Midwives' emotion and body work in two hospital settings: Personal strategies and professional projects

Juliet Liana Rayment

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To the midwives of Millside Maternity Unit and Northway Midwifery Unit, whose daily struggle is an inspiration.

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Declaration

I confirm that this thesis is my own work and it has not been submitted for a degree at another university.

Abstract

Much has been written in recent years of a 'crisis' in the recruitment and retention of midwives in the NHS. The crisis has been attributed variously to burnout, a lack of professional autonomy, a bullying culture, and an ideological conflict between the way in which midwives wish to practise and the way they are required to practise within large bureaucratic institutions, such as NHS Trusts. Negotiating these experiences requires a significant amount of emotional labour by midwives, which they may find intolerable. This thesis explores the strategies NHS midwives deploy in order to continue working in NHS maternity services when many of their colleagues are leaving. It examines the extent to which working in a midwife-led service rather than a consultant-led service helps or hinders midwives' capacity to manage the emotional and ideological demands of their practice.

Ethnographic fieldwork was carried out in a consultant unit and an Alongside Midwife-led Unit (AMU) in two NHS Trusts in England. The findings from negotiated interactive observation and in-depth unstructured interviews with eighteen midwives were analysed using inductive ethnographic principles.

In order to ameliorate the emotional distress they experienced, the midwives used coping strategies to organise the people and spaces around them. These strategies of organisation and control were part of a personal and professional project which they found almost impossible to articulate because it ran contrary to the ideals of the midwifery discourse. Midwives explained these coping strategies as firstly, necessary in order to deal with institutional constraints and regulations; secondly, out of their control and thirdly, destructive and bad for midwifery. In practice it appeared that the midwives played a role in sustaining these strategies because they formed part of a wider professional project to promote their personal and professional autonomy.

These coping strategies were very similar in the Consultant Unit and the Midwifery Unit. A midwife-led service provided the midwives with a space within which to nurture their philosophy of practice. This provided some significant benefits for their emotional wellbeing, but it also polarised them against the neighbouring Delivery Suite. The resulting poor relationships profoundly affected their capacity to provide a service congruent with their professional ideals. This suggests that whilst Alongside Midwife-led Units may attempt to promote a midwifery model of care and a good working environment for midwives, their proximity to consultant-led services compounds the ideological conflict the midwives experience. The strength of their philosophy may have the unintended consequence of silencing open discussion about the negative influence on women of the strategies the midwives use to compensate for ideological conflict and a lack of institutional and professional support.

Chapter One: Introduction

Midwifery is a profession in the midst of a 'crisis'. Academics and journalists (The Daily Mail 2007; Cleland 2008; Campbell 2010; Wighton, Watkins et al. 2010) write about the future of a profession that is losing members. In response to concerns over recruitment and retention of midwives, the Royal College of Midwives commissioned a cohort study of a sample of all midwives who left the profession between 1999 and 2000. The series of reports which followed (Ball, Curtis et al. 2002; Kirkham and Morgan 2006; Kirkham, Morgan et al. 2006) explained that aside from the midwives who were retiring and those leaving because of family commitments, the largest number left because they: 'were unwilling to practise the kind of midwifery demanded of them by the modern NHS, despite their desire to practise as midwives' (Ball, Curtis et al. 2002: 2).

This thesis explores how midwives in the UK negotiate the dissonance between the way they would like to practise and the way they are required to practise by the NHS in two organisational contexts. Specifically, it looks at the strategies described by midwives such that the benefits of remaining as an NHS midwife outweigh the costs of leaving. The thesis reports on a comparative organisational ethnography involving ten months' observation of midwives' work and a series of in-depth interviews with midwifery staff in a consultant-led maternity unit (Millside) and a midwife-led unit (Northway Midwifery Unit) in a large English city. These midwives were hospital-based and cared for women during labour, birth and the immediate postnatal period.

The aim of this project is to provide a clearer understanding of how midwives

compensate for short-fallings in the organisation, terms and conditions of their work.

With this knowledge, the midwifery profession and the NHS trusts that employ

midwives may be able to promote working practices that minimise the negative

aspects of midwives' work, or at least help midwives to negotiate them, without the

significant emotional labour that it currently demands. Furthermore, recent

government policy supports the development of Alongside Midwife-led services[1]

ostensibly to improve midwives' working lives. This thesis examines how far the

experience of midwives working in Alongside Midwife-led Units might differ in

terms of the gap between ideal and reality compared with those in consultant-led

units, and/or have different strategies available to them to negotiate that gap.

The early ideas for this thesis came out of reading Hunter's work on emotional

labour in midwifery (Hunter 2000; 2001; 2002; 2004; 2005; 2006). Hunter found that

midwives experienced a tension between the demands made on them by women, the

institutional demands of their employer and that their attempts to reconcile these

conflicting ideologies required considerable emotional labour. Both Hunter's work

and the Royal College of Midwives' studies told the same story: that midwives were

rarely able to practise the midwifery to which they aspired within the NHS. The

midwives I interviewed for my Masters dissertation (Rayment 2005) also told me of

the emotional distress caused by their inability to practise what they termed 'real

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[1] Alongside Midwife-led Units (AMUs) are those which are located on the same site as an obstetric service. These differ from 'Freestanding Midwife-led Units' (FMUs), which are located away from an obstetric service and therefore have no immediate medical back-up available.

midwifery'. In response, some had left the NHS and set up independently; others had stayed and tried to fight the system with varying degrees of success and satisfaction.

For my Masters project I had specifically chosen to speak to midwives who were involved in political action around their work: these midwives were frustrated by working within organisations and with colleagues whose practice was ideologically different to their own. Their strategy for coping with this frustration was to look beyond their work place and find kindred spirits in groups such as the Association for Improvements in the Maternity Services (AIMS), the Association of Radical Midwives (ARM) or any other of the groups pressing for change to women's care and midwives' work[2]. These midwives were extraordinary in many ways and their choice to stand up to the system like that was not an easy one. They were often left alienated from their colleagues who either did not share their views or for whom the costs of expressing their opinions openly seemed too high. So, what of those midwives who had not joined campaigning groups or otherwise openly taken a stand at work? The three RCM reports and my own Masters research threw up a number of interesting questions about what 'real' midwifery was and why it was so important to the midwives with whom I spoke. What was different about those midwives who stayed working in the Health Service in ways that meant they continued to be satisfied by their work, or at least found it tolerable?

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[2] Throughout this thesis I refer to 'midwives' and 'women' to distinguish between the midwives working in the units and the 'patients' in their care. This is, of course, a false dichotomy as all the midwife participants were women and some of the 'patients' may well have themselves been midwives. However the use of 'midwife' and 'woman' is ubiquitous within maternity services and I adopt it here as a useful, if clumsy, way to distinguish between the two groups.

This thesis provides a detailed ethnographic account of midwives' every day experiences at work in two hospitals in a large English city. The project makes a comparison between midwives at work in a consultant-led unit and those in an Alongside Midwife-led Unit in the same locality, in order to explore how far working within Alongside Midwife-led services may help or hinder midwives' abilities to cope with the negative emotions their work appears to engender.

