational Role' are provided in appendix 11.10 pages 236- 240.

alongside the frames entitled 'The Role of the Midwifery Educationalist' and 'Being a Midwife and a Lecturer'. The 'Tensions within the Educational Role' frame identified those wider elements which created difficulty for the respondents in performing their role, i.e. being a minority group. Eight respondents contributed to this frame. 'The Role of the Midwifery Educationalist' contained those elements which affected how the respondents were performing their role on a day-to-day level. Six respondents contributed to this frame. One respondent identified how 'Being a Midwife and a Lecturer' was important to her and without wanting to lose the strength of her conviction, I identified it as a separate frame. Her comments, representing a deviant case, highlighted the tension in the role and challenged my own perceptions.

From the framing exercise, 16 themes emerged according to common links. This also included those frames which posed a challenge to the theme. Through further comparison, I merged the 16 themes to form 4: living in two worlds, coping strategies, meaning of supervision I and meaning of supervision II¹⁶.

The themes identified how the respondents performed their role, what influenced them and the impact of statutory supervision upon that role. As such, the findings were generally descriptive and analytically rather than critically evaluative. At this stage, I revisited the evaluation and remedy stage of the framing analysis method posing deeper questions and challenging what the respondents has said. As the researcher, my ability to be reflexive was particularly significant as I was also challenging my own pre-conceptions. Gradually my emerging values as the researcher, the values of the respondents and the supporting theoretical framework

helped me to identify the underpinning concepts which influenced the social construction of statutory supervision in a higher educationally setting. The

This appendix also contains the summaries of those respondents who contributed to the frame 'Tensions within the Educational Role'.

¹⁶ Appendix 11.10, pages 236 - 240 identifies how the frames merged into a theme and the number of respondents in each frame.

original themes shifted as I recognised the power of agency and the power within relationships and organisations which can enable and limit individual agency. My final findings chapters emerged from this deeper evaluative understanding to become chapter 7 – ‘The Role of the Midwife Lecturer’ – chapter 8 – ‘Autonomy in Managing the Midwifery Identity’ – and chapter 9 – ‘Experiences of Statutory Supervision’.

The construction of the role of a midwife lecturer is influenced by how individuals construct their identity as a midwife. It is from this basis that individuals construct a meaning for statutory supervision.

5.44 Limitations with the Analysis Methods

The use of voice centred relational analysis was very positive. Using framing as an analytical method also proved valuable, although the final element of suggesting solutions to the ways in which different individuals frame problems, initially prevented further extensive literature searching. I had jumped upon solutions before thorough analysis. Hence, I found the temptation was to work quickly through the framing technique rather than recognise the four elements as triggers to phases of thinking over a sustained period of time.

5.5 Ethical Considerations

Protecting the rights of respondents who participate in research is fundamental (Polit and Hungler, 1997). Stake (2000, p103) highlights how qualitative researchers are ‘*guests in the private spaces of the world*’. I was mindful of avoiding situations where respondent's rights would be jeopardised by the aims and methodology of my study.

Confidentiality and anonymity were guaranteed during data collection in the first and second stage. Ethical approval was required in two higher education organisations before being allowed to ask for names of potential respondents. The decision to exclude supervisors of midwives from the sample population was taken in light of Stapelton et al (1998) findings that confidentiality was

paramount in allaying fears of respondents. Respondents were given information concerning the aims of the study and the length of time required to complete the questionnaire in order to facilitate voluntary decision making regarding participation. Those who did volunteer for the second stage supplied personal contact details. I contacted each of the respondent's volunteering for the second stage and provided details of the nature of the second stage. Interviews were undertaken on a day and in a place which suited the respondent.

No other ethical issues developed as the study progressed.

5.6 Summary

The methods selected reflect the theoretical framework, location of the researcher and conceptions of the respondents. A survey using a postal questionnaire administered to midwives in education and LSAMO gathered information on a national scale for the first stage. In-depth interviews in the second stage facilitated a deeper exploration of issues raised from the questionnaire with ten volunteers from the first stage. Results were analysed using voice centred relational analysis and framing analysis techniques.

6. FINDINGS FROM STAGE ONE

This chapter presents and analyses the findings from the two questionnaires administered during the year 2000 and analysed during 2001. At the time, the UKCC (1998) version of the Midwives Rules and Code of Practice was operational and is reflected within the questions posed. The first section presents the findings from the midwife teacher/lecturer questionnaire whilst section two presents those from the Local Supervising Authority Midwifery Officer (LSAMO) questionnaire. The SPSS package was used to manage the data, from which tables were produced¹. The limitations and personal learning points are discussed, concluding with how the first stage linked with the second.

6.1 Findings from the Midwife Teacher/lecturer Questionnaire

From the total of 434 questionnaires sent, 254 returned a completed questionnaire, providing a response rate of 58.5%. The findings are presented in the 3 sections, each section representing a specific domain for questions².

6.11 Section A – Your Role

This section provides information on the characteristics of the sample. The majority of the respondents (71%) worked as full-time midwifery lecturers/lecturers with between 10 and fifteen years experience. Thirteen per cent of the sample had been practicing as midwife lecturers for longer than 21 years.

Twelve per cent were also supervisors of midwives³.

¹ See appendix 11.6 pages 208 – 217 for a selection of charts and tables which expand upon the written analysis of the findings from this first stage of the study.

² See appendix 11.4, pp 196 - 202, for the questionnaire used.

This information identifies that this small group of midwives did not share the same characteristics as the midwifery profession at large. The NMC (2004e) identifies how the majority of midwives are part-time. Further, the majority of the sample was employed as midwife lecturers before the assimilation of Schools with Universities occurred. This group represented therefore an experienced set of individuals, established in the role of midwife lecturer.

6.12 Section B – The Organisation of Supervision for You

This section was designed to examine the supervisory arrangements/models in operation for midwives in education. The majority of the respondents had one named supervisor (94.5%) who tended to be the Head of Midwifery Services (80.4%)⁴. Those few who did not have a supervisor of midwives seemed lost in organisational changes. The majority of the respondents confirmed that the allocation of their supervisor of midwives was based upon clinical connections.

The striking conclusion is that midwife lecturers were predominantly supervised by supervisors of midwives with a managerial and clinical orientation. This determines that midwife lecturers were being supervised by individuals who may not have had an understanding of the role and demands of being a midwife lecturer in an academic setting. In addition, diverse pulls upon the midwife lecturer emerged. Although the majority of the respondents submitted their Notification

³ See table 1 entitled 'The Respondents Contractual Status', table 3 entitled 'Number of Years in the Role as a Midwife teacher/lecturer' and table 4 entitled 'The Percentage of Respondents who were also Supervisors' in appendix 11.6, pp 208 & 209 for further explanation.

⁴ See table 5 entitled 'The Number of Midwife teachers/lecturers who had a Named Supervisor' in appendix 11.6 page 209.

Of Intention To Practise forms to their named supervisor, the forms were also sent to supervisors in each clinical unit that either the respondent or the University liaised with⁵. Hence, midwife lecturers experienced differing styles of supervision by virtue of the midwifery lecturer's role: contact with several clinical units is part of the role of a midwife lecturer.

The nature of the contact also reveals interesting information concerning the significance of statutory supervision for a midwife lecturer. The majority of formal supervisory contact was through the annual supervisory review⁶. The amount of informal contact varied considerably however from more than five times a week to none. Unremarkably, the 'telephone' and 'face-to-face' were the most common forms of contact⁷. This pattern of contact is therefore suggestive of being grounded in the clinical practice setting.

The most common reason for any contact between the supervisor and the midwife lecturer was the annual supervisory interview, followed by discussion of students' practice and contact over the Notification of Intention to Practise forms⁸. The annual supervisory interview represents the opportunity for the midwife practitioner to discuss her/his professional development and is recommended within a supervisor/supervisee relationship (ENB, 1999). At the time of the questionnaire, the supervisory interview was not obligatory (NMC, 2004b). Discussion of incidents from educational practice was depicted as one of the least common reasons for contacting their supervisor whilst refresher activities represented the third most common reason for contacting a supervisor⁹.

⁵ See table 13 entitled 'The Role of the Individual to whom the respondent Submitted their Notification of Intention to Practise Forms' in appendix 11.6 page 210.

⁶ See table 14 entitled 'The Amount of Formal Contact Between the Supervisor and Supervisee in appendix 11.6 page 211.

⁷ See table 17 entitled 'The Most Commonly Used Means of Contacting the Supervisor' in appendix 11.6 page 212.

⁸ See table 19 entitled 'The Most Common Reason for Contacting a Supervisor' in appendix 11.6 page 213.

⁹ See table 20 entitled 'Ranking of the Reasons for Contacting a Supervisor Regarding Educational Practice' in appendix 11.6 page 214.

Hence, although frequent contact emerged, it generally concerned other people's practice rather than personal educational or clinical practice.

Support for educational practice arose from a variety of national and international organisations. Their own peers in education whether nurse or midwife lecturers constituted by far the most common form of support. Some referred to the supervisory network for support but these respondents were themselves supervisors. The nature of this support covered programme development and planning, advice and discussion of student performance. Hence, the respondents were more likely to access the non-supervisory network for support concerning practice in education.

In question 14, the respondents were asked to identify the advantages and disadvantages of the organisation of supervision on both a professional level and personal level. The multiplicity of responses highlighted the uniquely personal nature of their experience of statutory supervision. However, this uniqueness was underpinned by two key components: the effective use of people skills which enabled the development and maintenance of a relationship, i.e. holding expertise, being supportive and approachable; and understanding of the role of the midwife lecturer. The possession or absence of these components influenced how the supervisee responded to the supervisor and their experience of statutory supervision.

From the experiences of the respondents, this section revealed how statutory supervision was clinically orientated and defined by both the supervisee and supervisor. Individuals had developed their own support network locally, on the whole. The value of the supervisory relationship rested on the personal qualities of the supervisor and the degree to which the supervisor recognised and understood the dilemmas inherent within the role of the midwife lecturer.

6.13 Section C – Interpreting the Statutory Rules (NMC, 2004b) For Midwives in Education

Section C concerned how the statutory Rules (NMC, 2004b) governing midwifery practice are interpreted for midwives in an educational setting as these form the foundation for statutory supervision.

6.13.1 Practising Midwife Status

When asked whether the respondents would describe themselves as practising midwives, the majority (84%) identified that they would¹⁰. However, in clarifying why individuals described themselves as practising midwives, the responses indicated a divergence in opinion. This divergence centred on the significance of clinical practice in the role of the midwife lecturer: the status was justified through clinical practice, i.e. direct client care, versus clinical contact and use of the status in the educational and non-clinical role. The legal definition of a practising midwife is contained within Rule 2 (NMC, 2004b, p 8) and states that a practising midwife means a registered midwife who:

'notifies her intention to to a local supervising authority and who has updated her practice in accordance with the standards published by the Council, and who

- a) is in attendance upon a woman and baby during the antenatal, intranatal or postnatal period; or*
- b) holds a post for which a midwifery qualification is required'.*

From this definition, all midwife lecturers fulfil the status of a practising midwife by virtue of holding a midwifery qualification. However, what is clear is that for some, there were hidden and personally created criteria which further defined the meaning of being a practising midwife. The following quote indicates that the respondent was not sure of her practising status:

Although difficult to achieve fully 20% of time can be spent in clinical practice. Definitions of this vary – what is clinical practice? Is it attending a clinical meeting or is it 'hands on'? I choose to wherever possible spend my time working 'hands on' but need the support of the unit midwives, as it is impossible to be totally up to date with everything.

Other respondents stated that they were not practising midwives providing the following explanations:

Very involved with midwifery but am reluctant to consider myself 'practising' midwifery – I am tutoring & theorising but practical access is limited.

Definition of practising usually refers to practice clinically. I do not regard myself as clinically competent.

I see myself as an academic of midwifery – I feel I am not practising the art and science of midwifery with women – I am practising at teaching there and here only clinical practice – I do have clinical contact it is not time practice.

Conversely other respondents explained why they were practising midwives:

Most of my time is spent in aspects to do with the practice of midwifery. The physical doing of it is fairly sparse these days.

Although this does depend on definition of 'practising' midwife. Many people seem to think = delivery of babies = is the definition i.e. hands on at delivery/birth. This is not my definition only – care should be through the total spectrum & should recognise value of antenatal and postnatal care & support of others, i.e. students.

As a lecturer and holding a midwifery qualification under the Midwives Rules I am a practising midwife I practice midwifery a) personally b) with students c) as a named supervisor with midwives, but I do not pretend to have the same skills as my clinical colleagues who are in practice daily.

¹⁰ See table 48 entitled 'Clarification of whether the Respondents Described Themselves as Practising Midwives' in appendix 11.6 page 215.

6.13.2 Information and Advice Provided by the Supervisor of Midwives

The second question in this section, question 16, attempted to examine the information and advice provided by a Supervisor of Midwives for midwives in an educational role in order to establish whether the information and advice was tailored towards their needs. The responses were divided with 48% identifying that the information and advice was tailored towards their needs whilst 43% opposed this view¹¹. The explanations provided by those who felt that the information was tailored towards their needs identified that this occurred when the supervisor demonstrated a person-orientated approach and because the supervisee actively sought a beneficial relationship with her supervisor. In other words, under the right conditions, the supervisor and supervisee could create a situation where advice and information was relevant. Conversely, the explanations provided by those who felt that the information was not tailored towards their needs identified that the clinical orientation of supervision and lack of understanding of the educational role negatively affected the relevance of any information and advice provided.

6.13.3 Alternative Forms of Supervision

Question 17 was posed to identify whether the respondents could suggest alternative means of being supervised. This raised a range of responses which focused primarily on either increasing the number of supervisors within educational practice or increasing the level of understanding by supervisors of the educational role and increasing the clinical role for midwife lecturers. Although some respondents maintained a wish to distance the educational role from statutory supervision, the majority did indicate an adaptation of the present system to suit their needs more.

¹¹ See table 50 entitled 'Responses Concerning whether Information and Advice is tailored towards their need in Higher Education' in appendix 11.6 page 216.

6.13.4 Attitudes towards Statutory Supervision

The final question in this section was the same as the one used in the LSA Officer questionnaire and contained six attitudinal statements. The majority (81%) disagreed with the statement that 'supervision has no role in the context of higher education', whilst 9.7% of the respondents agreed. The majority of the respondents (72%) agreed that supervision was clinically orientated although 23 % disagreed. The majority disagreed (92%) that supervision was mainly concerned with discipline. Although there was a range of responses, the majority (68%) agreed that supervision was involved with supporting and empowering midwifery lecturers/lecturers practice. The majority (73%) also agreed that midwifery lecturers/lecturers do benefit from supervision¹². Finally, the majority (78%) agreed that supervision was essential for midwives in education.

The findings from this question as a whole suggest that the majority of midwifery lecturers/lecturers see statutory supervision as beneficial and useful. However, this is dominated by the view that statutory supervision is clinically orientated. This raises the possibility that statutory supervision may serve as a means of maintaining clinical links for the majority of midwifery lecturers and it is that reason which justifies its purpose in an educational context. The greatest area of diversity concerns how supervision operates for midwife lecturers to support and empower their practice. Certainly a significant minority demonstrated their ambivalence towards statutory supervision, stating that it had no place within their area of practice.

¹² See table 57 entitled 'Midwife Teachers/lecturers Do Benefit from Supervision' in appendix 11.6 page 217.

Overall, the conclusions were that statutory supervision had a strong clinical bias and orientation in the allocation of a named supervisor and in the supervisory arrangements. This was acceptable for the majority of the respondents whilst a notable minority expressed dissatisfaction with these arrangements. Whilst ever statutory supervision has a clinical focus, its relevance in the daily educational role must be questioned.

6.2 Findings from the Local Supervising Authority Midwifery Officer Questionnaire

Eleven from the total of 13 LSA Responsible Officers (Midwifery) (LSAMO) in England completed the questionnaire. This represents an excellent response rate of 84.6%. The questionnaire followed a different format from the one administered to the midwifery lecturers as the information sought concerned how the LSAMO supervised midwives in education. There were therefore nine questions¹³.

6.21 Identifying Supervisory Arrangements

The average number of Universities with which a LSAMO liaised was 4.8. Each LSAMO liaised with at least 2 Universities. In identifying the current, formal, supervisory arrangements for midwives working in Universities, no one clear national model for supervisory arrangements emerged. The LSAMO suggested that midwives in education could either choose or be allocated a supervisor from the clinical link unit¹⁴, educational organisation, any supervisor or the LSAMO. The most common model draws on supervision of midwife lecturers from the link unit or Trust, with or without choice. The responses highlight differing supervisory arrangements between Universities within the same LSA and between LSA's.

¹³ See appendix 11.5, pp 203 - 207, for the questionnaire used.

¹⁴ The clinical link unit is a NHS Trust providing maternity care and with which the midwife teacher has developed formal links in order to support staff and students on that site.

Seven of the LSAMO identified that supervisors did contact them for advice regarding midwives in education. This mainly concerned clinical updating, although the specific nature was not clarified. The series of questions which examined how the statutory framework was interpreted by the LSAMO for midwives in education, raised divergence between the respondents and a tension between recognition of the academic and practising midwifery status of midwife lecturers. At times this divergence represented opposing standpoints.

6.22 Interpreting the Statutory Rules for Midwives in Education

6.22.1 The Practising Status of Midwife Lecturers

Ten from the eleven respondents felt that midwives in education did have specific needs regarding the issue of clinical practice. However, as these comments demonstrate differing interpretations emerged:

*'need to be aware of current practice and developments although not necessary for them to be competent in the expanded role of the midwife';
'may wish to maintain their clinical skills... become increasingly difficult with the move to higher education and the pressures to be academics instead of practitioners';*

*'organisational constraints may lead to midwifery lecturers not being able to gain clinical practice... geographical/physical separation limits access';
'not necessarily to give hands on care but to familiarise themselves with current policies/procedures';*

'need time to be able to do clinical work to meet Rules and for credibility with peers - help to ensure time is protected and clinical practice is appropriate';

'lecturers desire to be 'practising' midwives – not the broad term used by the University';

'need to ensure 'in touch' with midwifery practice at clinical level and no theory/practice gaps'.

This divergence therefore affects the advice and guidance provided by the LSAMO across England. Midwives in education must therefore experience different

expectations from supervisors as the LSAMO did not agree on how and whether midwives in education should engage with clinical practice.

The interpretation of the Rule which defined the meaning of a practising midwife¹⁵ equally demonstrated a range of opinion as these comments demonstrate:

'midwife lecturers will need to meet the first part of the requirement of practising midwife and not merely hold a post for which a midwifery qualification is essential';

'we all need to remind ourselves of this Rule occasionally'

'to be reassured that they are indeed practising midwives – their supervision needs and support will differ to midwives practising in other spheres where a midwifery qualification is necessary'.

'educationalists clearly understand how they comply with Rule 27 however midwives in practice do not understand the definition';

'quite explicit – need to hold a midwifery qualification for post'.

These opinions represent opposite ends of the spectrum highlighting the differing demands and expectations of a midwife lecturer.

Interpretation of the set of Education Rules contained within section A at the time of the questionnaire (UKCC, 1998), revealed further differences. The supporting comments provided by four respondents highlight differing concerns from each:

'joint responsibility with clinical midwives and supervisors';

'they have a problem keeping a balance between practice and academia';

'which are confused';

'ensure that student midwives do have a working knowledge/involvement with supervision'.

This pattern of divergent interpretation was further confirmed from the analysis of compliance with Rule 36 (UKCC, 1998). Rule 36 set out the requirements for the

¹⁵ At the time of the questionnaire, Rule 27 defined a practising midwife as: 'a midwife who attends professionally upon a woman during the antenatal, intranatal and/or postnatal period or who holds a post for which a midwifery qualification is essential and who notifies her intention to practise to the local supervising authority.' (UKCC, 1998, p9)

notification of intention to practise. The respondents' comments highlighted differing perspectives towards the interpretation of this Rule and raised the conflict between professional, statutory and academic requirements as confirmed by the following comments:

'need to meet the same requirements as all midwives';
'can be difficult for them to know to whom to notify and current interpretation of this rule means multiple notifications';
'to maintain practising status and conform with professional requirement regardless of university views';
'because it is an 'intention' to practise – does not mean delivering babies as the only reason for notifying';
'should not be a problem if they have a named supervisor';
'notoriously late at sending these in or omitting to do so altogether'.

6.22.2 Professional Development

In the area of professional development (covered by Rule 37 at the time), again the respondents were divided. Six from the eleven respondents felt that midwifery lecturers/lecturers had specific needs in this area whereas the remaining five did not. The comments provided raised concerns about how midwives in education were fulfilling this Rule rather than its relevance for midwives in education:

'need to meet the same requirements as all midwives';
'should be given time to undertake professional education – should not rely on sitting in on colleagues lectures';
'lecturers have failed to complete statutory refreshment and recorded as being unable to practice';
'awareness of PREP changes - know where funding is available and understand individual midwife's needs and liaison with the LSA and clinical placement'.

Comments from the respondents regarding compliance with those Rules which centred upon specific clinical aspects of the role of the midwife, tended to emphasise the midwife lecturer's responsibilities towards educating students. Hence, interpretation of Rule 40 which defined the responsibility and sphere of

practice of a midwife, Rule 41 concerning the administration of medicines, and Rule 42, covering record-keeping, demonstrated some consistency. The respondents endorsed the added responsibility of midwife lecturers as role models.

The respondents agreed that Rule 43, which concerned the inspection of a practising midwives' practice, records, equipment and residence / institutional premise by a supervisor, LSAMO or UKCC (UKCC, 1998), held little significance for midwives in education. However, interpretation of Rule 44 highlighted a return to differing opinions. Rule 44 (UKCC, 1998) covered the criteria for becoming and training as a supervisor of midwives. Although there was some support for midwife lecturers in becoming supervisors of midwives, some respondents also highlighted a lack of credibility in undertaking this role. This reinforced the clinical orientation of statutory supervision as perceived by some of the respondents.

6.22.3 The Meaning of Statutory Supervision for Midwives in Higher Education

In discharging their statutory functions in relation to midwives in education, the respondents demonstrated a range of views. For some, this group of midwives had the same needs as any other whereas some seemed aware of the need for greater communication between supervisors and supervisees. This varied interpretation was qualified by question seven which invited free text on the topic of the meaning of statutory supervision for midwives in higher education. Respondents answered in a variety of ways, emphasising the lack of consensus and clear guidance for midwives in education nationally. Several of the respondents stressed the need for supervision to support midwives in education in their practice...

'to support, guide and empower the midwife to facilitate her practising to a high standard – thus promoting excellence in care and protecting women and babies. Although this statement applied

whatever area a midwife practises, methods of achieving this will vary dependant on what an individuals 'practice' involves.'
'teaching the midwife of today and tomorrow is an impressive responsibility and the supervisor should be in a position to be facilitating the lecturer to fulfil this critical role';
'outcomes of supervision should be the same and tailored to their individual requirements'.

However, no-one clarified how this could be achieved practically. Indeed, one respondent chose to repeat how midwives in education should practice clinically in order to meet the requirements of the regulatory framework. The conflicting interpretation of the regulatory framework by the LSAMO, emphasised the difficulties both midwife lecturers and supervisors must experience when issues arise. Further, the results highlight how the regulatory framework can be interpreted widely creating limited usefulness for midwives in non-clinical roles.

6.22.4 Alternative Mechanisms for Support

The suggestion, in question nine that alternative mechanisms could meet the needs of midwives in higher education, met with some opposition. Most of the respondents provided means by which midwives in education could become more involved with supervisory activities. Mainly though, the respondents maintained that statutory supervision provided a valuable and supportive mechanism for midwives in education. This is not an unexpected answer from individuals whose careers are invested within statutory supervision. However, in light of the considerable variation in the interpretation and therefore guidance and support for midwives in education by LSAMO, this response requires greater national examination and debate.

6.22.5 Attitudes towards Statutory Supervision

Considering the disparate interpretation of the regulatory framework for midwives in education, it is perhaps surprising that the LSAMO demonstrated considerable harmony in the attitudinal statements in the final part of the questionnaire. Using similar statements to those presented to the midwife lecturers in their questionnaire, the findings allowed comparison between the two groups.

The majority of respondents (10) disagreed with the statement that 'supervision has no role in the context of higher education'. These results concurred with the findings from the midwifery lecturer's questionnaire. In a similar vein to the findings from the midwifery lecturer's questionnaire, all the respondents disagreed with the statement that 'supervision is only for midwives in clinical practice'. All the respondents strongly disagreed that supervision is mainly concerned with discipline with which the majority of midwifery lecturers also disagreed. Further, the majority of the respondents strongly agreed with the statement that 'supervision involves supporting & empowering lecturers'/lecturers' practice'. This same question on the midwifery lecturers questionnaire yielded a range of responses although there was agreement overall that supervision is involved with supporting and empowering their practice. All the respondents agreed that midwifery lecturers/lecturers could benefit from supervision, mirroring the comments from the midwife lecturers. Finally, the respondents all agreed that supervision was essential for midwives in education. This concurred with the findings from the midwifery lecturer's questionnaire although a greater range of views was expressed.

These findings suggest that in principle the LSAMO strongly support statutory supervision and its relevance in midwifery education. However, diversity reins in the detail of how statutory supervision can support midwives in education. This creates a national picture of conflicting advice and guidance for midwives practising in a non-clinical setting.

6.3 Limitations and Personal Learning Points

Originally this section included a statistical analysis with graphs and charts depicting differences and similarities. However, these graphs and charts did not provide clarity: in some cases creating confusion. This was partly due to lack of clarity with the questions but also a realisation that there was no added value using pictorial representations.

Despite piloting the questionnaires, a number of issues arose. Primarily, I was heavily influenced by the questionnaires used by Duerden (1995) and Stapleton et al (1998). Their questions seemed to generate the answers they required. Hence, by adopting some of the questions developed (with permission) by these authors, I had failed to focus on the essentials for my study and became side-tracked. This created ambiguously worded questions and questions of limited value. I had asked questions¹⁶ which yielded data that I could not usefully analyse. Hence, the findings did not really give me many answers.

Also, although I had read widely on designing and administering a questionnaire, in my desire for neatness, I had expected straightforward answers. I had not considered how a questionnaire could yield contrasting and differing patterns from the data. This frustrated me. Now I see that this variety was symptomatic of the multiplicity and difference that Edwards (2005) refers to. I was then however having difficulty coping with the unexpected vastness of the variety – I had not anticipated and therefore not developed means of analysing the data. I was left with a vast amount of data which was for the purposes of the study meaningless. This waylaid my progress and seriously impacted upon my ability to complete the first stage effectively and on my enthusiasm for starting the second stage interviews.

¹⁶ For example, question 13 in the midwife teacher's questionnaire, asks the respondent to identify the personal and professional advantages and disadvantages of the supervisory model. This yielded a lot of data which was pointless and repetitive.

What I now realise is that these findings provided a basis, a stepping stone, from which to develop the second stage. In that sense, it was an essential stage to pass through and provided useful data. With hindsight, I would have still undertaken questionnaires but altered the content. I would develop the questions from focus groups comprised of midwife lecturers/lecturers.

6.4 Linking the First and Second Stages

The emerging diversity and pattern of responses initiated my paradigm shift and approach to the second stage¹⁷. The data suggested that midwives in education had to comply with a framework designed for clinical midwives and a set of criteria for a role they once fulfilled and which was no longer contractually recognised by their employers. The findings from the LSAMO questionnaire confirmed how midwives in education were being expected to comply with differing demands without clear justification. I used topics with greatest diversity in the first stage, as props for the interview in order to clarify the meaning of being a midwife lecturer and the impact of statutory supervision.

The topics for the interview plan covered: experiences of statutory supervision before becoming a lecturer; statutory supervision now; experiences of statutory supervision since becoming a lecturer; professional support from statutory supervision; statutory supervision and empowerment; statutory supervision and development as a lecturer; definition of a practising midwife; any improvement within statutory supervision for midwives; and three scenarios/critical incidents concerning the poor conduct of a lecturer, poor conduct of a student or issues concerning midwifery education. Each topic was linked to a specific question¹⁸.

¹⁷ Section 4.3 pages 36 - 39 in the Theoretical Framework chapter explains how I had initially commenced this study with a quantitative perspective. The results from the first stage and growing personal awareness contributed to my realisation that this study demanded a qualitative approach. Hence, my theoretical framework changed and I began to appreciate the value of the data yielded.

¹⁸ See appendix 11.7, p218, shows how topics arose from each question together with the three scenarios used during the interview.

As a result of the three year gap between undertaking the first stage and recruiting for the second stage, several of the volunteers had changed jobs, lost interest etc. The intention to use focus groups as a data collecting tool in the second stage was inappropriate due to insufficient numbers of respondents who replied after the lapse of such an extent of time: a combination of geographical and time constraints influenced the final number of respondents involved in the second stage. Ten interviews from the original forty volunteers were conducted across England.

Of the ten respondents interviewed all were geographically distant from each other, women, mothers and experienced midwife lecturers: two of the respondents recalled working as a midwife lecturer when the midwifery schools were attached to maternity units before amalgamating with Colleges of Nursing and Midwifery which later merged with Universities; four were supervisors of midwives and one was connected with the statutory preparation of midwives programme. This sample only contained midwives in education because I wanted their experiences as opposed to the advice given from LSAMO.

The interviews were not time – limited, lasted between one to three hours and at a local venue chosen by the respondent. Each was tape recorded and subsequently transcribed. The interview plan was purposeful rather than structured with areas as triggers for the respondents whilst allowing each respondent to speak freely (Mannion and Cohen, 1980). Each respondent was presented with the same topics starting with experiences of statutory supervision before becoming a midwife lecturer.

6.5 Summary

In this chapter, I presented the findings and analysis of the questionnaire completed by 254 midwife lecturers in England and a separate questionnaire completed by 11 LSAMO.

The findings from the midwife lecturer questionnaire indicate diversity and a range of responses surrounding the impact of statutory supervision in an educational setting. The clinical orientation of statutory supervision was reflected in the supervisory arrangements, particularly the allocation of a named and clinically based supervisor for the majority of respondents. Respondents indicated that they were more likely to seek support regarding issues in their educational practise from a non-supervisory network. Individuals held differing interpretations of the meaning of a practising midwife. The unique and personal nature of statutory supervision highlighted a range of experiences concerning the supervisor-supervisee relationship with a clear divide on whether supervision met their needs. These findings contrasted with those from the final section which asked the respondents to complete an attitudinal assessment of statutory supervision: the majority felt statutory supervision was beneficial and essential. Overall, there was evidence of ambivalence and conversely, commitment towards statutory supervision.

Findings from the LSAMO questionnaire on the whole, reinforced the clinical model suggested from the findings of the midwife lecturers' questionnaire. There was however variation between the respondents concerning the interpretation of the Rules as applied to midwives in education and guidance and support needed. Considering the influential role of the LSAMO, these findings suggest that

midwives in an educational and non-clinical setting receive differing advice and guidance concerning the implementation of statutory supervision.

I present the findings from the second stage interviews in the next three chapters.

7. THE ROLE OF A MIDWIFE LECTURER

Through discussing their experiences of either being a supervisor or being supervised, the respondent's described how they make meaning of the socially constructed reality of being a midwife lecturer. Although meaning is individually negotiated, all the respondents comments share key themes as presented in this chapter.

7.1 The Importance of Relationships

The third reading of the transcripts, when using relational analysis, requires reading to discover the relational world. The existence of relationships seemed central to being a midwife lecturer. Four types of relationships emerged: with clinical colleagues, with peer midwifery lecturer colleagues, with the supervisor of midwives and between midwifery education and 'the wider University'. The quality and nature of these relationships differed. As Taylor (2002) and Gilligan (1982, 1993) maintain women develop a social network and value care-giving and care-sustaining relationships as central to job satisfaction.

Of interest is that a relationship with the student did not emerge. Students were discussed in relation to monitoring practice which is presented in the chapter on support and power.

7.11 With Clinical Colleagues

The importance of establishing and maintaining relationships with clinical colleagues was discussed by all the respondents. As one respondent discussed....

'...we have a very, very close relationship with our clinical providers erm, they have been extremely supportive of us, been supportive of maintaining midwifery education, all our changes in the programmes erm, you know

they not only sit on our course development teams but they make an active contribution to them. ' (Frances)

Another stated how...

' it is very important you know like I say it's just 'presencing' yourself in the clinical area ..so that the midwives see you with the students but we're not only there for the students, we're there for the midwives as well. '(Jane)

The relationship with clinical colleagues is a source of support¹ in implementing midwifery education programmes. It also informs the midwife lecturer: developing and sustaining clinical relationships creates a source of knowledge about developments in practice.

' she (her manager) is supportive in forging links (with a clinical unit) and recognising that you may gain as much from that if not more and it will assist your teaching and your relationship with clinicians and with students as you know reading a book or publishing a paper. '(Michelle)

'...link areas, I think sharing your expertise, I always go out to different area and say you know you're the experts, teach me and I try to develop relationship and I've got good relations with my clinical link areas. '(Margaret)

The relationship also informs their teaching role regarding the progress of the students.

' ... a student was under, not achieving at the required competence level... she was with a very, very experienced midwife who's had a number of students and who... had concerns. That immediately then rang alarm bells, if this midwife's got concerns. '(Margaret)

The respondent is describing a situation, reflected in other respondents' comments, where the existence of a relationship between the clinical midwife and the midwife lecturer acts as a source of knowledge about a student's ability to pass or fail essential components in the educational programme.

¹ The concept of support is explored in section 9.2, pp 131 - 151, in the Experiences of Statutory Supervision chapter.

This reflects my own experiences as a midwife lecturer: the relationships built up with clinical colleagues have multiple benefits in performing the role.

7.11.1 Divorced and Misunderstood

The respondent's comments reflect tensions however within the essential relationship between the midwife lecturer and clinical colleagues: the quality of the relationship had changed and there is unease in how clinical colleagues perceive their role:

'I mean in the early days in education, Head of Services was a more , was a stronger relationship than it is now, we saw them every month, we were part of the senior midwives team.. er...when she retired that was stopped abruptly and we were no longer part of the senior midwives structure. We were told we were no longer invited to a whole range of meetings – it wasn't appropriate, because we weren't part of the Trust.' (Sarah)

'... ..when clinicians look at us, unless they come and do a little bit of teaching or something like that.. .they don't really have any idea of what our lives are like... what our working lives are like

Q: how do you know that?

..I think when in, the olden days if you like when the schools of midwifery were in the hospitals, there was a much better understood working relationship.' (Jane)

' ...right back in 1978...we had a very close relationship with other nursing officers and at that time of course, it was 93 so it was when we had gone into the college and we were then starting to get divorced from you know the units.' (Pauline)

'.. we do mentor updates where we talk about student issues, we talk about curriculum issues and whilst they're, you can see the interest is there, they don't I think.. they've not got any understanding of what we're...what our day to day stuff is like and what tensions and what pressures that we might be feeling – it's a different world.' (Jane)

The respondent's comments reflect how changes in the physical location of midwifery education, have affected the quality of the relationship between the individual midwife lecturer and the clinical colleague as well midwifery education and clinical practice generally. Organisational changes within midwifery education have distanced the group from clinical practice leaving clinicians unfamiliar with the modern role of a midwife lecturer. This state of

fracture from the clinical world confirms a physical and geographical distance from the source of learning for student midwives. It is in the clinical environment that students demonstrate the integration of theory and practice, yet paradoxically, the area where midwife lecturers experience increasing exclusion. This suggests that in constructing their role and negotiating meaning, midwife lecturers have developed and use a range of skills to overcome this difficulty and sustain a relationship which is of fundamental importance to the delivery of midwifery education².

7.12 With Peer Midwifery Lecturer Colleagues

In constructing the role of the midwife lecturer, the relationship with peer midwifery colleagues is important. Several of the respondents comment how...

'...we're very lucky, we're a small team of people erm, who we all work together very, very closely together and we're supportive of one another.'
(Frances)

'..we've been a team for ten years or more, we know each other quite well and we take all this with a bit of salt (students playing one off against another).' (Sarah)

The relationship with members of the team of midwife lecturers provides support. Both Belenky et al (1997a) and Taylor (2002) suggest that a social network is important in female health and well-being. Women in labour require emotional, informational and physical support as well as advocacy (Hodnett and Osborn, 1989) and the need for and the need to find support is essential in experiencing psychological well-being in all walks of life (Kirkham, 2000, Frost & Robinson, 1999, Taylor, 2002, Oakley, 1992, McCourt and Page, 1996, Bagshaw, 1997, Bluckert, 2004). Indeed, Doyle (2002, p474) maintains that...

'lack of support threatens individual performance and mental well-being.'

² The chapter on Autonomy in Managing the Midwifery Identity, pages 104 – 122, analyses how the respondents managed the tension created by the effect of organisational changes on their role as midwifery teachers and the impact on the relationship with clinical colleagues.

Support from others is valuable in developing a stronger sense of coherence and boosting personal confidence in one's own abilities and competence (Antonovsky, 1988).

Developing and sustaining supportive relationships with colleagues, with whom there is probably daily contact, is central to psychological well-being and central in the construct of performing the role of a midwife lecturer.

7.13 The Relationship with the Supervisor of Midwives

The relationship with the Supervisor of Midwives is different to the relationships with clinical colleagues and peers because it is statutory: each midwife must have a named supervisor of midwives (NMC, 2004b)³. All the respondents referred to the supervisory relationship identifying that it forms part of the network of individuals with whom a midwife lecturer interacts. However, there are distinct differences in the way that this relationship was referred to. For some of the respondents, this relationship symbolised one with emotional connection ...

'..I was very fortunate I think in my experiences to have erm, a supervisor who was also somebody whom I admired, somebody whom I had known for some considerable time....so it's longstanding erm, quality I think in the sense of collegiate, friendly relationship which made for open discussion and was very comfortable.

Q: What do you expect from supervision then?