Organisational ethnographic studies of midwifery such as this thesis are sparse, as discussed in Chapter Three, on Methods and Methodology. There have been particularly few studies on the work of Alongside Midwife-led Units or on midwives 'backstage' rather than 'frontstage' work. This study specifically addresses the influence of the spaces and places in which midwives work and their influence on the practice, ideology, emotional labour and body work of NHS midwifery. An appreciation of the experience of place amongst midwives is of particular interest when studying Alongside Midwife-led Units and has been little addressed before.

Midwife-led care

The history of the development of midwifery as a formal profession is an oft-told tale. Sandall (1998a), Witz (1992) and Heagerty (1996) have provided particularly extensive accounts of the story of the 1902 Midwives' Act and the subsequent gradual move of birth from the home to the hospital throughout the following decades. As the story of the profession of midwifery has been told so often, I do not

aim to write another full account of it here. Instead I will draw on moments in its history which continue to inform how it is organised, regulated and practised.

Until the early 1900s almost all midwifery care was carried out by 'lay' or so called 'granny' midwives who were self taught or apprenticed. They provided care within their communities to working class women and the very poor. During the late 1800s, there was growing unease about these granny midwives amongst middle class midwives and nurses who had grouped together to form the 'Midwives' Institute' in order to promote their own occupational interests. Their concerns were fed by worries for the 'social and economic effects of poverty and ill-health among the working class' (Heagerty 1996: 13), and it was the regulation, education and registration of midwives which was understood as central to improving public health. The Midwives' Institute was dominated by middle and upper class women who had 'little firsthand knowledge of lay midwives or the lives of working class families' (Heagerty 1996: 14). They aimed to 'rescue' working class families by instilling in them 'self-reliance and strict conformity to the moral code of bourgeois respectability…which needed the supervision of those with superior social backgrounds and refined sensibilities' (Heagerty 1996: 14-15). The Midwives' Institute succeeded in passing the Midwives' Act of 1902, which prohibited anyone from practising midwifery unless they were registered by the State and had carried out an approved training programme. Enshrined in this first Act were a set of 'Midwives' Rules' which, although since amended a number of times, fundamentally still hold true today: for example midwives are mandated to notify their Local

Supervisory Authority annually of their intention to practise midwifery in the region; they are required to have a named Supervisor of Midwives and they are forbidden to carry out any procedure, except in an emergency, which they have not been trained to do (NMC 2004).

The migration of the normal place of birth from the home to the hospital was supported by a number of changes in welfare policy during the late 19th and early 20th century. These included demands for hospital beds for women living in poor home circumstances (Sandall 1998a: 9) and not least the invention of the National Health Service in 1948, which made it cheaper for women to birth in a hospital, covered by National Insurance, than to stay home and pay an independent midwife. By the 1950s, the increasingly dominant profession of obstetrics was calling for hospital confinements on the grounds of safety (a claim which was as yet unproven) (Sandall 1998a: 9) and restrictions on midwives' freedom to prescribe analgesia meant that middle class women began to choose hospital births in search of pain relief (Sandall 1998a: 9). The NHS also brought payment to GPs for maternity care and a number of GPs took over former 'Maternity Homes' and ran them as GP Units situated away from hospital obstetric departments (Macfarlane 2008: 3). The trend towards birth in hospital continued throughout most of the 20th Century, and in 1970 the Peel Committee (Department of Health 1970), advocated 100% hospital birth. Subsequently, the number of GP Units halved between 1980 and 1990 from 212 to 106 (Campbell and Macfarlane 1994).

It was only in the 1980s that a comprehensive evidence base for maternity practice developed through the Cochrane Database, which highlighted both the benefits and the hazards of maternity interventions (Chalmers, Enkin et al. 1989; Sandall 1998a). For the first time, this evidence challenged the assumption that more technology always led to better outcomes for women and babies. This new evidence, and the greater understanding of the iatrogenic effects of some routine maternity interventions, brought about a change in policy from the Department of Health which culminated in the publication of the Winterton Report in 1992 (House of Commons Health Select Committee 1992) and *Changing Childbirth* in 1993 (Department of Health 1993). *Changing Childbirth* acknowledged the central role of midwives in the care of normal pregnancy and birth, the importance of continuity of carer and called for the support of a midwifery profession which was autonomous and accountable. Its publication was considered a campaign success by organisations such as the Association of Radical Midwives which had fought for the development of the profession and the provision of midwife-led services since the mid-1970s. However, over the course of the 1990s many of the recommendations from the report showed few signs of being implemented in practice (Bradshaw 1997).

In 2007 the Department of Health published *Maternity Matters: Choice, access and continuity in a safe service* a report which announced a 'choice guarantee' that by the end of 2009 women would be able to choose from the following options:

- Birth supported by a midwife at home.

- Birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre. The unit might be based in the community, or in a hospital; patterns of care vary across the country to reflect different local needs. These units promote a philosophy of normal and natural labour and childbirth. Women will be able to choose any other available midwifery unit in England.

- Birth supported by a maternity team in a hospital. The team may include midwives, obstetricians, paediatricians and anaesthetists. For some women, this type of care will be the safest option but they too should have a choice of hospital. All women will be able to choose any available hospital in England.

(Department of Health 2007)

At the time that the fieldwork for this thesis was being carried out in 2007-2008 there was estimated to be around 70 midwife-led units in England that were located away from obstetric units (Freestanding Midwife-led Units) and around 50 units located on the same site as an obstetric unit (Alongside Midwife-led Units) (Eden 2006). Estimates of the percentage of births occurring in these units ranged from 6% (National Health Service 2007) to the NCT's finding of 16% (Eden 2006) but there is a notable lack of reliable data on the locations and configurations of these units pending the outcome of the *Mapping Maternity Care Survey* currently being carried out as part of the Birthplace in England Research Programme at the NPEU,

University of Oxford[3]. Anecdotal evidence suggests that there are a variety of so-called 'Alongside Midwife-led Units' currently in use: from those that are simply a set of designated rooms on the main consultant-led Delivery Suite to others, like Northway Maternity Unit, which are purpose-built and separated from the Delivery Suite by doors, corridors, stairs or are in a separate building on the hospital site.

With the publication of Maternity Matters, it is expected that the number of Alongside Midwife-led Units in particular will rise in the next few years as Trusts seek to fulfil the demand for 'choice' of place of birth without necessarily needing the outlay costs of building Freestanding Midwife-led Units. Maria Fannin argues that the growth of home-like 'birth centres' in the US was a response to the demands of the discerning middle-class consumer (2003). Campaigns for normal birth in the UK and moves towards re-branding the 'patient' as 'client' or 'consumer', have shown that it has also become beneficial for Trusts in the UK to use their facilities to similarly promote their services to the public. Alongside Midwife-led Units may also provide reassurance for those worried about the safety of Freestanding Midwife-led Units, which is likely to support further growth in their numbers.

The thesis

Following this introduction, Chapter Two of the thesis provides a review of the literature divided into two parts. Part I looks at how the profession of midwifery has formed an identity for itself independent of medicine and nursing. It explains the

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[3] Details available at www.npeu.ox.ac.uk/birthplace/component-studies/mmcs

existence of the dominant discourse which surrounds midwifery and explores the evidence for and against the personal autonomy of individual practitioners and the professional autonomy of the occupational group as a whole. This then leads onto Part II which uses the existing literature to explore the extent to which this discourse of midwifery is played out in the reality of their work within the NHS. I situate midwifery within three areas of social science literature, which each present possible challenges for midwives in achieving the woman-centred care, autonomy and accountability their discourse suggests they have. These three areas of literature each represent a central facet of midwives' work: their emotional labour, the spaces in which they practise and the bodies they work with. Out of this review of the literature come the research questions, stated on page 76.

Chapter Three is an account of the methods and methodology employed in the research. It tells the story of the development of the research project and the story of fieldwork and analysis. It provides a justification for the use of ethnographic case study as a method. The account of the research process situates me, the researcher, within the text and explores how my *being* 'in the field' influenced the collection and interpretation of the stories told in this thesis. The experience of fieldwork was emotionally difficult and my strategies for managing this difficulty, plus the nature of my relationships with the midwives with whom I worked shed light on the midwives' own being in the world in which they worked.

Chapter Four describes the characteristics of the two research sites: the history and layout of the units and the demographics of the local population they serve. This chapter describes the scenery within which the rest of the thesis is set; but it is scenery that shaped almost every part of the midwives' work within it and as such can be understood as more than just a backdrop.

Chapter Five is the first of the three chapters that present the research findings. It is presented in two parts. Part I introduces the emotional demands of the midwives' work in both units as they occur both with the women in their care and with their colleagues. It details the strategies the midwives deployed in order to negotiate better the emotional demands and subsequent emotional labour their work involved. Much of these strategies involved 'hardening up' and learning to care less, which presents a potential conflict with their capacity to provide midwifery care according to their ideological ideals. This chapter begins to explore how the 'ideological conflict' of hospital midwifery was experienced by the midwives in both units and which will be addressed further in the remainder of the thesis. The second part of the chapter looks at the institutional and professional support systems that were provided for midwives. Whilst these systems went some way to ameliorating the emotional difficulties for midwives, they remained inadequate to do so satisfactorily.

Chapter Six explores how the midwives compensated for shortcomings in the formal support systems available to them, by deploying informal coping strategies to manage the emotional and ideological difficulties of their work. This chapter focuses

on those strategies where they relate to the spaces in which they worked. Taking each unit in turn, it describes how the spaces in which the midwives worked were imbued with ideology and as such constituted work*places*. The midwives' organisation of these workplaces tells much about their relationships with women, but particularly with other midwives, support workers and doctors.

Taking each unit in turn, Chapter Seven explores the informal coping strategies deployed by midwives in relation to the bodies they worked with. Such strategies shed light on their relationship with the women in their care. The chapter looks at how midwives negotiated the intimate and/or difficult body work of midwifery by organising, managing and categorising women's bodies in ways which were not 'with woman', as the discourse suggests they should be. I discuss this concept of 'with woman' in more detail in Chapter Two. The midwives also demonstrated a complex relationship with the Trust's clinical guidelines and protocols, which also sought to 'manage' women's bodies. The chapter looks at the extent to which midwives in both units embraced or resisted these guidelines and the implications this had on their perceived personal and professional autonomy and accountability.

Chapter Eight provides a discussion of the findings, bringing together the three themes of emotions, space and bodies. It answers the research questions and makes recommendations for changes in practice and further research.

Chapter Two: Review of the Literature

This chapter will locate my project within existing literature and provide a conceptual backdrop to a discussion of midwives' experiences of their work in NHS hospitals. In Part I of the review I will explore the way in which the self-identity of midwifery as a profession has developed out of the professional discourse that surrounds it, paying particular attention to the problem of autonomy and accountability of midwives at the level of the individual practitioner and the profession as a whole. In Part II, I situate midwives within the sociology literature relating to three key facets of their work and begin to explore the extent to which the discourse and ideology of midwives work from Part I may be played out in the reality of their every day practice.

Part I: The midwifery professional identity

The professional discourse

The professional discourse of midwifery pervades the literature that describes the work of midwives (e.g. Kirkham 1986; Donnison 1988; Witz 1992; Hunt and Symonds 1995; Davis-Floyd and Davis 1996; De Vries and Barroso 1997; Murphy-Lawless 1998; Walsh 1999; Kirkham and Stapleton 2000; Walsh 2007). The discourse is not only a series of familiar phrases or statements that are used to describe the profession of midwifery or the process of birth. These phrases also work to construct attitudes and beliefs about these phenomena. As Stuart Hall writes:

When statements about a topic are made within a particular discourse, the discourse makes it possible to construct the topic in a certain way. It also limits the other ways in which the topic can be constructed (Hall 1996: 201).

The discourse of midwifery constructs and maintains a professional identity for midwives. This is not to say that all midwives share this way of talking about what it means to be a midwife, nor aspire to practice in this way. However, the discourse works to produce a dominant narrative about (and therefore a dominant concept of) what a midwife is, what she does and how she does it.

The midwifery discourse's central tenet is that midwifery care is holistic and 'with woman' by which I mean 'woman-centred', allied with women (an allegiance often posited against doctors) and sensitive to the 'physical, social, psychological, emotional, spiritual and educational needs of women' (Robinson 2000: 190). Midwifery is meant to be practised in partnership with women, founded on intimacy and a supposed equality based on shared gendered experiences, independent and different from those of men (Leap and Pairman 2006; Pairman 2006; Mansfield 2008). This discourse around what midwifery is and how it should be practised is influential on midwives in the UK and across the world. However there has been little critical work done on its role and function within the context of the UK National Health Service.

There is a small but diverse body of literature on the function of discourse and rhetoric in wider reproductive health that has addressed issues such as the construction of cultural norms of reproduction (Martin 1987; Georges 1996; Lay, Gurak et al. 2000); women's desire for medicalised childbirth (Machin and Scamell 1997; Fox and Worts 1999); discourse analysis as a methodological tool in midwifery research (Nixon and Power 2007) and the construction of different nursing and medical identities (Leonard 2003). American midwifery scholars (e.g. Lay, Wahlstrom et al. 1996) have looked at the role of rhetoric and discourse amongst lay midwives in the USA, and have demonstrated a tactical use of rhetoric according to whether such midwives are demanding state recognition or resisting state intervention into their work.

Like the lay midwives in the USA who are battling for formal recognition or at least respect for their form of knowledge from the medical authority, midwives in the UK have a long history of battles for professional recognition, professionalisation and professional autonomy (Donnison 1988; Witz 1992; Murphy-Lawless 1998). Discursive norms are a powerful tool when establishing recognised standards of practice, education and professional registration. The British midwives who fought for such aims in the turn of the last century were creating an illusion of homogeneity amongst a disparate group of midwives divided by class and education (Donnison 1988; Warriner 2002).

Such a discourse has the effect of masking differences between groups of midwives divided by educational background, varying family commitments, full- or part-time working and an interest in caring for women during 'low-risk' or 'high-risk' birth. This suggests that it might be of value to explore midwives' work in different kinds of work places which support different levels of personal autonomy for midwives and provide care for 'lower' or 'higher' risk women, for example consultant-led and midwife-led units. In addition, social scientists working on midwifery and maternity services (following other feminist scholars) have questioned the assumption that all women have equal status, despite differences in ethnicity, social class and education and have asserted that women do not always defend the rights of, or indeed may actively persecute, other women (Annandale and Clark 1996; Sandall 1999).