A: Erm, I think from a personal point of view and in my role of support, I think support erm, another view, another perspective, another take on things and feedback in such a direction, making me, being more visionary, to think about things in a different way. Erm and I feel I've got that over the last few years....Yeh, no, I think there's been a real change, I've seen it with, in my, and (name of supervisor) role has been really good, and I erm, she brings real qualities to supervision and she's implicit rather than explicit in the way she handles it and I don't think erm, it's a nice relationship, it's open, I quite look forward to it..... Oh it's nice to, oh good I'm seeing (name of supervisor), that's goodI don't see it as erm, a task'. ..(Sheila)'

³ Rule 12 of the Midwives Rules and Standards (NMC, 2004b, p26) states how: 'Each practising midwife shall have a named supervisor of midwives from among the supervisors of midwives appointed by the local supervising authority covering her main area of practice'.

The nature of this relationship as expressed by the respondent and others mirrors the client-centred approach which Carl Rogers pioneered (Rogers, 1990). For Rogers, unconditional positive regard, acceptance, empathy, congruence, genuineness and non-possessive warmth are conditions which determine the quality of the relationship in a therapeutic environment. Bluckert (2005) identifies that these same qualities help to transform non-therapeutic relationships. When a 'client centred approach' operates, the respondents value and reacted positively to the supervisory relationship.

There is variation though in their level of ease with supervisory contact and conversations: whilst some welcomed a supervisory relationship others kept supervision at a distance.

' I think in a way we work too closely together to, to want erm, to take on that person as you know one of our.. , to do supervision within the team..' (Frances)

Both the respondents are wary of statutory supervision. This was also expressed by another respondent who is a supervisor of midwives:

' ..I think because I am a supervisor as opposed to being one that is being supervised, then I know about supervision and I feel that (name of supervisor) being approachable as my supervisor, if I've got an issue I can talk to her about it. I'm not too sure if I wasn't a supervisor whether I would do that automatically and that's not because its (name of supervisor) that's because its supervision.' (Pauline)

There is tension within the relationship between a midwife lecturer and statutory supervision: individuals have expressed differing experiences. The tension inherent within this relationship is critically explored in chapter three.

7.14 The Relationship between Midwifery Education and the wider University

All the respondents referred to the relationship with 'the wider University', distinguishing this relationship as a collective rather than individual one: it represents how midwifery education relates to 'the wider University'.

'we have quite a good learning and teaching department here...they'll put on training or development activity that we ask for ...if we've got curriculum development.. we're working on the assessment strategy at the moment, we'd like some objective input you know .. we can go out and ask.' (Jane)

'I think for a small team and maybe it's because midwives always like to be heard, I don't know, but I think we've been extremely proactive not only in the School of Health, but also within the wider University, wherever there's a committee you'll find a midwife on it.' (Frances)

Their comments reflect a different type of relationship to the one with clinical colleagues and peers: this is a purposeful and focussed relationship with the emphasis on using it for the advantage of midwifery education.

7.14.1 Moving away from first line midwifery

There were other layers and influences upon the relationship with 'rest of the University'. Several aspects of the construction of the role of a midwife lecturer appear to have been affected by the merger with higher education. In describing what they did, the respondents revealed how midwifery had become only part of their role since becoming part of a University organisation. For some of the respondents, the teaching role had become much broader than midwifery....

'... I've developed in this pathway means that I have had to be more broad based so er, while I teach women's health and sexual health and you know promoting women's health erm, I could be teaching, promoting health any gender, so it's not just women, I've had to develop skills very quickly, to teach across I don't just look at midwifery research ..if I'm teaching something to a broad base of people I've got to give them literature that will be relevant across a number of

disciplines so erm, I think that's why I'm not just into that little pocket, I just feel much wider than that now. ' (Margaret)

'..I've a large administration role within this School for exam boards again it's interesting because from an education point of view I'm moving away from first line midwifery ... and diversifying. ' (Margaret)

..in education there are, you, you've got so many strings to your bow, you know erm, so it's , it's not just the clinical side that erm again I do work on the bank, I am a bank midwife... I'm teaching, I do read and I do research so you know there's that kind of side going, I am interested in developments in education, ...curriculum development or assessment... latterly leadership. ' (Jane)

Midwife lecturers have a broader remit than the one previously held before Colleges of Nursing and Midwifery merged with Universities. There is a greater emphasis on the activities other than teaching midwifery. Whilst the construction of the role has expanded, so the demand upon the individual has increased:

' ...they're busy people, they're trying to develop and create .. not just doing the job the same, week in, week out and I can't expect them to be doing all those sort of things and trying to cram in all these clinical as well. '(Susie)

' ..you know the focus is so much more on academia and researching now and you know to do some practical updating, you really have to.....you know push for it really. ' (Claire)

The organisational goals have influenced the activities involved in undertaking the role of a midwife lecturer. Becher (1989) and Bourdieu (1988) write how membership of an academic community depends on excellence in scholarship and originality of research with the aim of gaining a reputation in leading academic circles. Research driven activities have a high profile representing a symbol of highest educational achievement and economic capital (Bourdieu, 1988). Research activities symbolise a higher class status and characterise professional status⁴. Paradoxically, the merger of midwifery education with Universities is a step towards increasing the power and influence associated

⁴ Chapter 3 on Professionalising Midwifery, pages 9 – 33, examines the professional status of midwifery during the twentieth and twenty-first centuries.

with professional status yet in so doing, the priority of a midwife lecturer is deflected from midwifery.

7.14.2 Square Peg In A Round Hole

Whilst the respondents discussed how their role had expanded since merging with higher education so the ease with which midwifery education fits within a University framework seems to raise tensions.

'I don't think there can be an advocate at the moment for us in higher education because I don't think we fit really... we're trying to, we're trying very hard to fit but I don't think we fit, it's a square peg in a round hole. In certain things, I think the only reason we're here is because of the amount of guaranteed NHS money we bring. I think in other respects we're quite a nuisance because you know our ways of working are different from how higher education works you know. We've slowly absorbed the culture but its taken time and doing that we have lost the NHS.' (Sarah)

'...feel that midwifery is a nuisance and the money brought with the contract is more significant than professional issues.' (Sarah)

In adapting to the organisational demands and expectations of a University, the respondents express concern about the validity of positioning midwifery education within such an organisation. The notion that midwifery education is a misfit is interesting. The first respondent's comments suggest that this concern stems from the fracture from the clinical setting⁵. There is a palpable sense of loss in no longer being part of that clinical world. One respondent offers examples demonstrating practically how nursing and midwifery education does not 'fit traditional working patterns' ...

'... there's always been a clear understanding that nurses and midwives are a bit different so for example we've always worked a three semester year and never had the summer off you know, different timetables, timetables close, closes down over the summer but we're still there you know..., no food on campus ... so there's been recognition that we kind of work the year through ... that we don't fit traditional university

⁵ The relationship between midwife teachers and clinical colleagues is discussed in section 7.1.1, pages 85 – 87, of this chapter.

patterns that easily and there's been acceptance of that ... that kind of respect for what we do that we work quite hard to do that.' (Michelle)

The length of midwifery pre-registration programmes is determined by the NMC (2004d) and Article 4 of the Second Midwifery Directive 80/155/EEC⁶. In meeting these statutory requirements, midwifery education cannot fit the traditional academic calendar which commences in October and completes in June. University facilities 'close down' between June and October despite the on-going requirement to resource midwifery education programmes. This highlights the increasing sense of isolation: distance from the clinical setting and a separation from the normal working patterns of other groups within a University.

The organisational change which resulted in the merger of midwifery education with higher education has highlighted a number of issues in the relationship with the 'rest of the University'. In adapting to the goals of the organisation, midwife lecturers are experiencing a new set of demands which are challenging the prioritisation of their workload and construction of their role. This is played out within a context of increasing distance and separation from the clinical setting and dissonance with organisational goals.

7.2 Significance of Being a Midwife

Significant in the construction of the role was 'being a midwife'. This section explores the meaning attached to 'being a midwife' within an educational setting. Respondents defined 'being a midwife' in two ways: the sense of responsibility and accountability towards the general public and in nurturing a midwifery identity.

⁶ The length of three year pre-registration midwifery programme must be 45 programmed weeks per year lasting 156 weeks. The shortened pre-registration programme for nurses wishing to become midwives is at least 78 weeks (NMC, 2004d).

7.21 Responsible and Accountable

The sense of responsibility towards the general public through their role as a midwife lecturer shone through.

'...you're teaching students, you're influencing a future generation and therefore they're going to provide the care to the women and it's almost like erm, I don't know what the word is, you're not there but you've kind of taught them and they're doing it for you So if you've given them mis-information or really old-fashioned kind of advice then the student does something....you are just as accountable I think for that care the student's given if she's basing it on...on what you told her.' (Michelle)

'...if I say that the moon is made of green cheese, those students will believe me.. and yet if it isn't then I will have said that I was still accountable for imparting the wrong knowledge so I still believe that you know, it is a responsible, the responsibility of me as a midwife lecturer, as opposed to being a lecturer of history.. you know for the university otherwise...I say history as an examplethe rest of the university they're teaching sessions erm, history, geography you know maths ... the nature of the role is such that we're dealing with people who have er special needs ... we're teaching on a course erm , that enables them to practise as midwives.' (Pauline)

Lecturers share similar responsibilities across a University, i.e. module development and leadership, but the respondents maintain that midwifery lecturers have added ones which affect how they construct their role. Standards for programme delivery promote the concept that student midwives upon qualification should be fit for practice, purpose and award (NMC, 2004d, QAAHE, 2003). These standards emphasise the public accountability that midwifery education collectively bears but that individuals recognise in developing and implementing programmes of education.

7.22 If I'm Going To Call Myself A Midwife

The midwifery identity, moulded during their socialisation, is pervasive: the respondent's comments suggested that being a midwife defines who they are. This definition seemed to revolve around the connection with clinical practice. As several respondents stated.....

'...I suppose I want to be all things to all people, you know if I'm going to be, If I'm going to call myself a midwife, then part of me and probably a big part of me still thinks that I should practice, I should have hands on practice and that's very difficult to achieve.' (Sarah)

'we're told you're a practising midwife whether you're in education, management or practice... but it's about being very much aware of what's going on ... we have to teach what should be happening.' (Susie)

'You know the credibility of your teaching is in your ability to do it in the first instance...how can these midwives teach the principles if they're no longer physically doing it... erm and how long ago is it that some of us were actually physically doing those tasks.' (Pauline)

Nurturing their status as a clinical practising midwife seems to underpin their construction of the role of a midwife lecturer. Currently, although a practising midwifery status is a pre-requisite for remaining on the NMC register and undertaking the role of a midwife lecturer (NMC, 2004d), there is no national or UK-wide strategy concerning whether 'practising' means working clinically for midwives employed in non-clinical roles. The RCM (2001) in its document 'A Vision for the Future' suggested that midwife lecturers should practise clinically as the way forward. The NMC (Moore & Way, 2004) has commissioned a review of pre-registration midwifery education which also reviews how and whether a midwife lecturer should support students directly in clinical practice.

However, tension exists between meeting organisational goals, developing an academic identity associated with University status and their midwifery identity. The opportunity to work clinically and nurture that element, which the respondents feel maintains their midwifery identity, is influenced by the demands associated with the academic role:

'...I do try and take at least one or two weeks per year (working clinically) depending on scholarly activities and other such work demands where I go in purely for my own benefit for practice.' (Sheila)

'...I used to go in as part of my university work to do some clinical work but our workloads now it's extremely difficult to do that and I just haven't, for over a year I have not had the time to do it, ...it's extremely, I don't think people realise, I think they still see teaching as, you know a

nice, easy number, oh, you're a lecturer... but I think, we have so many different roles now, it's, it's an extremely demanding job.' (Frances)

'... when our intakes shift as they are going to, we're not going to have any space in the academic calendar that you could take time out (for clinical updating).' (Sarah)

Within a higher educational organisation, how individuals manage their area of expertise, whether midwifery, civil engineering or physiotherapy, is viewed as a matter for individual concern and secondary to the drive towards research excellence (Becher, 1989). This contrasts with the midwife lecturer's construction of their role where 'being a midwife' matters possibly more than the drive towards research excellence. Argyris (1964) referred to the marginal man where differing organisational and individual values antagonise each other leading to dissatisfaction and conflict. This creates both individual and organisational ineffectiveness⁷. More recent authors make reference to this concept (Warr, 1987, Todd, 1994, Noon & Blyton, 1997) and Lipsky (1980) particularly identifies how an antagonistic but mutually dependent relationship can develop between the organisation and the individual. As these comments demonstrate, the differing constructions of a role create a source of tension:

'... at the moment, you're expected if you've got that term midwife in your title, you're expected to be a midwifery expert you know and how you maintain those skills is part of your own personal development plan.' (Claire)

'... my IPR person is an educationalist not a midwife and she is more concerned about my role as a manager of erm midwifery education and making education credible and to make sure I'm getting academic consistency across the college.' (Claire)

The respondent's comments indicate an area of conflict between organisational and individual values and identities. The values of the academic organisation are constraining and subsuming the values of the midwife lecturer who identifies more with 'being a midwife' than achieving academic standing. They

⁷ Individual and organisational dissonance is discussed in the chapter on organisation culture. The organisation relies on the individual for success yet as Helms and Stern (2001) identify a range of factors can influence the degree of harmony between the individual and organisational disharmony.

are physically and psychologically pulled in two directions (Fairbrother and Ford, 1997).

7.23 Battling

The depth to which their sense of responsibility towards the general public and the need to nurture their midwifery identity affect the construct of their role is demonstrated by the frequency with which 'battles' are mentioned.

' if you've got a lot of battles academically, which you have and you've got personal issues, you really don't want to be engaging with clinical fights as well ... your own credibility is on the line here... .. I don't expect them (supervisor of midwives) to fight the battle in the University. ' (Sarah)

' ... when we were developing the first curriculum (three year), we had a joint curriculum (with nursing), we knew that midwifery could not be a branch of nursing. The ENB was telling us that the midwifery officers were telling us and we could only have a wholly midwifery orientated three year course and the suggestion from the university was to usefully use shared learning experiences which meant that for the whole of the first eighteen months they would be bundled with, the student midwives would be bundled with student nurses. Well if that's not CFP⁸ followed by a branch I don't know what is. ' (Pauline)

There are other occupational groups within Universities who would equally claim responsibility towards the general public for the quality of the qualifying student e.g. in the fields of dentistry, civil engineering or medicine. There is a lack of literature indicating any similar tensions between responsibility towards the public and the need to meet organisational demands. The comments by the respondents may highlight a perceived disempowered state and dissatisfaction with the organisation. Their comments may also be part of the growing theme around the issue of the impact of establishing midwifery education in an organisation which is physically and functionally different to the practise of midwifery.

7.24 Minority Status

In discussing their experiences of being midwife lecturers, minority status was referred to by several but not all of the respondents. Reflecting the history and sub-ordination of midwifery, the way in which minority status was discussed suggested that for some it is part of being a midwife lecturer:

' what we need is strategically placed midwives in the confederation⁹, unfortunately we always remain a minority so the majority of clinicians in the confederation are nurses with their own agenda, so they don't understand midwifery, same as they don't anywhere else, it's very difficult and the universities are such, you know large bodies, a small group like us has almost no influence whatsoever. In this School, it is made absolutely clear that the biggest player is the ADNS¹⁰ – every other programme is minor compared to that – meetings, most staff development, everything revolves around it, because of its sheer size and the amount of the budget it takes up.' (Sarah)

'...from a recent audit, it was identified that midwife lecturers... are quite marginal to midwifery and they need pressure and support from supervision.' (Celia)

These comments suggest that as a group midwifery lecturers are marginal to the rest of midwifery and in the minority organisationally. Both statements are true: the number of midwife lecturers is small in comparison to midwifery as a whole and the number of midwifery students is small in comparison to the total number of nursing students.

However, the significance of the respondent's comments regarding minority status becomes clearer in the context of the following respondents' comments:

⁸ CFP is the common foundation programme which lasts one year and which all four branches of nursing students (children's nursing, mental health, learning disabilities and adult nursing) share the same modules.

⁹ A confederation is responsible for commissioning pre-registration midwifery education across defined geographical area. Members of the commissioning group are senior representatives from individual Trusts and strategic health authority.

¹⁰ ADNS is the Advanced Diploma in Nursing Studies programme. The numbers of student nurses are significantly higher than midwifery students nationally thereby becoming the major focus for planning and user of resources.

'... prior to nursing and midwifery education being incorporated in this institution here, erm well immediately prior to that yes, it was a college of nursing and midwifery, but prior to that it had always been the school of midwifery, it had always been separate, it had always been unique in that way.....we've lived through a lot of changes but at the end of the day, if we don't say and what about midwifery, and what happens in midwifery then, and this is what we do in midwifery... .. I mean you know, it's a bit of a standing joke and it probably is in a lot of institutions about er oh, you know there's the midwives again, well, you know actually this is what we do in midwifery.' (Michelle)

'...a university is a huge institution, it employs lots of different people , in many different spheres and walks of life, it cannot possibly (and this sounds really defensive on behalf of universities) but you know it can't possibly know how each, what each professionals' boundaries are , particularly when it comes to professions that deal direct with the public so thinking it through that way, erm that can be really difficult when you're in a minority group, midwives are, we're always kind of not belittled but teased by our nursing colleagues 'oh you think you're different'. I say yes that's because we are different. Its interesting having just moved as a I said you know to a new building into faculty of applied sciences where there are pharmacists and microbiologists who totally respect you as a different profession.' (Margaret)

'In many respects I think we were leaps and bounds ahead of, of the, of the nursing side who, you know I suppose they've got more students and it's perhaps more, the impact of the change on the curriculum changes perhaps hit them harder than it did us, but I think we've tried to share our good practices with our nursing colleagues and sometimes that worked well and sometimes it's been a bit of a thorn , a bit of a thorn in the side really.' (Jane)

Their experiences reflect their experiences of perceived unequal power relationships. Behaviour, emanating from a few nurse lecturers, is experienced as ridicule. As Freire (1996) identified, horizontal violence may occur as power battles develop and as anxieties are projected onto others. In the context of this study, the midwifery lecturers perceive that the academic values transmitted through organisational relationships subordinate their needs. This mirrors the pattern where patriarchal attitudes and sub-ordination of midwives have limited the degree of control midwives have had over their own occupational role and transfers it to the higher educational setting.

The following comment is revealing:

'no-one advocates for midwifery within the University especially since the demise of the English National Board for Nursing, Midwifery and Health Visiting ..'(Sarah)

In light of a perceived minority status and in light of the strength of feeling towards their midwifery identity, this respondent recognises a need to 'battle' for midwifery education and resist oppression. It is true that the dislocation and increasing geographical distance from familiar clinical midwifery backgrounds, has created tensions: Hughes (1999) comments on how the fragmentation of the profession of midwifery - the relationships between education, clinical midwifery, maternity care management and research - have been weakened by the boundaries imposed by health service and university structures. Her comments support the respondents' experiences of isolation and role conflict. There is the sense of 'traction' when an individual is pulled along one direction not necessarily kicking and screaming but not with ease either (Baldamus, 1961). It is also true that higher education has provided a new context with diverse opportunities, e.g. involvement in CETL's and interprofessional learning¹¹. The opportunities available within higher education provide new challenges and career development which were not present in the traditional Schools of Nursing and Midwifery.

Reducing respondents' perceptions of isolation and role conflict may mean aligning individual and organisational goals. As Eisele (1996) suggests, this requires the demonstration of trust and openness to alternative ideas and values. There has to be a commitment towards sorting out differences, understanding meaning and a preference for co-ordination of behaviour based on shared norms and values (Eisele, 1996). The respondents have demonstrated the strength of the pull towards maintaining the identity and focus of midwifery education in the construct of the midwife lecturer's role. Reviewing individually held values suggests relinquishing the attachment to clinical midwifery, breaking free from the mould of standardised, role-based behaviour, assessing cultural differences

¹¹ See section 3.4 pages 29 – 33 entitled 'Midwifery Knowledge Base' for a review of the influences upon midwifery education and new strategic directions.

and realising new opportunities (Biljsjema-Frankema, 2001, Schabarcq & Cooper, 2000, Handy, 1985).

7.3 Summary

The midwife lecturer's construction of their role highlights three important issues. Firstly, relationships are important in sustaining the role of the midwife lecturer. The midwife lecturers revealed four categories of relationships which they negotiate in undertaking the role.

Secondly, on an individual level, the picture emerges of a midwifery teaching role which has become increasingly diverse and complex since the merger between Colleges of Nursing and Midwifery and Universities. This has required substantial adaptation to the demands of an academic organisation: adapting to an academic identity equates to re-aligning personal and occupational identity and conforming to the dominant ideology. The socialisation of a midwife embeds values which conflict with those of the academic organisational culture. In response, some of the midwife lecturers are demonstrating resistance to the values implicit within the dominant ideology.

The respondents' collective experiences of marginalisation and isolation parallel those of midwives in the NHS (Ball et al, 2002). Ball et al (2002) found that the reasons midwives left midwifery were influenced by the organisational culture, organisation of the workload and workload pressures. Their feelings of vulnerability, discontentment and lack of control are not unlike those expressed by the midwife lecturers in this study. The parallel experiences of clinical midwives and midwife lecturers indicate how the rhetoric of the organisation is different to individual's experiences of working within it.

Thirdly, the re-location of midwifery education within an academic organisation is challenging not only individual construction of the role of the midwife lecturer but also challenging the nature of midwifery education. Certainly some of the respondents' experiences highlight a lack of fit between

midwifery education and developing practitioners within an academic organisation. This 'misfit' seems to stem from the distance from clinical midwifery practise, the dislocation of relationship which sustains their teaching role and the diminishing status of midwifery education. Their discomfort symbolises resistance to a setting and ideology which they perceive as undermining those relationships and practices which seem fundamental to a midwifery teaching role. However, adaptation requires re-adjustment and realisation of the individual and professional opportunities available within higher education.

8. AUTONOMY IN MANAGING THE MIDWIFERY IDENTITY

A difference between individual and organisational goals emerged from the analysis of the interviews. The issue of how the respondents chose to manage their status as a practising midwife¹ lies at the heart of how a midwife in education defines and aligns her midwifery identity with the organisational drive towards an academic identity.

All the respondents performed 'clinical link' duties as part of their role, i.e. 20% of a midwife teachers role is allocated to support the students and staff in non-clinical activities in an NHS Foundation Trust maternity unit contracted to train students with the University. However, in the absence of either organisational or professional directives on whether the role of the midwife teacher should involve engagement in direct clinical care², the respondents' comments reveal that each had chosen to create their own reality in order to verify their own midwifery identity.

Exploring how the respondents managed the difference between the individual and organisational identity is important to their sense of self and their experience of working within an academic organisation. Lipsky (1980) maintains that individuals make decisions, establish routines and invent devices to cope with uncertainties and work pressures. Making decisions and exercising personal power confirms autonomy (Jones, 1994). Limiting personal decision-making

¹ Rule 2 states that a practising midwife '...notifies her intention to practise to the local supervising authority and who has updated her practice in accordance with the standards, published by the Council, and who a) is in attendance upon a woman and baby during the antenatal, intranatal or postnatal period; or b) holds a post for which a midwifery qualification is required' (page 8, NMC, 2004).

² Engagement in direct clinical care means actively caring and taking personal responsibility for caring for women in a clinical setting. It fulfils the first part of Rule 2 (NMC, 2004) quoted above.

'...potentially undermines the person, their sense of themselves and their self-esteem.' (Edwards, 2005, p250)

The midwife teachers' responses to the position in which they found themselves shows how individuals can act autonomously despite the existence of oppressive structures and socialising influences. Their personal decision making effectively surrounds how individuals managed membership of two communities – midwifery and academia. Individual autonomy emerged from the findings in two overall ways: individuals either chose to engage with clinical practice or they chose to confine clinical activities to clinical link duties.

8.1 Maintaining Membership of the Midwifery Community through Clinical Practice

Whether and how individual's prioritised clinical practice revealed how they chose to maintain membership of the midwifery community. From the analysis of the interviews, the personally defined value attached to practising midwifery status led to differing interpretations in action: 'working bank', managing a caseload and refresher style period of time.

8.11 Differing Interpretations in Action

8.11.1 'Working bank'³

Two of the respondents worked clinically on 'the bank'. This respondent explains how she 'works bank':

'...I work full-time so my bank activity is one shift a month, I've just had holidays so I've done a little bit more in the holidays but to be able to do it justice... I find it's very difficult to get a whole day off in the clinical area, because I might have a meeting in the morning, I might have something else in the afternoon where I can only spare a few hours.. an

³ 'Working bank' is a colloquial phrase which refers to a non-permanent contractual arrangement whereby a midwife supplements the number of midwives working over a period of time or clinical shift. Bank working represents a bank or reserve staff who hold a separate contractual agreement between an individual and an agent – Health Care Professionals' – it is independent of the contractual agreement between the individual and the University.

hour or two snatched here and there.. It's frustrating for me, it's probably frustrating for the clients you know for the women 'oh well I did have a midwife but she's gone.' (Jane)

She is explaining how working as a midwife teacher precluded contact with women in a meaningful way: the activities involved in supporting students and staff meant that she was only able to 'snatch' time 'here and there'. This 'snatched' time interrupted the philosophy of continuity of care and carer which draws on developing a relationship between the mother and the midwife⁴. She compensated for these problems by 'working bank'. She added later in the interview that:

'...a lot of us do bank because there aren't enough hours in the day...once a month I have one night (bank shift), because I do a night ...and that's mine....you know that's mine for midwifery...' (Jane)

It was important to her to continue working in this way – it defined who she was and supported her self-esteem.

The second respondent demonstrates the same commitment towards maintaining a midwifery identity by explaining when and how often she 'works on the bank':

'I only work on delivery suite and I say when I want to work, they don't call me up and say oh can you do a shift, I just put my name down and request for, say, you know I'd like to work on Saturday

Q: it's over and above your work as a midwifery teacher?

A: Yeh

Q: right and you can't get time out of work for that then?

A: No, but I am getting paid for itthere are compensations.' (Frances)

Whilst both the respondents derived satisfaction from this activity, it was separate and unconnected with their midwifery teaching role. From my own experience of working clinically as a separate and unconnected activity to my teaching role, I have found that clinical mentors, who support and assess students in the clinical setting, have been suspicious of my motives. To some,

⁴ Section 3.2.1, page 15, in the literature review chapter entitled 'Professionalising Midwifery' examines the principles behind the social model of health and explains the centrality of developing of relationships between midwives and women.

my presence seemed to suggest that their ability as a mentor was under review. Therefore during the interview I asked this respondent:

Q: *'...are you worried about stepping on the mentors toes when you're working the bank shifts?*

A: *'Yeh, I just... even though I'm bank I still feel part of the team – it's very weird, I've almost got you know I've almost got two hats, two uniforms, two separate people really.'* (Jane)

Her reply re-enforced how 'working bank' was an activity undertaken to sustain her midwifery identity and membership of the midwifery community. Any difficulties were worth overcoming. Both the respondents' comments reveal how their identity is embedded in the midwifery community and how important it is to shape their lives to maintain that identity. As Barclay (2000, p61) states:

'... the identity of the self is constituted by various social attachments....self's aims and aspirations are determined by the communities of which one is a part.'

Membership of a community motivates attachment and a sense of solidarity (Barclay, 2000). Feminists emphasise how agents desire maintaining valuable relationships even though this identity may be conditioned by membership of subordinated groups (Stoljar, 2000). The comment from the respondent regarding having 'two hats, two uniforms and being two separate people' also reveals however the issue of intersectional positioning and experiences or 'border dwellers' (Meyers, 2000, p155) applies in the situation: individuals can be drawn to membership of two groups or both sides of the border, not completely comfortable in either. Faced with the potential loss of membership with the midwifery community, these two respondents have autonomously negotiated means to retain identification with that social group.

8.11.2 Managing a caseload

Managing a caseload refers to a model of care in which a midwife has a caseload of clients for whom she provides continuity of care through the antenatal, intranatal and postnatal periods. Models of caseloading vary

particularly in how many women each midwife has (McCourt & Page, 1996, Dorling 2005, DoH, 2004, NZCOM, 2001). The one respondent, who practised in this way, combined managing a caseload and a full-time contract as a midwife teacher:

'I have since 1996 had a caseload of ten to twelve women which I looked after with two colleagues. We felt we needed to maintain our clinical skills and caseloading was the buzz thing at the timeWhat's changed since working with colleagues (the two colleagues have left) is I no longer offer erm that I'm available all the time so before we had a rota between the three of us....

Q: so you fit that in with your working week?

I fit it through my working week and I personally find that that works really well, because I'm doing caseloading I don't do clinics, I'm not, I'm not linked to 'it's Thursday' so I've got to be there to do an antenatal clinic. I do all home visits, evening times, weekends what fits around, what fits around my diary but also what fits around the women.'
(Michelle)

Maintaining her midwifery identity was very important to her and worth committing to over and above her role as a midwife teacher. She managed both her full-time role as a midwife teacher and a substantial commitment to the care of ten to twelve women per year. Other colleagues undertook similar activities but not in the same way:

'... one of my colleagues has just started work at the midwifery unit and has just taken on a partnership.... That's kind of two us that do 'caseloady' type things. Other colleagues do other things like one's very involved with erm, asylum seekers ...another does things like daily massage and erm alternative therapies which she offers to women and babies ...so there's lots of different ways people see of being clinically kind of involved.' (Michelle)

The respondent is indicating that maintaining a midwifery identity is important for several of her colleagues yet for all of them this activity does not involve student midwives. There is a clear distinction between practising as a midwife and working as a midwife teacher.

8.11.3 Refresher/update

Three of the respondents identified engagement with clinical practice for defined periods of time and for specific purposes. This is a distinct activity from 'working bank' or managing a caseload because it is undertaken as part of the occupational role rather than in addition to. This first respondent describes how she works with her supervisor of midwives:

'Q: what are those experienceshow do you use your supervisor?

A: I go out with her to do a refresher for my community experience and I also work with her a day in the erm labour ward suite to update my skills on water birth. I've never delivered anybody in a pool and I still haven't personally but I've been there while a woman had a water birth experience so I use her to update myself clinically.' (Claire)

The second respondent is equally identifying clear decision making regarding the nature of involvement and contact with clinical practice.

'... what I gain from clinical practice is updating to make sure that what I'm teaching in theory is related to practice so I want to access clinics, I want to go and see midwives I want to go and work with a midwife for a day, I want to just sort of touch base with them, I don't feel I need to spend three weeks doing hands on care erm to do my area of education.' (Margaret)

In her managerial capacity, the third respondent has herself defined a set amount of time which justifies the maintenance of a midwifery identity:

'...I always insist that my staff get out there as much as possible and they have to do at least five days a year clinical updates as far as I'm concerned. They decide what it is and where they do it but they have to do that in addition to any other stuff. I think every professional should be doing the job.' (Susie)

All three respondents have established routines within the job as a midwife teacher to cope with maintaining a midwifery identity – the commitment toward maintaining a midwifery identity is mediated and integrated with their responsibilities as a midwife teacher. They have crafted an identity (Meyers, 2000) and managed their individual goals within the confines of their

organisational role. The divergent demands from the University and from their self-defined membership of the midwifery community, has provided opportunities to create meaning. One respondent identifies how she subversively encouraged some regular clinical activity even though it was not officially accepted:

'...it is statutory we do have to do this and this is the best way for us to do it but I'm fortunate in the fact that my managers don't cause me a problem ...when we first came into the university it's a very different kettle of fish altogether – one of the managers didn't want us to work clinically and so for most if you know most of us did carry on doing it but we didn't let on – economical with the truth and creative in the diary and things. ... But it's about the commitment and it's about saying it's an important thing to do and we are going to do it.' (Susie)

The possibility of losing membership of the midwifery community and a midwifery identity in the organisational changes was too great a risk and therefore worth protecting.

8.12 'I do know what it's like in practice'

Whether individuals chose to establish a routine independently of or integrated within the contractual time as a midwife teacher, the need to work clinically resonated deeply for each of them - it confirmed their midwifery identity and status as a practising midwife. Margaret Chesney (1995) comments on how practising clinically gave her enormous personal satisfaction. Baillie (1994) found that personal satisfaction rated highly amongst nurse teachers who worked clinically.

Personal satisfaction appears not to be the only reason for practising clinically. Chesney (1995), Baillie (1994) and Day et al (1998) refer to the links between working clinically and maintaining credibility with students. Although there was a sense of personal satisfaction, clinical practice helped with the quality of their contact with students. One respondent commented on how working clinically contributed positively to the role of a midwife teacher:

'...you know very often one of the criticism of educationalists was, 'well what do you know, you're stuck in a classroom every day, you don't' know what it's like in practice'. I do know what it's like in practice because I still go into practice and I think that's important because I do need to understand the current tensions and pressures that they feel erm I also need to be able to maintain my clinical credibility.' (Jane)

Clinical credibility is also a motivating factor in deciding to practice clinically. It seems important to be credible with students. As another respondent stated:

'I think it's very important that now if I go into a classroom next week... I can talk about cases.....in the classroom when they're talking about something, I can say, oh, do you remember that woman we saw last week and it makes it live and relevant and that's important.' (Susie)

Currency of experience adds to the quality of the discussion between students and midwife teachers. There is little evidence to support this link between working clinically and improving the quality of teaching. As Day et al (1997) report, there needs to be greater evidence concerning role effectiveness in the practice setting. However, it is a form of personal knowledge based on a blend of the subjective voice with contextual understanding.

8.2 Maintaining Membership of the Midwifery Community through Non-clinical Activities

Just as some of the respondents felt strongly that being a midwife equated with 'doing midwifery', the other respondents provided responses which supported an opposing view. Faced with the same situation of being 'border dwellers' (Meyers, 2000, p155), these respondents chose alternative solutions to managing their academic and midwifery identities. This respondent focused on the lack of clarity within the official guidance from the NMC to challenge the connection between being a practising midwife and engaging with clinical practice directly:

'Q: what is your definition of a practising midwife?

A: Difficult, officially that's somebody who holds a qualification, holds a post for which erm a midwifery qualification is essential, it doesn't actually mean you give hands on care and so, that's debatable but then you got the PREP standards that says you should work a hundred days in five years. What that actually means is debatable.' (Sarah)

This respondent identified variation among colleagues:

'I would say half (of the rest of the midwifery teaching staff) don't get clinically involved apart from maybe going two weeks to update themselves in that, the form that takes sometimes is questionable erm, don't on a weekly basis go anywhere.' (Michelle)

There were a number of reasons provided to support an alternative definition of being a midwife in their role as a midwife teacher. These reasons chronicle the history for their autonomous action.

8.21 Reasons for Not Working Clinically

8.21.1 'I'm a danger'

One of the respondents felt very clearly that clinical practice and educational practice are two separate areas of speciality. Her role as an educationalist had taken in new directions which changed what she needed from midwifery practice to support her role:

'...I firmly feel I'm not a clinician, I'm an educationalist...so I think if I walk onto a clinical area somebody should grab me, put a paper bag over my head and put me in a cupboard, 'cos I'm a danger...What I want to gain from clinical practice is updating to make sure that what I'm teaching in theory is related to practice, so I want to access clinics, I want to go and see midwives, I want to go and work with a midwife for a day, I want to just sort of touch base with them, I don't feel I need to spend three weeks doing hands on care erm, to do my area of education..' (Margaret)

In acknowledging how she would be 'a danger' in the clinical setting, this respondent has re-defined her midwifery identity in relation to the context of working within an academic organisation and the demands to establish an academic identity. She had realised that clinical practice was not integral to her

midwifery identity, in fact as Meyers (2000) identifies, membership of the community in this way was too confining. Her self-definition now included affiliation with an academic group causing her to re-negotiate and modify her midwifery identity. She maintained relationships with the clinical midwives although the nature of these relationships and the nature of her midwifery identity had altered. Clinical contact was sufficient to ensure the currency of the teaching material and support her academic identity.

8.21.2 Workload

Several of the respondents discussed the issue of workload in relation to the feasibility of working clinically:

'I do attend all the annual updating lectures and.. erm recently she (her supervisor) helped me sort of increase my clinical practice which was quite useful ...erm...I used to try to go in as part of university work to do some clinical work but with our workloads now it's extremely difficult... and I just haven't for over a year I have not had time to do it.' (Frances)

'...you know we have speculated about taking a caseload here, as midwife teachers but it simply hasn't been practical.' (Sarah)

Their comments allude to the increased workload midwifery teachers are experiencing in meeting the organisational priorities. Working within a University organisation has re-orientated and re-prioritised a midwife teacher's workload. Time available for clinical practice has been squeezed as the provision of undergraduate and postgraduate programmes has increased. Day et al (1998) describe how midwife and nurse teachers alike have had to attain and maintain academic credibility to meet the requirements of the University employee. The drive to attain graduate and post graduate status is linked with role performance placing greater demands upon academic development than previously required (Pay and Reward scheme, University of Sheffield, 2004). Baillie (1994) even twelve years ago found that allocating time to clinical practice adversely affected other parts of the role.

Other factors have altered the nature of the workload. The use of personal computers has increased (Day et al, 1998), with expansion in on-line learning. The recruitment of increasing number of students from a widening academic background on both pre-registration and post-basic programmes has necessitated greater theoretical support (Dearing Report, 1997). There is less time and space to undertake meaningful engagement in clinical practice. The rules of the game have changed considerably forcing some respondents to create and establish routines which seem meaningful for them and establish control over their working life.