The dominant discourse around midwifery persists despite these caveats. Its persistence suggests that it remains important for midwives because it forms a basis for a professional project that has emerged out of a position of relative weakness as an occupational group (Kirkham 2000b: 234):

> Formulation of a philosophy statement is fundamental to the development of a profession. Not only does it clarify the focus and the direction of the work to be accomplished by establishing professional norms, but it also grounds the profession or professional by rooting the discipline and its members in certain basic beliefs (VandeVusse 1997: 43).

An identity independent from medicine

The distinctive discourse of midwifery has been developed as an antithesis to midwives' perception of the role, aims and ideals of both medicine and nursing. The prevalence of this kind of discourse amongst the midwifery literature shows how midwives hold close to their hearts their *difference* from these other healthcare professions. Much of the academic midwifery literature tells a story, either explicitly (e.g. Donnison 1988; Murphy-Lawless 1998), or implicitly of a battle for the control of childbirth by two contrasting groups of attendants: midwives and obstetricians, who represent either side of a dichotomy. The application of this binary model was particularly strong in feminist texts of the 1970s and 80s, which formed part of a political project to reclaim birth from male control (for example Rothman 1982; Martin 1987). Edwin van Teijlingen (2005) has written a comprehensive account of the social and medical models in maternity care at the three levels of practice, ideology and sociological analysis. In his explanation of the nature of ideology, van Teijlingen emphasises its dogmatic nature, whereby:

> It is the exclusive correctness of a certain approach that the person who makes the claim tries to establish, in order to win others over to this practice… One should always bear in mind that ideology does not simply reflect social reality, but also influences and shapes it by helping it to mobilise action on behalf of particular interests (van Teijlingen 2005: 10.3).

Proposed definitions of 'ideology' are diverse across Sociological and Philosophical literature (Eagleton 1991: 1). In this thesis I am using a definition of 'ideology' that posits it as a way of thinking about a subject which deploys persuasive rhetoric for political ends, but 'irrespective of whether such action aims to preserve, amend, uproot or rebuild a given social order' (Seliger 1976: 14). The benefit of such a definition is that it the *subordinate* midwifery beliefs are exposed as a rhetorical tool for political ends (and thus an ideology), as much as the *dominant* model of biomedicine.

Drawing from the midwifery literature, van Teijlingen creates two lists of the key features of the medical and social/midwifery models of care. These lists (similarly in Oakley 1999; Walsh and Newburn 2002; 2002a) demonstrate how the two models are set up as dichotomies, in order to persuade the other of their 'truth':

Medical Model	Social/midwifery model
Doctor centred	Woman/patient centred
Objective	Subjective
Male	Female
Body-mind dualism	Holistic
Pregnancy: only normal in retrospect	Birth: normal physiological process
Risk selection is not possible	Risk selection is possible
Statistical/biological approach	Individual/psycho-social approach

Biomedical focus	Psycho-social focus
Medical knowledge is exclusionary	Knowledge is not exclusionary
Intervention	Observation
Public	Private
Outcome: aims at live, healthy mother and baby	Outcome: aims at live, healthy mother, baby and satisfaction of individual needs of mother/couple

(van Teijlingen 2005: 4.1)

Some activist practitioners (Fielder, Kirkham et al. 2004) and academics (Annandale and Clark 1996; Foley and Faircloth 2003; Annandale 2009) have warned of the dangers to midwifery of persisting with such a dichotomy. Fielder and her colleagues argue that the value judgments inherent in such dualisms are based on 'othering', in which those who are considered 'unsafe' as opposed to 'safe' or who birth at home as opposed to in hospital are considered 'outside social norms for a particular group. The group can therefore deny responsibility, or it may be possible to subject the 'other' to 'therapy' in order to bring it back once again into the fold' (Fielder, Kirkham et al. 2004: 'Safe-unsafe', para. 1). In other cases, midwives may also resist norms by simply turning them on their heads to assign value judgments by which, for example, 'birth at home = good' and 'birth in hospital = bad'. It is difficult to imagine, however, that all midwives share the view that midwifery can and should be home-based or consistently woman-centred, altruistic and/or focused on 'love' rather

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than 'science' (Oakley 1999). Fielder and her colleagues' (2004) comment that

midwives identify other midwives as different to them, using categories such as:

> Experienced – Inexperienced
>
> Nurse-trained – Direct entrant
>
> Full-time – Part-time
>
> Highly educated – Highly skilled
>
> (Fielder, Kirkham et al. 2004: ''Opposites' and bullying', paragraph 2)

Aside from the work of Jane Sandall (1996; 1998; 1998a), Fielder and colleagues'

work is one of the only references to differences *amongst* midwives within the

academic and practitioner literature, rather than the ever-present focus on the

differences *between* midwives and other professional groups, such as nurses (Witz

1992; Davies 2002; Pollard 2003). Annandale and Clark (1996) argue that the

preoccupation with the differences between midwives and other professional groups

has an unintended consequence:

> A clear line of demarcation tends to be drawn in the literature between
>
> obstetrics and midwifery: each is portrayed as a unitary and internally
>
> coherent body of thought and practice which is at odds with the other
>
> (Rothman 1982; Oakley 1984; Graham and Oakley 1986). The 'alternative'
>
> female-midwifery is clearly put forward as the better model…Thus feminist
>
> work *tends to enter into complicity with male hegemonic culture by*

attributing to it the power which it gives itself (Annandale and Clark 1996: 29

and 30) (my emphasis).

This power dynamic is perpetuated further by the gendered nature of the

doctor/midwife relationship. Thomas (2007) describes a version of the 'doctor-nurse'

game (Stein 1978) in which some midwives flirted with doctors to try and get their

own way (Thomas 2007: 26) whilst others 'did not put themselves in the same

category' [as those flirtatious ones], 'presenting an impression of being able to act as

equals rather than inferiors' (2007: 26).

There is a vast array of literature on inter-group relations and 'othering' at work in

the psychology and industrial relations literature (see for example Haslam, Clare et

al. 2000; Haslam 2004). Whilst these disciplines fall outside the remit of this review,

I acknowledge their dominance in the field of group relations at work. Sociology,

particularly of health services, has had less to say on the topic in contrast to the

attention given to group identities and conflict within the fields of Organisational

Psychology and Industrial Relations. Existing sociological literature on 'othering'

and group identity in healthcare has looked at topics such as the 'othering' of

stigmatised service users by healthcare professionals (Johnson, Bottorff et al. 2004;

Chan 2009) or the pervasive othering of obstetricians by midwives (and vice versa) I

have already described. There have been a small number of studies dedicated to the

signs of 'othering' including rivalry, back-biting and 'horizontal violence', a term

first coined by Frantz Fanon (1963) and identified within nursing (Gerald 1997;

Thobaben 2007) and midwifery (Leap 1997a; Kirkham 1999).

The ideological division between midwives is one that has caused much

consternation amongst practising midwives and scholars. Some scholars have

suggested splitting the profession down ideological lines, forming two groups of

'midwives' (those who support the midwifery discourse) and 'obstetric nurses'

(those who would prefer to practise within an obstetric model) (van Teijlingen 1999;

Mason 2000-2001):

> Some midwifery practitioners accept obstetric standards as the "midwifery
>
> norm" and prefer the identity of an American style obstetric nurse-midwife
>
> who mediates involvement with women through machines and the
>
> pharmaceutical agents prescribed by obstetricians and anaesthetists. Others
>
> wish to develop autonomous midwifery practice that assists women and their
>
> families in unproblematic "bio-social" birth processes through skilful
>
> manipulation or "masterful" observant inactivity (Mason 2000-2001: 'The
>
> deterioration of midwifery', para. 3).

This debate draws once again on the *difference* between midwifery and medical

practice, which is here manifested in obstetricians, anaesthetists and 'American style

obstetric nurse-midwives'. The term 'obstetric nurses' has been deployed in a

derogatory fashion by British midwives when describing reproductive healthcare

practitioners who are not seen to be independent from medical control, instead described as 'handmaidens' to obstetricians (e.g. Cluett and Bluff 2006). The differences between nursing and midwifery are not presented as a binary as they are with obstetrics. However, both midwifery and childbirth activist literature has clearly pointed out the distinction between the two professions and a key theme of the discourse is that midwives are legally independent, autonomous practitioners, whereas nurses must work under the supervision of a doctor.

An identity independent from nursing

Nursing has a tradition of deference to medicine which was sustained through the early 20th Century, in part as a strategic move to continue to allow women to benefit from a career in nursing at a time when few other options were available to them (Jameton 1984). Midwives, who had practised independently from physicians, do not share this same history of obedience to, and dependence upon, medical practice (Kirkham 1996: 175). Midwives continue today to make this distinction between the two professions and despite the rise in the status and autonomy of nurses during the 20th Century, nurses are used as a foil against which midwives assert their status and independence.

The often disparaging attitude of midwives towards nurses is reciprocated. The demands of midwives, a small but vocal minority in the wider 'nursing' community, have not always been well received by general nurses. In an issue of *International Journal of Nursing Studies,* editors Norman and Griffiths (2007) wrote:

For those of us who work in the UK, the phrase 'don't forget the midwives!' is often heard and is wise advice to any nurse leader preparing to address an audience on many topics, lest s/he cause offence through omission. Adding the words '…and midwifery' to the end of pronouncements, which are in the speaker's mind really about 'nursing' is currently the politically correct response. (Norman and Griffiths 2007: 521)

In the same set of editorials, Thompson, Watson and colleagues (2007) bemoan what they see as midwifery's hypocrisy in its relations with nursing:

While simultaneously denigrating the connection, why does midwifery routinely identify itself with nursing to develop career pathways, to exploit research and development opportunities and to influence government and trades union policy? (Thompson, Watson et al. 2007: 523)

Midwifery's struggle for independence from nursing, as well as obstetrics, has implications for the use of nursing literature in laying a foundation for research into midwifery. The accusation that midwives exploit nurses' research opportunities could be seen as valid when so much of the midwifery literature draws on nursing theories. This 'piggybacking' on nursing research is controversial amongst a midwifery community, for whom an independent research culture is crucial to their professional development. Whilst midwifery shares many of the characteristics of

nursing identified by McCarthy and Deady (2008), it has developed a professional identity that is self-consciously distinct from nurses, further supported by the development and growth of 'direct entry' midwifery training within the UK, which means midwives are no longer required to also be nurses.

Using literature from other healthcare professions in midwifery research

This drive for a conceptual separation of the two professions is primarily an attempt by midwives to strive for professional self-regulation within the confines of a joint regulatory authority, the Nursing and Midwifery Council. Whilst midwives' professional discourse asserts that they have more individual *personal* autonomy in their work than nurses do, their experience at the level of *professional* autonomy, that is regulation, is somewhat different. Midwives have struggled to develop autonomy through self-regulation since they were first inaugurated as a profession in 1902. At first the profession was heavily regulated and controlled by medicine but today it is nursing that exerts a strong influence over the practice and regulation of midwifery because of their shared regulatory body, the Nursing and Midwifery Council founded in 2002 (which was formerly the *United Kingdom Central Council for Nursing, Midwifery and Health Visiting* (UKCC) from 1979-2002). When the regulatory bodies of nursing, midwifery and health visiting were combined in 1979, midwives found themselves in conflict with nurses over their professional needs (Davies 2002) and today remain very much in the minority, numbering 5.22% of the register (NMC 2008). This is why the elision of nursing and midwifery experience at an individual and a professional level is both controversial and potentially misleading in some

cases. Whilst many of the theoretical assertions made about nurses' work can also be applied to midwives, the differences in their relative clinical autonomy and midwives' care for 'healthy women' as opposed to 'sick patients' do challenge the cross-disciplinary applicability of some theories. This distinction has become all the more important since the instigation of direct entry training of midwives. Despite these difficulties, Rosemary Mander defends the use of nursing literature in midwifery research noting that 'nursing material is more relevant [to midwifery] than other non-midwifery material' (2004: 132).

A similar problem exists with midwifery literature from other countries. Systems of maternity care have developed in very different ways across the world (De Vries, Benoit et al. 2001; Benoit, Wrede et al. 2005; van Teijlingen, Wrede et al. 2009). In some countries (most notably the Netherlands and New Zealand) autonomous midwives practise almost entirely independently from doctors as the lead care providers for women during pregnancy and the perinatal period. In others, such as the UK, they work in partnership with doctors but have a long established legal independence which is heavily regulated by the state and recognised and largely supported by the medical community. Then there are countries such as the United States where midwifery (as opposed to obstetric nursing or nurse-midwifery) has remained outside of the mainstream system and midwives who are trained through informal apprenticeships almost exclusively attend births at home. In some states such lay midwives practice illegally and the education and regulation of midwives has not been adopted across all the States and only very recently in some provinces

of Canada. Whilst these differences mean that much of the midwifery literature from other Anglophone countries, particularly the USA, Canada and Australia is largely irrelevant in a British context, some of the themes are transferable. It is with these caveats in mind that I have chosen to selectively draw on both the nursing literature and midwifery research from international authors to provide a context for UK midwives' experiences.

Discourse vs. the reality of practice

The daily demand on midwives to negotiate the difference between the ideals of the midwifery discourse and the realities of practice has been named as a key reason why midwives leave the profession (Ball, Curtis et al. 2002; Hunter 2002; Hunter 2004). As Linda Ball and her colleagues wrote:

> Midwives are unwilling to practise the kind of midwifery demanded of them by the NHS, despite their desire to continue working as midwives (Ball, Curtis et al. 2002).

Hunter's work on the emotional labour of midwifery (Hunter 2000; 2001; 2002; 2004; 2005; 2006; 2010) focuses on this discrepancy between the ideal and the reality of midwifery practice. Hunter describes the difference as that between the midwifery enshrined in the discourse and the reality of practising midwifery within restrictions on resources, guidelines and legal scope of responsibility. Hunter explains how these different positions simultaneously demand that midwives be

'with woman': that is to be woman-centred, flexible, holistic and responsive to individual women's needs and 'with institution': that is attend to the needs of their employing institution. Hunter suggests that midwives' requirement to negotiate this conflicting demands to be 'with woman' and 'with institution', and the corresponding conflict in ideology between the two, is a key source of emotional labour for them (Hunter 2004). This finding is supported by the reports 'Why do Midwives Leave?' quoted above (Ball, Curtis et al. 2002), 'Why do Midwives Stay?' (Kirkham, Morgan et al. 2006) and their accompanying publications, (Curtis, Ball et al. 2006; 2006a; 2006b; 2006c; 2006d; 2006e).