8.21.3 Altered relationship with practice and the NHS

The relationship between the midwife teachers and the NHS maternity services has changed since the merger with academic organisations:

'...there's a real problem with academics going into the clinical area, there was a Head of Service in another Trust who basically said, it's not possible any more – we can't do it because they've changed their systems, their paperwork, their computers. The way they work now is becoming increasingly difficult for anyone to go in unless you're part of the team – kind of a closed world and the wards are becoming increasingly like that because it's caseload managed and you can't interfere with the caseload.'. I can look after a woman in labour, absolutely no problem, but your blessed systems are driving me demented....' (Sarah)

Pregnancy and childbirth remain the same but the organisational systems have altered the manner in which this takes place, effectively closing and excluding clinical practice to midwife teachers. The organisational change associated with merging midwifery education with academic organisations has distanced midwife teachers from clinical activity, preventing the lack of familiarity with computer systems etc.. Midwife teachers no longer belong to the NHS and have been marginalised from engaging with clinical practice. The respondent's comments reveal how she no longer feels comfortable being part of the midwifery community.

The issue surrounding the viability of honorary contracts emphasises the changed relationship further:

'I found out that once I arrived that the Head of the Trust wouldn't give honorary contracts to any nursing and midwifery lecturers. There were people happily going and doing work and I suppose the Trust would have been ultimately responsible because they'd invited these people in but I've been a RCM steward and for a long time. I just said to them 'no, no way we can't do this'. So we fought for three years to actually get honorary contracts so for the first three years I was there I couldn't do any clinical work.' (Frances)

From an NHS Trust perspective, the reason for not providing honorary contracts may stem from the implementation of Clinical Negligence Schemes for Trusts (CNST). CNST is a co-ordinated national strategy to reduce the number of litigation claims within the NHS, including the maternity services, by introducing auditable risk management and communication systems. Achieving level 1, 2 or 3 (the maximum) of the set standards significantly influences the financial contribution each Trust makes to the scheme (NHSLA 1999). Any member of staff, including those with honorary contracts, has to fulfil and be familiar with the organisational requirements which Trusts have put in place to meet the CNST standards. This creates difficulty for a midwife teacher when the contract of employment with the University does not acknowledge or therefore facilitate time to undertake clinical practice and fulfil the requirements necessary to engage with clinical practice. In the absence of a contractual commitment towards the NHS Trust, a midwife teacher has little option in the face of competing organisational demands but to withdraw from clinical practise.

8.22 Differing Approaches

In response to the set of reasons provided for not working clinically, respondents had developed their own means of connecting clinical practice with their role as a midwife teacher. The respondents demonstrate how they have found ways to *'synthesise and reconstruct familiar traditions'* (Meyers, 2000, p165).

8.22.1 'Clinical Link Role'

Although all the respondents performed a 'clinical link role', this group of respondents defined their midwifery identity through this activity alone. Several of the respondents discussed the activities involved in the 'clinical link role':

Q: 'Can you just identify some examples of how closely you link with the Trust?'

A: OK erm.. I've just been doing G grade interviews last week and this week, they always come and sit on our interview panels when arranging viewing for students and for members of staff. They always invite us to erm to interview new members of staff.. We've just worked closely with the clinical providers to develop the clinical examination of the newborn. I think what says it all is that they give you a call if there's a problem not only with a student but anything. They were developing evidence based guidelines for the labour ward and I was invited to be on the group.' (Frances)

' ... it's a kind of philosophy of the team that we ensure that that is not one of the things that goes by the board when we get pushed and harassed ..so we do reflective clinical seminars with the students and that happens six times a semester, erm we do head link meetings once a semester, every month we do a mentor updating and and that all that happens in the clinical area ... we do mid and end of semester clinical interviews with the students and midwives we do those in clinical practice ..

Q: there's a lot of activity...

Yeh ...it's very important you know like I say that it's just 'presencing' yourself in the clinical area.' (Jane)

Whilst the viability of working clinically had changed there was a clear commitment towards maintaining a relationship with the clinical area albeit in a different format. The 'clinical link role' supports the continuance of a relationship between midwifery education and midwifery practice and redefines those activities with which a midwife teacher can become involved. These activities are centred more on ones which support both students and staff in the clinical setting in monitoring the performance of students. This role conforms to the organisational goal of delivering the educational programme and therefore conforms more to organisational expectations.

8.22.2 Being a Supervisor

One respondent indicated how becoming and being a supervisor of midwives helped her maintain clinical knowledge – this maintenance served as an update rather than engaging directly with clinical practice:

*Q: is there a role for a supervisor to be an educationalist?
Absolutely I think so, I mean that's why I put myself forward to be a supervisor because I felt that erm a) a supervisory team would be strengthened by having an educationalist within that team and as an educationalist, being out of practice for some time, I felt that it would be of more value for me to find out about what's happening in clinical practice.'* (Claire)

Being a supervisor of midwives facilitates a mechanism for maintaining a mutually beneficial relationship with fellow supervisors of midwives based in clinical midwifery practice⁵.

8.23 A Midwife Rather Than a Practising Midwife

One respondents' comment made me question my own assumption that a midwife teacher must be a practising midwife. Although the NMC (2004) state that a midwife teacher is a practising midwife, this respondent challenged that thinking:

'I was a practising midwife but I've been in education for twenty years so my core work is education not clinical practice. I have passion for midwifery but it's not driven through regulations, I don't have the security of being a registered midwife – I will always be a registered midwife as I was always a registered nurse and I don't mean, care whether I'm on the professional register or not so I'm coming from that take really.

Q: do you still consider yourself to be a practising midwife

A: No

Q: because you're not working clinically?

Yeh probably because I'm not doing some hands on care but I don't think that over the years - erm, I'm thinking midwifery day to day I think these midwives are much more looking at things very differently, their work pattern is different to mine. So I don't regard myself as a

⁵ See section 9.1, pages 123 in the chapter 'Experiences of Statutory Supervision' for further discussion and analysis of how being a supervisor affected the role of the midwife lecturer.

practising midwife I do regard myself as a midwife. ' (Margaret)

Her comments challenge the norm that there is a connection between being a practising midwife and being a midwife teacher. In the face of the changing role of the midwife teacher and the requirement to conform to the academic organisational goals, it is feasible to consider whether midwife teachers can and should realistically sustain engagement with clinical practice directly. The Midwives Rules (NMC, 2004d) do not maintain that a midwife teacher or manager or researcher must be attending a woman to qualify as a practising midwife. However, there is a strong norm operating that membership of midwifery and maintaining a midwifery identity, involves clinical practice. This may represent a socially constructed meaning which is outdated in light of the modern world of teaching. In the absence of national strategy or debate on this topic, individuals have become subject to the domineering socialising influences and those of their employing organisation. In light of the conflicting priorities and instead of losing autonomy, individuals have responded differently. This confirms Natalie Stoljar's (2000) comments that relationships and connection permit autonomy. In acting autonomously, individuals can...

'...opt for a range of different life plans and conceptions of good, thus respecting recent feminist concerns to preserve the diversity among and the multiplicity of agents. ' (Stoljar, 2000, p95).

Differences between individuals in response to the issue of how and whether a midwife teacher maintains a midwifery identity confirms the significance of diversity and multiplicity from a feminist perspective. There is a desire to create one model of clinical or non-clinical practice for all. However, diversity and multiplicity stem from individuals desire to establish and maintain valuable relationships and from the influence of the social context in which the agent is embedded (Stoljar, 2000). Individuals have acted autonomously and created personal meaning.

8.3 Where Is The Student?

All the respondents, whether practising clinically or non-clinically, maintained that their definition of their practising status supported their role and relevance of teaching material. Given how well each respondent defined their status as a practising midwife, it is difficult to establish in the context of this research whether these definitions contributed to the effectiveness of their role as a midwife teacher. It is significant that the student midwife was absent in all the discussion surrounding the ways in which midwifery teachers maintain a midwifery identity. The student midwife is the reason that midwifery education exists and the future of midwifery itself. Questioning the connection between the practising status of midwife teachers and clinical practice detracts attention from the focus for midwifery education unless a parallel discussion occurs concerning the development and implementation of the most appropriate strategies for supporting students to learn about midwifery.

None of the respondents follow a model which is student centred: there is a clear demarcation between practising clinically for personal motivation and developing strategies to support students in the clinical setting. This raises the issue of how best students can be supported to learn about midwifery in the context of modern health care and where the midwife teacher fits in this learning. Midwifery education has lacked the authority to argue whether the current fragmentation of midwifery is the most appropriate for students (or women). The social orientation of an occupational role dominated by women lends itself to lack of authority and control over those elements which make up the role of the midwife. Thompson (2004, p144) discusses how caring is devalued and the 'embedded and embodied nature of 'birthing' knowledge' is suppressed by the:

'...reductionist mind-body duality of problem-solving bioethics.'

Medicalised and patriarchal values are evident in the dominant structures which influence midwifery education and impose goals which detract midwife teachers

from working with students and women. In a similar vein with which Edwards (2005) discusses how women achieve a sense of empowerment and disempowerment in the face of obstetric ideology, it would appear that the midwife teacher is re-negotiating her midwifery identity in order to exert personal autonomy in her working life. In light of the demands to change both the academic and NHS organisational styles, the opportunity to explore new ways of working in order to support the midwifery curriculum, the student midwife and a midwife teacher's midwifery identity seems present.

8.4 Midwifery versus Academic Identity

Through the interviews and analysis, I admired the respondents for creating ways of managing their midwifery and academic identities. I did feel frustrated that the connection between clinical practise, supporting the student midwife and the role of a midwife teacher had fallen to individuals to manage rather than identification that this is a national issue for midwifery and midwifery education within University organisations. As one respondent identified:

' You are supposed to get personal development time, it is not always recognised as personal time you know getting your hands dirty and the University certainly does , I mean I think they don't object when I diarise myself a clinical day but erm they probably don't know about it. '(Claire)

Her comments reveal how she subversively created and prioritised time for clinical practice rather than receiving formal and legitimate confirmation from the employer of the how clinical practice may both inform and support the role of a midwife teacher.

The position of the midwife teacher contrasts sharply with the clinical and non-clinical lectureship posts awarded to medical practitioners within Universities. Whilst medical colleagues have had the status and power to negotiate their clinical and non-clinical lectureship contracts, midwife teachers have not had the same level of influence. This limits opportunities for both clinical practice and developing research capabilities. None of the respondents' comments suggest

that they had found a strategy which embraced clinical, teaching and research led activities. Their academic identity centred on teaching rather than research - a position which hinders career development: academic promotion hinges on excellence in research. This respondent indicated that:

'...there is very little professional development within our own structure – there is limited clinical development that we can undertake and there's the quest for further academic development which I think is er limited as well, Masters, PhD, whatever, that's extremely limited.' (Sarah)

The frustration contained within her comments is palpable. She is commenting how opportunities for development and variety are contained – she wants to develop in new ways however. This lack of professional development and career structure compares differently with the tripartite arrangement between clinical practice, research and teaching for a doctor. There seems a lack of consideration of which model of working would suit the occupation of midwifery and fulfil midwife teachers.

The historical sub-ordination of midwifery as an occupation over the last two hundred years is reflected in the current situation: as a small group and as a predominantly female occupation, midwives have limited bargaining power within a large organisation. The experiences of these respondents suggest increasing pressure to conform to organisational expectations and requirements without addressing whether these expectations are appropriate. The disharmony between individual and organisational goals concerning the maintenance of a midwifery identity is symbolic of disharmony between the current arrangements for midwifery education and the promotion of a social model of health based on the midwife-mother relationship.

8.5 Summary

Midwife teachers employed within an academic organisation face the challenge of adapting to an academic identity and organisational goal. The need to consider the meaning of their midwifery identity has driven each respondent to develop ways which have personal meaning. As Meyers (2000, p156) states:

'...the divergent demands entailed by ties to different groups can lead to estrangement from oneself and from others, yet they endow individuals with opportunities for agency, both for self-definition and for affiliation with others.'

The respondents had defined what was important to them and taken measures to maintain affiliation with midwifery practice in a variety of ways. How individuals chose to manage this conflict of interests is influenced by the organisational culture and model for supporting and developing student midwives and midwifery education.

9. EXPERIENCES OF STATUTORY SUPERVISION

This chapter examines how midwife teachers experience statutory supervision. Section one examines the altered sense of identity supervisors of midwives express whilst section two examines the difference between support and compliance. The third and final section explores whether the protection of mother and baby are legitimate claims within educational practice.

9.1 Being a Supervisor of Midwives

9.11 'It's an Inbred Thing'

The 5 respondents who were supervisors of midwives referred to an all-embracing nature of supervision. They all described a way of being in the world such that making the distinction between being a supervisor, a midwife or a lecturer was not possible:

'I never intended to go that way but actually functioning with supervision, I'm sure that that's had a major influence and I'm sure most of the time I think like a supervisor rather than a manager on occasions... when they come to see me as a manager, I can't take off totally supervision because it's a sort of inbred thing...it's about your whole professional person really.' (Susie)

'I find it really difficult now to dissect it all...it's like a chicken and egg isn't it. As a midwife I was always aware of professional issues, accountability etc. so moving into supervision seemed a natural progression ... it's really hard to kind of articulate what I'm thinking.... you know you could probably learn to live without doing it... but it really would be quite difficult I think.' (Michelle)

'It's very difficult to separate out what's the supervisory bit of me you know, what's the midwife bit of me and what's the educationalist bit of me... you are what you are aren't you and they do overlap. It is difficult to say that if I wasn't a supervisor I wouldn't do this.' (Claire)

Supervision had become integral to their make-up. Even the one respondent who was not a supervisor of midwives but involved with the preparation of supervisors of midwives programme, identified how her outlook had changed since engaging with supervision:

'I've been involved with supervision at consortium level but I'm also on the LSA strategy group now so it has made me do things differently and has opened doors that I wouldn't, I mean I went to the supervisory conference last week and some of the things they were talking about, I'm thinking 'oh I didn't know that.' (Margaret)

Working within the system of statutory supervision adds a new dimension to the sense of identity which integrates midwifery, supervision and education. This new dimension is reminiscent of the internalisation process that Jarvis (1983) and Freidson (1994) discuss where members internalise the set of values and practices which are acquired through a period of training. Mirroring the comments of Gilligan (1993) and Belenky et al (1997a), it is as if the respondents experienced a new layer of professionalisation enabling the development of a new voice, new sets of skills and practices which contributed to a different world view. The process of becoming a supervisor of midwives or a close liaison, leads to greater adoption and internalisation of the dominant professional paradigm. This respondent's comments symbolise her new world view and her defence of it:

'I have a passion for midwifery and a passion for supervision. I get quite upset when we were going through all that time when people were.... a lot of people were saying you don't need it... because if you see supervision positively then you don't want to get rid of supervision. You can't get away from professionalism and professional issues in any care... I think it heightens your awareness.' (Susie)

The question is whose professional paradigm are supervisors of midwives adopting? The self-defining and self-regulating activity associated with statutory supervision, can insulate the supervisor of midwives and create an ideology which

validates specific spheres of socially constructed reality¹. The close alignment between statutory supervision and clinical governance demonstrates how statutory supervision has been influenced by the NHS organisational values. The regulatory framework, which is the basis for supervisory activity, is based on medical values. The development of authority in the area of midwifery practice allows therefore the possibility of internalising the values and practices of the dominant discourse represented by both medical and organisational values. The added dimension of being a supervisor may therefore be connected with greater compliance with the values of others rather than establishing whose purpose it serves. Freire (1996) maintains that the danger in being oppressed is that the oppressed aspire to the model of the oppressor. This aspiration can lead to transformation into the oppressor and a reversal of roles. As Foucault (1979) suggests the development of power and authority is associated with acceptance of the ideas, concepts and way of thinking of the dominant discourse.

Embracing a professional paradigm within statutory supervision can create further difficulties: the supervisee can be overlooked and other sources of knowledge obscured (Wilkins, 2000). Wilkins (2000, p31) writes how:

'(The professional paradigm) also situates the professional and the client in wholly different 'planes of being' (or social dimensions), thus precluding any analysis of their relationship to each other and their similarities'.

Her comments challenge the source and purpose of the plane in which a supervisor operates and questions the purpose of the relationship between the supervisee and supervisor. The power and authority invested in the supervisory role heightens the potentially disempowering effect of a power differential between the supervisor and supervisee. Being a supervisor of midwives and being part of a powerful

¹ Section 3.3.1 pp 26 – 29 within the chapter on Professionalising Midwifery, discusses how supervisors of midwives and LSAMO on behalf of the system of statutory supervision, undertake the function of self-regulation and act as authoritative experts. However, supervisors of midwives judge another midwife's practice and define safety in accordance with medical and organisational values whilst claiming to act in women's best interests.

system creates an elitist perspective and can lead to difficulties in understanding a supervisee's perspective especially when this perspective is very different (Hoyle, 2001).

Hence the process of professionalisation does create a new identity. In so doing, it also creates the possibility that the new identity serves to establish a self-serving authority not shared by others.

9.12 Reasons for Becoming a Supervisor

Two of the respondents commented upon their reasons for becoming a supervisor:

'...that's why I put myself forward to be a supervisor because I felt: a) a supervisory team would be strengthened by having an educationalist within the team and :b) it would be more value for me to find out about what's happening in clinical practice area.' (Claire)

This respondent is highlighting how the arrangement is mutually beneficial. Her skills as an educationalist are added to the team whilst she equally creates links with events and developments in the clinical setting. This next respondent is highlighting the need for a 'mixed' team of supervisors:

'I was asked by the Head of Midwifery back at the unit where I was still a link teacher if I would like to get involved with supervision. I didn't know whether I wanted to get involved at that stage because I am in education and I was unaware at that time of any midwife teachers who were supervisors but then the conversation went such a way 'we value your experience as an educator and feel that this unit will benefit from somebody not being in the management role.' (Pauline)

Both respondents' comments reflect a period during the 1990's when the arrangements for statutory supervision changed. The reduction in a supervisor's caseload to the current requirement of 15 supervisees (NMC, 2004b), has necessitated an increase in the total number of supervisors of midwives. The reduction in the number of midwives on each supervisor's caseload was also

connected with breaking the historical connection between statutory supervision and management (Duerden, 2002)². Developing a mixed team of supervisors, i.e. supervisors who are clinical, managerial, educational or research based, is encouraged by the NMC (2002) to accommodate the needs of all supervisees.

For both respondents, taking on the role of a supervisor also represented a way of working with clinically based midwives. Like the ways in which midwife teachers maintained their clinical identity, being a supervisor may well serve as a means to maintain links with the clinical rather than academic world.

9.13 ‘Doing Supervision’

This section identifies those activities which are undertaken by a supervisor of midwives which Mead and Kirby (2006) refer to as ‘doing supervision’.

9.13.1 The Make-up of the Supervisory Caseload

Carrying a caseload of supervisee’s is integral to ‘doing supervision’. Three of the respondents commented on the make-up of their supervisory caseload. The facilitation of a wider choice of supervisor is connected with greater support: supervisees can now choose an educationally, clinically or managerially based supervisor (LSA, 2003). These first two respondents comment on how the supervisee’s choice resulted in the make-up of their caseloads:

‘I’ve got a wide and interesting caseload – they were all offered choice. I’ve got some independent midwives, midwives who work in the Trust I link with and midwifery lecturers... I suppose they chose me because they felt that I was more accessible.’(Celia)

‘... at the moment I supervise midwives across both Trusts ...I have a real mixture ...I have mainstream clinical midwives and I have midwifery

² Appendix 11.12, pages 245 – 249, provides an overview of the current arrangements for statutory supervision.

supervisors but some are managers and some are Heads of Midwifery... a wide variation but some have asked for me to be their supervisor. We strive to have a mix of supervisor ...some are clinicians, lecturers, researchers and I think that's good. '(Michelle)

Both supervise a range of midwives based in NHS Trusts, independent practice and academic organisations. The diversity of the caseload is referred to by this next respondent as the 'odd bods':

'I do supervise colleagues within the Trust.. we tend to have the odd bods sort of things you know practice development, Heads of service... '(Claire)

This respondent's comments intimate that midwifery lecturers who are supervisors tend to supervise a wider section of midwives than clinically based supervisors. Whilst this suggests that midwifery lecturers are more likely to supervise those midwives who do not work clinically or who work outside mainstream clinical NHS practice, it is difficult to establish this from the interviews. The connection may be linked to the type of support an educational supervisor can provide:

' Over the last five years I would say I have been part of the supervisory group and conscious that we've been trying to raise the profile of supervision in the local Trust.... as an educationalist, as a supervisor I would expect them to liaise with educationalists to look at education needs for their supervisee but not necessarily for them...I support my clinical supervisees with the education aspects. '(Claire)

The respondent is discussing her contribution to the team of supervisors and supervisees, identifying how she provides educational support. This raises the possibility that non mainstream and mainstream midwives find greater appeal in a person who can provide an educational rather than clinical perspective. However it does raise the issue as to whether the model of statutory supervision operating is too clinically biased for those who do not work clinically.

9.13.2 Doing 'On Call'

Doing 'on call' refers to the statutory requirement that practising midwives have access to a supervisor of midwives over the twenty-four hour period (Rule 12, NMC, 2004b). Locally, the supervisors of midwives complete an 'on-call' rota to ensure that a supervisor is always available. This respondent comments how she is excluded from this activity:

'..because I've got an honorary contract which is obviously an unpaid contract this issue about on call rotas and things, you know I don't go onto the rota of supervision because I'm not employed and because I can't get time reimbursed because I'm still expected to do my full day's teaching or whatever.' (Claire)

This highlights the differences between midwives employed within NHS and University organisations: the responsibilities and priorities of a midwife teacher conflict with the possibility of being part of the 'on call' rota.

9.13.3 'It's Almost Incidental'

Two respondents identified a tension between individual and organisational goals which arises from doing supervision. This first respondent refers to the lack of organisational recognition of statutory supervision:

'...because I'm a midwife teacher I'm responsible for the quality of midwifery education so I mean whether I'm a supervisor or not... it's almost incidental as far as the university's concerned. I see it as part of link role and I use it as link time that's how I get round it. ...how do you get universities to take....to see that they do have a role in supporting supervision. I mean ours see that it's worth being a supervisor because you can run the supervisors programme.' (Claire)

The value the organisation places on supervision is in relation to organising the preparation of supervisors of midwives programme. She comments how she subversively uses time allocated to her clinical link role to undertake supervisory activities because she attaches greater importance to it than the organisation. This

highlights how individuals demonstrate autonomy in managing friction between organisational and individual goals. This next respondent is also referring to the lack of organisational value attached to statutory supervision:

'I do know about supervision because I have that working experience... I would come and ask for advice. What I'm not certain is whether our systems of supervision deliberately enables that for anyone else ...you know I think they (other midwife teachers) don't see supervision as a priority within the school.' (Pauline)

Her comments suggest that the lack of organisational value has contributed to a lack of involvement of non-supervisors with supervision. This suggests that if the organisation committed itself more to supervision then individuals would become more involved. However, this does ignore individual decision-making in deciding whether they wish to become involved with supervision. It also challenges whether a system designed in relation to one organisation can transfer to another.

9.13.4 'They Won't See Supervision Within It...'

One respondent was also the Lead Midwife for Education (LME). The LME is responsible for implementing and monitoring the quality of the midwifery educational programmes against NMC standards (NMC, 2004d) and developed from the Approved Midwife Teacher role. She refers to the difference between the organisational value attached to the LME and the supervisors role:

*'Q: how do you feel the University sees you as a midwife?
A: They see me in my role as the lead midwife so to look at strategic development in education and to make sure that programmes are credible and practitioners are fit for practice but they won't see supervision within that.'* (Claire)

Whilst this is similar to the lack of organisational commitment towards statutory supervision, this respondent is highlighting the similarities between the activities of the LME and the supervisor. Both are involved with adherence to standards and

promoting quality within the programmes. The role of the LME is referred to within NMC documentation and explicitly relates to educational programmes and standards (NMC, 2004d); the role of the supervisor in education is relatively recent and does not have explicit direction from the LSA or the NMC. Like the role of the supervisor, the LME is not expected to be the manager rather an experienced midwife teacher. Unlike the role of a supervisor however, a connection between discipline and support within the role of the LME does not exist.

These findings suggest that those who are supervisors of midwives and educationalists are personally motivated to do so even though this creates tension within the management of their time. It demonstrates the level of personal commitment towards statutory supervision but also how employees will create individual patterns of working to their own advantage.

9.2 Support and Compliance

Support is a stated aim of statutory supervision (ENB, 1996, ENB, 1999a, NMC, 2004b). Gilligan (1982), Belenky et al (1997a) and Freire (1996) all associate support with enhancing personal confidence and liberation – both beneficial qualities wherever the midwife is working. All the respondents mentioned support but not always in connection with statutory supervision. Understanding the meaning of support and what qualifies as support seems, pivotal, in individuals' experiences of statutory supervision in the role as a midwife teacher. Two key areas, in which support is discussed, are the supervisory relationship and the supervisory review.

9.21 The Nature of the Relationship between the Supervisor and Supervisee

The relationship between the supervisor and supervisee underpins the availability of support. Three factors influenced whether support existed within the relationship: the existence of psychological safety, the influence of choice and the respondents' expectations.

9.21.1 Psychological Safety

From analysing the respondents' comments, the nature of the relationship between the supervisor and supervisee is inextricably linked with the perception of being able to find psychological safety: finding psychological safety provides the foundation for all other supportive activities. As this respondent identifies:

'...my current supervisor is also a friend, not a good friend but an acquaintance...there isn't that sense of position and power that I had with my previous supervisor ... she is a colleague....there is a trusting relationship which is perhaps better than a friend... you can have professional conversations but these very private conversations can only be done in an atmosphere of mutual trust so both of you take risks that in other circumstances you wouldn't.' (Sarah)

The existence of trust and taking risks is connected with a perception of the supervisor as a friend. This equates to the notion of a 'professional friend' by recognising it has a specific purpose yet exhibits intensity and intimacy (Fleming, 2000). Being able to express vulnerability safely and with trust seem critical factors in defining psychological safety and support. Other respondents identified these same factors.....

'I was fortunate I think in my experience to have a supervisor who was also somebody whom I admired somebody whom I had known for some considerable time – it was a collegiate, friendly relationship which made for open discussion and comfort.' (Sheila)

'...now the last time I saw her, I hear about her tales of woe in relation to something in her personal life... and she was talking to me about something that's going on in my life.' (Sarah)

Sharing experiences and openness are qualities within the relationship which contributed to the feeling of being at ease and the creation of psychological safety. In the presence of psychological safety, an individual feels at ease.

Gilligan (1993) discusses the significance of the presence of 'care' in relationships:

'...the ideal of care is thus an activity of relationship, of seeing, of responding to need, taking care of the world by sustaining the web of connection' (Gilligan, 1993, p62)

'Caring' supports the emotional connection the respondents reported. When 'caring' operates, the respondents valued and reacted positively within the supervisory relationship, heightening the integrity of the supervisor as a supporter and attracting individuals. Caring is however a mutual activity and not a quality exclusive to the supervisor: the supervisee equally cared.

Others also take on a caring approach within relationships. Taylor (2002) discusses how a professional mentor with a committed, caring and non-judgemental approach can help an individual feel supported. Midwives returning to practice after a sustained period of absence also value the support from an identified mentor (Kirkham, 2005). A mentor providing continuity of support with encouragement and patience, contributed to feelings of confidence and competence within the returnees. Returnees lacking support, found difficulty fitting in as their needs were not understood and there was a lack of interest in them (Kirkham, 2005). Women experiencing a model of caseloading midwifery likewise derive support from a midwife who is committed and caring (McCourt & Page, 1996). This highlights how caring and commitment are generally beneficial qualities promoting the existence of psychological safety and are not distinctive hallmarks of support available from statutory supervision.

Forces Working Against Psychological Safety

Comments from other respondents within this study show a different perspective on the availability of psychological safety from supervisors of midwives. The respondents' experiences from the first and second stage demonstrate a variation in their level of ease with supervisory contact and conversations: whilst some valued supervisory input others shied away and kept supervision at a distance. As the following comment highlights, attitudes and experiences of statutory supervision and the supervisor of midwives can be markedly different to those discussed before....

' ...I never felt with the supervisor since I've been in education that they would sort of say right, slap on the wrist er , first warning, whatever and then suspend, never a sense of policing attitude ... but I am aware that others in the clinical area feel that very strongly. ' (Sarah)

None of the respondents identified the existence of specific qualities which individual supervisors possessed and which negatively affected their perception of support but their comments suggest hesitancy, reservation and fear of punishment. This mirrors the comments from independent midwives who report how supervisory meetings are described as unhelpful, negative and destructive (Demilew, 1996). One system offering support is experienced in different ways.

As the last respondent alluded to, there is tension between the behaviour of those who implement statutory supervision and the power of the system. Results from the midwifery teacher's questionnaire in the first stage of this study indicate that unprofessional behaviour and lack of confidentiality are qualities which deter rather than attract individuals to statutory supervision. Despite the rhetoric concerning the availability of support from statutory supervision, the protection of the mother and baby is the main concern of supervisors of midwives (NMC, 2004b). Kath Mannion (2005), a LSAMO, explains that aspects of a midwife's practice may need to be revealed in the interest of protecting the public and

supervisory records have to be disclosed in fitness to practice investigations (NMC, 2004b):

'Confidentiality is one of the basics of the supervisory relationship. As such, interaction between the supervisor and the midwife may be confidential in full or part, depending on the situation.' (Mannion, 2005, p12)

Separating confidentiality from the protection role inherent within statutory supervision is difficult to achieve (Mannion, 2005) and an issue which undermines the creation of psychological safety. Deery & Corby (1996) argue that a supervisee is unlikely to feel 'safe' and free to discuss all areas of her practice because of the ever-present policing role of a supervisor.

Clulow (1994) in discussing probation officers' experiences of supervision in the workplace highlighted a similar tension between confidentiality and the availability of support. He identified how probation officers, even though there was a need for support, exhibited a fear of disclosure with their supervisors due to feelings of mistrust, fear of criticism and loss of credibility. A conversation or relationship where confidentiality or trust is subsequently broken undermines the perception of psychological safety, highlighting a serious weakness within the system and jeopardising the possibility of support (Clulow, 1994). As Kirkham (2000, p242) states...

'Feeling safe enables us to achieve our maximum potential, either as mothers or as midwives. Where there is threat (the opposite of trust) we are inevitably defensive, rigid, unable to give and clinging to the power we have.'

There is a fundamental emotional connection between feeling safe and finding support. Within that connection is the guarantee of confidentiality. Confidentiality sustains trust and psychological safety. Lack of confidentiality undermines the possibility of trust and psychological safety.

This confirms a paradox within the system of statutory supervision: it is disabling for the supervisor and the supervisee as supporting a supervisee cannot sit comfortably with the possibility of investigating the conduct and competency of the same supervisee based on a peer assessment of safety. There is a conflict of responsibility for the supervisor.

Midwives in whatever practising environment want support, supervisors want to give support and the system recognises the need for support yet the values inherent within the system can prevent its happening. The supervisory relationship cannot provide the optimum conditions for support. Kirkham (2000, p236) states that

'Support is known to be effective, yet the values of the system in which we work prevent this knowledge being put to best use.'

The system is unable to guarantee psychological safety as it cannot guarantee confidentiality, trust and the feeling of being at ease for all. It is therefore essentially anti-task (Menzies Lyth, 1988). Psychological safety is socially constructed and central to understanding how individuals respond to the offer of support from statutory supervision.

9.21.2 How Choice Affected the Relationship

The ability to choose a supervisor of midwives is symptomatic of the importance attached to support within modern statutory supervision. The NMC (2004b, p27) states that ...

'You should be able to choose your supervisor if you know them or one will be allocated to you by the LSA if you do not. If the relationship is not beneficial to you both, either of you can request to change.'

Choice suggests a better quality supervisory relationship by providing the foundation for meeting individual needs. It suggests that by engaging with statutory supervision, individual needs can be taken into account. The following

comments from two respondents identify how this matches individual's experiences:

'I chose her because I thought she would be a good supervisor and would supervise me well...I had a choice of all people working in different roles....but I saw that as an advantage that I saw somebody who was aware of my working environment and also because of her personal qualities.' (Margaret)

'I could have chosen a supervisor from each of the three Trusts. I basically chose a midwife that I had respected as a midwife and who I had known as a colleague for some time.' (Claire)

Understanding educational practice played a role in the decision making surrounding choice of supervisor of midwives. Their comments also reflect the same factors that facilitate the development of psychological safety.

Deciding Who

Several respondents commented upon the usefulness of educational supervisors in understanding the tricky situations and demands in education...

'.. I would say half the team actively chose not to choose (name)... but I saw that as an advantage, I saw that somebody who was aware of my working environment ... was also my supervisor.' (Margaret)

For others, the conscious decision to choose a clinically or managerially based supervisor was influenced by factors which were purposively unrelated to educational practice...

'...because she's got a different perspective on things.' (Michelle)

'...basically I chose a midwife that I had respect for, as a midwife and who I've probably known as a colleague for some time.' (Claire).

One respondent commented on the inability of a supervisor to understand educational issues, thereby influencing the selection process:

' I think they (clinical supervisors) are helpful from the fact that you know there's something you want to do in practice but they can't possibly have the first idea of what practice in the educational field and therefore I don't think they can help particularly. '(Susie)

The following comments demonstrate how the remaining four respondents, who were not able to choose their supervisor, hold a different perspective on the importance of choice. Two of the respondents were allocated senior managers within the Trusts whilst the remaining two were allocated clinically based supervisors:

' she's a new supervisor

Q: did you choose her?

A: No actually I didn't. No because I've got, you know, I haven't got issues with anybody so I wouldn't mind. They would allocate and if I'd an issue I suppose I could have changed. I was given her and that was fine. ' (Jane)

'Apparently the supervisors got together and looked at their caseload... how many had they got on their caseload, what's appropriate and they tried to decide who would have the midwife teachers and none of them wanted us. So all the midwife teachers were given the Head of Midwifery Services. ' (Sarah)

'...I was allocated a clinical supervisor and I meet with her on a yearly basis. I do attend all the annual updating lectures and recently she helped me sort of increase my clinical practice. '(Frances)

Despite this apparent lack of control and possible hindrance in the development of a supervisory relationship, the respondent's comments suggest that they carry no expectation that statutory supervision would be a mechanism for assisting them with work-related issues. Their needs and expectations were different to those who had chosen their supervisor. They had chosen to define and contain statutory supervision by limiting the level of engagement.

How Important Is Choice?

Choice seems implicitly connected with control. Certainly both choice and control are frequently mentioned phrases in Government and professional policy (DoH, 1993, 2004, RCM, 2001). However as Edwards (2005) found, women's choice regarding place of birth was often limited and defined by others. Similarly, Tanassi (2004) identifies how birth plans provide women with a sense of being in control whilst simultaneously providing clinicians the sense of 'being fair'. As she says:

'... birthplans, however, can be overridden at any time by reasons of safety as defined by clinicians.' (Tanassi, 2004, p2054)

Statutory supervision reflects this: whilst including a choice of supervisor, the number of supervisors has increased and the supervisory review has become mandatory. Hence, the appearance of softening disguises greater dominance and surveillance.

Those respondents allocated a supervisor of midwives, viewed supervision differently. Their experiences of supervision reveal compliance and a sense of simply getting it over and done with. Far from conveying their compliance as passivity, their comments reveal attempts to resist the power of statutory supervision and exert control rather than exist in a culture of silence as Freire (1996) suggests. Tanassi (2004) discusses how women seem compliant in obstetric institutions but actually this compliance is a means of achieving their ideals and desires. Supervisee's equally can comply as a means of achieving their desires which they define.

A supervisees' ability to tailor supervision to her own needs, permitted an element of personal power over their choice of individual supervisor. Being able to exercise control within the psychosocial working environment is a significant contributor in reducing stress at work (Marmot, 2004). However, choice was only afforded to those who were supervisors of midwives or involved with delivering statutory

supervision. It is possible that these respondents were more able to influence conditions which suited their needs. Their enthusiasm is also reminiscent of Freire's (1996) theory of self-preservation as activities really support those in power.

Choice can therefore support the construction of meaning which has personal relevance; by constructing meaning, individuals can manipulate the extent to which they accept being governed. Foucault (1979) maintained that individuals accept being governed whilst others can govern themselves. The respondents in this study suggest that they can blend both being governed and self-government whilst also complying. This supports Lipsky's (1980) view that individuals create meaning within the limits imposed upon them. It also supports DeBold et al (1996) comments that women can hold multiple positions when conflict between their own experiences and authoritative knowledge occurs.

9.22 'Help through Tricky Situations'

Many of the respondents provided examples of when support equated to talking through situations and issues. This respondent, comments on the usefulness of having a supervisor of midwives to discuss issues with:

'...one of the things I felt secure and able to discuss with my supervisor that I didn't want to discuss with my manager was when I was contemplating a move... you know certain things you can discuss when someone has a managerial hat on. I might speculate more with my manager; plan more with my manager... I've got to be precise – I've got this and this objective.' (Sarah)

She was able to discuss an issue which she did not want her manager to know about. Requiring career advice and guidance, the supervisor represented an individual who was independent of the respondent's contractual status. This respondent widens the perspective:

'Q: what would be your definition of supervision?

A...it's useful to have a colleague who you respect and you trust to talk through professional issues, whether they be about practice, whether they be about education er. And I suppose that does require an individual who does understand the different elements of your role erm and to be able to reflect with that person ...to chew the fat if you like ... we all get to a bit of a crossroads and we're not quite sure which way we're going to. To be able to do that with somebody who understands you and knows you as a person is a good thing.' (Jane)

With the knowledge that the other person understood her role and understood her, the respondent felt able to talk through issues and gain advice from the supervisor. However, not all respondents shared her perspective:

'A supervisor is really, someone who is supportive and who can help you through tricky situations when you are involved in some sort of incident in the clinical area... well I always thought that the role of statutory supervision was to address any clinical problems, I never really thought about it as having an educational function. But I think supervision is doing what I need of it.'(Frances)

She identifies how, in her mind, supervision although supportive, is restricted to talking through clinical problems and incidents which is an unrelated activity to her educational role. The expectations surrounding the possibilities within statutory supervision and therefore, what support means, differs.

Other respondents provided alternative perspectives on whether talking through issues was expected as part of the supervisors' role:

'...interspersed with our normal contact would be issues of my practice, knowledge and it's always difficult to work out during the course of a chat, we would probably touch on matters that should be supervision – it's hard to pin down when it actually moves from a professional discussion to a supervisory matter.' (Sarah)

This respondent is expressing her difficulty in clarifying the specific role of supervision in providing support as opposed to a discussion with another colleague

regarding an incident or problem. Difficulty in being able to identify the specific role of supervision is also referred to by this respondent:

'...if I've got an issue I'll talk to my supervisor. If I wasn't a supervisor I don't know whether I would automatically do that.' (Pauline)

She is suggesting that it is the nature of the relationship that she has with her supervisor that enables her to talk through issues. Her comment suggests however that supervision is not viewed by all as an opportunity to talk through issues.

'Talking through' therefore is constructed differently: what an individual wishes to talk through and whether this is specifically a function of supervision, influences the perception of support. All the respondents have found access to individuals who listen, enabling them therefore to talk through issues for which they feel they need support. Paralleling the findings from Belenky et al (1997a), the feeling of 'being heard' conveys a sense of being valued, importance and affirmation. The art of listening contributes therefore to the perception of support.

9.22.1 Offloading

Of particular significance was how frequently offloading was mentioned by one particular respondent. Although these quotes arose from the one respondent they do mirror the sentiments of others regarding the support:

'.. she was acting as my supervisor but she was also becoming more of a friend. I wouldn't say friend in the normal sense..... but she would offload the issues very professionally mind, I would be able to offload the issues....we can all go home and talk to friends and partners and so on but they are not in the business as it were and they don't want to be burdened by all of this and anyway the fine details are sometimes lost on them. You can offload...sometimes they only listen but occasionally a piece of very sensible advice will come back.' (Sarah)

'because one of the things I've noticed since I came into education is that those in managerial positions in the Trust, need someone to, offload to from

time to time, and it's not always appropriate to do it within the Trust.'
(Sarah)

Without listening offloading cannot occur: offloading seems a core element in this individual's definition of support and in her role of providing support. Offloading is connected to the role of the toxic handler identified by Frost and Robinson (1999) and is not unique to midwifery or statutory supervision. Frost and Robinson (1999) developed the concept of the 'toxic handler' after recognising that some individuals work surreptitiously to promote a more conducive working environment. A toxic handler is an individual who absorbs and softens the impact of sadness, frustration and anger endemic in working lives (Frost & Robinson, 1999). From their observations of activities within organisational cultures, Frost and Robinson (1999) identify a number of qualities that toxic handlers share: the ability to listen empathetically, to suggest solutions, to work behind the scenes to prevent pain, to carry the confidence of others and reframe difficult messages. Colleagues turn to a 'toxic handler' because of their trustworthiness, calmness and a non-judgemental approach³.

This respondent is explaining how useful and subtle a concept 'toxic handling' is. The value of a toxic handler lies in his/her ability to understand the context, be non-judgemental and say the right things so the other person feels better. In essence the toxic handler acts as a dumping ground for emotional distress (Deery and Kirkham, 2005) so that toxic feelings are re-cycled to produce healthier ones. In combination, these skilful qualities are rare in one individual.

³ Frost and Robinson (1999) are linking the activities of toxic handlers with individual survival in coercive organisational cultures. Toxic handlers create a system which receives and recycles damaging emotional and toxic experiences by helping the individual view the situation in a new way without judging. This is an interesting role and relatively new within the literature. Although the existence of coercive organisational cultures is recognised, discussion of the existence of a toxic handler widens the debate to consider how individuals manage within such cultures. Recognition that this activity takes place also validates how damaging interactions at work can be for the individuals' well-being. It also raises the issue of how the toxic handler survives whilst he/she works in a coercive culture and also acts a dumping ground for others' emotions. The valuable and valued role may confer status upon the individual with colleagues at work contributing to a heightened sense of identity.

There are two important features within this respondent's comment. Firstly, finding the support of a supervisor of midwives as a toxic handler suggests she has found a unique individual. Supervisors are not trained to provide support, particularly in that way. Therefore, the individual who happens to be a supervisor of midwives has developed these qualities on her own initiative or certainly independently of supervision. Secondly, the respondent comments on how she equally acts as a toxic handler for her toxic handler. It is possible that she is developing and reciprocating these skills through contact and experience much the same as Frost and Robinson (1999) suggest.

As Bluckert (2005) discusses though, individuals may only be prepared to reveal their vulnerabilities when psychological safety and a safe space have been created. A safe space is a pre-determinate for authenticity, exploration and discovery (Alexander and Renshaw, 2005). The creation of psychological boundaries therefore seems important and parallels the comments of Leap (2000) and Fleming (2000) when working with women in partnership.

9.23 The Contribution of the Supervisory Review

Opportunities within the statutory supervisory relationship and framework for professional development and growth can theoretically occur at any point. The annual supervisory review though is most likely to concentrate attention as it is designed to support professional development and PREP requirements⁴ (LSA, 2003). At the time of these interviews, the review was recommended and optional. However, the review is now mandatory (NMC, 2004).

The respondents in the second stage of this study all identified that they had attended a supervisory review recently. The fundamental difference for

⁴ See the Definition section on page ii for an explanation of PREP.

respondents in their experience of the supervisory review was how they defined it, whether it appeared as an act of compliance or a genuine development activity. This construction of statutory supervision was linked very strongly with whether they had chosen their supervisor of midwives. Those who had chosen their supervisor mainly viewed the supervisory review as a positive and nurturing experience allowing development...

'.. you are able to discuss... the way that you are going professionally... you can talk about your own professional development, in a way that is not considering maybe always what the institution wants.' (Pauline)

'...when we discuss action plans, she's very open, you know she'll bring suggestions to it as well, have you thought of this and have you thought of that, and generally you know I come up with, I prepare for the meeting before.. so I've got a rough idea of what I'm going to say, what I, what I think, er and she's really there in her, sort of more as a facilitator.' (Michelle)

'I think from a personal point of view and in my role I think support erm, from another view, another perspective, another take on things and feedback in such a situation, making me more visionary to think about things in a different way. She comes in and says... you know you're doing really good and she highlights your strengths. We discuss action plans, she's really a facilitator... I make, I'm prepared and that I've thought through things.' (Margaret)

This last respondent viewed the review positively, prepared for it and enjoyed her experience. She expected the supervisory review to challenge and stimulate. Most of the group of respondents who chose their supervisor of midwives discussed the review as a means to reflect upon their progress, clarify and identify further developmental needs. There was a clear relationship between the supervisory review and personal growth. Belenky et al (1997a), Leap (2000) and Kirkham (2000) all comment on the significance of support when confidence is inspired and personal growth stimulated.

9.23.1 Gateway to Clinical Practice

For some, the supervisory review was defined in relation to clinical practice.....

'.. I go out with her... to do a refresher for my community experience.....so I use her to update myself clinically, meet with her on an annual basis...'
(Claire)

'... I was allocated a clinical supervisor and again I meet with her on a yearly basis, I do attend all the annual updating lectures and erm recently she helped me sort of increase my clinical practise which was quite useful...' (Frances)

'..my supervisor is a senior manager and she's very supportive of me doing things – she helped me to get a bag together and any bits I wanted and she made sure I knew what I was doing (attending a family member).' (Susie)

A supervisory review becomes an opportunity to address clinical needs very much in line with the supervisory review for a clinically based midwife. The review acted as a gateway to clinical practice which some respondents discussed as helping to keep them 'grounded' and maintained links with the clinical areas. Interestingly, findings from the midwife teacher questionnaire in the first stage support this respondent's perspective. The vast majority (73%) viewed supervision as clinically orientated. This suggests that support from statutory supervision can be framed in relation to a clinical model rather than one which addresses challenge and growth for educational practice.

9.23.2 'Just Get On With the Job'

The following respondent reveals how statutory supervision seemed to serve an administrative function only...

'...you have somebody to give your intention to practise form to every year.' (Frances)

Having a supervisor enabled her to fulfil the statutory requirement to submit the notification of intention to practise (NMC, 2004b). In a similar vein, for other respondents, the function of the supervisory review was questionable:

'I don't clinically practice as a midwife, my practice is education so therefore the documentation doesn't lend itself so you know you make the comments and you say not applicable...but it's a tool for everybody that doesn't fit everybody.' (Margaret)

She is identifying how inflexible statutory supervision seems to be for non-clinical midwives. This next respondent is highlighting how the parallel system of staff appraisal or Individual Peer Review (IPR) meets her needs sufficiently:

'...if you're looking at midwives in education I think there is an awful lot of overlap between supervisory review and IPR. You know the problem is that both elements come together.' (Claire)

This next statement seems to summarise the sentiment of the respondents in this section:

'I think a lot of educationalists just get on with their job and go for their interviews but that's it. I don't know that it's necessarily a negative experience but I don't think it's a positive one either.' (Susie)

The imposition of mandatory support reveals a tension for statutory supervision: individual's access support when, where and how it suits. Conceptually, this challenges the assumption that statutory supervision is designed to meet individual needs and facilitate growth. The mandatory nature standardises the annual supervisory review. This can be interpreted as raising standards of practice just as it can be interpreted as greater dominance over individuals. Claiming to serve the interests of the individual, the mandatory nature of reviews may actually now enforce both medical and organisational agendas⁵.

⁵ For further discussion of how statutory supervision may act as a tool for other rather than professional leadership see section 3.3.1 pages 26 – 29 in the chapter 'Professionalising Midwifery'.

9.23.3 Mastered Their Own Development

Several respondents, even two of those who were supervisor of midwives, commented on how they had developed themselves without any input from statutory supervision:

'I suppose what's helped me as a teacher was really being dropped into it and having to swim or not succeed in the job... if anyone of the four of us had not been able to make a significant contribution to the team, the whole team would have suffered.' (Frances)

*'Q: How would you feel if you didn't have supervision?
A: I think I would seek other ways of support, we'd just find informal networks that you would use that I felt could be the open door. Has it contributed to my teaching...in the first part of my career not at all ...it was peers and people I worked with and my self-development as well as doing courses and degrees and that sort of thin. Further on in my career, having supervision has been a bonus, another dimension, it's useful to have.'* (Margaret)

Both respondents have identified how alternative sources provided support and direction other than statutory supervision. Indeed statutory supervision failed to support the first respondent new to her teaching role.

Statutory supervision did not therefore achieve its claim of supporting these respondents. Previously developed strong patterns of self-sufficiency (Bluckert, 2005) may influence the connection between statutory supervision and support. The culture may favour self-development rather than acknowledging the need for support (Kirkham, 1999).

Alternatively, the supervisory review can be interpreted as an instrument of power because it serves to monitor how the midwife is performing against pre-determined standards. As an instrument of power, its use serves to justify acceptance of the dominant organisational and medical values and depicts a situation of cultural invasion (Freire, 1996).

However, contrary to feeling disempowered and rather than accepting the power of the statutory supervision, some of the respondents' comments highlight how individuals construct their own meaning indicating an element of resistance. The priority attached to a supervisory relationship and supervisory review may appear supportive and individualised but they do also serve to highlight the power for monitoring and self-monitoring practice. As women experience in maternity care⁶, individualised care within statutory supervision is limited.

9.24 What Is The Meaning Of Support?

Qualifying the meaning of support has identified a number of conceptual contradictions within the system of statutory supervision. The fundamental contradiction surrounds the fragility associated with the creation of psychological safety: the power invested within statutory supervision can be experienced as disempowering. Hence, there is tension in the assumption that support is available from the supervisory relationship as the relationship is a smoke screen for a power differential and a tool for encouraging conformity with the dominant discourse. Individuals react and respond differently to this power and its connection with the possibility of support from statutory supervision.

Psychological safety, with the implicit need for confidentiality, is central and acts as a gateway either unlocking or locking the potential for support from the system of statutory supervision. Where psychological safety and trust have been created, individuals create options varying between offloading, gaining advice or growth from challenge. This is particularly true for those who are supervisors of midwives. Movement between the options is dependent on the skill of the supporter particularly surrounding listening abilities and valuing the other person. It also depends on what type of support the individual requires. Where psychological

⁶ See section 3.2 p14 – 21 in the chapter 'Professionalising Midwifery' for an analysis of how competing ideologies within maternity care affect women's experiences of choice.

safety does not exist, individuals distance themselves from statutory supervision. Individuals construct their own meaning, resisting power and exerting control in the face of imposed limitations. Their growth is self-determined and support is found from other sources. Hence in both situations, individuals are exercising personal power and constructing a personal meaning. For some however, this involves activating the system whilst for others it involves keeping it at bay and resisting its power.

This inability to find psychological safety may explain why some respondents, from the first and second stage, found support from other sources:

'Q: who is there to support you with your educational role?

A: My team leader ... but the onus is on me really..... we kind of support one another ...that's where the main channel of support would come from.'
(Jane)

'I have plenty of opportunities for support that I need for my education programme ... you see if you didn't have this kind of team it might be much more important to have somebody who you could go and speak to in confidence.' (Frances)

Far from feeling alienated, as Marx discussed, or feeling powerless (Freire, 1996), the respondents actively created their own meaning and exercised personal power. Cheyne et al (2000) provide an example of a group of midwives who formally looked outside the model of statutory supervision for the existence of a system of support without conflicting obligations and the threat of disciplinary action. They successfully developed a model of peer review in a cultural milieu that supported their learning and development. As Kirkham (2000, p237) states

'...midwives also build better support systems for themselves ... this may well be because they are outside, or sheltered from, disempowering hierarchical pressures.'

Hence, unsurprisingly, the desire for support drives a healthy need to seek out individuals who can offer support (Doyle, 2002). The variability of the midwifery

lecturers' responses challenges the assumption that firstly statutory supervision can provide support and secondly that it can meet the needs of midwives in education. These findings from this study corroborates with Duerden (1995), Stapleton et al (1998) and Rogers (2002) that a divide exists between the rhetoric and the reality of statutory supervision. The power within the system jeopardises the effectiveness of statutory supervision as a professional support mechanism.

9.3 Protecting the Mother and Baby

Safety is linked with the clinical setting where clinical governance and statutory supervision within the NHS monitor practice and respond to incidents⁷. Linking the protection of the mother and baby to the educational setting requires a shift in focus. All the respondents and not just those who were supervisors of midwives demonstrated a deep commitment to protecting the public despite working in a non-clinical setting. This commitment manifested itself in three ways: as guardians in both the theoretical and clinical components of midwifery educational programmes; in the way students are introduced to statutory supervision; and in the way that colleagues manage colleagues.

9.31 The Public Want...

Every aspect of a student's performance is assessed and monitored as is required by the Standards of Proficiency in Midwifery Education and in preparation for qualification (NMC, 2004d). The respondents demonstrated their sense of responsibility towards protecting the public by guarding the standards set:

⁷ In section 3.2 pp14 – 21, in the chapter on Professionalising Midwifery, I discuss the strength of the connection between risk and safety in healthcare. Strongly based on the values inherent with the biomedical model, risks in maternal and perinatal health are assessed and managed during pregnancy and childbirth. Clinical governance and statutory supervision function within this model adopting a similar approach to risk management.

'You know if look at some of the university students, they take drugs...the award of their qualification, is not dependent on whether they take drugs or not. They have academically proved they've studied at that level but we're coming from ...they're getting a qualification that entitles them to work with the public. These people that they're working with are vulnerable.' (Pauline)

'...the public want people who are knowledgeable and able to do the job...I don't think they give a hoot whether that's attached to a diploma or a degree or anything else, they just want to know that the midwife can do, safely, do the job.' (Sarah)

The respondents have taken on that responsibility as guardians of the standards within education. This is similar to the professional advocacy role that Grace (2001, p160) refers to as:

'...those actions taken to further the goals of the profession with regard to health.'

Professional advocacy is an obligation of role towards the consideration of those actions which support the profession's goals or professional promises which are discoverable in the NMC published codes and standards and which sanction professional practice (Grace, 2001). The comments from the respondents suggest that they would define the profession's goals as preparing practitioners who will do the job safely and as midwife teachers they act to protect the mother and baby. In this sense, professional advocacy translates as compliance with professional standards.

9.31.1 Jumping Up and Down

Three of the respondents, two of whom were supervisors of midwives and the other involved in the preparation of supervisor of midwives programme, mentioned incidents involving theoretical components which indicated a failure to meet

professional standards and which warranted specific action to address these concerns:

'I do look at it through the eyes of a supervisor thinking OK if you got onto the register what would I want to do with you then. I have to say we have had some situations of misconduct – we're able to provide a chanceit's all very well saying the system will decide but as a supervisor I would have to deal with this through the LSA⁸ or refer directly to the NMC. I can't justify allowing or keeping such a student there.' (Susie)

'...you know people come and say this student's handed this in as evidence what do you feel about it?

Q: and you feel they're coming to you specifically because you're a supervisor?

A: If there are professional issues... I have jumped up and down several times with issues we could take down the supervision route...if there's anything that I think would harm the mother and baby or the midwifery profession, then I get a bit sensitive..' (Michelle)

'... sometimes they (students) raise issues that cause concern...I would ring a supervisor and say you know, one of the students in class mentioned this...' (Margaret)

All three identified situations where the student had written or discussed something which did not comply with the professional standards and raised concerns in their eyes. Their comments suggest that they seemed particularly sensitive to incidences which they interpreted as evidence that a mother and baby may be harmed as a result of a student's actions. This sensitivity compelled them into action – they could not overlook an incident of this nature:

'If they can't engage with women or their families (you would involve the supervisor) from the practice and safety point of view I'd go to the top and get the LSA. If you're unhappy about a student then you need all the support you can get and if you've got to fight the establishment of the university because we clearly do not want these people.' (Margaret)

⁸ The LSA represents the LSA Midwifery Officer (LSAMO) who is responsible for the implementation of statutory supervision within a defined area. The role carries strategic influence and all supervisors, in an area, are accountable to the LSAMO for the role and actions as supervisors (appendix 11.10, pp 245 – 249).

As discussed earlier, the power and authority associated with being a supervisor triggered the respondents to define the incident as one which had the potential to harm a mother or baby. This belief justified their intervention. As Wilkins (2000) commented though there is the possibility of ignoring alternative sources of knowledge and exerting power over the student in the name of safety. The rationale for intervening based on the premise of protecting the mother and baby takes place without involving any woman in the process. Therefore the supervisors within the educational setting are assuming that their actions are in the best interests of women. Moreover, the claim that an individual's practice is unsafe mirrors the strategy used by doctors to limit the role of the midwife at the turn of the twentieth century. Whilst statutory supervision, through supervisors of midwives, is seeking to extend its power and influence in education, it is losing any connection with women in whose interests the system claims to serve.

The following respondent's comments vindicate the danger of a professional paradigm:

' ... if as practitioners ourselves we firmly believe that this is not the right way forward, then we have to fight the cause .. enlist the help of others .. the ENB⁹ .. the statute book. ' (Pauline)

' ...most colleagues would fight the midwifery corner.. quite vociferously erm, but then they'd look at avenues that would support their arguments and if supervision was another prop ...then they'd use that. ' (Michelle)

The strength of their conviction which rested on values inherent within a medical ideology would drive the respondents to pull on all sources of help especially the statute book to prevent what was, in their eyes, unsafe practice.

Those respondents who were not supervisors or involved with statutory supervision possessed a different outlook and challenge the authority of statutory supervision.

⁹ This respondent is referring to previous situations when the ENB (English National Board for Nursing, Midwifery and Health Visiting) existed.

The following respondent expressed her perspective:

'Q: so in education, who is the advocate for the women?

A: I would have thought all midwives would be advocates for the women and we should be working together as educators and clinicians to prepare the students to take on that role. The University is very supportive of courses with a professional component. ' (Frances)

Her comments demonstrate how she recognises an advocacy role for her self but defines it differently to those who are supervisors of midwives: she views advocacy as a collective responsibility rather than the exclusive domain of a few. She equally suggests that should a problem arise, the systems developed within the University would assist in deciding the future for the student. My own University has established fitness for practise regulations which apply to health care professionals (Sheffield, 2006). This challenges the extent to which statutory supervision has any authority within an organisation which has developed systems of managing students.

As two respondents commented:

' Q: would you at any point consider bringing in a supervisor or the LSA Midwifery Officer?

A: with the problems we've had over the last five or six years we have discussed it but we haven't felt it useful... no influence over the institution. The biggest clinical influence would be the confederation¹⁰.

Q: who is the advocate for midwifery in higher education then?

A: no-one. ' (Sarah)

'I don't really see the LSA Officer as somebody who would be particularly useful in helping us to sort out a problem that we had, I don't know how well LSA Officers actually fulfil that role. ' (Frances)

The respondents who were not supervisors had not experienced any advocacy themselves or confidence in a LSAMOs' ability to influence non-NHS organisational activities. In their view contractual considerations were more

¹⁰ The confederation is the commissioning body for midwifery education.

significant influences upon midwifery education. The respondents' comments suggest that they are aware of the power of statutory supervision, but they choose whether to activate it or not. As a means of protecting the mother and baby within the educational setting, the findings mirror the tensions identified within the literature¹¹, in that it is conceptually flawed, lacks sufficient authority in another organisation and individuals perceive its value very differently.

9.31.2 Clinical Issues

Similar concerns about a student's inability to meet the standards required were also raised by some of the respondents in connection with clinical practice. All but one of these respondents was a supervisor of midwives:

'...the student was about to qualify, she was right at the end and it was recognised that perhaps the student needed to do quite a bit of work on her interpersonal skills, how her actions could affect other, be more considerate and we did that through a series of reflective practice sessions with her supervisor. This student midwife then went off and got a job somewhere else without a reference from her educational institution which was noted by the LSA officer to pass on through the LSA network.' (Michelle)

'We did have an incident about medication about whether our eighteen month students could actually give paracetamol because they were registered nurses – we tend to get the supervisor coming back saying 'this is ours to take on'. We had an issue about students being involved with giving prostin...my immediate thought was supervision.' (Margaret)

'If it's a clinical practice matter then yes supervision will probably be involved and has been involved ... a student was showing a poor attitude, poor practice and supervision was absolutely wonderful.' (Sarah)

All three of these incidents demonstrate that the system of statutory supervision

¹¹ See section 3.3, pp 22 – 28, in the chapter on Professionalising Midwifery analyses the assumptions underpinning statutory supervision.

was used as a mechanism for addressing the issues raised. There is a sense of collective working but also a sense of demarcation – the comment ‘this is ours to take on’ arises from the one respondent who was not a supervisor of midwives. The comments suggest that there is a limit to which educationalists can be involved with incidents over which supervisors of midwives have authority in the clinical setting.

9.32 Learning to Comply

Some of the respondents emphasised the theme of professional advocacy further by stressing the importance of introducing the students to statutory supervision to prepare them for practice...

‘...we introduce it right at the beginning of the programme, involve the LSA officer, we get different clinical supervisors to come in, erm I bring the supervisors into erm a management modulethey know they’ve got supervisors.. and all the way through now.’ (Margaret)

‘...we are shaping the midwives of the future, as are clinicians and I believe that during everything that we er facilitate them learning... we can give the message of supervision ...’ (Pauline)

Involving and teaching student midwives about statutory supervision was a recommendation of the Stapleton et al (1998) study after it was found that both students and qualified midwives lacked knowledge on supervision. In the local and national LSA guidelines regarding the supervision of student midwives, all students are allocated a supervisor at the beginning or part way through their programme (LSA, 2006, 2000, NMC, 2004).

The following respondent highlights how the topic of statutory supervision was integrated within the curriculum...

‘I’m making sure they get supervisors in to teach supervision, we bring them in to share incidents and we involve them in the course board.... and

they're also involved in developing the PBL scenario's¹². The only other thing we do to familiarise the students with supervision is we invite a group of students to meet with the supervisor as a group on a six month basis. '(Claire)

Another respondent who was a supervisor of midwives found that she could introduce the students to the role and scope of practice through discussion...

'...it's not just about teaching but it's about enabling students and supporting students. You know that it's also been about students coming with a problem and wanting to discuss that problem... and the way in which...I could approach it and maybe within supervision...' (Pauline)

Introducing students to statutory supervision enables the identification of situations where accessing a supervisor of midwives would prove useful. In that sense, increasing the amount of curricular time addressing the meaning of statutory supervision and the activities of a supervisor of midwives, also allows more time to highlight what is expected from them as qualified midwives. The values inherent within the statutory framework governing midwifery practice can be passed on to the student in a relaxed and friendly manner when in reality the importance of compliance is being nurtured.

9.33 Colleagues and Compliance

Professional advocacy changes in relation to colleagues. When asked to consider how colleagues would be managed should poor practice become evident, this respondent who was a supervisor of midwives, suggested a gentle and understanding approach:

'...because they're in education, they shouldn't be treated,[they are] human beings and people under the same stresses as anybody else, they may be different stresses but because you know they've all got lives and it*

¹² The course board refers to meetings arranged to monitor the quality of midwifery programmes. PBL refers to problem based learning which is teaching and learning strategy which uses scenarios from practice as the basis for group work activities.

shouldn't be, oh you should know better you're such and such a professional.. (Michelle)

*[words in brackets are my own and not those of the respondent]

The emphasis should poor practice arise, centred on reminding and giving them appropriate support:

'Part of the midwife's role is giving the right advice and as educators is giving the right advice to students. I think supervision then has a role in reminding people and giving them the right support to ensure that they... er... deliver education in a safe way.' (Pauline)

This compares starkly with the action that would be taken with a student...

'... we go all guns blazing.' (Margaret)

The respondents suggested a softer way of managing their colleagues so that the use of the regulatory system within the University or contacting a supervisor of midwives was not considered. Motivation may be affected by their association of statutory supervision with investigation and policing of another's practice:

'...prior to coming into education the limited experience of supervision I did have, was inextricable from management... hardly see the gap between the two and we were conscious of a possibility of disciplinary or punitive action if you didn't perform. I never felt with the supervisor since I've been in education that they would sort of say, right, slap on the wrist er, first warning, whatever and then a suspend, never a sense of the policing attitude but I'm aware that others in the clinical feel that very strongly.' (Sarah)

'I know in the past people have always, not all people, but people have always worried about it being reactive and so therefore if you step out of line supervision will come down like a big claw. That's not really what we're suggesting, we're trying to suggest the positive nature of it and how useful it can be to support the individual.' (Pauline)

Both these respondents recall a negative and powerful image of statutory supervision. Alternatively, respondents seemed reluctant to involve supervisors of midwives because midwife teachers work closely together. The formation of

relationships with colleagues is crucial to job satisfaction and significant in managing stress (Taylor, 2002, Kirkham, 2005). Contrasting slightly with the findings from Belenky et al (1997a) and Gilligan (1993), the midwife teachers have demonstrated the centrality of certain relationships in their role: maintaining relationships with their immediate colleagues is more important than involving statutory supervision and disturbing those relationships.

Advocacy is therefore socially constructed and managed differently. Supervisors use their self-defined knowledge to justify intervention and limit the power of the supervisee. Supervision within educational practice could be viewed as an extension of the surveillance of clinical practice yet its influence within a non-clinical organisation is very limited. Universities have their own systems by which to monitor student behaviour and individual midwife teachers view the value of statutory supervision differently.

9.4 SUMMARY

Support in connection with statutory supervision is a complex concept and inextricably linked with power. Accessing support within a system that rests on ensuring compliance with values which constrain midwives and women, and which pre-defines the meaning of support and the individual from whom support should be found, contradicts the very personal nature of support. However, there is a direct relationship between feeling supported and the establishment of trust and psychological safety. In the presence of safety, support can take various forms depending on the skill of the supporter and the requirements of the individual requesting support. In parallel with women's experiences of maternity services, those supervisee's who do not participate in statutory supervision and comply are termed deviant. Hence, whilst ever the threat of a supervisory investigation for non-compliance exists, individuals are unlikely to discuss and examine their practice comfortably with a supervisor of midwives.

Advocacy as a supportive strategy was questioned by the analysis of the respondent's comments. Some of the respondents felt able to be an advocate for the standards of the profession without necessarily contacting a supervisor of midwives. There was times however when a supervisor of midwives or LSAMO would be contacted regarding serious issues where the respondents required additional influence. Generally though, the advocacy role undermines the autonomy of both the midwife and the mother by assuming this function.

10. DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

In this thesis, I have sought to understand how a sample of midwife lecturers constructs statutory supervision. I have explored my data for an understanding of their experiences and responses to statutory supervision. In so doing, I became aware of the socially constructed nature of the role of a midwife lecturer as described by the respondents in my sample. I examined the conflict which arose as respondents struggled to maintain a midwifery identity which sometimes contradicted the values associated with being an academic. Their role strain signified resistance to a setting and ideology which threatened the relationships and practices which sustained their midwifery identity. Using my data and the work of others, I characterised their collective experiences as associated with feelings of vulnerability.

Throughout the analysis of my data, the role of statutory supervision in supporting midwife lecturers has been perplexing. My assumption at the outset of the study was that all could benefit from statutory supervision. This assumption was false as I have shown that my respondents' experiences of the power differential within the supervisory relationship shaped their responses. Statutory supervision was constructed differently by each respondent which challenged my generalised preconceptions.

In this concluding chapter, I discuss further the role of the midwife lecturer and their diverse responses to statutory supervision. I make recommendations as I discuss each theme. These recommendations are based on the findings from a small sample and cannot be viewed as generalisations concerning the experiences of all midwife lecturers. Drawing on the theoretical basis for my study, I weave my findings with the literature review in chapter 3, to deepen my understanding of the role of the midwife lecturer and the influence of statutory supervision. I comment on how my shortcomings influenced the development of this study and suggest practical ways forward.

10.1 The Experience of Support

The theoretical framework for this study rests on the perspective that supportive relationships and connection are important in enabling personal development: a network of support sustains growth and development, particularly women's (Belenky et al, 1997). Tending, befriending, creating and sustaining social networks are primary physiological responses for females to promote safety and reduce distress (Taylor, 2002, Hopson, 1986, Oakley, 1992, Pedler et al, 1986, Adams et al, 1976).

Wheeler (2000) argues that a formal system of professional support promotes good practice. Support from statutory supervision, as a mechanism for professional support, has a much greater profile today than previously. Critics had commented on the feelings of victimisation brought about through their contact with statutory supervision, e.g. Seaman, 1995). The last ten years have witnessed a significant re-organisation of the supervisory framework with the introduction of choice of supervisor and the prominence of the supervisory relationship as a means of providing and accessing support (NMC, 2004b). Studies by Duerden (1995), Stapleton et al (1998) and Rogers (2002) conclude that midwives, including midwife lecturers, need support from statutory supervision in order to empower the clients they cared for.

The cyclical process of analysing the literature and the respondents' comments has highlighted the prominence of the concept of support. What was so striking in my findings is that even though statutory supervision has adopted the model of relationships and choice as a basis for supporting supervisees, half of my respondents did not find this supportive. Their experiences of supportive supervision were impaired by the lack of psychological safety within the supervisory relationship: trust, confidentiality and listening without judgement were missing. The statutory responsibility to investigate potential poor practice contradicts a supervisor of midwives' ability to maintain confidentiality.

The respondents, who were not supervisors of midwives, found alternative sources for support. They demonstrated their ability to act autonomously, which I discussed in chapter 4. In line with Foucauldian thinking, these respondents resisted the domination of statutory supervision by exploiting possibilities for exerting personal power and control over their psychosocial environment (Marmot, 2004). As agents of power, they constructed a supportive element of statutory supervision which served a personal, practical purpose: this equated with gaining access to clinical practice. As a bridge to clinical practice, statutory supervision was helpful and supported the respondents' maintenance of their midwifery identity.

Only those respondents who were supervisors of midwives found the supervisory relationship supportive and psychologically safe. The lack of a deviant case in the data leads me to suspect that this may be attributable to the length of time the supervisor and supervisee had known each other. They spoke of the relationships as mutually supportive with emotional and cognitive connection. This polarises the respondents' experience of support from statutory supervision even though they all shared a need to find support which they perceived as safe and rewarding.

The respondents' experiences of support highlight its complex and socially constructed nature. So although one of the primary purposes of statutory supervision is defined as supporting the midwife (ENB, 1996, ENB, 1999a, NMC, 2004), the implementation of effective support without psychological safety is problematic. Effective support from statutory supervision only seems achievable for those who are members of the club and understand the 'rules of the game'. As I noted in chapter 9, the process of becoming a supervisor of midwives or a close liaison with statutory supervision, led to the adoption and internalisation of a dominant professional paradigm. Accepting the dominant discourse and being part of a powerful system creates an elitist perspective. As this study shows, the elitist supervisory perspective is self-serving.

10.11 The Meaning of Support

Based on the significance of relationships as a vehicle for finding support and recognising the cyclical nature of power, I have examined the experiences of the respondents and heard their voices. Defining the meaning of support seems critical in suggesting ways forward for midwife lecturers.

Yegdich (1999) attempts to differentiate between support, supportive and feeling supported by identifying how a supportive attitude or relationship is comfortable, useful and common throughout life. A supportive relationship can serve to confirm an individual's perceptions rather than challenge them thereby failing to help an individual develop or enhance self-awareness which is necessary for personal growth (Yegdich, 1999, Pedler et al, 1988). Although useful, her definition falls short of clarifying the distinctive features of support and how individuals can be supportive.

The toxic handler, which I referred to in chapter 9, is an example of a supportive colleague in the work situation. By listening empathetically, suggesting solutions, working behind the scenes to prevent pain, carrying the confidence of others and reframing difficult messages, a toxic handler receives and recycles damaging emotional and toxic experiences. The activities of a toxic handler help the individual view the situation in a new way without judging. Colleagues turn to a 'toxic handler' because of his/her trustworthiness, calmness and a non-judgemental approach. It is not only an orientation within the relationship which others perceive as favouring the opportunity for support but also the possession of skills which means support will be available. The respondents have identified how being heard, feeling valued and feeling psychologically safe are pre-requisites for feeling supported. Unlocking the meaning of support, supportive and being supported seems inextricably linked with an orientation within a relationship which values the other person, with the aim of facilitating confidence and growth. I see this as the essence of the respondent's comments.

As Belenky et al (1997a) discuss, given support, women can develop their mind, self and voice. Antonovsky (1988) uses the term sense of coherence to describe

personal confidence in own abilities and competency. Those with a weaker sense of self view the world as dangerous employing defence mechanisms and blaming others for their own situations. Those with a stronger sense of coherence welcome challenges, are prepared to take risks and interact with others more positively. A sense of coherence can be intentionally modified by using the support of others (Antonovsky, 1988). This support takes the form of planned modification by practitioners by encouraging individuals to re-interpret their experiences and seek out confidence boosting activities. The concept of sense of coherence seems to underpin finding mind, self and voice. My respondents seemed to demonstrate a more positive sense of coherence by recognising and seeking the support of others.

Bandura (1995) discusses the value of working with individuals to improve their belief in themselves and confidence. Encouraging individuals to take responsibility for their own actions and behaviour and respond positively to events is viewed as a technique useful within a supportive relationship. Self-efficacy refers a belief in the self and confidence to take responsibility for personal actions and behaviour (Bandura, 1995). My data indicates that the respondents have self-efficacy by demonstrating their autonomy in managing their midwifery identity.

Both sense of coherence and self-efficacy, seem implicit within the notion of peer support. Freire's (1996) model of collective, community working valued dialogue, problem posing and shared goals as a means of promoting social action and individual growth. Sure Start¹ schemes across England adopt the principle of collective working by bringing people together with similar experiences to promote sharing and fostering of peer support and build personal confidence (RCM, 2001a, Bandura, 1995).

There are other examples where collective and peer support helps to develop individual confidence. Olive Jones (2000) describes how she developed a

¹ SureStart schemes are a government initiative designed to help families with infants and small children in targeted areas of deprivation. The schemes are employing midwives to support families in their parenting role (RCM, 2001a).

collective enabling culture in the Edgware birth centre. As a supervisor of midwives, she explains how she utilised strategies which facilitated self-esteem and confidence. Uniquely, Jones (2000, p167) outlines a cyclical model of empowerment where...

'In the model of supervision employed, the midwife is empowered, in turn, the woman is empowered, positive feedback from women and families empowers the midwife, endorsement of the approach to practice empowers the supervisor.'

Belenky et al (1997b) discuss the concept of 'invisible colleges' where 'connected knowers' drew out the voice and minds of others. The 'invisible colleges' are community co-operatives where collaborative working leads to;

'... a better way of living, the people reach high, stretching themselves in ways they would not have dreamed possible' (Belenky et al, 1997b, p15).

They discuss how key people within the 'invisible colleges' acted as 'midwife lecturers'² drawing out the abilities of the women. The skills to 'draw out another' centred on listening with care and respect.

Developing an individual's self-belief seems central to supporting an individual for growth when activities occur within a relationship which develop confidence and motivation. Socialisation can influence the development of sense of coherence (Antonovoksy, 1988). Stapleton et al (1998), Kirkham (1999) and Ball et al (2002) have demonstrated that values operating within a midwifery NHS culture, where the majority of midwives work, include a sense of powerlessness, learned helplessness and an ethic of self-sacrifice. It is a coercive culture, which I referred to in chapter 3, rather than an enabling one that Jones (2000) fostered and as described above. Socialisation within a coercive culture fosters a weak sense of coherence, a propensity to not take responsibility and an inability to work together towards solutions (Antonovsky, 1988, Bandura, 1995,

² The term 'midwife teacher' does not refer to a formal teaching role as discussed throughout this thesis. It is used in relation to an individual who helps women to articulate and expand their latent knowledge. They help to give birth to ideas, support thinking and encourage the voice of others. In this sense, the same term implies an alternative way of considering the formal role of the midwife teacher/lecturer that I am researching.

Kirkham, 1999). My respondents did not seem to demonstrate a weak sense of coherence because they used personal power to create meaning in their working lives. It is important though to consider how socialisation in midwifery can influence an individual's outlook and confidence.