Finlay and Sandall's (2009) article on Lipsky's concept of 'street level bureaucracy' as applied to midwives, explores the role of midwife-as-advocate within bureaucratic NHS institutions. Sandall and Finlay draw on the model of 'with woman' vs. 'with institution' to see whether improved continuity between women and midwives through a caseload practice model allows them to be better 'with women' and practise 'away from a people-processing model' (Finlay and Sandall 2009: 1230) of the institution. They acknowledge that for midwives working with little continuity of care 'it is arguably unsurprising that their allegiance was at times closer to the organisation and its needs to ration available resources, than to their individual clients' (Finlay and Sandall 2009: 1230) because they did not have the opportunity to build relationships with women and so had no particular desire to advocate for them (Liaschenko 1994). The midwives in all of these studies experience a discrepancy between their ideals of practice and the way they are required to practise. The

demands on them to work in a way which is incongruent with the midwifery ideal

come about because of resource constraints and norms of practice that have

developed amongst staff to defend themselves against the ideological conflict they

experience (Menzies 1960). Finlay and Sandall, for example, suggest that the

'standard-care' model may in fact provide protection for midwives against

demanding relationships with women (Finlay and Sandall 2009: 1231), an

unintended consequence that is rarely spoken about in other midwifery research.

Autonomy and accountability

Two of the most influential tenets of the ideology of midwifery are that midwives are

autonomous and accountable professionals. The accountability of midwives is

legally, as well as culturally, enshrined within the profession in the UK. It is

mentioned in the International Confederation of Midwives definition of a midwife as:

> A responsible and accountable professional who works in partnership with
>
> women to give the necessary support, care and advice during pregnancy, labour
>
> and the postpartum period, to conduct births on the midwife's own
>
> responsibility and to provide care for the newborn and infant (International
>
> Confederation of Midwives 2005).

And in the Nursing and Midwifery Council 'Midwives rules and standards', which

state:

You are accountable for your own practice and you cannot have that

accountability taken from you by another registered practitioner, nor can you

give that accountability to another registered practitioner (Nursing and

Midwifery Council 2004: 19).

The autonomy is, however, not mentioned in the legal documentation and yet is

frequently alluded to within activist literature (Ewing 2006) and indeed some

government recommendations (Department of Health 1993). This discrepancy

between the discourse of midwifery practice and its legal regulation suggests that

there may be a tension present for midwives in a similar way to the tension they

experience between the discourse of woman-centred, holistic care and the

bureaucratic reality of their work within the NHS.

Personal autonomy

Midwives' autonomy is explained in the literature as operating at two levels: the

autonomy of the individual practitioner, which I have termed 'personal autonomy'

and the autonomy of the profession as a whole: 'professional autonomy'. Personal

autonomy includes factors such as 'control over work pattern, managerial authority,

decision making; freedom of referral and scope of practice' (Sandall 1998: 222) and

professional autonomy is mainly measured by a profession's capacity to be

independent and self-regulating. This distinction is important because in some cases,

professionalisation strategies that aim to give professions greater autonomy have

unintended consequences for the autonomy of individual practitioners, particularly

those already vulnerable because they are part-time workers, less well educated, have domestic caring responsibilities or are of a minority ethnic group (Robinson 1993; Stock 1994; Sandall 1995; Sandall 1996) and there is no evidence to suggest that the situation has changed since the mid-1990s. In addition, nurses and midwives have been made more vulnerable by drives for professional autonomy, which leave them increasingly personally accountable for their actions (Annandale, Elston et al. 2004). An example of this has been the move towards greater continuity of care, caseload and team midwifery, which forms part of a wider professionalisation project to provide more woman-centred care and yet has been attributed to greater levels of exhaustion and burnout amongst midwives (Sandall 1998; Beake, McCourt et al. 2001).

Midwives have experience of compromises to both their personal and professional autonomy. The literature suggests that there are a number of restrictions on midwives' personal autonomy, including:

- Medical power (e.g. Arney 1982; Rothman 1982; Cahill 2001; Simonds 2002; Leonard 2003)
- Guidelines and protocols (Ledward 1996; Segaar, Bolman et al. 2007)
- Legal restrictions on the scope of their practice (De Vries 1996; Dimond 1998; Dimond 2006)
- A loss of traditional hands-on midwifery skills such as palpation of the foetus and use of a Pinard stethoscope (see Glossary) (Cowie and Floyd 1998)

- The effects of working within a large bureaucracy (Finlay and Sandall 2009; Phillips 2009: 61ff)

- Routinisation of work and a focus on the completion of tasks (Kirkham 2004)

Traditionally, it is medical power that has been labelled as the factor that most diminishes midwives' professional and personal autonomy. When medicine is set up as the antithesis of midwifery, this results amongst some groups in a 'simple' but also simplistic rhetoric which tends towards value judgements, for example 'midwives = good; doctors = bad', which then leads to a perception of doctors as perpetrators and midwives as their victims. The problem with attributing such power to doctors is that it implies that power is finite and something that doctors take from midwives, which leaves midwives seemingly little power to resist. This status as 'victim' is supported by the literature on the restrictions to midwives' autonomy, listed above, which cite factors that originate from outside of midwifery, reinforces this notion that midwives are powerless to change them. The second problem with this discourse of all powerful doctors is that it fails to take into account the ways in which doctors' own autonomy and power (both professional and personal) has changed in recent decades (Harrison and Pollitt 1994). The introduction of management structures that mimic the private sector, including a dramatic increase in the number of non-clinical managers in hospitals has worked to limit the power of doctors (Harrison and Pollitt 1994).

Aside from the introduction of business managers into NHS Trusts, one of the most significant examples of such reforms to limit medical power was the introduction of the National Institute for Health and Clinical Excellence (NICE) in 1999. NICE was set up in an attempt to standardise treatments available to patients on the NHS across England and Wales. They have published a series of guidelines on the appropriate treatment of a large number of health conditions and on the care of women during pregnancy, birth and the post-natal period. Other governance processes have since continued to reinforce the dominance of NICE. The Clinical Negligence Scheme for Trusts (CNST) regularly assesses Acute Trusts on their risk management processes, grading them Level 1, 2 or 3 according to their performance in areas such as risk management, staffing levels, guidelines development, record keeping, incidents and training needs (NHSLA 2010). Achieving Level 1 in the assessment gives Trusts a discount of 10%, Level 2 20% and Level 3 a discount of 30% on their premium for insurance against litigation.

For CNST, Trusts are required to have comprehensive risk and governance processes in place and clinical guidelines that are deemed 'appropriate' by the NHS Litigation Authority, who require concordance with NICE Guidelines as a minimum requirement. Whilst most acute services are assessed collectively, there is a separate assessment for maternity, which intends to reflect the high level of litigation in maternity care. This puts obstetricians and midwives under disproportionate scrutiny compared to other health professionals, which has implications for their individual clinical autonomy. Thus the CNST process gives Trusts a financial incentive to

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follow NICE guidelines. This coincides with a managerial imperative for regular

appraisal of financial and clinical outcomes by the Care Quality Commission, which

includes an evaluation of the use of NICE guidelines within the Trust.

The use of external incentives (e.g. targets or financial rewards) to influence

individual practice has an impact not only on doctors but also on other healthcare

professionals, including midwives. McDonald and her colleagues (2007) found that it

was nurses, not doctors who were mostly required to use the templates, tick boxes

and forms, which are used not only to audit practice but also to regulate it:

> [Nurses] ...were aware that much of the box ticking had been delegated to
>
> them. Templates in the electronic medical records were valued by staff as
>
> reminders of what to do but were considered as particularly constraining by
>
> nurses, who had less discretion than the doctors over their use. Some general
>
> practitioners were quite explicit that the process of following protocols was
>
> delegated to nurses (2007: 1359).

Protocols and guidelines are not only used to standardise care and conform to the risk

management requirements of CNST, but also as a form of surveillance: 'not

following guidelines can be a reason for being reported to risk management for both

doctors and midwives and to supervision for midwives' (Stephens 2007: 146). This

evidence suggests that whilst the legislation that has been put in place affects all

NHS employees, nurses and midwives are likely to experience a greater impact on

their individual autonomy because they lack the professional autonomy of doctors, which allows the doctors to adopt the measures selectively at the level of the individual practitioner.

Professional autonomy

The shift in power from doctors to managers within the NHS has not always reflected in the traditional rhetoric about midwifery's poor status and 'powerlessness' in the face of medical dominance. This tendency to attribute power to doctors is likely to be a result of midwives' long fight for the right to regulate and educate themselves that I have already described. Following the 1902 Midwives' Act, the Central Midwives' Board of the time, which regulated the profession, contained one representative for midwives who was required to be a doctor and the chair of the Central Midwives Board was not a midwife until 1973 (Park 2005).

'Autonomy' at the level of practitioner and of profession is understood as a key quality of midwifery but despite the importance given to autonomy within the formal and informal midwifery professional discourse, its translation into practice is not without problems. Clarke (1996) and Ledward (1996) both argue that the profession of midwifery is not in fact autonomous but exists under the *illusion* that it is. Clarke writes:

> Deep in the psyche of midwifery lies the myth of the independent,
> autonomous practitioner. Belief in this myth is the result of a fractured

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reflection of midwifery's perception of itself which is rarely, if ever, questioned by midwives…. The contrast between the myth of professional freedom and the observed control of midwives by the state, through employers and medicine, exposes the fallibility of the midwife's beliefs about her autonomous status in 20th Century child-bearing. (Clarke 1996: 205)

According to Clarke, the effect of this 'myth' is that midwives are required, by their regulatory body, to be highly accountable for their actions but they lack the corresponding professional autonomy to be able to do this. This tension makes them vulnerable to scrutiny and reprimand by the Nursing and Midwifery Council, the same body that Clarke argues has put them in the situation in the first place.

The Code [of Professional Conduct] is fundamentally flawed and therefore unethical for the following reason – it is based on the unwarranted assumption that midwives are autonomous practitioners professionally, clinically and morally…[the UKCC, now the NMC] justifies the imposition of the Code's principles upon them [its midwives] in an environment where the employers prohibit their freedom to act on them. (Clarke 1996: 219)

Accountability

In her chapter on accountability in midwifery, Rosemary Mander (2004) explains that, unlike nurses, midwives have spent little time explicitly considering their accountability, instead, preoccupying themselves with concerns about their autonomy. In fact, as Mander argues, these two factors are very much intertwined.

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She too spends much of the article appearing to use the term 'accountable' where it could be readily replaced with 'autonomous', for example, in reference to the existence of the *Midwives' Rules* and *Code of Practice*, she writes 'such a framework causes one to question the extent to which the midwife is truly accountable' (2004: 137) where it is clear that such a framework primarily affects midwives' autonomy.

Mander defines four aspects of midwives' accountability: accountability to their employer, to themselves, to the women in their care and to their profession (2004). She suggests these accountabilities form a hierarchy from personal accountability at the top, to organisational accountability at the bottom. Whilst she acknowledges the way midwives are frequently and publicly held account to their organisation, she still persists in writing that this accountability 'pales into relative insignificance compared to personal accountability' (2004: 137) by which she means a midwife's accountability to herself. I would argue that these different accountabilities cannot be so neatly put into a hierarchy. Whilst accountability to their employing organisation may not be a central part of midwives' collective identity, it is a feature of their every day experience at work in the NHS. Shirley R. Jones (1994) also lists midwives' accountabilities as those to the family, the UKCC (the regulatory body, here in effect acting as a proxy for 'the profession'), to her employer, and to herself and like Mander she does not mention, for example, any accountability to the law. In her description of a midwife's obligation to her employer, Jones fails to recognise possible conflicts between the demands made by the employer and her professional obligation to women:

A midwife is contracted to carry out the duties for which she is employed in accordance with the statutory rules and codes; also, she must adhere to the policies within the employing authority. Any breach of duty to the woman and/or baby in her care could be considered to be a breach of contract, thus resulting in possible dismissal (1994: 56).

In reality, the tension between midwives' accountability to their profession (and to women), and that to their employer has been the source of a number of well-publicised disciplinary proceedings for midwives. In these cases, despite carrying out duties 'in accordance with the statutory rules and codes', midwives have been dismissed for failing to follow the rules of their employing authority. One example was midwife Paul Beland, dismissed by Peterborough & Stamford Hospitals in 2004 for attending a woman at home whilst his employing Trust had suspended their homebirth service. Whilst his professional obligation remained to attend the woman wherever she chose to give birth, he was disciplined for failing to follow the Trust's order that homebirths were not to take place.

All of this debate presupposes that autonomy is unquestionably good for midwives and there is little acknowledgement or critique of this taken for granted position. For example, in a survey about role redesign for midwives in the NHS, Peter Prowse and Julie Prowse asked midwives for their response to the statements: 'development of new roles will give midwives more autonomy' and 'changes to the way midwives

work in the future will give them more autonomy' (Prowse and Prowse 2008: 703) both of which presuppose that autonomy is something to aspire to, even if midwives might believe it is unrealizable. Individual midwives may not wish for the kind of responsibility which comes from having autonomy (and accountability) at work and evidence suggests that increased autonomy also brings with it higher levels of stress (Sandall 1999).

Katherine Pollard (2003) has produced the only empirical study to date on midwives' perception of their own professional autonomy and her findings mirror many of the discussions found in the wider literature. The midwives Pollard interviewed identified hospital policies, medical guidelines and the hospital hierarchy as key barriers to their autonomy, and many felt that working alone was the only way in which midwives could work autonomously. Only two of the midwives actively viewed autonomy as a state involving collaboration with other professionals (2003: 118). Pollard argues that midwives' inability 'to understand and consolidate their professional autonomy, particularly in terms of inter-professional collaboration and control of their own practice has contributed to this failure [of their professional project]' (2003: 120). If midwives aspire to be autonomous, as their professional discourse would suggest they do and their colleagues are perceived as barriers to their autonomy and their professional project, then this could adversely affect their inter-professional relationships.