10.12 Statutory Supervision and Support

Integrating the literature and respondents' experiences is important as a means of examining why support from statutory supervision was experienced differently. I have established that the respondents' construction of support refers to a philosophical stance best practiced within an effective interpersonal relationship which is based on caring and commitment. My own experiences as a supervisor of midwives and talking to others supervisors, has made me realise that the term 'support' is being used differently and needs clarification.

The respondents, the literature review and theoretical basis for the study concern 'support' in a psychological sense and as a means by which an individual can grow and develop. My experiences with statutory supervision suggest that the term 'support' is used in relation to improving practice practically: it has a different connotation. The supervisory review, the relationship and choice of supervisor are strategies by which to ensure compliance with the statutory framework in order to 'support' the midwife to practice. A recent example of an award winning innovation in supervisory practice was entitled 'Enabling Supportive Midwifery Supervision' (Stephenson, 2006). It relates to the development of a competency model by which midwives and supervisors can begin an action plan surrounding skills required to care for women, e.g. obstetric emergencies, suturing. These two constructions of support are different: one refers to support in relation to nurturing and growth; the other refers to support and standards in practice. Both are equally valid but very different. The difference in the use of the term 'support' affects individual expectation and social construction of statutory supervision.

The statutory preparation of supervisors of midwives does not address the 'nurturing' and 'growth' element of support: investigatory skills and knowledge

of the regulatory framework are prioritised to fulfil the primary function of public protection which is about centrally defined standards (NMC, 2004b). Linking psychological nourishment with statutory supervision is a misnomer. Meeting the challenge of developing skills which foster a nurturing element within statutory supervision is unachievable given the statutory responsibility to investigate potential poor practice and the inability to guarantee confidentiality and trust: both important pre-requisites for nurture.

I conclude that it is advisable to reframe the meaning of professional support within statutory supervision and break any connection between the methods adopted by statutory supervision to monitor compliance with the statutory framework and other set standards, i.e. the supervisory review, choice of supervisor of midwives and supervisory relationship, and the potential for support which suggests nurture. I propose that a system for professional support which engenders nurturing, is developed independently from statutory supervision.

10.13 Alternative Models for Professional Support

In this section, I suggest two alternative models for providing professional support which develop and individuals' sense of coherence and self-efficacy.

10.13.1 Life Coaching

Alexander & Renshaw (2005, p15) describe coaching as ...

'...an enabling process to increase performance, development and fulfilment....in enabling people to go beyond what they thought was possible'.

Mirroring Rogers (1990) client centred approach, life coaches value trust, openness and honesty in order to support and challenge the coachee. It is a relationship entered into with the specific purpose of fulfilling the definition provided above and creating a safe space for individual psychological exploration and discovery. The core belief and orientation within the relationship is that individuals have tremendous potential which can be liberated

if the conditions are appropriate and the individual shoulders responsibility for personal development. Both the coach and coachee have responsibilities.

Coaching is fashionable currently. It does provide a model orientated towards facilitating growth without reference to counselling. Counselling makes the same explicit connection with personal growth but adopts specific effective interventions adopted from counselling and psychotherapy as a way of working with and supporting an individual to develop themselves as practitioners (Sloan and Coit, 2000, Wilkin 1998, Holloway, 1995). Gilmore (1999) and Yegdich (1999) found that nursing practitioners expressed anxiety in exposing one's self in a counselling situation and resisted models of professional support which offered counselling.

Coaching offers confidentiality, trust and psychological nutrition in a constructive and developmental manner. The coach needs to be skilled however in supporting without counselling. Hadikin (2002) discusses the practical implications of becoming and sustaining a role as a life coach (<http://toopten.org/public/CE/CE57.html> – accessed 19.6.06). Her comments highlight how life coaching is viewed an occupational role wherein individuals develop a business. This likens the role to a sports coach and suggests an independence from the working environment.

10.13.2 Professional Mentor

The term professional mentor refers to the ability to support an individual through a relationship (Taylor, 2002). It refers to an individual who is committed to the welfare of another individual through a relationship. This mirrors the comments from Davies (1995) that:

'Caring can mean just 'being there' for someone else ...giving commitment to the nurturance, growth and healing of that other. Caring does not involve specific tasks; instead it involves the creation of a sustained relationship with the other...' (Davies, 1995, p141).

This reflects the ethic of care and responsibility orientation I mentioned in chapter 4. Kirkham and Morgan (2006) found that midwives returning to

practice after a sustained period of absence valued the support from their mentor. The mentors' encouragement, patience and commitment enabled feelings of confidence. The returnees' feelings of confidence and competence inspired by her mentor parallel women's experience of caseloading midwives (McCourt & Page, 1996). Those returnees who did not receive such a level of support reported their mentors as too busy, not understanding their needs and not being interested in them. They found difficulty fitting in.

Both suggestions follow similar principles: a relationship geared towards one purpose - the psychological support of the other in order to create a space in which to grow. In addition, the supporter and the supported recognise the purpose and their responsibilities within the relationship. Deciding who could act as a life coach or professional mentor challenges our current arrangements. Both Newburn (2006) and Leap (2000) have demonstrated that women want what I now refer to as nutritive support during childbirth – listening, trust, patience, praise, empathy. Midwives, midwife lecturers and women all want the same thing. Newburn (2006) and Leap (2000) refer to this as 'being with woman'. Those same skills would support 'being with midwife'. Hence, the concept of nurture is generic. Being nurtured and giving nurture are skills for all. As Belenky et al (1997b) identify, where nurturing exists within a relationship, the pattern of care will be modelled and passed on in other relationships. I suggest that if nurturing skills were seen as important as for example as performing a vaginal examination, all midwives could not only develop and maintain these skills but also choose a colleague to act as a mentor or life coach. Both would be clear on the purpose of the relationship and would not be constrained by conflicting responsibilities. These skills could be mirrored when working with women and student midwives.

The creation of interdependency as described above, contradicts the traditional model of independence that I discuss in chapter 4. Interdependency is central to support and personal development suggesting a shift in cultural and social values to acknowledge its importance. It also favours the adoption of a professional mentor role rather than a life coach: the professional mentor allows

a spiralling form of nurture between individuals in an environment which would be absent in the professional and detached role of a life coach.

10.14 Recommendations Regarding the Meaning of Support

Based on the analyses of my respondent's experiences, the literature review and mine own experiences I have two recommendations surrounding support:

- ❖ The term support is clarified, recognising it serves different purposes. Statutory supervision is unable to provide the form of support required to create a safe psychological space which nurtures an individual's sense of coherence and self-efficacy. Accessing support within a system that rests on ensuring compliance with values which constrain midwives and women, and which pre-defines the meaning of support and the individual from whom support should be found, contradicts the essence of psychological nurture.
- ❖ As support skills are implicit within the role of every midwife not only for each other but for the women or student they care for, I am recommending that all midwives learn how to be supportive and search for relationships which provide support. The skills that Leap (2000) summarises as facilitating being 'with woman', are those necessary to women, workers, midwives and midwife lecturers: the ability to embrace uncertainty, developing trust, suggesting, being patient, informing, withdrawing and inspiring confidence.

10.15 Limitations Regarding the Meaning of Support

Although I have commented on some of my limitations during the development of the theoretical framework and methods section, there is a major error with the way I collected data. My lack of delving and questioning during the data

collection stages in relation to what support is and how individuals define it, hampers an in-depth analysis. It would also have been extremely useful to question supervisors of midwives concerning their views on support: how they define and provide it, what skills they have and how supported they feel. An area for further research surrounds critical analysis of the concept of support in the area of professional practice.

10.2 Protection of the Mother and Baby

In chapter 3, I traced the origins of statutory supervision. Introduced as a means of inspecting midwives practice in 1902, supervision was a mechanism for ensuring that midwives practiced within the limitations framed by the statutory framework and set by male doctors. In the context of that particular historical and cultural moment, which I describe in chapter 3, it was assumed that high maternal and infant mortality and morbidity was attributable to the unsafe practices and skills of midwives (Haegarty, 2000).

Over the last century, modifications have occurred in the way that statutory supervision is implemented at a local level: midwives rather than non-midwives are supervisors of midwives and there is greater choice of supervisor. In chapter 3, I demonstrated how modern statutory supervision has become embedded within the bureaucratic hospital culture and hierarchies (Silverton, 2000, Cruess et al, 2000, Kirkham, 1996). The retention of the function of protecting the mother and baby from unsafe midwifery practitioners legitimises the role of the supervisor, as the definer of safety. I explained how definitions of safety are value-laden revealing those associated with the dominant obstetric ideology. Using the experiences of Baker (2005) and Edwards (2005), I demonstrated how statutory supervision claims to represent and protect the interests of women when in reality it imposes a construction of safety which can differ from that of the woman and the midwife. It excludes and silences women in supervisory decision-making, denying client autonomy.

Protecting mothers and babies from unsafe practitioners is an important and necessary function. I demonstrated how in modern healthcare, two parallel systems claim authority to protect the public: self-regulation by the NMC which governs nurses, specialist community public health nurses and midwives collectively; and clinical governance within the NHS which incurs responsibility upon all health care practitioners for risk management, quality improvement and quality assurance.

My findings and the literature review raise important issues concerning the professional monopoly that statutory supervision has over safety and protecting the mother and baby. The analyses of the respondent's comments reveal that the assumed exclusive right of a supervisor to judge the practice of a student midwife or midwife is challenged in a non-clinical and non-NHS setting. 'Protecting the mother and baby' in an educational setting takes on a different meaning to one in a clinical setting. All the respondents recognised their responsibilities towards protecting the mother and baby from unsafe students and midwives. All the respondents acted as guardians of professional standards although the mechanisms for ensuring this differed: whereas some of the respondents felt the University's own fitness to practise regulations were sufficient to manage an issue concerning a student, others perceived the need to involve supervisors of midwives. I found that the fitness to practise of students and colleagues were perceived differently by the respondents. None of the respondents would involve a supervisor of midwives if a colleague was suspected of poor practice.

In my experience as a midwife and supervisor of midwives, there is an assumption that issues surrounding 'safety' are automatically referred to statutory supervision. My findings indicate that statutory supervision does not hold exclusive authority over the protection of the mother and baby.

A national and international debate on the future of self-regulation grows. Much of this debate centres on greater moves towards multi-professional education before qualification (Jolly, 2001), developing stronger means of assuring practitioner competence post-qualification (Crossley et al, 2002) and a modernised approach to shared fitness to practise regulations for all health care practitioners (Jolly, 2001, Walshe and Benson, 2005). A government initiated review of medical and non-medical regulation of health care practitioners (DoH, 2005, NMC, 2005a, DOH, 2006a) highlights a more harmonised approach to professional regulation, suggesting a move away from the model of statutory supervision. I referred to the rise of consumerism in chapter 3 which is reflected in shifts in current social policy (DoH, 2002, 2004). The establishment of the Council for the Regulation of Healthcare Professions (CHRP), by the

Department of Health in 2001, and requirements within the Nursing and Midwifery Order (HMSO, 2001) signal a move towards acknowledging the importance of lay representation and involvement. It also undermines monopoly of regulation by individual governing bodies.

Involving users of the service is a recent and relatively uncharted ground for statutory supervision. In some parts of the country, users are involved in the recruitment of supervisors of midwives and in the annual LSA audits of maternity units. Reducing the professional paradigm in the current supervisory arrangements provides opportunities for statutory supervision to respond more effectively to consumerism.

Referring to woman centred care, Linda Barclay discusses how:

'We remain very good at defining what women want from our perspective, but poor at listening to their needs. We run the risk, if we do not listen, of creating 'midwife' rather than 'women' centred care' (Barclay, 1997, p1).

These sentences could easily be translated to show how supervisors of midwives are very good at defining what midwives and women want but poor at listening to either group's needs. 'We run the risk of creating 'supervisor' rather than midwife or woman centred care'. The effective management of poorly performing practitioners is crucial in promoting public confidence and public accountability (Pickard et al, 2002, Donaldson, 2003). Public confidence and accountability in the current historical and cultural context translates as openness and honesty. Statutory supervision, by excluding women and midwives in decision-making concerning the safety of a midwife, acts in secrecy and in isolation. This contradicts the approach adopted by the NMC which welcomes the views of the mother and partner in fitness to practice cases (Lewis, 2006). In chapter 3, I referred to Fairtlough (2005) who argues that the hegemony of hierarchy should be replaced by heterarchy in order to reflect the modern pluralist society. In light of wider regulatory reform and socio-political changes, the continuance self-regulation and the continuance of statutory

supervision as a method for the self-regulation of midwives, in its present format, is questionable.

10.21 Alternative Model for Regulation

The Midwifery Standards Review (MSR) is an alternative model for developing midwives, from the model of statutory supervision in the UK. Developed in New Zealand and set within a social and political culture which is different to UK, it is based on the principles of heterarchy. MSR is defined as a system...

'...to provide the midwifery community with a mechanism for accountability that also encourages the ongoing professional development of each practicing midwife' (New Zealand College of Midwives (NZCOM), 2001, page 1).

The model follows the principles of openness and public accountability by establishing panels of equal numbers of consumers and midwives who review a midwife's practice annually. The role of the reviewer has a fixed term and is rotated. The midwife is encouraged to audit and discuss issues arising from her practice in relation to ten standards published by the NZCOM (Philosophy of Midwifery, Code of Ethics and Standards of Midwifery Practice NZCOM, 2001). These standards provide the boundaries for practice yet facilitate autonomy and responsibility. Feedback from women, for whom the midwife has cared, is integral to assessing the skills and competency of the midwife. There is no relationship between assessing the midwife's competence and commencing a disciplinary investigation (Campbell, 2003).

Midwives evaluate MSR as empowering (Stewart, 1999, personal discussions with midwives in New Zealand). It also fosters responsible autonomous practitioners (Fairtlough, 2005). MSR is voluntary and orientated towards independent midwives who hold their own caseload. This constitutes 70% of the workforce in New Zealand although there were discussions concerning how and

whether to introduce this model for hospital midwives (Campbell, 2003). Although the values of the New Zealand society are different to the UK, I suggest that there are useful elements within this model – user involvement, professional responsibility and accountability, audit of practice using the feedback from women - which provide a different and fresh approach to protecting women and babies. It suggests an alternative way of regulating practice.

10.22 Recommendations for the Protection of the Mother and Baby

Based on the analyses of my respondent's experiences, the literature review and my experiences, I have two recommendations surrounding protecting women and babies:

- ❖ Decisions regarding the fitness to practise of a midwife or student midwife should involve and welcome the participation and contribution of users of the service to promote greater accountability and openness.
- ❖ A new system for verifying competence of a practitioner post-qualification should also involve the user perspective and recognise the wide variety of settings in which health care practitioners practise.

10.23 Limitations for the Protection of the Mother and Baby

My lack of appreciation of the elitism associated with statutory supervision shone through as I re-read the transcripts from the interviews in the second stage of this study. The scenario's I used on the spur of the moment, to highlight potential protection issues within education, were poorly thought through: a colleague's lack of confidentiality, poor conduct of a student and a policy which contradicted professional values were superficial and failed to address the issue of user involvement. Although I asked respondents if there were any ways they would want to improve statutory supervision, this question was biased towards the current model. An area for further research may surround consideration of an alternative model of statutory supervision such as MSR.

10.3 The Role Of The Midwife Lecturer

In chapter 7, I identified that the respondent's were experiencing role strain as midwife lecturers. The respondents demonstrated how relationships with clinical colleagues, peers, supervisors of midwives and the wider University helped them overcome the difficulties associated with role strain and sustained their role and identity as a midwife. Conspicuous by its absence was however the mention of any relationship with student midwives. The respondents' comments highlighted how working within a University organisation had presented them with a new set of demands, challenging their construction of the role of a midwife lecturer.

Chapter 3 provided a basis from to which to understand how differing social and organisational ideologies may affect an employees' working environment and practices. By weaving my findings with the literature, I am suggesting that the experiences of my respondents highlight the tension created as they reconstruct their role as a midwife lecturer in a higher educational organisation. In line with the comments of Mackenzie and Stoljar (2000), who I refer to in the theoretical framework, the respondents have displayed the skills of self-direction and self-definition to establish personal meaning. All the respondents demonstrated autonomy in managing themselves but there were two significant victims of the culture clash: the student midwife and the lack of emphasis on research.

Both Menzies Lyth (1988) and Obholzer (1994) maintain that working practices, relationships and social systems are structured so as to defend individuals against the anxiety implicit within organisations. Menzies Lyth (1988) uses the example of nursing care which is organised to minimise contact with patients whose suffering and pain raises anxieties within the nurses. The primary task of the organisation can become deflected by anti-task activities, i.e. creating activities which distance the nurse from the patient. Anti-task activities serve to contain nurses' anxieties. Such working practices and relationships can be viewed as defensive structures as they become the accepted way of working, both fiercely defended and difficult to change (Menzies Lyth, 1988).

In relation to my study, anti-task activities become important when connecting with the absence of the student in the respondents' comments. I was shocked when I realised how little the respondents raised 'student stories' which contrasts with midwives who discuss stories of caring for women despite difficult working situations, e.g. Stapelton et al (1998), Ball et al (2002). My own experiences as a midwife lecturer indicate that it is difficult to keep the needs of the pre-registration student at the forefront when faced with increasing pressures for curriculum development and supporting students at postgraduate level, managing and developing assessments, monitoring and reporting on quality assurance strategies and the need to publish. There is little time left for the pre-registration student. In light of my analysis and personal experience, I am suggesting that the educational system may serve to hide the real reason for working and routines have become anti-task.

Belenky et al (1997b) discuss a 'midwife lecturer' as an individual who nurtures the young. Developing the theme of relationality and the development of voice, self and mind, upon which I have based my theoretical framework, they emphasise the importance of a community permeated with values associated with nurturing the development of human beings. I am proposing that this is the basis for future working models for midwife lecturers. Developing responsible autonomous practitioners requires developing ways which foster their sense coherence and self-efficacy. This draws together the importance of support based on nurture, which I discussed above, a supportive environment and working models which allow relational autonomy.

The lack of emphasis on research also draws my attention to the national picture with which I have only a little knowledge. There are Professors of midwifery and midwifery lecturers who have managed to combine research and teaching. I am aware that a few combine research with clinical practice but am unaware that anyone manages to combine research, teaching and clinical practice. Maybe the three elements combined in one role, is unachievable – my respondents have demonstrated that and I too find juggling two presently difficult.

Working as a lecturer-practitioner role creates tensions as individuals do not feel they 'fit' in either the academic or NHS organisations (Fairbrother and Ford, 1997). In 1998 after an evaluation of midwifery educational programmes, Fraser (1998) recommended working practices which incorporated a range of roles within one team. Roles could favour a combination or concentration on teaching, research or clinical practice. This approach supports the adoption of heterarchical and responsible autonomous working practices where individuals rotate between roles within teams and blends research with teaching and clinical practice. However, this model also raises questions concerning the development of expertise in one area if there is rotation and individual choice and control.

10.31 Recommendations for the Role of the Midwife Lecturer

Integrating the literature, my respondents and my own experiences, highlights that maintaining established and traditional patterns of working fails to acknowledge the extent of the changing occupational landscape. Identifying the strain generated from the need to develop an academic identity and maintain a midwifery one, points to a need to reframe the role of a midwife lecturer and one which becomes student-centred. I have two recommendations concerning the role of the midwife lecturer:

- ❖ A national study should examine new ways of working which blend an academic and midwifery identity for midwife lecturers and which recognise their responsibilities;
- ❖ In developing new ways of working, the priority of the role of the midwife lecturer in 'nurturing the young' and supporting student midwives to become practitioners who are fit for purpose, practice and award is emphasised.

10.32 Limitations Regarding the Role of the Midwife Lecturer

My understanding of the midwife lecturer role is much broader than previously. I would now have the confidence to manage the interviews differently: I would ask the respondents to tell me about their role as they experience it – what helps and hinders. I believe I would develop a better understanding of their context and the role of statutory supervision in supporting their practice.

10.4 Summary

Several strong messages emerge from this study regarding statutory supervision and the role of the midwife lecturer. The respondents sought relationships which nurtured the growth of sense of coherence and self-efficacy. Caring and committed relationships create interdependency and spiralling support. Statutory supervision offers professional support but pre-defines who offers the support and cannot guarantee psychological safety. The responsibility towards protecting the mother and baby, conflicts with offering nutritive support. This is professionally significant for student midwives and midwives and suggests the need for a separate professional support system unconnected with statutory supervision.

Protecting the mother and baby is an important function of a supervisor of midwives. This study has challenged the elitist and paternalistic way in which statutory supervision undertakes this function. Conflicting constructions of the meaning of safety and the exclusion of women as users of the midwifery service in supervisory decision-making, highlights the need for change. Moving towards regulation which welcomes the participation of users signals professional maturity.

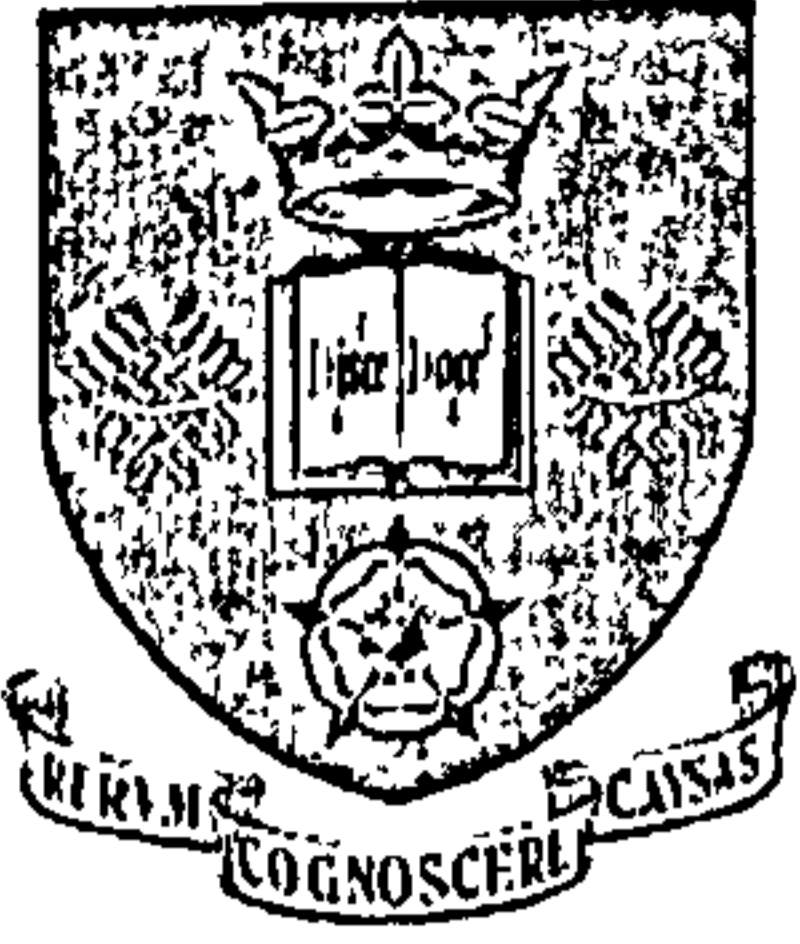
The culture clash arising from the assimilation of midwifery education within University organisations is reflected in my respondents' difficulties adjusting to masculine styles of working. This style of working emphasises activities which deflect attention from the student midwife, demonstrating how midwifery

education is becoming anti-task (Menzies Lyth, 1988). New ways of working are required to facilitate a system of education which 'nurtures the young' whilst simultaneously providing a supportive environment for midwife lecturers.

10.5 Dissemination Strategy

Upon completion of the study, the findings will be disseminated locally through seminar presentation and nationally through the proposed publication of articles in research and midwifery journals on the following topics: the value of voice centred relational analysis and framing analysis in research methodology; the experiences of midwife lecturers in relation to statutory supervision in higher educational settings and introducing support in midwifery curriculae.

**LETTER TO HEAD OF MIDWIFERY EDUCATION & MIDWIFERY
LECTURER**



THE UNIVERSITY OF SHEFFIELD

Dean

Dame Betty Kershaw

School of Nursing and Midwifery

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Heather Wilkins

Name & Address

22 February, 2000

**The Pattern and Role of Statutory Supervision for Midwifery Teachers/Lecturers in
England**

Dear

I would like to ask for your assistance with a research study which is examining the issue of statutory supervision for midwifery teachers/midwifery lecturers in higher education. The aim of this study is to:

- i) Establish a national picture regarding present statutory supervisory arrangements for midwifery teachers/lecturers
- ii) Explore the relationship between supervision and midwives' practice within higher education;
- iii) Determine the role and meaning of supervision for midwives within higher educational settings.

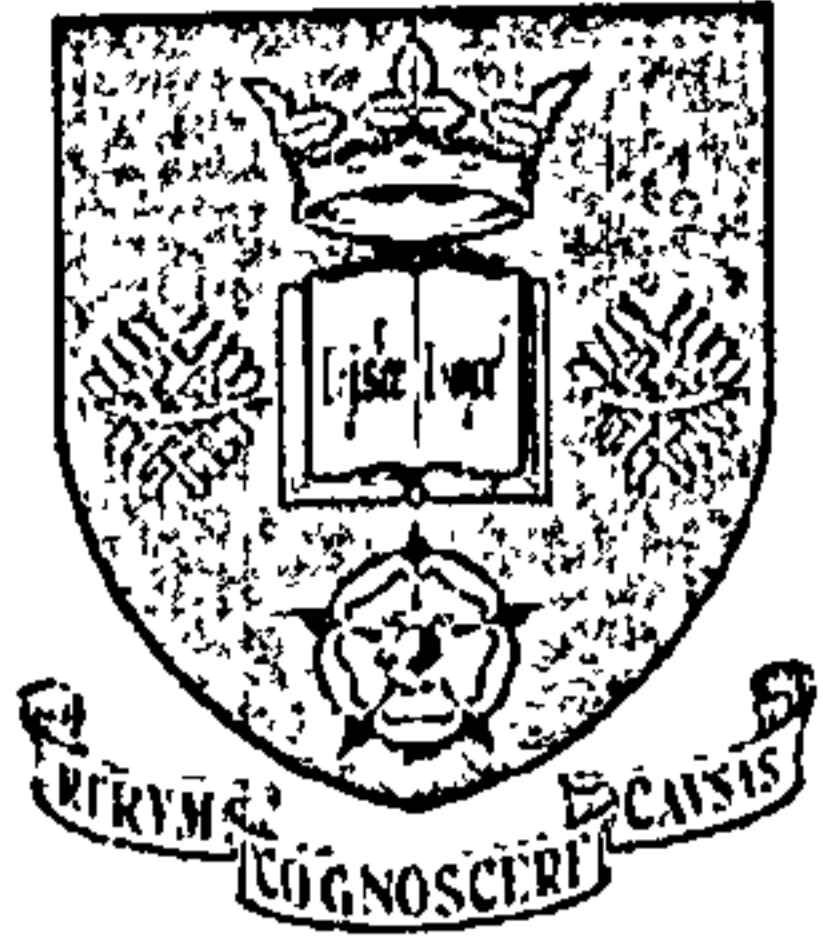
The first phase of this involves a survey of all midwives involved in education throughout England by way of a postal questionnaire. My target population includes all midwives within England who teach students on pre-registration and post-registration midwifery education programmes and who hold a substantive post within a University.

To assist me therefore, would you mind completing and sending me a list of all the midwifery teachers/lecturers working within your University so that I can send each a questionnaire for participation in the study if they wish. I have enclosed a self-addressed envelope for that purpose. Your assistance would me help me enormously. If you have any queries, I would be only too pleased to discuss them with you. My academic supervisor is Professor Mavis Kirkham (0114 2229704) should you wish to contact her for clarification.

Thank you in advance.

**LETTER TO HEAD OF MIDWIFERY EDUCATION & MIDWIFERY
LECTURER**

Heather Wilkins, Midwifery Lecturer & Supervisor of Midwives



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Heather Wilkins

June 5, 2000

**The Pattern and Role of Statutory Supervision for Midwifery Teachers/Lecturers in
England**

Dear Colleague

I would like to ask for your assistance with my research study which is examining the issue of statutory supervision for midwifery teachers/lecturers in higher education. The aims of this study are to:

- i) Establish a national picture regarding present statutory supervisory arrangements for midwifery teachers/lecturers
- ii) Explore the relationship between supervision and midwives' practice within higher education;
- iii) Determine the role and meaning of supervision for midwives within higher educational settings.

The first phase of this study involves a survey of all midwives involved in education throughout England by way of a postal questionnaire(enclosed). My target population includes all midwives within England who teach students on pre-registration and post-registration midwifery education programmes and who hold a substantive post within a University. The second phase will involve focus groups to discuss and clarify issues which arise from the questionnaire's.

If you would like to participate, please complete and send me the enclosed questionnaire by 23.6.00 in the stamped and self-addressed envelope. I have estimated the questionnaire will take 15 minutes to complete. The final sheet within the questionnaire is designed to help with the second phase of the study – this sheet will be dealt with separately upon receipt of the questionnaire. Anonymity and confidentiality are fundamental and assured – it will not be possible to identify any individual or University eventually.

If you have any queries, I would be only too pleased to discuss them with you. My academic supervisor is Professor Mavis Kirkham (0114 2229704) should you wish to contact her for clarification. Thank you in advance.

Heather Wilkins, Midwifery Lecturer & Supervisor of Midwives

LETTER TO LSA MIDWIFERY OFFICER


THE UNIVERSITY OF SHEFFIELD

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Heather Wilkins

LSA Midwifery Officer

January 20, 2000

The Pattern of Statutory Supervision for Midwifery Teachers/Lecturers in England

Dear

I am writing to you regarding the statutory supervision of midwifery teachers/lecturers practising in higher education. As an LSA Officer, your views are very significant and I am therefore requesting your co-operation and assistance in kindly agreeing to complete the enclosed questionnaire by 25.2.00. The time taken to complete the questionnaire is estimated as 15 minutes. All answers will be treated confidentially & anonymously.

As part of an MPhil, I am exploring the pattern and role of formal supervision for midwives who work outside the clinical mainstream and in higher education throughout England. The first phase of the study includes investigating how supervision translates for midwifery teachers/lecturers. This involves a survey of midwifery teachers/lecturers and the LSA Responsible Midwifery Officers by way of a postal questionnaire (enclosed). The second phase will involve deeper exploration of the significance and value attached to supervision through focus groups. The nature of these groups will depend upon the issues raised from the questionnaire.

I am a midwifery lecturer and Supervisor of Midwives. If you have any queries, I would be only too pleased to discuss them with you. My academic supervisor is Professor Mavis Kirkham should you wish to contact her for clarification.

Thankyou in advance.

With regards

Heather Wilkins

Midwifery Lecturer & Supervisor of Midwives

APPENDIX 11.3

**RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY
LECTURER AND LSA MIDWIFERY OFFICER
QUESTIONNAIRES**

**Midwife Lecturers Questionnaire: Source & Rationale for Each Question with
Intended Measurement**

Midwifery Lecturer Questionnaire

A. YOUR ROLE

1. What is your job title ?

This question provided an initial picture of the nature of the post the individual undertook. Variations on the theme of a lecturing role may have influenced the experiences and utilisation of statutory supervision. This was only supposition but some factual information was needed as the principal element in role profiles.

Hence, the question was worded with the three known variants of the role to me with the option to identify other roles in a simple tick-box fashion. The findings were collated on a bar graph.

2. How long have you been a midwife in education ?

Behind this question was the need to identify how long an individual had been practising within education as this could have influenced their experience and understanding of supervision. There was a need therefore to group the number of years into bands which would correlate with trends in statutory supervision in the clinical arena – those who had mostly recent moved into education may have differing perceptions and experiences of supervision to those who had more of their career in education. This was an assumption, a tentative hypothesis, which the further questions would either confirm or dispel.

Again, a tick-box question was devised for ease of statistical analysis and ease in answering. The findings were collated on a bar graph.

**RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY
LECTURER AND LSA MIDWIFERY OFFICER
QUESTIONNAIRES**

3. Are you a Supervisor of Midwives?

Using a yes/no answer, this question was developed from discussions and the pilot study as I realised that being part of statutory supervision would affect personal experiences.

B. THE ORGANISATION OF SUPERVISION FOR YOU

4. Do you currently have a named Supervisor of Midwives ?

The need for this question came to light from the 2 major references on supervision of midwives in education (Duerden, 1995, Stapleton et al, 1998). Both highlighted a number of midwives who did not have a Supervisor of Midwives. It is a legal requirement that all midwives are allocated a Supervisor of Midwives (UKCC, 1998/NMC, 2004b). Although a yes/no question was all that was required at this stage, a feeder question was needed however, as it was necessary to delve deeper as to why individuals did not have a Supervisor of Midwives. Those who did have a Supervisor of Midwives did not need to answer this question and could therefore proceed to a further question. From the pilot, it was also necessary to include a potential answer of 'don't know' for those who are unsure of their supervisory arrangements.

5. Are there any reasons why you do not have a named Supervisor of Midwives ?

This was a deliberately open question for those midwives without a Supervisor of Midwives to identify reasons rather than a question devised around my own perception and assumptions. Further questions were not relevant for this sub-group so a feeder question was necessary.

6. Please state how many Supervisors of Midwives you have?

The source for this question was a mixture of personal experience and experiences of midwives in other areas of the profession. The movement of midwifery education into University settings & away from clinically based units highlighted the cross-boundary issue, which arises for other midwives practising between different supervisory areas. Midwifery lecturers undertake the majority of their practise in a classroom setting but are attached to specific clinical units. Independent midwives in a similar position are

APPENDIX 11.3

**RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY
LECTURER AND LSA MIDWIFERY OFFICER
QUESTIONNAIRES**

documented as having several Supervisors of Midwives because the nature of their work. Within the context of this knowledge, I could not assume that if they had a named Supervisor of Midwives, they only had one such individual. This question therefore was an attempt to clarify a difference between having a named supervisor of midwives and having a supervisor.

7. Indicate below, the main area of practice for each of your Supervisors.

In order to explore further the response from question 6, a range of roles were identified and the respondent had to link the main area of practise with each of their Supervisors. In such a way, it was intended to identify the range of roles undertaken by those who supervised the midwifery lecturers. The format was taken from the annual Notification of Intention to Practise form that each midwife receives. The option of 'other' was included due to recognition that the questions were designed in the context of my experience and reading and may not therefore have corresponded with others' experiences.

8. Is/are your Supervisor(s) connected to the clinical areas with which you liase?

Again in an attempt to establish the pattern of statutory supervision for other midwife lecturers rather than just my own, this question was intended to uncover a rationale for the supervisory arrangement. Using 'yes' or 'no' plus room for other explanation, the results were analysed for frequency.

9. To whom do you submit your Notification of Intention to Practise?

This is a statutory requirement (NMC, 2004b) and the Notification of Intention to Practise forms should be sent to individuals' nominated Supervisor of Midwives who forwards it to the LSA. Personal experience rather information from the literature, indicated that these forms were sent to a whole host of individuals because supervisory arrangements are not clear. Therefore, a national picture would identify others' experiences. Individuals were provided with a range of potential answers including a 'don't know' and 'other (please specify)' to allow for suggestions that I was unaware of.

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**RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY
LECTURER AND LSA MIDWIFERY OFFICER
QUESTIONNAIRES**

Results were analysed for frequency of occurrence.

10. How often do you make contact with your named or each Supervisor in a supervisory capacity per year ?

This was an issue that arose from the literature (Duerden, 1995 & Stapleton et al, 1998) highlighting how frequently and potentially how valuable the mechanism of statutory supervision was. Individuals were provided with two options which they then completed. This was chosen because the pilot study indicated that the range of responses was impossible to predict. The results were analysed for clarification of a modal group and frequency.

11. How do you contact your Supervisor(s) – tick as many as appropriate.

This question was included to identify how individuals accessed their Supervisors. Within the clinical setting and in line with the provision of midwifery care, supervisory arrangements ensure that a Supervisor of Midwives is available for 24 hours and seven-days per week. Within the educational setting, the role of the lecturer is confined to 5 days per week on a 8.30 – 4.30 basis. The results were analysed for frequency.

12. Please rank (number 1,2,3 etc) in order of greatest frequency, the reason for contacting you Supervisor(s) in a supervisory capacity.

Again from the literature, the issue of the nature of the supervisory contact was a valid topic to ask as it conveyed further information on the use of the mechanism. Pre-defined categories were provided as sourced from the literature. Results were analysed and demonstrated by a line diagram and a pie chart for frequency.

13. Please describe your present professional network? Under which circumstances would you use this network?

Both Duerden (1995) & Stapleton et al (1998) found that midwifery lecturers identified a range of needs for which they needed some support. Statutory supervision is a mechanism for support (ENB, 1999a) and this question was intended to discover

RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY LECTURER AND LSA MIDWIFERY OFFICER QUESTIONNAIRES

other means of support which midwife lecturers use and the circumstances in which they would use them. An open question was provided with categorisation of the themes and frequency.

14. Please identify the advantages and disadvantages of the present organisation of supervision for you on A) a professional level and on B) a personal level

This open question represented the first opportunity for respondents to comment on their perception of the effectiveness of their supervisory arrangements. The question purposively asked for advantages and disadvantages to ensure individuals would consider a balanced approach to the answer. Results were provided as tables of comments.

INTERPRETATION OF THE FRAMEWORK FOR SUPERVISION

15. i) Would you describe yourself as a practising midwife

ii) If you feel this answer needs explaining, please do so below

This open question was designed to allow individuals to comment on this issue. Certainly the literature highlighted that some midwifery lecturers did not view themselves as practising midwife despite the definition in Rule 27 of the Midwives Rules & Code of Practice (1998) (now Rule 2 of Midwives Rules and Standards (NMC, 2004b). The transfer of employment from the NHS to Universities has decreased frequency of contact with the clinical environment and lessened opportunities to maintain clinical skills and contact. An open question was more appropriate than pre-defined answers. The results were grouped and presented in tables of comments.

16. i) Is the information and advice provided by your Supervisor of Midwives tailored towards you needs in higher education

ii) If you feel this answer needs explaining, please do so below

This is very similar to a question asked by Duerden (1995) but adapted to an educational setting. This was included to gauge the effectiveness of advice for a setting which some Supervisor of Midwives may be unfamiliar with. This was based

APPENDIX 11.3

**RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY
LECTURER AND LSA MIDWIFERY OFFICER
QUESTIONNAIRES**

on an assumption and therefore required clarification through the questionnaire. Results were analysed according to frequency followed by tables of comments.

17. How would you like statutory supervision to develop for midwives in education?

This open style question was designed to elicit their perception regarding statutory supervision and whether there were alternative ways of implementation. The suggestions were individually identified with the frequency of response within tables.

18. Please tick the box

- supervision has no role in the context of higher education
- supervision is only for midwives in clinical practice
- supervision is mainly concerned with discipline
- supervision is involved with supporting and empowering midwifery lecturers' practice
- midwifery lecturers could benefit from supervision
- supervision is essential for midwives in education

The attitude assessment question was designed to elicit respondents understanding of supervision with value-laden comments developed from comments that I had heard. The same statements were included in the LSAMO questionnaire.

19. This was a simple means of identifying those who would be willing to participate further in the study.

APPENDIX 11.3

**RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY
LECTURER AND LSA MIDWIFERY OFFICER
QUESTIONNAIRES**

**LOCAL SUPERVISING AUTHORITY QUESTIONNAIRE: SOURCE &
RATIONALE FOR EACH QUESTION WITH INTENDED MEASUREMENT**

This was designed a fact-finding questionnaire which was not intended to challenge any individuals knowledge base concerning statutory supervision. It needed to be short and concise to underline the intention.

1. Please identify below each University in your area providing midwifery education.

In order to establish the range and extent of guidance possible, this first question requested information regarding the number of Universities each LSA Officer liaised with. Results were analysed using a bar diagram.

2. Are you able to identify current, formal, supervisory arrangements within each University for midwives in education.

This question was phrased in this way after suggestion from my critical reviewers when developing the questionnaire. It was important to establish whether LSAMO were familiar with the supervisory arrangements for midwifery lecturers in all their Universities with two possible answers. A percentage was calculated.

3. Please describe the current, formal, supervisory arrangements within each University for midwives in education.

After establishing the numbers of Universities and knowledge of the supervisory arrangements, it was necessary to determine the pattern of supervision for midwifery lecturers within each organisation as the potential for differences was possible. The responses were grouped.

4. Do supervisors contact you asking advice concerning the supervision of midwives in education?

RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY LECTURER AND LSA MIDWIFERY OFFICER QUESTIONNAIRES

This question was posed as a yes or no to indicate whether advice was required from LSAMO regarding the statutory supervision of midwifery lecturers. The percentage of the responses was calculated.

5. Please identify the areas with which supervisors request your guidance.

After establishing whether advice was sought, it was necessary to establish the nature of the advice and guidance. In this open question, the frequency of each response was depicted as a bar chart.

6. As the LSA Responsible Officer, do you feel midwives practising in education have any specific needs regarding the following: i) clinical practice, ii) interpretation of the definition of a practising midwife; iii) complying with Education Rules; iv) complying with Rule 36; v) complying with Rule 37, vi) complying with Rule 40, vii) complying with Rules 41-45, viii) other.

From my own experience, individuals including LSA Officers displayed a range of attitudes towards the statutory supervision needs of lecturers. Hence, it was necessary to determine their views in relation to the from these key individuals Midwives Rules including Rule 27 (UKCC, 1998) (now Rule 2 NMC Midwives Rules and Standards, 2004b). For each question, the percentage of agreement was calculated and the range of reasons documented.

7. As the LSA Officer, how do you interpret the meaning of statutory supervision for midwives in higher education?

The topic for this question was similar to question 6 but without the regulatory framework. The question allowed for freedom of comment. All responses were documented.

8. Are there other mechanisms which could meet the needs of midwives in higher education?

Personal experience had revealed that some individuals had expressed the view that annual managerial reviews and informal peer support was sufficient for midwives in non-clinical settings thereby negating the need for statutory supervision. This question

**RATIONALE FOR QUESTION DEVELOPMENT: MIDWIFERY
LECTURER AND LSA MIDWIFERY OFFICER
QUESTIONNAIRES**

was included therefore to determine how LSAMO's viewed the effectiveness of alternative systems in achieving the same aim of statutory supervision. Results were documented.

9. Please tick the appropriate box:

- **supervision has no role in the context of higher education**
- **supervision is only for midwives in clinical practice**
- **supervision is mainly concerned with discipline**
- **supervision is involved with supporting and empowering midwifery lecturers' practice**
- **midwifery lecturers could benefit from supervision**
- **supervision is essential for midwives in education**

This table assessing attitudes was included as a comparison with the responses from the lecturers' questionnaire. The critical reviewers felt that one element in particular (supervision is concerned with discipline) was too basic and old-fashioned but recognised the need to compare. Hence, an explanatory sentence was included so as not to offend the respondents and influence their perception of the researcher.

**APPENDIX 11.4
MIDWIFERY TEACHER/LECTURER QUESTIONNAIRE**

6. Please state how many Supervisors of Midwives you have ?

.....

7. Indicate below, the main area of practice for each of your Supervisors.

Supervisor :	named	second	third	fourth	fifth
LSA Officer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head of Midwifery based in education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Approved Midwife Teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head of Midwifery Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Midwifery teacher/lecturer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinically based midwifery manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinically based midwife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lecturer/practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state) :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Is/are your Supervisor(s) connected to the clinical areas with which you liase ?

yes no

other explanation.....

MIDWIFERY TEACHER/LECTURER QUESTIONNAIRE

9. To whom do you submit your Notification of Intention to Practise:

yes

My named Supervisor of Midwives

Supervisor of Midwives in each clinical unit I liase with

Supervisor of Midwives in each clinical Unit the University liases with

Approved Midwife Teacher

Midwifery Manager in each clinical Unit the University liases with

Midwifery Manager in each clinical Unit I liase with

Don't know

Other (please specify):

10. How often do you make contact with your named or each Supervisor in a supervisory capacity per year ?:

i) formally

ii) informally

11. How do you contact your Supervisor(s) – (tick as many as appropriate):

telephone

letter

e-mail

face-to-face

other (please specify)

MIDWIFERY TEACHER/LECTURER QUESTIONNAIRE

12. Please rank (number 1,2,3, etc.) in order of greatest frequency, the reasons for contacting your Supervisor(s) in a supervisory capacity:

	rank
Annual supervisory interview	<input type="checkbox"/>
To discuss an incident from personal educational practice	<input type="checkbox"/>
To discuss an incident from personal clinical practice	<input type="checkbox"/>
To discuss issues arising from a students' practice	<input type="checkbox"/>
Refresher activity	<input type="checkbox"/>
Notification of Intention to Practise	<input type="checkbox"/>
Other (please specify)	

13. I) Please describe your present professional network ?

ii) Under which circumstances would you use this network ?

MIDWIFERY TEACHER/LECTURER QUESTIONNAIRE

14. Please identify the advantages and disadvantages of the present organisation of supervision for you on A) a professional level and on B) a personal level:

A) Professional level

Disadvantages

Advantages

Personal level

Disadvantages

Advantages

C. INTERPRETATION OF THE FRAMEWORK FOR SUPERVISION

15. i) Would you describe yourself as a practising midwife:

yes no

ii) If you feel this answer needs explaining, please do so below:

16. i) Is the information and advice provided by your Supervisor of Midwives tailored towards your needs in higher education:

yes no

MIDWIFERY TEACHER/LECTURER QUESTIONNAIRE

ii) If you feel this answer needs explaining, please do so below:

17. How would you like statutory supervision to develop for midwives in education ?

18. Please tick in the appropriate box:

SA = strongly agree

A = agree

U = unsure

D = disagree

SD = strongly disagree

	SA	A	U	D	SD
Supervision has no role in the context of Higher Education					
Supervision is clinically orientated					
Supervision is mainly concerned with discipline					
Supervision is involved with supporting & empowering midwifery teachers'/lecturers' practice					
Midwifery teachers/lecturers do benefit from supervision					
Supervision is essential for midwives in education					

APPENDIX 11.4

MIDWIFERY TEACHER/LECTURER QUESTIONNAIRE

19. The second phase of the study will involve focus groups to allow a deeper exploration of the issues which may arise from this questionnaire. If you would be willing to participate in this second phase of the study please indicate below:

yes no

20. If you would be willing to participate, please fill in the details below;

NAME

CONTACT ADDRESS

ROLE

TELEPHONE NUMBER

E-MAIL ADDRESS

Eventually all identifiable information will be detached in order to maintain anonymity & confidentiality.

Thank you for your time and assistance.

APPENDIX 11.5

**LOCAL SUPERVISING AUTHORITY MIDWIFERY OFFICER
QUESTIONNAIRE**

Please tick the appropriate box. Thankyou

1. Please identify below each University in your area which provides midwifery education:

2. Are you able to identify the current, formal, supervisory arrangements within each University for midwives in education ?
i.e. who supervises the lecturers, whether these supervisors are selected by the lecturers

yes

no

(proceed to question 3)

(proceed to question 4)

3. Please describe the current, formal, supervisory arrangements within each University for midwives in education.

4. Do supervisors contact you asking advice concerning the supervision of midwives in education ?

APPENDIX 11.5
LOCAL SUPERVISING AUTHORITY MIDWIFERY OFFICER
QUESTIONNAIRE

Yes

(proceed to question 5)

no

(proceed to question 6)

5. Please identify the areas with which supervisors request your guidance.

6. As a Local Supervising Authority (Responsible Officer), do you feel midwives practising in education have any specific needs regarding the following:

Please tick the appropriate box & briefly explain your rationale

	yes	no
i) clinical practice	<input type="checkbox"/>	<input type="checkbox"/>
ii) interpretation of the definition of a practising midwife (Rule 27)	<input type="checkbox"/>	<input type="checkbox"/>
iii) complying with the Education Rules	<input type="checkbox"/>	<input type="checkbox"/>
iv) complying with Rule 36	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX 11.5
LOCAL SUPERVISING AUTHORITY MIDWIFERY OFFICER
QUESTIONNAIRE

- | | Yes | No |
|--|--------------------------|--------------------------|
| v) complying with Rule 37 | <input type="checkbox"/> | <input type="checkbox"/> |
| vi) complying with Rule 40 | <input type="checkbox"/> | <input type="checkbox"/> |
| vii) complying with Rule 41 | <input type="checkbox"/> | <input type="checkbox"/> |
| viii) complying with Rule 42 | <input type="checkbox"/> | <input type="checkbox"/> |
| ix) complying with Rule 43 | <input type="checkbox"/> | <input type="checkbox"/> |
| x) complying with Rule 44 | <input type="checkbox"/> | <input type="checkbox"/> |
| xi) complying with Rule 45 | <input type="checkbox"/> | <input type="checkbox"/> |
| xii) please identify any other needs | | |

APPENDIX 11.5

**LOCAL SUPERVISING AUTHORITY MIDWIFERY OFFICER
QUESTIONNAIRE**

7. As a Local Supervising Authority (Responsible Officer), how do you interpret the meaning of statutory supervision for midwives in higher education?

8. Are there other mechanisms which could meet the needs of midwives in higher education ?

9. Please tick in the appropriate box:

SA = strongly agree

A = agree

U = unsure

D = disagree

SD = strongly disagree

(This grid has been used in the questionnaire for midwifery lecturers.)

	SA	A	U	D	SD
Supervision has no role in the context of Higher Education					
Supervision is only for midwives in clinical practice					
Supervision is mainly concerned with discipline					
Supervision is involved with supporting & empowering midwifery teachers'/lecturers' practice					
Midwifery teachers/lecturers could benefit from supervision					
Supervision is essential for midwives in education					

APPENDIX 11.5

**LOCAL SUPERVISING AUTHORITY MIDWIFERY OFFICER
QUESTIONNAIRE**

10. Are you a qualified midwifery teacher/lecturer ?

yes

no

11. The second phase of the study will involve the formulation of focus groups to enable a deeper exploration of any issues which may arise from this questionnaire.

i) Would you like to participate and volunteer for the second phase of the study ?

Yes

No

ii) If you would like to volunteer, could you please fill in the details below and enclose in the attached envelope. I need this information to administer the second phase only. I will however, remove all information upon receipt, to ensure anonymity is maintained.

NAME

CONTACT ADDRESS

ROLE

TELEPHONE NUMBER

E-MAIL ADDRESS

Thank you for your time and assistance.

Table 1: The Respondents' Contractual Status

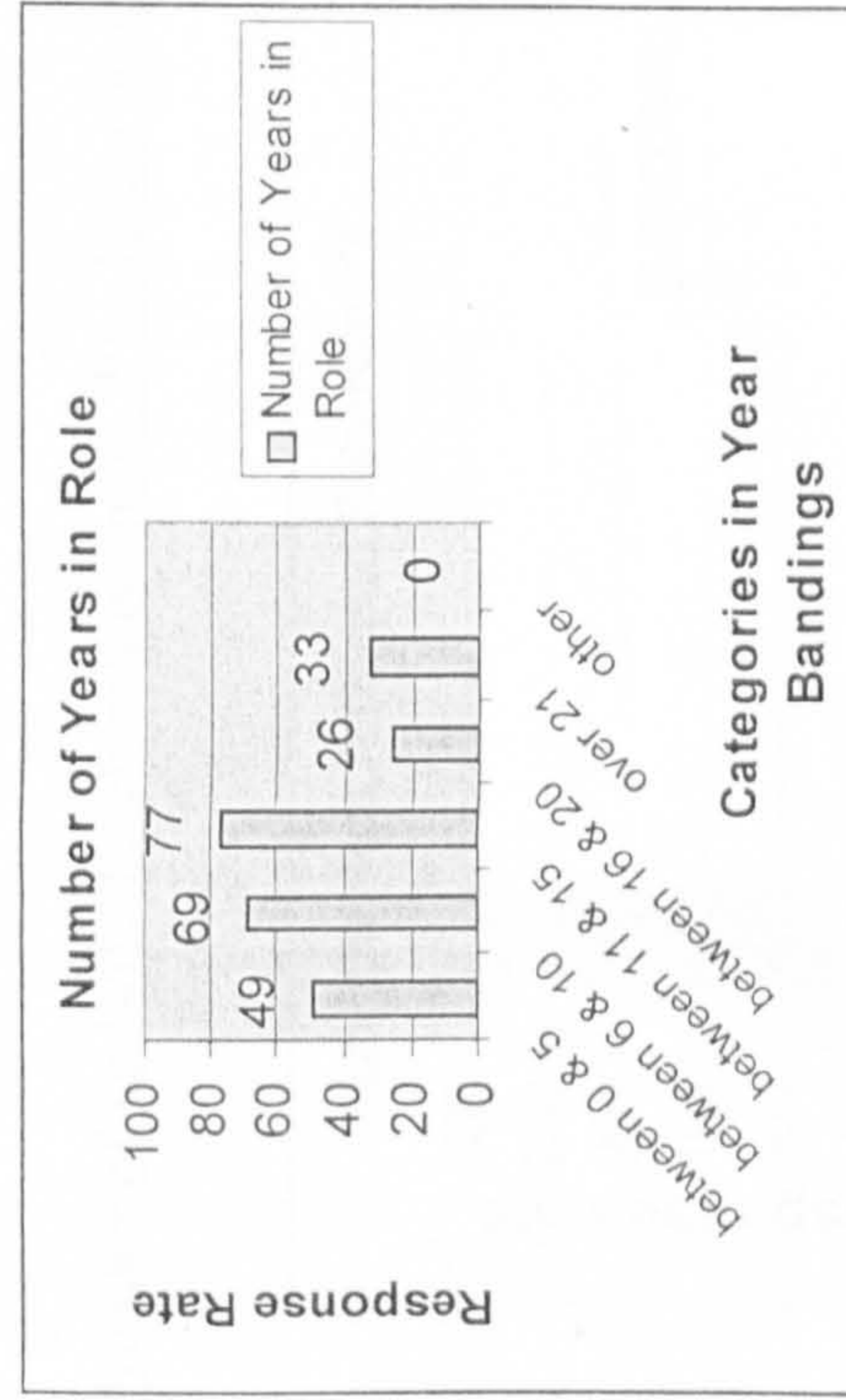
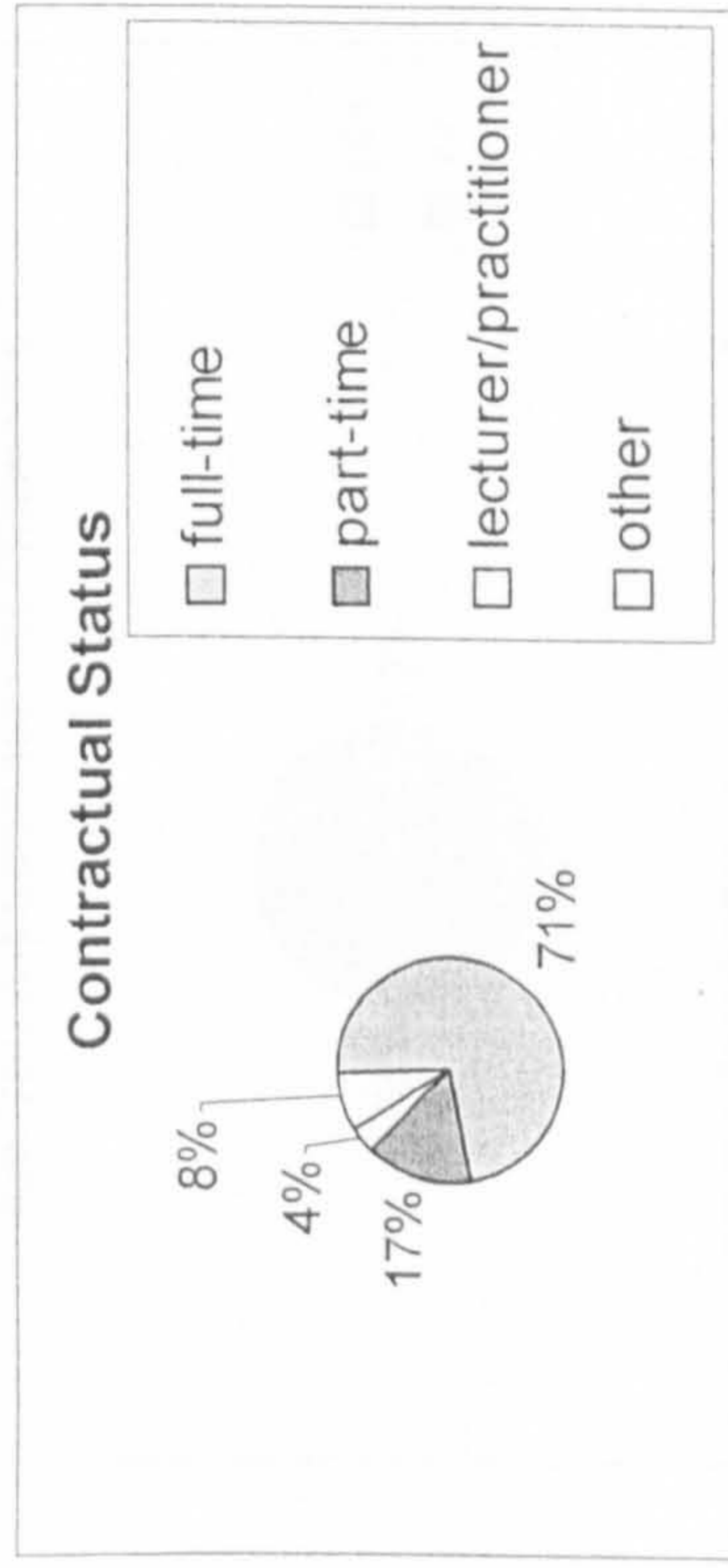


Table 3: Number of Years in the Role as a Midwife Teacher/Lecturer

Table 4: The Percentage of Respondents Who Were Also Supervisors of Midwives

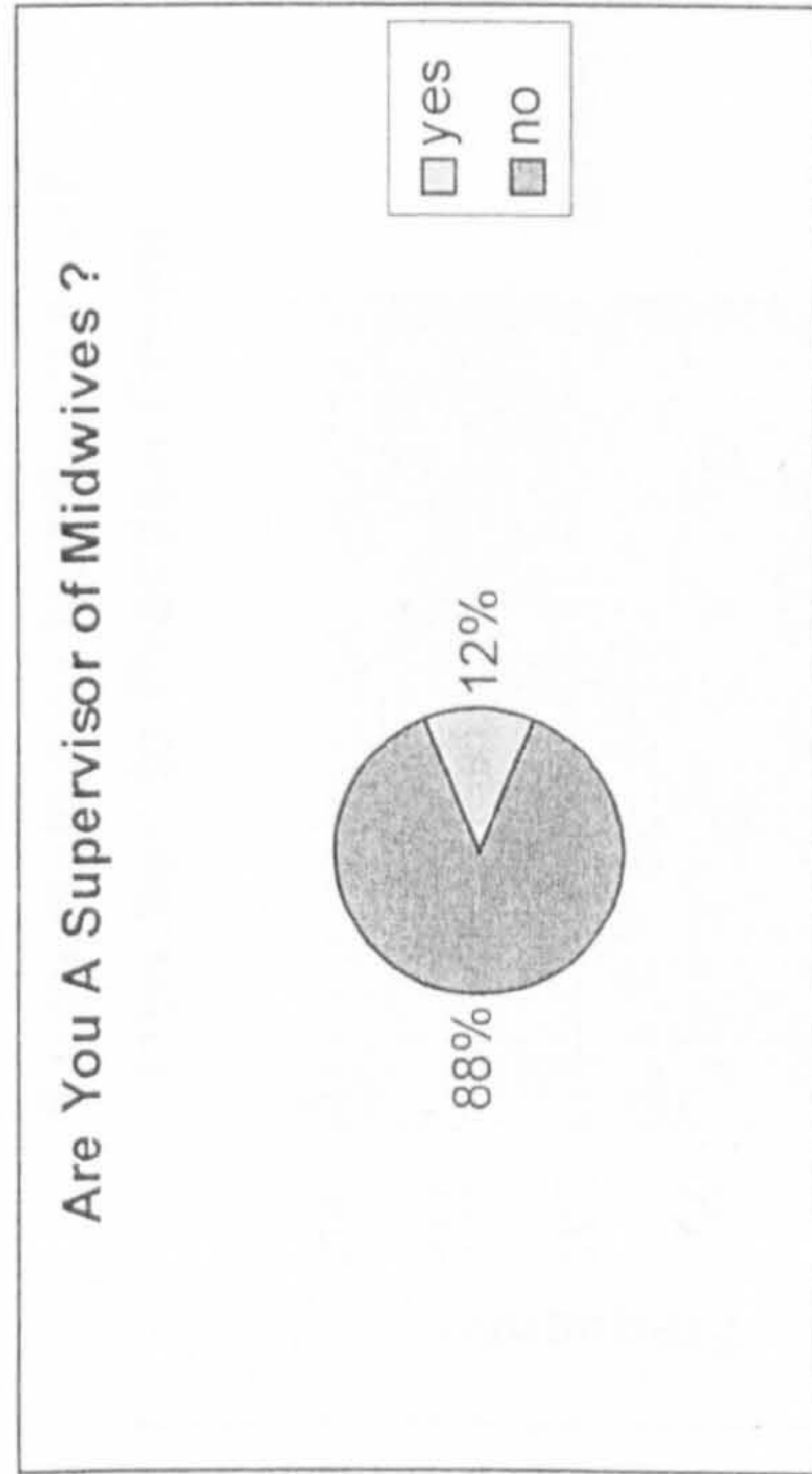
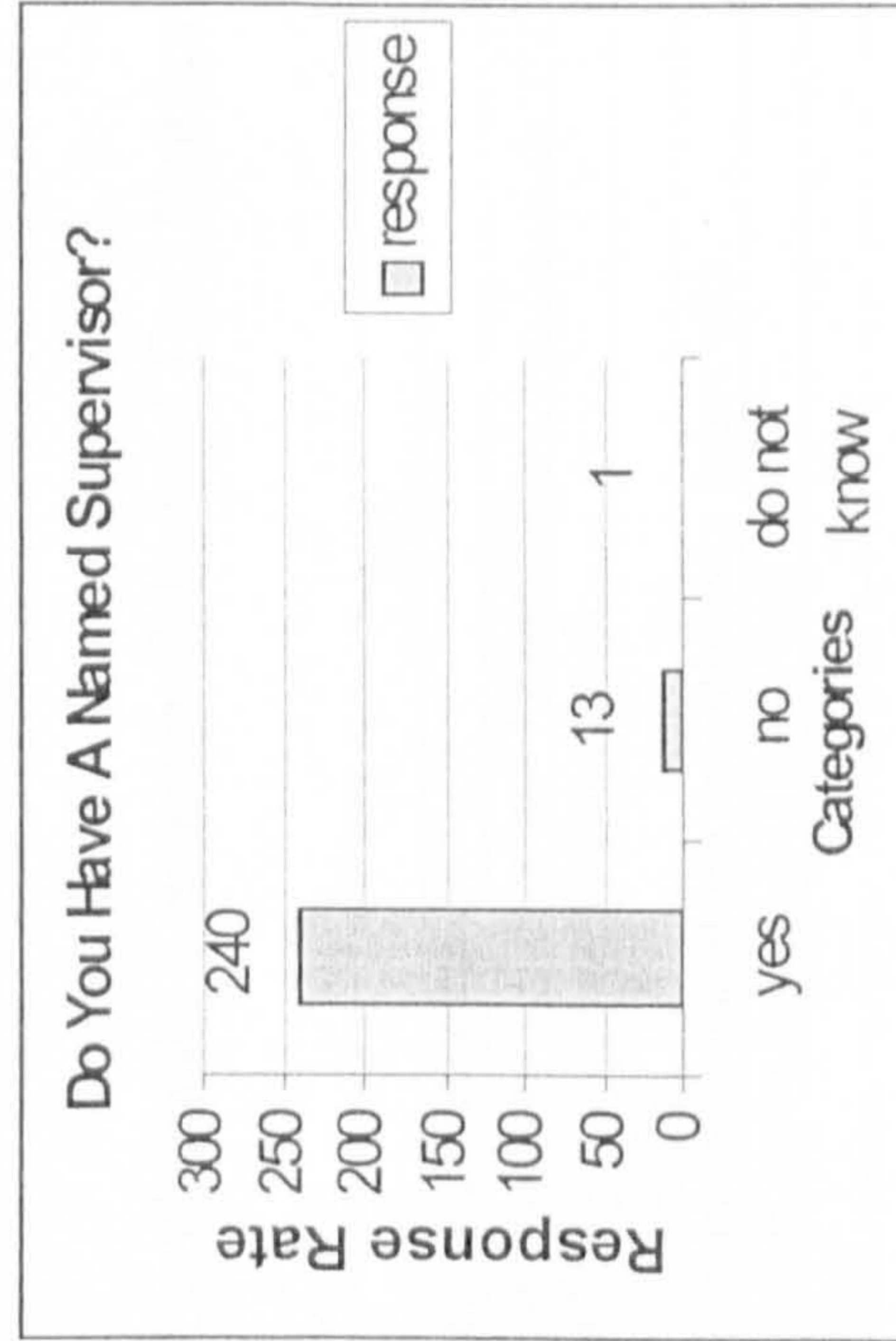


Table 5: The Number of Midwife Teachers/Lecturers Who Had a Named Supervisor



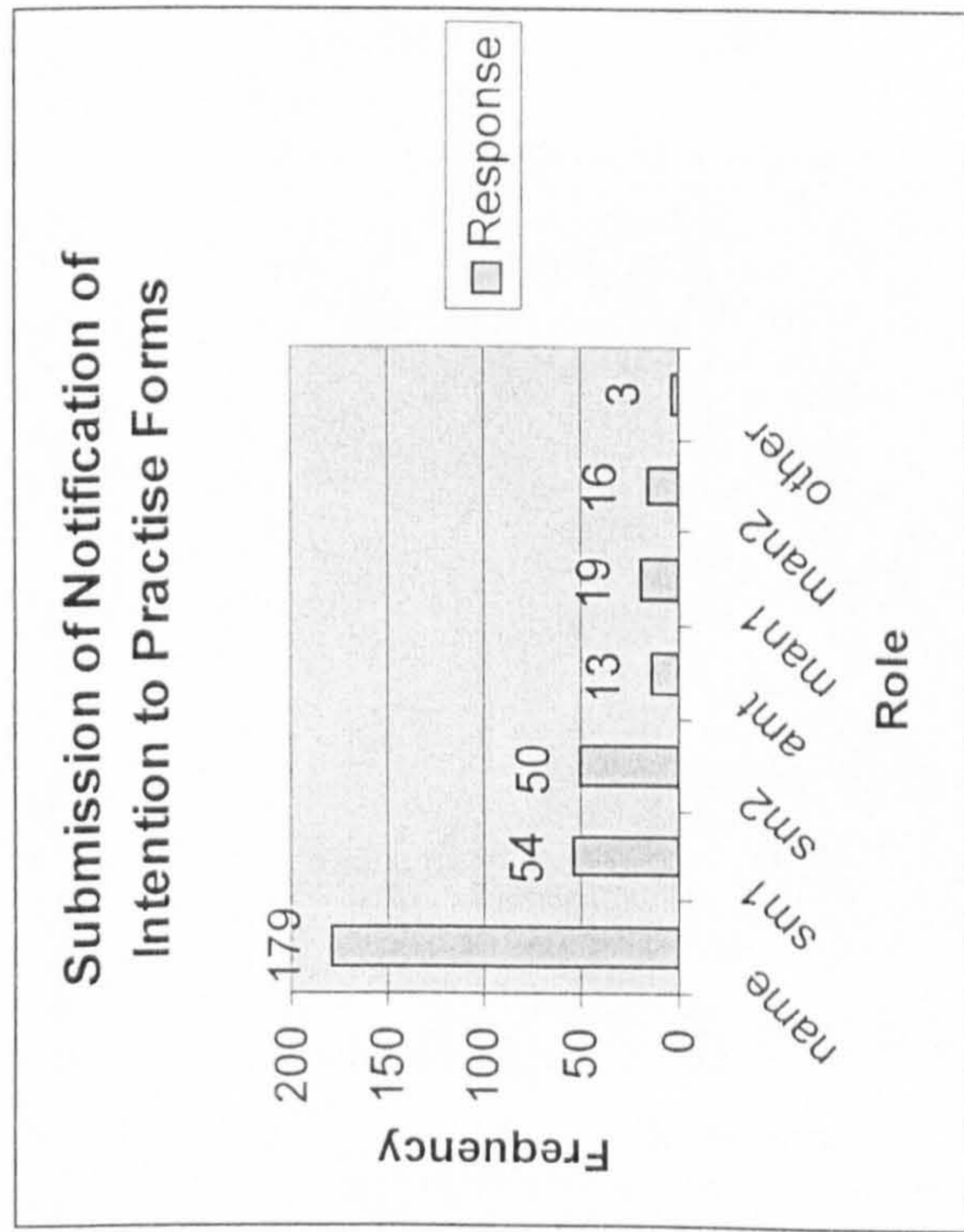
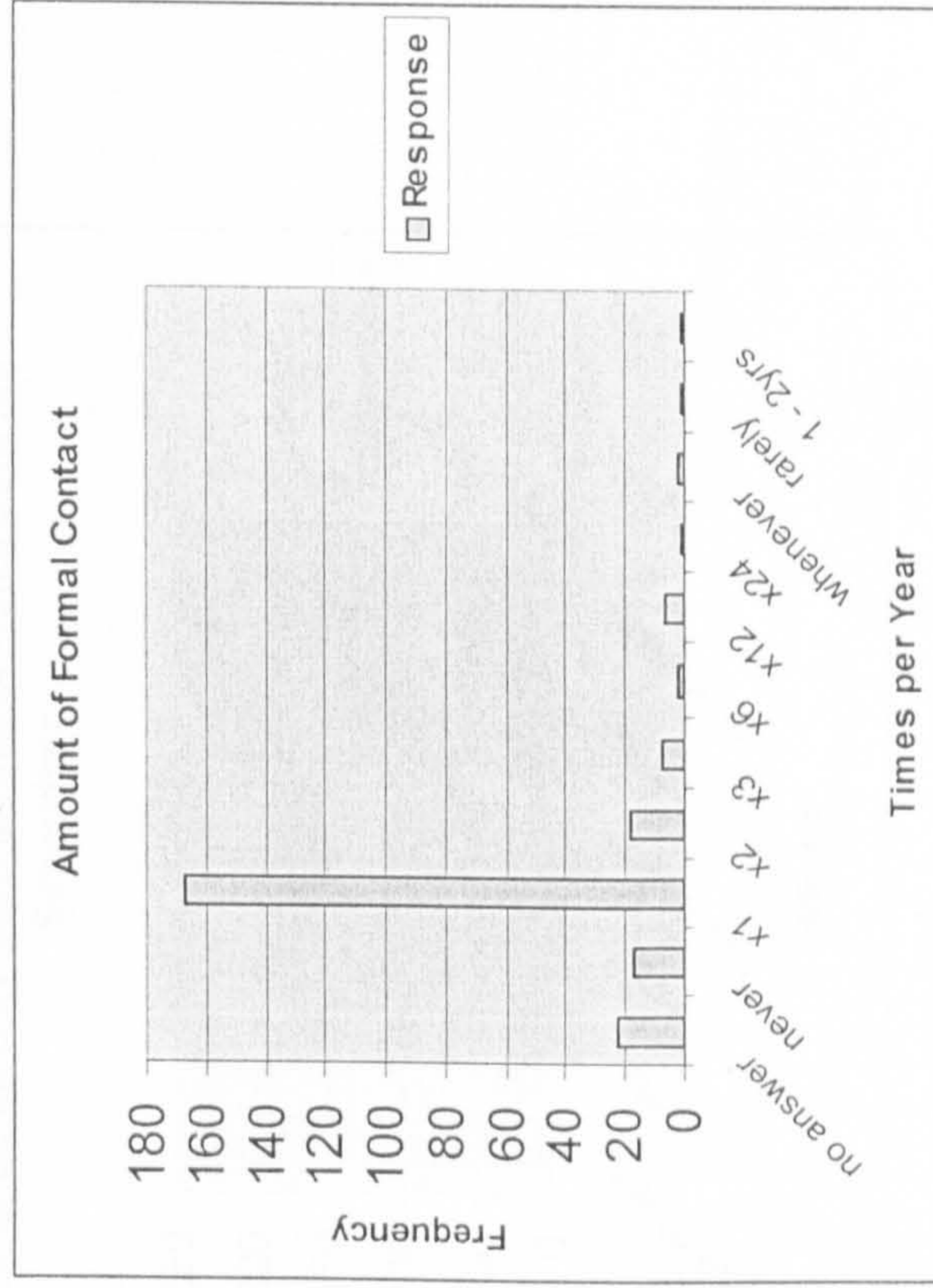


Table 13: The Role of the Individual to Whom the Respondent Submitted Their Notification of Intention to Practise Forms
 The key for these categories is:

CODE	KEY
name	my named supervisor of midwives
sm1	supervisor of midwives in each clinical unit I liaise with
sm2	supervisor of midwives the University liaises with
amt	Approved Midwife Teacher
man1	midwifery manager in each clinical unit the University liaises with
man2	midwifery manager in each clinical unit I liaise with
other	any other individual

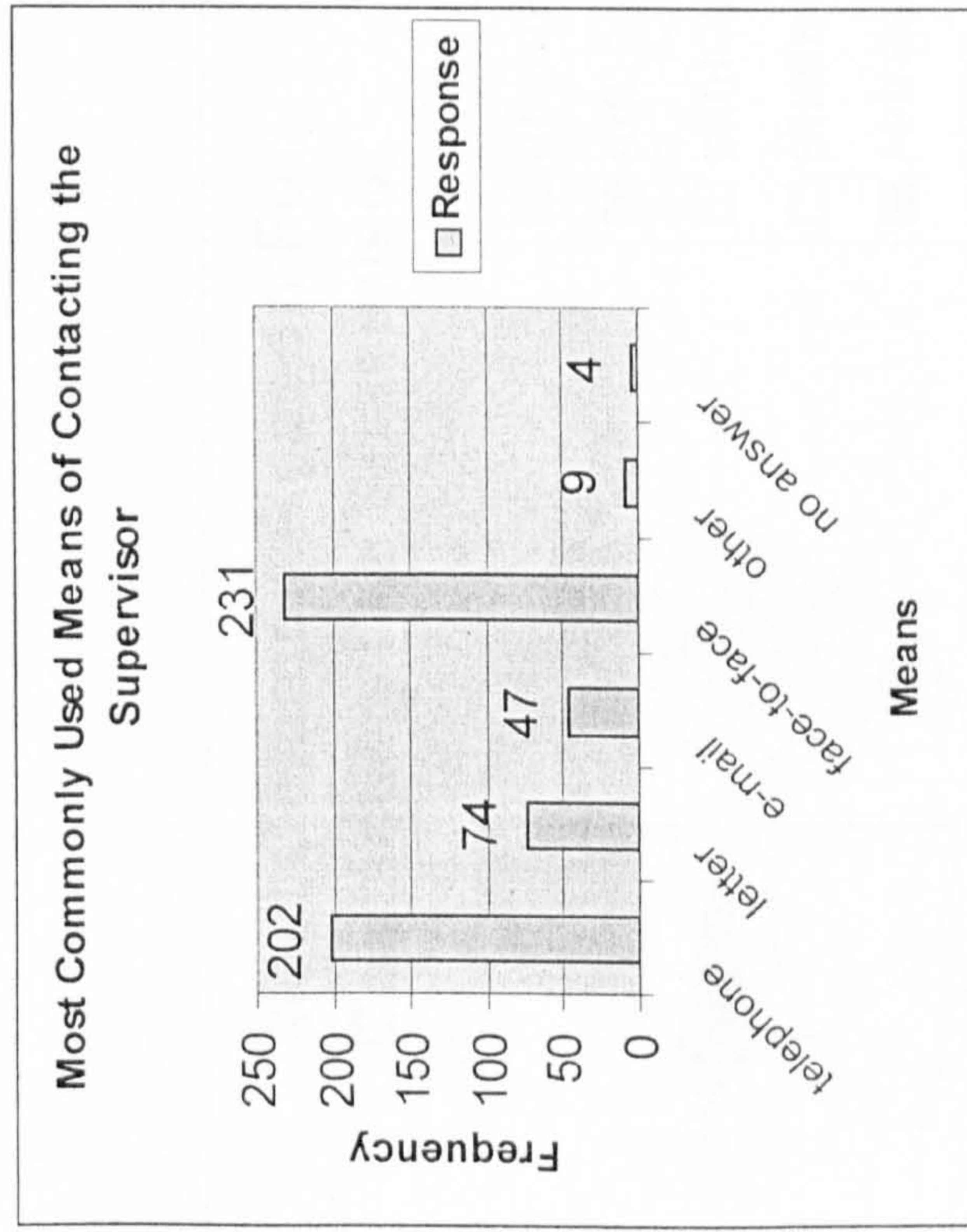
Appendix 11.6
EXPLANATORY CHARTS ACCOMPANYING THE FIRST STAGE FINDINGS

Table 14: The Amount of Formal Contact Between the Supervisor and Supervisee



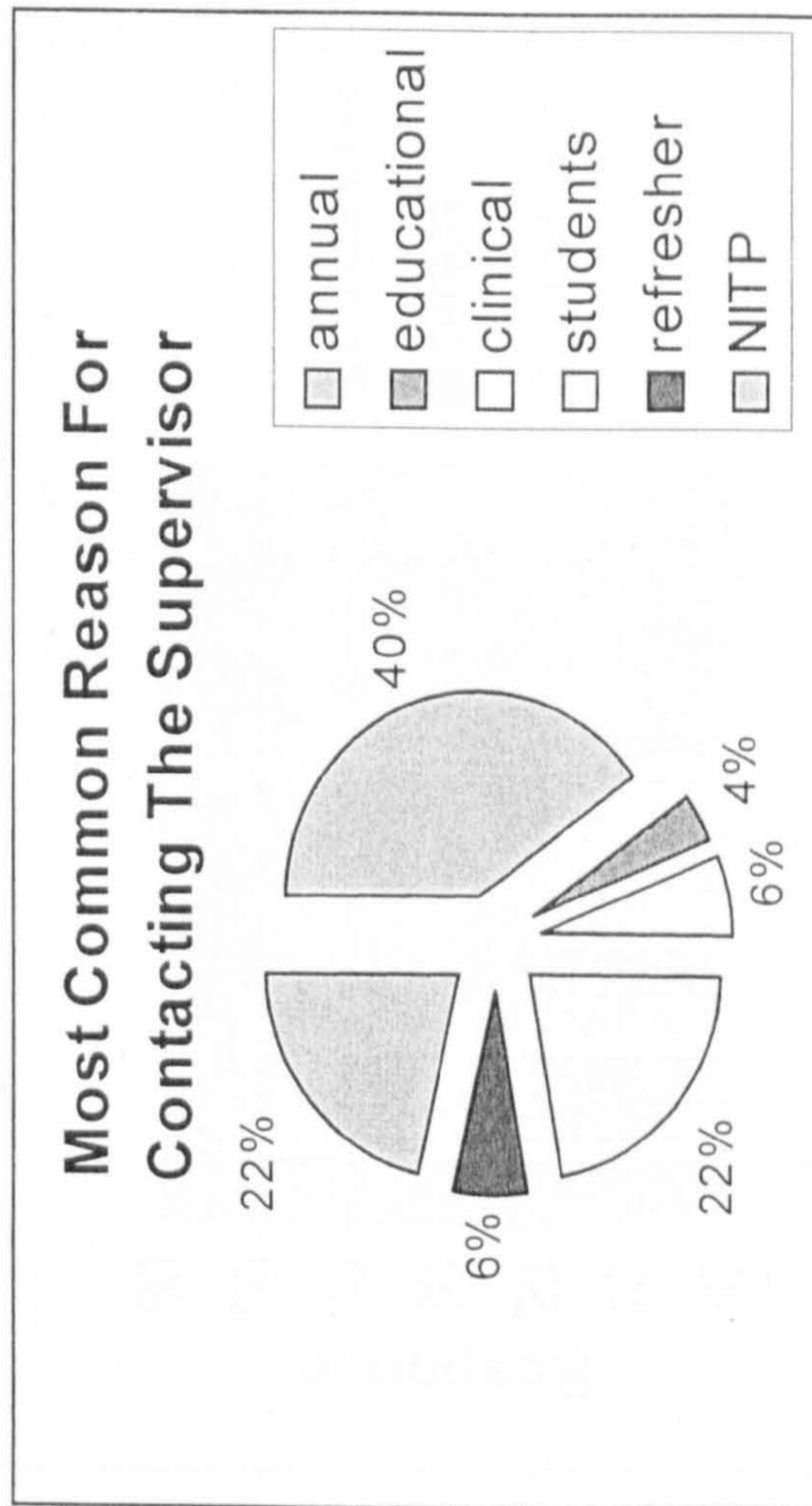
Appendix 11.6
EXPLANATORY CHARTS ACCOMPANYING THE FIRST STAGE FINDINGS

Table 17: The Most Commonly Used Means of Contacting the Supervisor



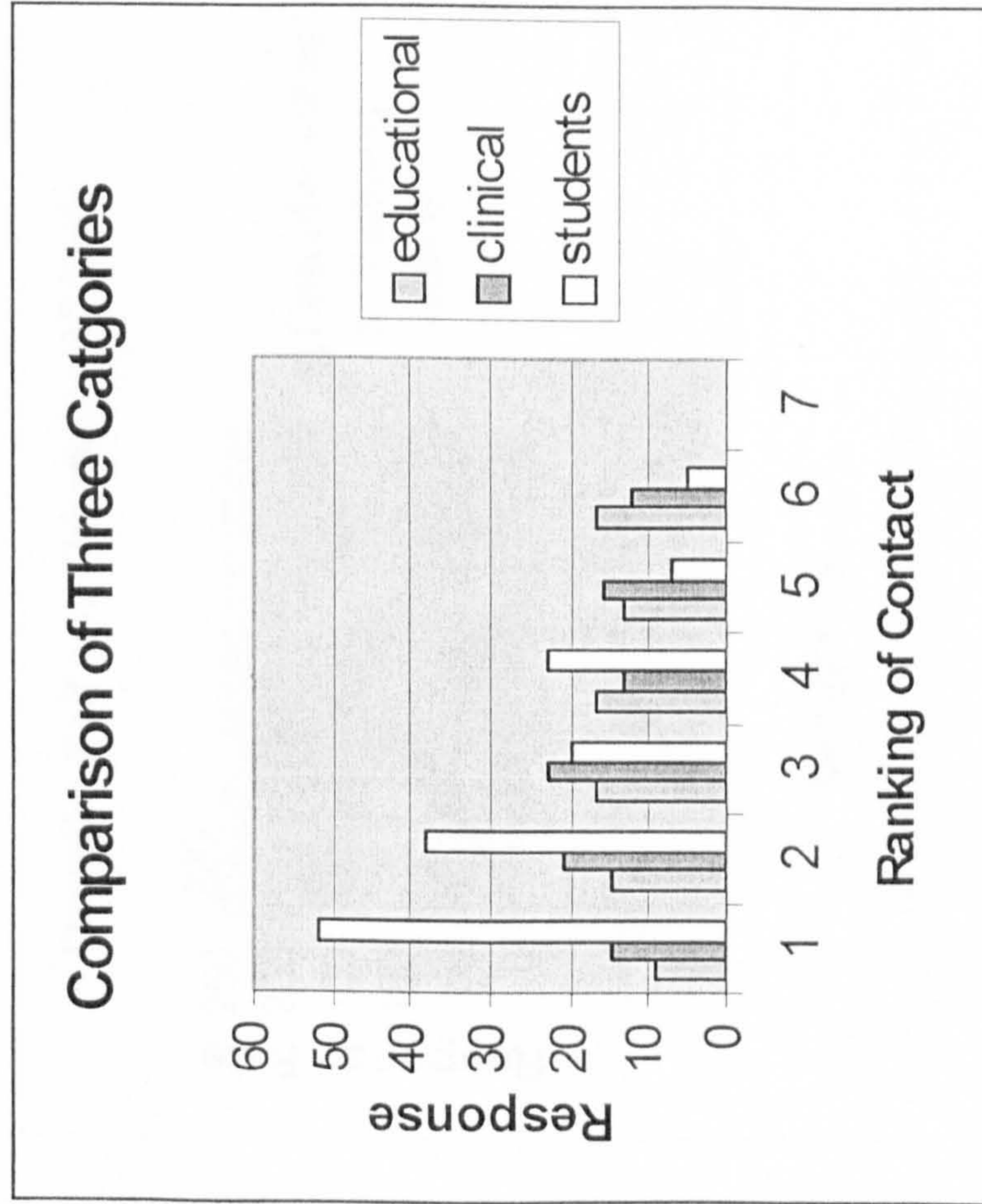
EXPLANATORY CHARTS ACCOMPANYING THE FIRST STAGE FINDINGS

Table 19: The Most Common Reason for Contacting a Supervisor of Midwives



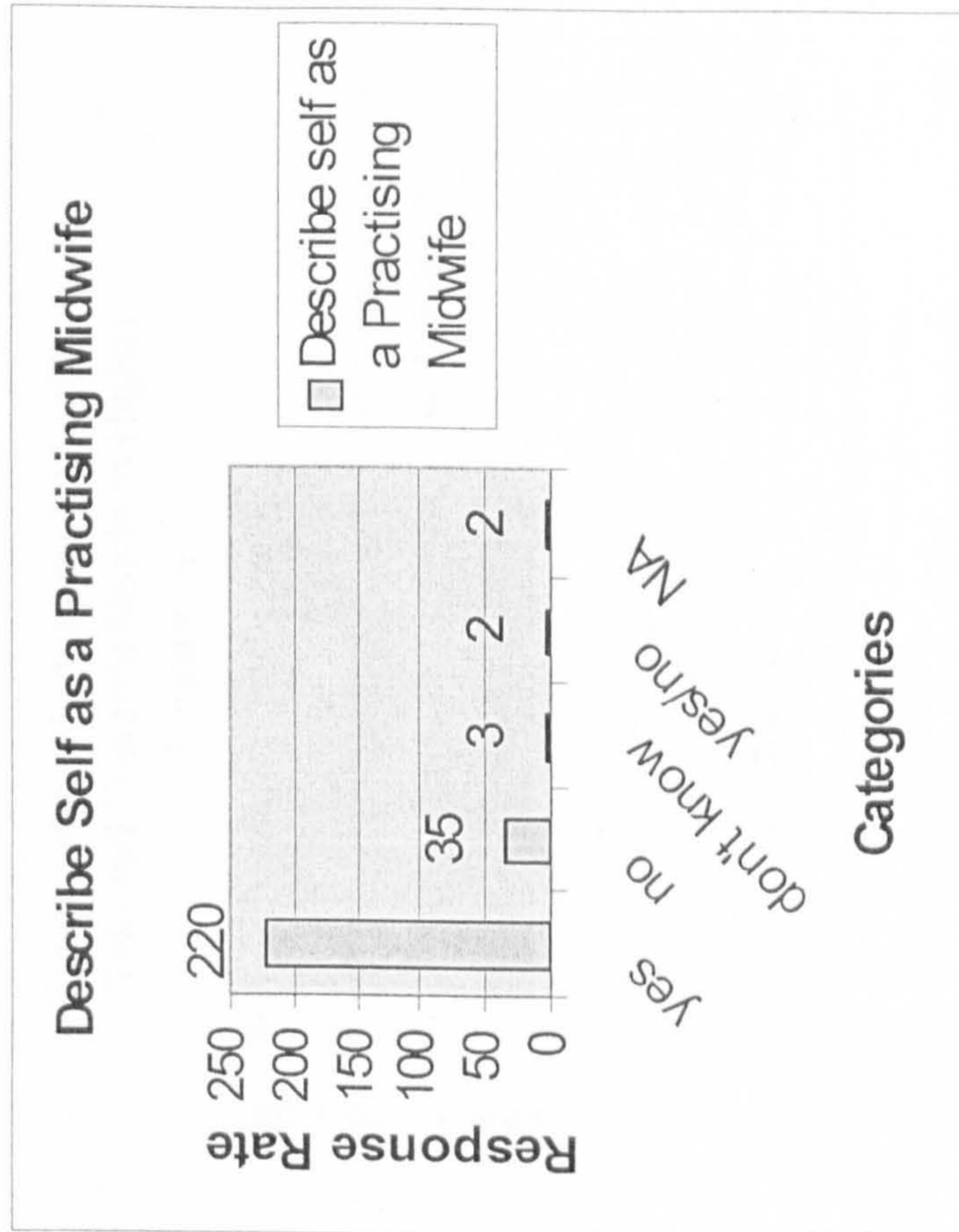
Appendix 11.6
EXPLANATORY CHARTS ACCOMPANYING THE FIRST STAGE FINDINGS

Table 20: Ranking of the Reasons for Contacting a Supervisor Regarding Educational Practice



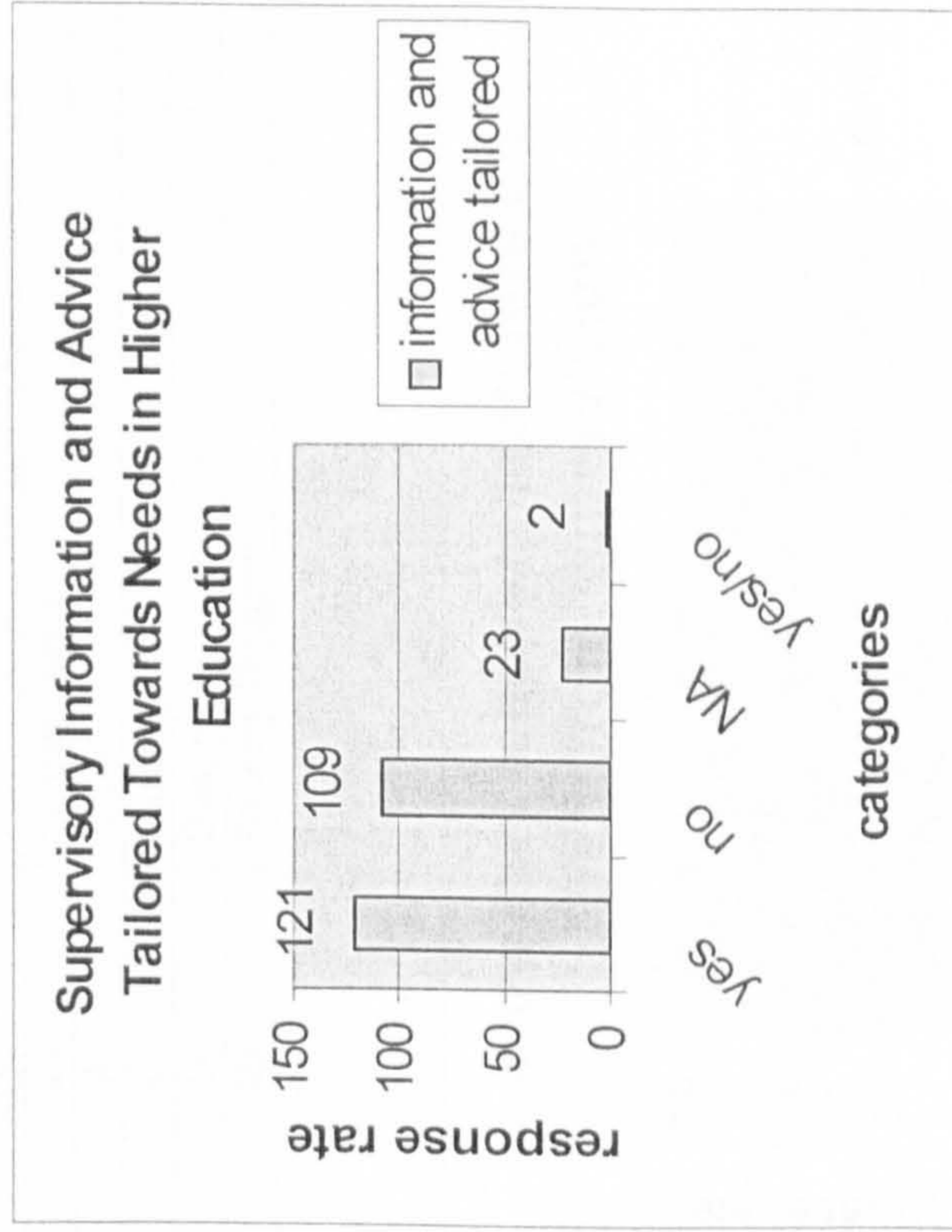
Appendix 11.6
EXPLANATORY CHARTS ACCOMPANYING THE FIRST STAGE FINDINGS

Table 48: Clarification of Whether Respondents Described Themselves as Practising Midwives



Appendix 11.6
EXPLANATORY CHARTS ACCOMPANYING THE FIRST STAGE FINDINGS

Table 50: Responses Concerning Whether Supervisory Information and Advice Is Tailored Towards Needs In Higher Education

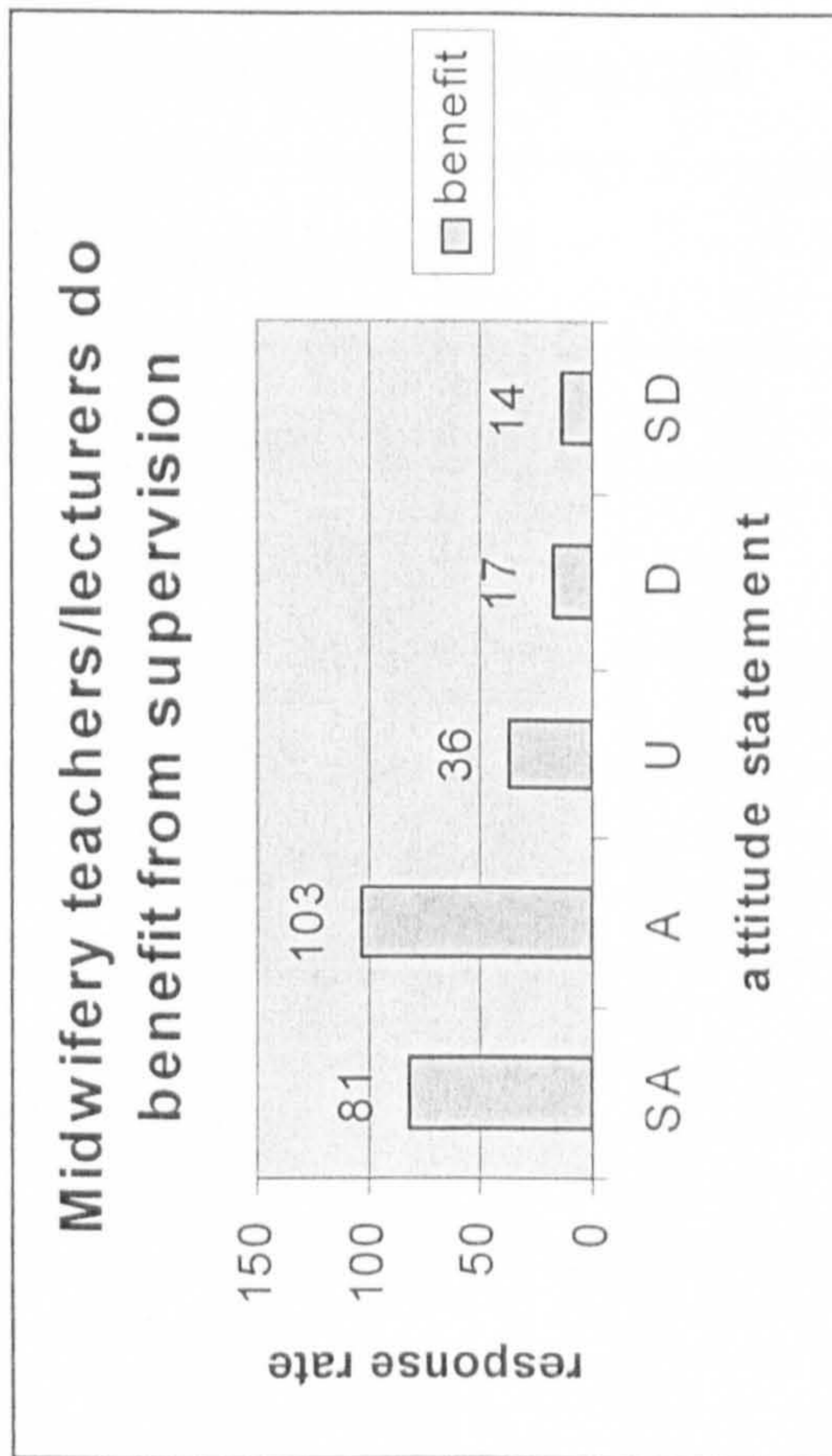


Appendix 11.6
EXPLANATORY CHARTS ACCOMPANYING THE FIRST STAGE FINDINGS

Table 57: Midwifery Teachers/Lecturers Do Benefit From Supervision

The key for these categories is:

CODE	KEY
SA	Strongly Agree
A	Agree
U	Unsure
D	Disagree
SD	Strongly Disagree



APPENDIX 11.7

TOPICS AND SCENARIO'S COVERED DURING THE INTERVIEW PLAN

TOPIC	LINKAGE WITH THE FIRST STAGE
Experiences of statutory supervision before becoming a teacher	
Statutory supervision now	Questions 8,9,10,14,18
Experiences of statutory supervision since becoming a teacher	Questions 4,5,6,7,10,11,12,18
Professional support from statutory supervision	Questions 12,13,16
Statutory supervision and empowerment	Questions 14,16,18
Statutory supervision and development as a teacher	Question 15
Definition of a practising midwife	Question 15
Any improvement within statutory supervision for midwives	Question 14, 17
Scenarios/critical incidents: <ul style="list-style-type: none"> - poor conduct of a teacher, i.e lack of confidentiality - poor conduct of a student, a third attempt in practice or theory - issues concerning midwifery education, i.e. a policy which contradicts professional values 	
Any issues	
Any way of improving your situation?	

APPENDIX 11.8
CLAIRE'S TRANSCRIPT

NOTES OF INTERVIEW HELD ON 30TH JULY 2003

BETWEEN

Heather Wilkins

& 'Claire'

- HW Speak up a bit but erm, would you like to introduce yourself
- Claire Right I'm and I'm Lead Midwife for Education at (*name*)
- HW So this is all about your experiences of supervision as a midwife working in education, so could you tell me firstly what were your experiences of supervision before you came into education
- Claire I don't know if I can remember that far back *laughs* I've been in education now for more than twenty years. Erm, and at the time supervision didn't have a very high profile and I think that erm, it was like the old type inspector rather than supportive supervisor so I can't honestly remember whether I had, I didn't really have any outstandingly positive or negative experiences that I remember you know, so
- HW Mmm, yes, because it was, didn't have a high profile or
- Claire No
- HW What about since you've come into education then, what, what has supervision for you been like?
- Claire Again I would say that probably it hasn't really entered our consciousness, er very much until the last probably ten years I would say, certainly when we started to have LSA erm supervisors erm, it tended to assume more of a high profile and since the works been done by (*name*) and erm, er (*name*)
- HW Yes, yes
- Claire Erm, when I first came into education I would say probably it wasn't on the agenda of the curriculum and I would also say that probably although I had an annual supervisory review with a clinical colleague in a Trust it again didn't happen as regularly and perhaps in the same manner as it does now
- HW Right
- Claire Over the last five years I would say I have been part of the supervisory group and conscious that we've been trying to raise the profile of supervision in the local Trust and my own experiences of supervision have also improved because I've had a, a good relationship with my supervisor
- HW Right, in what role is your supervisor?
- Claire She's a erm, G grade in the local Trust
- HW Right, did you choose her?
- Claire Yes
- HW Right, OK. What options were available to you?
- Claire Er well to be honest because we link to three Trusts I probably had a broader choice than most people because I could have chosen a supervisor from each of the three
- HW Right
- Claire Places, so I basically chose a midwife that I had respect for, as a midwife and who I've probably known as a colleague for some time

APPENDIX 11.8
CLAIRE'S TRANSCRIPT

- HW Right, OK, so how long have you had that relationship then?
- Claire I've been with the same supervisor for five years
- HW Right OK, so what are those experiences like, what are the sort of, how do you use that supervisor?
- Claire I erm, go out with her as a er, to do a refresher for my community experience
- HW Oh right
- Claire And I also work with her a day in the er, labour ward suite to update my skills on my link work really when I first came in because I've never delivered anybody in a pool and I still haven't personally but I've been there while women have erm, had a water birth experience erm, so I use her to update myself clinically, I also erm, meet with her on an annual basis to do a formal sort of erm, you know review of where I'm at generally erm, *three seconds pause* I, we have erm, monthly supervisory meetings as well, so I see her within supervisory groups on... probably on an informal basis as well.
- HW Yeh, lovely, I mean could you tell me what, what, what do you discuss at the supervisory reviews, do you talk about erm, keeping yourself up to date, where you're at
- Claire Well that's not usually much of an issue because obviously in my role I'm up to date because I'm up to date educationally
- HW Yeh
- Claire And through supervision with the networking groups erm, my main area deficit I feel is making sure I'm credible clinically
- HW Mmm
- Claire And so that tends to be an aspect that we focus on really because I'm probably more up to date educationally than she is
- HW Mmm
- Claire Erm, where obviously she's more up to date clinically than I am
- HW Yes
- Claire So we tend to share, share experiences I suppose
- HW Yes
- Claire You know we talk as peers, you know we talk as equals, we don't talk down, although it is a supervisor supervisory relationship, because we both bring different things, it's more like sharing, things like that *laughs*
- HW What, how, how does that role though, that relationship help you in education? I know you've said about erm, keeping yourself clinically credible
- Claire Mmm
- HW What about your educational practice?
- Claire Erm I don't think that necessarily supervision is the most effective mechanism in education to be honest, I mean I'm a member of the learning and teaching erm forum and er, attend the er, Lead Midwife Education meetings and that sort of thing so, I see I've got a personal responsibility if you like to keep myself up to date with education because of the role I'm in
- HW Yes
- Claire So erm, I don't necessarily use my supervision for education
- HW Right
- Claire For that sort of focus to be honest
- HW Right
- Claire Erm,

APPENDIX 11.8
CLAIRE'S TRANSCRIPT

Four seconds pause

HW In, in terms of your development then as an educationalist - how's that?

Claire I suppose through the line management here

HW Mmm, mmm

Claire Erm, we do have *IPR* in education and so I have sort of made my own development plan really because I wanted to get involved with the erm, we had some problems within the team erm, individuals in conflict and so I particularly asked to go forward for the conflict management training programme, which I have now done and I have also become part of an action learning set for educationalists within the university

HW Mmm

Claire But as I say that's facilitated through line management maybe rather than trained supervision

HW Mmm, do you think there is a role there for supervision, to, to help you develop educationally?

Claire Personally I don't think you can expect clinical supervisors to be as up to date educationally as educators, otherwise

HW Mmm

Claire There wouldn't be a need for both really, erm, so no I don't really think, I mean I think the groundfloor midwives look to their supervisors for support for education - for keeping up-to-date - and like I say because a supervisor should be the leader in the field but certainly as a senior educationalist I can't see that I should expect supervisors to understand my needs. I see my role as an educationalist to support them in supporting midwives.

HW Mmm

Claire For education so, I suppose what I'm saying is that as an educationalist as a supervisor I would expect them to liaise with educationalists

HW Mmm

Claire To er, look at education needs for their supervisees but not necessarily for them

HW Right

Claire As an educationalist

HW I understand totally what you're saying, it's, it's just looking at your normal supervisor

Claire Yeh

HW And it's the fact that we're all entitled to, you know we all should have a supervisor wherever we practice

Claire Yeh

HW And so it's looking at our practice environment really, what if a supervisor is based in education?

Claire I support my clinical supervisees with the education aspects really of the role

HW Yeh

Claire Erm and I think that's the way we should work, I think we should work in partnership with education and supervision

HW Yes

Claire And research really, I mean erm we haven't got much of a research base in the clinical area erm, but certainly I think that it should be supervision, education and research I think

HW Yes, so is there a role in there for you know for a supervisor to be an educationalist?

Claire Erm

APPENDIX 11.8
CLAIRE'S TRANSCRIPT

- HW To support midwives in their education
- Claire Absolutely, I think so, I mean I, I, that's why I put myself forward to be a supervisor
- HW Right
- Claire Because I felt that erm, (a) a supervisory team would be strengthened by having an educationalist within that team and (b) as an educationalist, being out of clinical practice for some time, I felt that it would be of more value for me to find out about what's happening in clinical practice area.
- HW Mmm
- Claire You know I certainly think it's a mutually rewarding relationship hopefully *laughs*
- HW Oh yeh definitely, do you supervise any of the edu, any of the other midwife teachers?
- Claire No because I'm their line manager
- HW Right
- Claire And so erm, I don't, basically I encourage them to have a clinical supervisor, probably for the same reasons that I use mine, to make sure that they have opportunities for input and er, erm so I made a conscious decision not to, I do supervise colleagues within the Trust...erm, we tend to be the odd bods sort of thing, you know the practice development midwives
- HW Yes that's right
- Claire Erm
- HW As long as you feel though if somebody said, you know, if I was a mid, like you, a midwife teacher and I would like a supervisor for my educational practice?
- Claire Erm I mean I think if I can help you with that then that's fine, I would you know be happy to, to support you as a, as a supervisor erm, bearing in mind that I would also be doing IPR's for er personal organisation development and also you know point out what the curriculum supervisors are there for
- HW Right, OK, because you feel that this the right direction to go really
- Claire For me personally it is, yes
- HW That's a difficult one really isn't it, because sometimes midwife teachers, you know, we can get lost and end up without effective supervision
- Claire Mmm and I think one of the other concerns, but you know it does depend on whether as a midwife teacher you've got a good relationship with your line manager because if you're looking at how you can develop education as well as, er you know professionally then you do need somebody to support you to develop educationally. So if you haven't got an effective IPR system then I think it is probably important that you get them an educationalist as a supervisor
- HW Mmm
- Claire Erm, but it's difficulty isn't it, it comes down to personalities and people at the end of the day
- HW Probably it does yeh, because erm if you think about your supervisory reviews and your IPR's erm, is there a lot of similarity?
- Claire Erm, no because my er, IPR person is an educationalist not a midwife and she is more concerned about her role as a manager of erm, midwifery education and as er, education credible and to make sure I'm getting academic consistency across the college whereas my personal supervisor doesn't see any of that as relevant. She is more concerned with er, how comfortable I feel in my role I suppose and how I take the midwifery profession and midwifery sort of thing you know - so she's more professionally focused whereas my educationalist is educationally focused. You know I know that's professional as well

APPENDIX 11.8
CLAIRE'S TRANSCRIPT

- HW Yeh
- Claire But er
- HW But that's the issue isn't it?
- Claire Yes
- HW Because there is a lot of this is you as a professional within an educational setting really and what's the best way of using supervision
- Claire That's right and I think as in, if you're looking at erm midwives I think there is an awful lot of overlap between the supervisory role and appraisal and you know the problem is elements, both do come together really and if you were an educationalist supervised by a midwife teacher who is a supervisor, again you could do the same thing. But whether that is most appropriate for me I'm not sure. I've made the choice to do what I do erm
- HW Yes
- Claire I mean I suppose I could have chose (*name*) to be my supervisor because I know she's a midwife teacher who's a supervisor and I've got a reasonable relationship with her because I used to teach her on the supervisors' course
- HW Yes
- Claire Erm so, you know I, there are other options that one could pursue if you wanted to
- HW Yeh, yeh
- Claire Er similarly I suppose you could ask (*name*) or, you know (*name*) or somebody to be your supervisor if you wanted to
- HW Yes
- Claire Erm,
- HW You do sound though, I mean you, I mean you seem quite focussed, is that the right word, on what you need to be doing in your role?
- Claire I think I am fairly self-directed
- HW Yes, yes and so from a supervisory point of view erm, you know if I was doing a supervisory review with you it would be quite straight forward really because you
- Claire *laughs*
- HW *laughs* you've got it sorted really haven't you?
- Claire Well I mean I like to think I have, I mean I, I, I know what I want from my supervisor as it were
- HW Yes
- Claire Erm but I accept that there are a lot of people who aren't like that
- HW Yes
- Claire Erm but they shouldn't be in education you see if they aren't self-motivated, because as an educationalist you've got to do your own diarising, you've got to look at where you want to go and how you're going to get there really but if you're, if you're a midwife teacher then how did you get there if you haven't got those skills really
- HW Yes and I, I think it's that recognition as well of your professional responsibility even though you're in a non-NHS er, institution, sometimes that gets a bit lost I think
- Claire I think it does, I think it does and particularly now we are remote from the clinical area
- HW Mmm
- Claire Because erm, you know the focus is so much more academia now and researching now and that sort of thing
- HW That's right
- Claire And you know to, to do some practical updating, you really have to, *sighs* you

APPENDIX 11.8 CLAIRE'S TRANSCRIPT

- know push for it really
- HW Mmm
- Claire Because although you get your, supposed to get some personal development time, it is not always recognised as personal development, you know as getting your hands dirty hands dirty. I mean I think they don't object when I diarise myself for a clinical day but erm, probably because they don't know about it
laughs
- HW We have ways *laughs* yes
- Claire But equally you know, if you're, if you're teaching midwifery you've got to know midwifery haven't you?
- HW Yes
- Claire So erm,
- HW Yes and keep yourself up to date
- Claire Absolutely and that's why I think it's, being a supervisor helps you
- HW Yeh I find that as well, have you ever had to use supervision within the university context, I'm thinking there may have been a student - where you've felt they were unsafe to practice - you've given them a second attempt, you didn't really want to give them a third attempt but the university you know was generally in favour of a third attempt for a student. What would you do in that situation?
- Claire Er what we did do, because we did have a situation like that, it wasn't necessarily the supervision that was in doubt but certainly the need to have a clinician on the appeals panel and we have now got the university to accept that for practice there is always a erm, clinician erm, I say clinician she usually is a supervisor erm, on the, on the appeals panel so that the professional voice is, is heard
- HW That's excellent, has that taken much persuasion?
- Claire Er well it took erm, I wrote a letter to object erm to this girl being accepted back on the programme and my boss did and in both of our letters we suggested that it was inappropriate for academics to make professional decisions on practice and there should be a clinician on the panel and so, because I forwarded a copy of what I sent to the university to my boss, so in fact a decision was made from there really
- HW Oh that's excellent, did you use the supervision element at all there?
- Claire No other than the recommendation for somebody to be on the supervisory, on the appeals panel erm, what I did approach the Head of Midwifery and I said, it should be a supervisor
- HW Mmm
- Claire So just because they're credible people in the profession
- HW That's right
- Claire That would erm make the decision
- HW Got, got that professional hat haven't they. Were you a supervisor at the time
- Claire Yes
- HW Yes, do you think that influenced you? Do you think you'd have, you know because when you do the supervisor's course you change don't you?
- Claire You do, absolutely
- HW Yes and so would you have viewed it the same, it's very hypothetical but
- Claire It is, it's difficult to say isn't it, I would like to think I wouldn't, because I would like to think that I had a clinical purpose before I became a supervisor
- HW Mmm
- Claire But probably I might have had the erm, perhaps a bit more assertiveness perhaps or I was made to feel professionally responsible erm, which probably was reinforced by the supervisor's course but erm, whether that is the difference, in all honesty *laughs*

APPENDIX 11.8
CLAIRE'S TRANSCRIPT

- HW Yes, yeh it just sort of twangs inside you doesn't it
- Claire Yes
- HW When there's an issue
- Claire Yes certainly.
- HW Yeh, yeh and I think it is reinforced when you do the supervisor's course
- Claire Yeh I would agree and certainly probably on the basis of having a supervisor on our steering group in midwifery and that sort of thing I think, because I'm a supervisor, that those sort of issues are a bit more pronounced because I'm making sure they get supervisors in to teach supervision
- HW Yes
- Claire And that sort of thing has, has become more obvious as a supervisor
- HW Yeh, so how, how else then, have you got any examples yourself other than student issues, for highlighting supervision, using supervision in education
- Claire Er, we do use supervisors to help with our erm, practice assessments plus we bring them for teaching supervision to share practice erm, erm, and we involve them in the course board and they're also involved in developing the PBL scenario type things.
- HW Right and those changes have come about since you became a supervisor?
- Claire They have but whether that is cause and effect I don't know
- HW Mmm
- Claire Erm we've only introduced the OSCE into the curriculum with our last Degree curriculum which started in 2001 erm, so that's difficult to say really
- HW Mmm
- Claire The only other thing that I suppose erm, we do with students is that erm, in order to, to familiarise them with supervision we invite a group of students to meet with the supervisors as a group on a six month basis and at *name* they erm, they have a supervisor allocated to a group of students so that the student can work, you know with their own supervisor. We did it before the national guideline
- HW Yes, I think we all did *laughs*
- Claire Yes, yeh
- HW Lovely, OK, that's great, it is difficult to identify what has led to what
- Claire Absolutely
- HW It all takes place together doesn't it
- Claire And also you know it's very difficult to separate out what's the supervisory bit of me, you know what's the midwife bit of me and what's the educationalist bit of me, because you know, you are what you are aren't you and they do overlap and it's very difficult to say, if I wasn't a supervisor I might not do this *laughs*
- HW Yes, that's right, yes I think that's a very common thing that people are telling me actually, that it just becomes so much part of you
- Claire That's right
- HW That you just can't imagine not being a supervisor. What about any scenarios then concerning colleagues
- Claire Er, I can't think of any example, the only other sort of examples are where they often raise issues of poor practice or, unsafe practice even and erm, so we use the supervisory mechanism and supervisory meetings so that we can raise concerns.
- HW Right
- Claire Erm, so that's another way we bring supervision in the curriculum, issues with colleagues
- HW Say, say there was an issue, lack of confidentiality, a professional issue - what

APPENDIX 11.8 CLAIRE'S TRANSCRIPT

would you do then?

Claire I would probably do it as a line manager

HW It's just trying to identify a professional issue where you would consider supervision

Claire I don't know, I suppose it depends what the issue is really, because by the very nature of the role they're in, you know they can't, even if confidentiality is still an issue at their stage of development I mean it's a big worry isn't it?

HW Mmm

Claire I mean I think erm, I've got one colleague who was very concerned about how a breach of confidentiality in clinical practice and so, you know I advised her to talk to her clinical supervisor about developing an action plan to do that, and then to come to me for an IPR for what she needs to do it, so

HW Yeh, yes because you know we do, there are assumptions aren't there about you know qualities of midwife teaching

Claire Yes that's right, because you know you would think that as a midwife, if you had a identified a breach of confidentiality, it might be handled through supervision, it might be handled through the disciplinary but you know you'd think that midwives should have the same right but it could either be handled as a supervisory issue or as a disciplinary, erm, but as I say you just anticipate the behaviour of people in that position that they've got you know the professional nouse *laughs* not to breach confidentiality really

HW Yeh, what about erm, the LSA Officer then erm, how, you know what are your experiences of that role, would you ever use that role you know in education, you know not the person, it's the, it's the situation isn't it?

Claire Yeh that's right er, I mean obviously they are involved on the supervisors course we do involved them in curriculum development

HW It was thinking through you know like in a clinical setting

Claire Yes well I've used her for, I've used her for advice in relation to clinical issues

HW Oh right

Claire But I haven't had any educational issues as such, that I haven't been able to handle through the ordinary supervisory mechanism erm,

HW What do you mean there that you erm,

Claire Like we've had for example, we've had erm, students that have been involved in a clinical incident

HW Right

Claire With their mentors and erm, their mentor has had support from their supervisor and so we as a personal teacher have got together with the supervisor to see the student

HW Right

Claire Get together so, use what I call the normal supervisory mechanisms for that

HW Yeh, right, yeh

Claire Erm, the only time as I say I've used the LSA actually apart from sessions on leadership erm, has been to supervise on clinical issues, you know erm, more from the point of view, of you know doing development plans for midwives and that sort of thing

HW To get them, involved or contacted regarding an educational issue

Claire You know, what do I do with this case, when I'm a line manager and a supervisor erm, I mean I would see her there as an advisory person if I needed her

HW Mmm

Claire Erm, but I'm not sure quite, er, I mean as I say, I mean I suppose I could have asked her to be my supervisor as well if I wanted support from her

APPENDIX 11.8
CLAIRE'S TRANSCRIPT

- HW Mmm. I get the impression, you know, I mean, you know you're very sorted. Yeh, so, so and you know you're very focussed about what your role is and what your responsibilities are and so on, you know supervision supports you in that process really
- Claire Yes
- HW Is, is that a fair impression?
- Claire I think so, yes, as I say I mean erm, because I made my own choice of supervisor, I mean, I could have as you say, made a different choice if I'd have wanted to really
- HW Mmm, mmm, that's lovely thank you, let me just er, see what else you haven't covered
- Claire *laughs*
- HW *laughs* Erm, would you, is there, is this the ideal situation for you, you know could, could you see any ways of improving statutory supervision?
- Claire Er only by having more time for it really I think erm, so I could get more involved in some of the, taking supervision forward in our local Trust basically, increase although we've got a group of supervisors some of them are very new to supervision erm and, there is a lot of work to be done in the local Trust and I think it would be good to have some identified time really, rather than just a normal contract with the local Trust which is where I work
- HW Oh right
- Claire Erm, you know to actually have some dedicated time for supervision
- HW Yes, so that would be on your list
- Claire Yes
- HW Yes so, are they not really recognising you
- Claire Yes
- HW You're doing a lot of it in your own time,
- Claire Yes well erm, it's difficult to say really because I don't suppose they do recognise the supervisor of midwives role, they see my role as a lead midwife for education, as somebody who does keep themselves updated clinically as well as educationally
- HW Yeh
- Claire Erm, and I doubt very much whether at a higher level - they won't have any understanding I don't think about actually what supervision's all about, I think probably my direct line manager has some understanding because erm, I mean she did do her part one midwifery *laughs*
- HW Right
- Claire So she keeps telling me, many years ago erm, but again, it all comes down to a question of priorities doesn't it and time because you're supposed to have these twenty-five days a week, a year and on academic time really erm, which is very hard for us to get and you know if you include your LSA and conferences and your er, contact time and your educational links within London and all of that within those twenty-five days
- HW Mmm, mmm
- Claire They're soon eaten up and erm
- HW Yes
- Claire As I say I've got them in my diary so, I do diary myself time for supervisory reviews and that sort of thing but unless my diary was audited that might not be recognised. Do you see what I mean, they don't necessarily understand the commitment that is needed.

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CLAIRE'S TRANSCRIPT

- HW Oh no, yes I do
- Claire Yeh
- HW The LSA standards
- Claire Yes
- HW Erm, I mean they do identify dedicated time
- Claire They do yes
- HW For supervision, but they're, that's, you know that's a difficulty for us really isn't it, so you weren't like seconded to do supervision from university
- Claire Oh no, no, no
- HW you were nominated through the Trust?
- Claire Yes
- HW Right, could you have been nominated through the university?
- Claire I suppose I could by my colleagues but
- HW Mmm
- Claire There's only six of us as a group of midwife teachers
- HW Mmm
- Claire So erm, but you see why would the, why would the colleague want to second me, er, I mean that would be more time and money for them wouldn't it? But they see my professional role, if I'm a lead midwife, then I have a, part of that role is to keep myself professionally updated
- HW Yes
- Claire How do my colleagues manage without supervisors
- HW But you've got a statutory responsibility to have a supervisor
- Claire And as a midwife teacher
- HW Yes, this is the, this is the issue isn't it about raising the profile with the university
- Claire Mmm
- HW And, and I think these are part of the dilemma is that you know clinical colleagues don't face, these are sort of hidden from them, we just sort of carry on
- Claire And it's like erm, because I've got an honorary contract, which is obviously an unpaid contract, this issue about on call rotas and things, you know I don't go on to the rota for supervision
- HW Yes
- Claire Erm (a) because I'm not employed (b) because I can't get time reimbursed because I'm still expected to do my full day's teaching
- HW Mmm, right
- Claire So, so you get some seconded time for being on-call?
- HW I don't no
- Claire Are you a supervisor for a Trust
- HW I am a supervisor for the midwives in education
- Claire Right
- HW So I have links with the Trusts but I don't carry caseloads
- Claire Oh right
- HW Erm but I do do lots of supportive work
- Claire Yes I'm sure you do. I draw the line at being on-call *laughs*
- HW It's just fascinate, I just find it fascinating
- Claire The different ways people work
- HW Yes and I think there's something about the fact that you, you, you are juggling it all
- Claire Yes
- HW And, and trying to erm, you're aware of the constraints of the university, but you're aware of your professional responsibilities and you're sort of, erm ...

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CLAIRE'S TRANSCRIPT

- Claire Manage my diary *laughs*
- HW Yes
- Claire *laughs*
- HW Yes and that's really skilful though isn't it?
- Claire Well yes and no, I mean I do a lot of extra hours I think
- HW Yes
- Claire I would say I work on average 45 hours a week
- HW Yeh but you see in a sense, you know we're employed as professionals within this setting so we should, you know them, you know the university, should take on our needs lock stock and barrel?
- Claire Yes but they will probably see it as a Trust responsibility to second me if they want my services as a supervisor, you see they would turn it around and say, they are using my expertise and my time so they should support us,
- HW Mmm
- Claire But I see it as part of my link role and I use it as link time, that's how I get round it, I see my supervisory role as part of my link role
- HW Yes, oh yeh I can see where you're coming from
- Claire Yeh
- HW But what about your role in education, you know it's your professional responsibility to work isn't it
- Claire It is erm, but because I'm a midwife teacher I'm responsible for the quality of the midwifery education, so I mean erm, whether I'm a supervisor or not, I've got to ensure the quality of courses, so you know being a supervisor, it's almost incidental as far as the university's concerned,
- HW Mmm, do you feel that, because like the quality issue, is a supervisory issue
- Claire Yes but it's also a midwife manager's erm responsibility
- HW Right
- Claire You know, I mean I personally put myself forward for supervision because I felt that it would keep me, let's say clinically
- HW Mmm
- Claire Aware of what the issues are
- HW Mmm
- Claire Erm I've got one colleague who is wanting to become supervisor as well but again it's a case of whether she can get the support from clinical colleagues
- HW Trust
- Claire Trust erm, and it's how you go about, because as I say, as far as the university's concerned, why should you need clinical supervisors
- HW Mmm, if you could rewrite the scripts though and you know like, you could dictate what the university, how they should perceive us, how would you see us?
- Claire Well you see I think erm, like we erm, they're developing standards for the LSA Supervisors, I think we ought to develop standards for the lead midwives of education
- HW Mmm, mmm
- Claire Erm, because if you've got standards that said that midwife teachers were involved in supervision ... that you would have some clout, you would
- HW within the university setting?
- Claire Absolutely
- HW Mmm, mmm
- Claire Erm, although you know how much clout is obviously open to debate misinterpretation of student staff ratios is an example

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- HW Yes
- Claire That sort of thing but you know if you've got a standard then that would give you some clout but at the moment, you're expected, if you've got that term midwife in your title
- HW Mmm
- Claire You're expected to be a midwifery expert aren't you?
- HW Yes
- Claire You know and how you maintain those skills is part of your own personal development plan that you develop with your line manager so where does supervision come into that
- HW Yes and you know you're just making me think really now, maybe er, there are midwife teachers in a similar situation across the country acting as supervisors without necessarily...
- Claire calling themselves supervisors
- HW Yeh
- Claire But I think the roles overlap you see
- HW Mmm
- Claire This is, this is the issue isn't it, because there's lots, I would imagine there's lots of universities where their midwife teachers aren't supervisors
- HW Mmm
- Claire You know and
- HW And certainly lead educators
- Claire That's right
- HW How many are supervisors?
- Claire I don't know, there's some
- HW There's some
- Claire There's certainly some
- HW But it's not, it's not across the board
- Claire No, they're certain people like erm (*name*) and erm, (*name*) there's several but I mean there's quite a few people that aren't
- HW Mmm
- Claire But again they're not seconded by the Trust, they're, they er put themselves forward
- HW Mmm
- Claire So how, how's your supervision bit work then?
- HW Well I am seconded by the University
- Claire Right
- HW Erm, because we felt that we needed er supervisors. There's been a number of changes clinically, we merged six units so we needed to ensure we had statutory supervision
- Claire Yes, yeh
- HW And so it grew out of that really
- Claire Yes, so how many midwifery teacher colleagues do you supervise?
- HW Well there are seventeen of us
- Claire Yes, interesting is it?
- HW Mmm
- Claire *laughs*
- HW It is but I mean it's certainly thinking around clarifying issues, and the bottom line is we have a statutory right & responsibilities
- Claire We do
- HW It's just how that happens at the moment - it's all down to interpretation

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- Claire And that's the difficulty and you know how do you get universities to see that they do have a role in supporting supervision, I mean ours would only see it, oh it's worth being a supervisor because you can run a supervisors' course, you know *laughs* so
- HW Right
- Claire From that perspective
- HW Yes but if you think about other professions, social work
- Claire Yes
- HW Or medicine
- Claire Yes
- HW I mean social work's got a long history of supervision you know and time out for that supervision and it's different to ours
- Claire Yes it's, it's a sort of a debrief type
- HW It is but that build up of relationship is over a long time
- Claire Yeh and the medical model I think is an excellent educational role
- HW And that's accepted within the university
- Claire Yes, but that is with a very different history isn't it
- HW Yes
- Claire I mean it's come up from you know permission to teach
- HW Mmm
- Claire And whatever whereas our hasn't really
- HW No
- Claire And I think that's got quite a lot to er commend it, I think ideally it would be nice to have educational supervisors
- HW Yeh, right
- Claire We've talked about it as a group quite a lot, but it's been very disparaging over the years and it's difficult to erm, establish
- HW Right, how, how do you feel the university sees you as a midwife, you know as a professional
- Claire They see me in my role as the lead midwife so to look at the strategic development really in education and erm, to make sure that midwifery programmes are credible and producing practitioners who are fit for practice
- HW *laughs*
- Claire Fit for purpose and fit for award
- HW What about the professional element though, you know like I've just been saying about medicine and social work
- Claire But they see midwifery but they won't see supervision within that, I don't think
- HW Mmm
- Claire Erm, you know because by the very erm, job role they think that if you are, responsible, midwifery you know, you're responsible, they wouldn't look at supervision and say you need to do that. Until we as a group of nursing and midwifery erm, courses came on board in ninety-five they hadn't had any health related courses as such erm, and so they had lots to learn *laughs*
- HW Yeh
- Claire But you know it does take time doesn't it, because it's not until things like these appeals start, you know keeping people on programmes that shouldn't be there that you suddenly realise, you know there's an issue there
- HW Mmm, that's right, as a supervisor
- Claire Mmm
- HW You probably would have done it before

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CLAIRE'S TRANSCRIPT

Claire I'd like to think I would have done but you know you don't know.

HW Erm, is there anything you think you should, you know I haven't asked you or you'd like to say about supervision?

Five seconds pause

Claire Er not really *five seconds pause* erm, I'm just, I mean one of the the erm, issues that came up to me was, when these LSA erm, standards came out for er consultation erm, the first time out there was no mention at all of higher education and I see we've got one line in this

HW Mmm

Claire So it's obviously there but, you know I think if, if it isn't seen as a partnership between education and research and supervision, then you know I think that's a shame because, you know supervision represents I think the practice element as it were and you know research and education should also be part of the underpinning so in many ways I think there ought to be some comment for those three elements really

HW Within the LSA standards do you mean or?

Claire Oh no, no, no

HW No

Claire It's just that the LSA standards I felt, well initially there was no mention

HW Yes

Claire As I say, now they've given lip service to liaison HEI's

HW Mmm

Claire And so, you know you were saying how does university see education or supervision. Erm you know because it doesn't have a very high profile. I mean that's why I was pleased to see it at least got a line in the revised erm standards er and certainly as far as here goes erm, we were discussing standards for the lead educators

HW Mmm

Claire And hopefully that will develop

HW Yes

Claire Oh and we erm, we have erm approached the LSA's to actually have some input into our teachers meetings

HW Oh great lovely thank you, I'll just have a quick look, oh, that's lovely thank you very much

END OF TAPE

APPENDIX 11.9

CLAIRE'S RELATIONAL ANALYSIS

IMPRESSION DERIVED FROM APPLYING RELATIONAL ANALYSIS TO
PARTICIPANT TEN

FIRST READING

This midwife teacher undertakes many roles - a lead midwifery educator, a midwifery teacher, a manager of the other teachers, a supervisor of midwives for a clinical Trust team. It was clear from the discussion that she managed her time and diary to accommodate all these varying roles without receiving recognition from the university about the need to be a supervisor. Her drive to be a supervisor was personally driven and yet in so doing recognised that this was not given much credibility within the University although she felt it contributed to her continuing professional credibility. Hence, she represented the face of the managerial and University role of the teachers versus the professional face which was not supported by the University but is supported by the profession.

She seemed to have everything sorted so that everything has its place and worked well for her needs. Supervision was a clinical activity to which she contributed and through which she kept-up-to-date and felt part of a clinical team. Supervision in the setting of education was replaced by her role as lead midwifery educator which involves promoting the quality of educational programmes. She rejected the role as a supervisor for midwives in education because she is also their line manager, minimising potential role conflict. As the University did not view statutory supervision as essential to her role, she worked within the constraints of the university to meet her own professional needs.

Personally, I felt great respect for this experienced midwife who was clearly focussed on the needs of her self within her professional role and clearly committed towards using her skills effectively for midwives. She made it clear that supervision was important but in the context of clinical practice not education - there are other mechanisms in place to promote quality. My only issue concerned the statutory responsibility to have a supervisor even as a midwife in education.

APPENDIX 11.9 CLAIRE'S RELATIONAL ANALYSIS

SECOND READING

I - stated as own experiences or own decision-making in relation to practice as a supervisor, lead educator and as a manager of the team of midwifery teachers

YOU - used as a figure of speech but also in a mythical sense - a way of describing events or actions without directly relating to I. Used also to teach me as if I was the person involved in the situation

WE - used in different ways - to represent the relationship between herself and her supervisor, the team of midwife teachers when discussing events out of house (but not in-house) or affecting the team of teachers and finally when discussing the team of supervisors for the Trust with which she has a honorary contract

THEY - very clearly 3 groups of people - the students, the University and the team of midwifery teachers when discussing her line management role

OUR - used rarely but when it was used, the use of our referred to the whole team of midwives whether in education or clinical practice and the group of midwifery teachers.

THIRD READING

The respondent spoke of several relationships. Her relationship with the 'University' portrays an individual who was controlled, but yet tried within this, to manage herself and her professional responsibilities. In this sense, a picture grew of an individual balancing a number of demands beyond the remit of the University but yet ensuring she undertook her role as the University required.

There also exists the relationship with the team of other lecturers. Although she is not their employer they are accountable to her as the line manager. At times she spoke of this relationship as if referring to a social group but then at other times the power difference became evident.

The relationship between her and the other supervisors seemed much more of an equitable, sharing one hence portraying a different philosophical approach. However the nature of this relationship is that no managerial responsibilities exist. This is replaced by a commitment and philosophical standpoint shared by those others in

APPENDIX 11.9 CLAIRE'S RELATIONAL ANALYSIS

these relationships. This is emphasised when she discusses her own relationship with her supervisor whom she chose and has known for 5 years - it is clearly a friendly supportive one of mutual respect.

She also referred to a relationship with students as a social group with whom she interacted. This relationship was formal and referred to when discussing their needs for supervision.

FOURTH READING

Cultural and social contexts

The picture emerges of a multi-skilled professional whose role both organisationally and professionally means that she has to balance the demands of her employer, her role as a supervisor and her role as lead midwifery educator. This means that she interacts with differing cultural contexts - the academic community, the NHS Trust culture and her own professional code of behaviour.

TABLE OF FRAMES AND EXAMPLE – TENSIONS WITHIN THE EDUCATIONAL ROLE

FRAME	SMALLER FRAMES WHICH SUPPORTED THE OVERALL FRAME	NUMBER OF RESPONDENTS PROVIDING COMMENTS IN EACH FRAME	
LIVING IN TWO WORLDS	the role of a midwifery educationalist	8	
	tensions within the educational role	6	
	being a midwife and a lecturer	1	
COPING STRATEGIES	being a midwifery educationalist	8	
	clinical practise as a lecturer	4	
	the midwifery community	1	
	issues with students	2	
	supervision as an influence	1	
	MEANING OF SUPERVISION I	the philosophy of supervision	4
		tensions within supervision	1
the role of the supervisor from a supervisor's perspective		6	
the contribution of supervision to own development		4	
the qualities and attributes of a supervisor		5	
the profile of supervision		7	
the vision		3	
being a supervisor and a manager		2	
THE MEANING OF SUPERVISION II	being a Lead Midwifery Educator and supervisor	1	
	support other than supervision	1	

TABLE OF FRAMES AND EXAMPLE -- TENSIONS WITHIN THE EDUCATIONAL ROLE

TENSIONS WITHIN EDUCATIONAL ROLE

FRAME	DEFINITION	DIAGNOSIS	EVALUATION	REMEDY
<p>TENSIONS WITHIN THE EDUCATIONAL ROLE</p>	<p>A number of tensions can be identified from the comments of the participants:</p> <ul style="list-style-type: none"> - management by non-midwives - the University culture is different to the more familiar NHS background - being a minority group within a large corporate organisation - demise of the ENB - increasing separation from clinical roots - unrealistic demands from clinical supervisors unaware of role 	<p>These tensions are highlighted when the participants have been most aware of the need to promote the interest of midwifery within the University setting and there has no been no-one to support and be the advocate. The university governance has required adapting but this has been a difficult process - 'square peg in a round hole'. Attempts to incorporate professional needs by including clinicians have further excluded educationalists by undermining their own professional roles. National consultation over the LSA standards excluded midwifery educationalists. Efforts made by educationalists to conform to University demands have further distanced the group from clinical practise leaving clinicians unfamiliar with the modern role of an educationalist.</p>	<p>The overall effect is that of an increasingly frustrated and isolated professional group with little professional support.</p>	<p>Recognition of these sentiments and activation of professional support mechanisms to drive the interest of midwifery forward - supervision, RCM, NMC.</p>

APPENDIX 11.10 TABLE OF FRAMES AND EXAMPLE – TENSIONS WITHIN THE EDUCATIONAL ROLE

<p>Page: 238 Sheila9 Claire 27 Claire28 Claire35 Claire36 Claire45 Claire61 Claire67 Claire68 Claire69 Claire71 Claire73 Claire38 Claire39 Frances 8 Frances 9 Page: 238 Frances 10 SUSIE14</p>	<p>linking performance in education with University plan (not professional direction) not managed by a midwife - does this therefore heightens own awareness of professional needs supervisor concerned with role as a midwife and within the midwifery profession getting your hands dirty not seen as personal development Clairén diary time believing the university doesn't really understand deal with unprofessional behaviour of colleagues through line management rather than supervision difficulty in becoming a supervisor when based in eduClairetation - University does not recognise supervision and colleagues need to support appointment struggle to get legitimacy of statutory rights and responsibilities within University culture and organisation University perspective is on being able to run a supervisors programme comparison with other health professions models and mediClairel profession viewed as excellent University recently entered world of health related programmes - therefore need to learn LSA standards initially had no partnership with HEI's thereby denying an opportunity to raise the profile within the profession and therefore within universities - eduClairetation not recognised as signifiClairent by those developing the standards changed the appeals system to incorporate a clinician - but this negates the eduClairetionalists professional background ? inappropriate for aClairedemics to make professional decisions - but what about the midwife in eduClairetation ? high workload of lecturers making fulfilment of cliniClairel activity difficult working as a bank midwife in own time to undertake clinical work perceived perceptions of other about the role of a lecturer - an easy number conflict between one supervisors way of working and her own - conflict of working practices -own supervisors helped her</p>
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APPENDIX 11.10 TABLE OF FRAMES AND EXAMPLE – TENSIONS WITHIN THE EDUCATIONAL ROLE

SUSIE62	issue of 35 hours clinical practice, clutches from thin air and yet clinical based supervisors insisting that educationalists undertake
SUSIE67	no clear guidance for teachers - differing perspectives and answers plucked from the air
SUSIE69	actual clinical hands-on not always necessary , i.e. discussing a birthing centre
SUSIE73	some conflict over practices at supervisory review between supervisors
SUSIE86	links those who are not so professional to requesting that supervision stops
SS111	overlooked within the School as a small programme
SARAH112	limited ability of any midwife to make a difference within the University
SARAH116	midwifery not big enough within the University to allow supervision to have any influence (but statutory - ? University bigger than the law)
SARAH117	experiences of discrimination within school of nursing and midwifery and now feeling listened to to be PC
SARAH118	experiencing different worlds - anxiety about CHI and QAA varies and highlights the differences between the worlds
SARAH122	no-one advocates for midwifery within University especially since the demise of the English National Board for Nursing, Midwifery and Health Visiting (yes and how effective can NMC visitors be)
SARAH123	RCM concerned with qualified midwives and their battles
SARAH125	midwifery education trying to fit in University but square peg in a round hole
SARAH126	feel that midwifery education is a nuisance and the money brought with the contract more significant than professional salaries
SARAH127	in adopting the culture of the University have lost the NHS
JANE 13	supervisors role not compatible with understanding own role
JANE 16	clinicians not aware of the role of a teacher - no idea what our lives are like
JANE 17	range of mentor update activities show that clinicians unaware of the demands of teaching role
JANE 18	

APPENDIX 11.10
TABLE OF FRAMES AND EXAMPLE – TENSIONS WITHIN THE EDUCATIONAL ROLE

sees the tensions and pressures within the role and that she feels these tensions and pressures

JANE 34

tension between own needs and those of the mentor

JANE 35

feels that mentors and students feel she is checking up on them

JANE 36

take on educational role even when working as a bank midwife

JANE 38

feels has 2 roles, 2 hats and 2 uniforms - multiple personality or separate entities

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JANE 39

wants to be all things to all people (is this personal or an implicit aspect of the teaching role)

JANE 41

tension between practising through the student or doing it for herself

Summary of the 1902 Midwives Act

The Act of 1902, entitled 'An Act to Secure the Better Training of Midwives and to Regulate Practice' was officially cited as the Midwives Act 1902, and came into operation on the first of April 1903. This Act established the template for the implementation of the regulatory mechanism: sanctioning those who could legally practise using the title of midwife, the professional body named as the Central Midwives Board (CMB), a register or Roll to record those certified as midwives and a system of national statutory supervision of the certified midwives (General Public Acts, HMSO, 1902).

1. The Definition of a Midwife

The Act provided the following definition of a midwife:

'No woman shall habitually and for gain attend women in childbirth otherwise than under the direction of a qualified medical practitioner unless she be certified under this Act' (Midwives Act HMSO, 1902, section 1:2).

'The certificate under this Act shall not confer upon any woman any right or title to be registered under the Medical Acts or to assume any name, title, or designation implying that she is by law recognised as a medical practitioner, or that she is authorised to grant any medical certificate, or any certificate of death or of still-birth, or to undertake the charge of cases of abnormality or any disease in connection with parturition'(Midwives Act HMSO,1902, section 1:5).

A distinction between the title of midwife and the title of a medical practitioner was drawn meaning that a midwife had to be a woman who had undertaken a period of study, successfully achieved a certificate from an approved institution and was conversant with the rules and regulations issued by the CMB. She would attend women during childbirth habitually and for gain. In accordance with the Rules, she would work under the direction of a medical practitioner whilst attending women during childbirth.

2. The Central Midwives Board (CMB)

The Central Midwives Board was responsible for the regulation and supervision of all midwives in practice. Its function was to frame the secondary legislation through the Midwives Rules to raise the standards of care given by existing midwives, produce a roll of midwives qualified to practice after a prescribed training and the assessment and discipline of those midwives judged to have disobeyed the rules and regulations. By statute, it had to consist of 4 registered medical practitioners, 2 persons (one of whom had to be a woman) appointed by the Lord President of the Council and three others – one appointed by the County Councils and the other two from nursing organisations.

None of the members of the Board understood the dilemmas faced by midwives from their perspective. It is only through fortune that the two nursing representatives were prominent midwives (Cowell & Wainwright, 1981).

3. A Roll of Certified Midwives

By 1st April 1905, the possession of a recognised midwifery certificate was the primary condition for entry on the Roll managed by the CMB. Certificates awarded by the Royal College of Physicians of Ireland, the Obstetrical Society of London, the Coombe Lying Hospital and Guinness's Dispensary and the Rotunda Hospital for the relief of the Poor Lying-in Women of Dublin were permissible (Carter et al, 1963). The CMB was permitted to add to the Roll those midwives who had trained at the larger maternity hospitals where certificates were issued.

Alternative criteria for application to the Roll included evidence that she had been practising in a bona fide capacity for at least a year at the time of the passing of the Act, that she bore good character and was willing to comply with the Rules issued by the CMB. A period of eight years 'grace' was granted to those women who were unsure, did not want to become certified midwives or underwent a period of training at the approved institutions.

APPENDIX 11.11

SUMMARY OF THE 1902 MIDWIVES ACT

The creation of Roll of midwives and the criteria to gain access to the Roll fulfilled the ambition of the midwifery leaders within the Midwives Institute who were aiming to improve the calibre of midwives, both educationally and morally (Paget, 1892, 1901). Hence, it established the first exclusionary strategy on access to midwifery (Witz, 1992).

3. The Supervision of Midwives

Various articles and letters in Hansard demonstrate that establishing a system of monitoring midwives reassured members of the medical profession that occupational competition would be minimized and their income would be unaffected by the regulation and training of midwives in statute.

Within the Act, the duty to regulate, supervise and restrict within due limits the practice of midwives was conferred to newly created bodies identified as Local Supervising Authorities (LSA's). County councils or county boroughs throughout England and Wales undertook this function. Each authority was authorised to appoint a committee within each council, many of which appointed midwifery committees. These were often sub-committees of the Health or Maternity and Child Welfare Committees (Carter et al, 1963). Hence, the LSA's became part of the fabric of local government but were also accountable to the CMB.

The duties of an LSA were clearly itemised within the Act as :

1. general supervision within the Rules;
2. the investigation of malpractice, negligence, misconduct constituting a prima facie offence and which required reporting to the CMB;
3. suspension from practice;
4. to report any offence to the Board;
5. to notify the CMB during January, the names and addresses of those having notified the LSA within that year and maintain a roll of midwives ;
6. to report the death of a midwife;
7. to give notice of the effect of the Act (General Public Acts, HMSO, 1902).

The activities focused on monitoring and reporting poor practice.

APPENDIX 11.11

SUMMARY OF THE 1902 MIDWIVES ACT

Based on the model of factory inspection, the agent of supervision was the Inspector of midwives. The Inspector of midwives was a medical officer of health or a medical officer appointed specifically to undertake this role. This was a whole-time officer appointed by the county borough, county or county district to be its chief executive. The post-holder would have been male and he must have been a medical practitioner holding a diploma in public health (Carter et al, 1963). It was also possible to have assistant medical officers of health who must have been qualified for three years and had experience in midwifery and child welfare work. Hence, the Act facilitated the appointment of medical and non-medical inspectors of midwives.

The Organisation of Statutory Supervision

The statutory source for the supervision of midwives stems from articles 42 and 43(3) of the NMC Order (HMSO, 2001) which is primary legislation. It is viewed as a professional self-regulatory mechanism that enforces national statutory regulation locally (Jenkins, 1995, Dimond, 1996) and is legally binding over all practising midwives within the UK (NMC, 2004b).

The NMC is required to issue rules, standards and guidance for the exercise of the supervision of midwives (HMSO, 2001). There are three elements in the operational model of statutory supervision within the United Kingdom: the Local Supervising Authority (LSA), the Local Supervising Authority Midwifery Officer (LSAMO) and supervisors of midwives.

1. The Local Supervising Authority (LSA)

The LSA is defined under section 15 of the Nurses, Midwives and Health Visitors Act (1997) as Health Authorities within England and Wales, Health Boards within Scotland and Health and Social Service Boards in Northern Ireland. This definition has been carried forward into the Nursing and Midwifery Order (HMSO, 2001) and under the Health Reform Act (2002) the LSA function is designated to the Strategic Health Authorities (SHA). Each SHA either employs an LSA Midwifery Officer or formed part of a consortium arrangement to ensure the LSA function is carried out (Guest, 2005).

Under article 43 of the Nursing and Midwifery Order (2001), 'each LSA shall:

- *exercise general supervision in accordance with rules made under article 42 over all midwives practising in its area;*
- *where it appears that the fitness to practise of a midwife in its area is impaired, report it to the Council;*
- *have power in accordance with the rules under article 42 to suspend a midwife from practice'* (Nursing and Midwifery Order, 2001, page 58).

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Guest (2005) provides further detail, stating that the LSA :

- *provides a framework of support for supervisory and midwifery practice;*
- *receives intention to practise notifications from all midwives practising within the LSA boundary;*
- *ensures that each midwife meets the statutory requirements for practice;*
- *accesses initial and continuing education and training for supervisors of midwives;*
- *leads the development of standards and audit of supervision;*
- *determines whether to suspend a midwife from practice, in accordance with Rule 5 of the Midwives Rules and Standards (NMC, 2004b);*
- *investigates cases of alleged impairment of fitness to practice (Guest, 2005, p7).*

The function of the LSA is delegated to an individual referred to as the LSA Responsible Midwifery Officer (LSAMO). Where consortium arrangements exist a lead authority is held responsible for the appointment of an LSA Responsible Midwifery Officer.

2. The Local Supervising Authority Midwifery Officer (LSAMO)

There are 13 LSAMO in England (Guest, 2005). The role and position enables extensive influence on midwifery practice at both the local and national level. The NMC prescribes the necessary qualifications and core standards for appointment to the post of LSAMO whilst the lead SHA recruits and issues terms and conditions of employment (Nursing and Midwifery Order, 2001, NMC, 2004 a,b). Each LSAMO is a senior and practising midwife who will be accessible to all supervisors of midwives and women as service users for advice and guidance (NMC, 2004, a, b). Rules 13, 14, 15 and 16 of the Midwives Rules and Standards (NMC, 2004b) provides further clarification of the role and responsibilities of the LSAMO whilst Rules 4, 5, 9, 11 and 12 issue guidance concerning the activities and standards expected from a LSAMO. The following strategic goals have been identified by the LSAMO for England group:

The LSAMO will:

- *promote and facilitate equitable and effective supervision of midwives across England to support competent midwives and a safe service which encourages women-centred care;*
- *establish a robust mechanism for auditing supervision of midwives within LSA boundaries to ensure efficiency, safety and compliance with the NMC Codes of Conduct, Midwives Rules and Standards and with LSA guidance;*

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- *actively promote statutory supervision of midwives as a means to influence midwifery practice, by encouraging engagement with service users, external bodies and managers;*
- *provide professional leadership for supervisors of midwives and midwives through networking, and through influencing and facilitating good practice;*
- *promote the inter-relationship between self-regulation, professional accountability and statutory supervision in order to strengthen the protection of women and babies' (Guest, 2005, p 15-19).*

Each LSAMO within England acts independently although there are regular national meetings with the NMC and the Lead Midwives for Education (Truttero, 2000).

Networking and developing working relationships with organisations such as the NMC, Department of Health, local Trusts, Higher Educations Institutions, CNST, CEMACH and the Healthcare Commission supports the role of the LSAMO (Guest, 2005). The LSAMO is responsible for the recruitment and selection and in establishing and developing the statutory preparation of supervisors of midwives programme (NMC, 2004b, LSA 2005a). The role of the LSAMO has also been recognised as one of professional leadership encouraging developments in practice and representing women's and midwives interests at local and national level (English National Board for Nursing, Midwifery and Health Visiting, 1999, Duerden, 1996).

3. Supervisors of Midwives

The LSA Officer delegates the implementation of statutory supervision at a local level to a supervisor of midwives: a supervisor of midwives is accountable to the LSAMO in performing statutory supervision. The role of a supervisor of midwives is contained within the Local Supervising Authority standard section of Rule 12 in the Midwives Rules and Standards (NMC, 2004b) as follows:

- *Supervisors of midwives are available to offer guidance and support to women accessing maternity services*
- *Supervisors of midwives give advice and guidance regarding women-centred care and promote evidence-based midwifery practice*
- *Supervisors of midwives are directly accountable to the local supervising authority for all matters relating to the statutory supervision of midwives*
- *Supervisors of midwives are approachable and accessible to midwives to support them in their practice (NMC, 2004b, p29).*

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A distance learning package developed by the NMC supports the preparation of supervisors of midwives programmes. Last published in 2002, the pack is undergoing critical review and updating and due for re-publication in light of the new legislative framework in late 2006.

Midwives who fulfill the criteria within Rule 11 of the Midwives Rules (NMC, 2004) are eligible to be considered as a supervisor. Article 43(2) of the NMC Order states that the necessary criteria to be eligible to undergo the preparation programme are as follows:

- *'be a practising midwife*
- *have 3 years' experience as a practising midwife of which at least one shall have been in the period of two year period immediately preceding the appointment; and*
- *have successfully completed a preparation of supervisors of midwives course' (NMC, 2005, p25).*

Eligibility is subject to nomination and selection by peers and the LSAMO before commencing the statutory preparation programme (LSA 2005a). The preparation programme maybe at degree or masters level (English National Board for Nursing, Midwifery and Health Visiting, 2001), reflecting the emphasis for supervisors to act as professional leaders with necessary academic skills. The Local Supervising Authority via the LSAMO appoints all supervisors of midwives, who have successfully passed the preparation programme although this is not an automatic appointment (LSA Guidelines, 1999, Rule 11 NMC, 2004b, LSA, 2005a). Those undertaking the role may be clinicians, managers, researchers or educationalists (LSA information, 2000). Fifty-three per cent of supervisors are clinical midwives whereas previously most were managers (Duerden, 2002).

The numbers of supervisors of midwives required depend upon the number of practising midwives within the LSA area as each supervisor carries a caseload of practising midwives. The NMC has set the standard for the number of supervisor of midwives to midwives as 1 to 15 (NMC, 2004). This is an improvement from the UKCC (1998) recommendation that a supervisor should have no more than 40 practising midwives in their caseload. All supervisors within a defined area work together to support the midwives locally so that as required by Rule 12 of the

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Midwives Rules and Standards (NMC, 2005) there will be a supervisor available for advice and guidance 24 hours a day 7 days a week.

The role of a supervisor of midwives has been voluntary and undertaken in conjunction with the paid contract of employment as a midwife. The Agenda for Change (DoH, 2004a) has acknowledged the contribution of a supervisor of midwives to clinical governance activities within a Trust and rewarded those undertaking the role by paying individuals between £500 and £2000 nationally. Supervisors of midwives remain accountable to the LSA for her/his standard and performance of the duties associated with being a supervisor. The LSAMO, who is paid to undertake statutory supervision specifically, is in turn accountable to the midwifery officer within the Nursing and Midwifery Council (Nursing and Midwifery Order, 2002).

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