What is particularly interesting about Pollard's discussion is that it begins to make clear the clinical safety implications of such an attitude towards autonomy. Pollard noted that her midwife colleagues 'appeared to interpret the nature of professional autonomy inconsistently, and in some cases...put themselves at professional risk by doing so' (2003: 115) but she does not acknowledge the potential risks to women and babies of poor relationships between midwives and obstetricians (Opoku 1992). She writes that increased midwife autonomy would result in 'better care for service users' (2003: 116) but does not recognise the potential risk to women and babies of being cared for by midwives who, in order to gain 'more job satisfaction and confidence' and professional recognition, may wish to work in isolation from their obstetric colleagues. The feeling amongst midwives that they can only practise autonomously when working independently from others is reflected in Hally McCrea and Valerie Crute's (1991) study of the midwife/client relationship, in which the midwives explained that they could develop closer relationships with women when they were able to practise more autonomously and that this was particularly possible at night when other professionals were not around.

One of the most important preconditions of midwives' autonomy identified by Pollard is that 'midwives have the authority to make and act upon decisions within their sphere of practice' (2003: 116). It is doubtful, of course, that this level of autonomy is ever possible as there are so many factors which prevent midwives from having the authority to act upon their decisions: for example, statutory professional control, medical professionals, women's preferences, Trust protocols and guidelines,

the limits of their knowledge, legal restrictions and limited resources. Much of the literature describing such restrictions on midwives' autonomy positions them as detrimental to the progress of midwives' professional project (Mander and Fleming 2002). Only Clarke (1996) and Ledward (1996) have written that these factors rightly and properly constrain midwives who should not (and can never) have unlimited control over women's treatment. The problem therefore might not be midwives' lack of autonomy or accountability, but that there is such a discrepancy between the 'myth' and the reality. There is also a question to be asked as to the implications for midwives of working in places where they might be expected to have greater clinical autonomy, for example in midwife-led units or community practice.

Grandey and colleagues (2005) write that a sense of personal control makes people better at managing situations which may otherwise lead to distress. Furthermore, it provides individuals with resources to resist the most distressing effects of controlling, regulating or performing their emotions at work:

> Directly, a sense of control or autonomy provides affective, motivational and cognitive resources, such as positive moods, intrinsic interest, and focused attention, respectively. Indirectly, personal control has been shown to have a buffering effect against threatening or draining situations. Personal control thus provides resources that compensate for situations that would otherwise be draining or depleting (Grandey, Fisk et al. 2005: 3).

The existing literature presents a scenario in which midwives have a clearly defined and pervasive rhetoric that provides them with (largely unspoken) cultural rules about how they should practise. Not being able to practise in this way, including an inability to respond 'appropriately' to situations, is a source of distress and frustration for many midwives, to the point that some of them leave midwifery altogether. Those who stay, however, must find strategies for managing it adequately, either because they wish to continue to practise as a midwife, or because the potential costs of leaving: such as unemployment, job insecurity, the loss of NHS employee benefits or a requirement to relocate, are unsupportable to them. The question is then: how do midwives working in the NHS sustain their confidence and personal autonomy (whether real or perceived) so that the benefits of staying in midwifery continue to outweigh the costs of leaving?

Part II: Situating midwifery in the social science literature

Power and control

Many midwifery scholars have found, in conversation with midwives, that it is midwives' opportunities to build close relationships with women which is a key source of satisfaction with their work and an opportunity for women to gain control over their labour and birth (Sandall 1997; Kirkham 2000a; Hunter 2002; 2006; Kirkham, Morgan et al. 2006; Walsh 2007). However, there appears to be a collective shyness within the midwifery profession about discussing the power inequalities present in the midwife-mother relationship and the ways in which

midwives may seek control. An enormous amount has been written about the

negative aspects of the power dynamic between midwife and doctor (e.g. Donnison

1988; De Vries and Barroso 1997; Evendon 2000; Pinki, Sayasneh et al. 2007) and

between midwives (Kirkham 1999) but analyses of the midwife-mother relationship

have tended to hold back from exploring the inevitable cultural power inequalities of

the relationship. Differences of class, race, age, educational level and occupational

skill can all influence the dynamic of the relationship between a worker and a client

or patient (Twigg, Wolkowitz et al. 2011) and midwifery is no different. The power

dynamics at play in healthcare are particularly complex because the status for skilled

professionals, including midwives, which comes from education and technical skill,

can also be lost through the effects of sexism, racism (Kyriakides and Virdee 2003;

Alexis and Vydelingum 2004) and the polluting influence of 'dirty work' (Shildrick

1997; Lawton 1998; Ashforth and Kreiner 1999; Bolton 2005).

Recognition of the *difficulties* inherent in the relationship between midwife and

mother tend to attribute blame to, 'the context in which care is given … dominated

by industrialized and fragmented models of maternity care that are far from

conducive for relationship formation' (Hunter, Berg et al. 2008: 133-134) rather than

social inequalities and prejudice. Furthermore, whilst Hugman (1991) writes

explicitly that '[caring] professionals seek to control the client/patient, not only in the

form of power exercised over individuals, but also to the extent of the capacity to

define who and what a client/patient is and should be' (Hugman 1991: 113), similar

analyses of this relationship within midwifery have not explicitly acknowledged the

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potentially destructive or controlling nature of the relationship. Midwives are reluctant to talk about the ways in which they may seek to control women either because they rarely do so, or because it is antithetical to the woman-centred ideology of the midwifery professional discourse and is therefore taboo. This is a question which requires further exploration. In order to do this, Part II of the chapter focuses on the material reality of midwives' work and how this then intersects with the ideological discourse I have discussed in Part I. Here I will choose three areas of social science literature that are most relevant to midwifery in order to provide a sociological context for the exploration of midwives' daily experience of discourse, relationships, cultural norms and taboos that follows later in the thesis.

The work of Hunter (e.g. 2004), Ball and her colleagues (2002) and Kirkham (1996) has suggested that midwives, particularly those who work in hospitals, experience a tension between the demands of the women in their care and the institution in which they work. In order to provide a theoretical backdrop to an ethnography of midwives' work, it would seem necessary then to explore both the literature that relates to midwives' experiences of being 'with women' *and* the literature on the influence of the employing NHS trust: the 'institution' of Hunter's 'with institution' model. As I have shown in Part I, it is the institution, not the women, which is predominantly blamed for not allowing midwives to practise according to their ideals because of, for example, the institutional bureaucracy, NICE guidelines, Trust protocols, resource constraints and so on. The literature I have reviewed has also suggested that midwives lack the personal (and professional) autonomy that would buffer them

against the worst effects of their work and so in order to continue practising, they must devise coping strategies to manage their and others' emotions. This second part of the chapter looks at the literature within these three areas:

Emotion: The emotional labour of midwifery;

Space: Midwifery within institutional spaces, and;

Bodies: Midwifery as body work.

Emotions: The emotional labour of midwifery

The Sociology of Emotions

There are any number of collections on the Sociology of Emotions, providing both a theoretical review, for example Turner and Stets (2005), and more empirical work on the role of emotions in society, such as Williams and Bendelow's (1998) edited collection, which contains sections on emotions in cyberspace, lifecourse research, personal relationships, and health. The study of emotions in work and organisations began in earnest with the publication of Arlie Hochschild's (1983) study of the emotional labour of flight attendants and debt collectors. Her thesis was that emotion work, which has use-value within the private sphere, when elicited and managed as part of the wage contract, becomes emotional labour. It is given an exchange value and has thus become a requirement for successful employment in the service sector. The flight attendants in Hochschild's study were required as part of their jobs to self-consciously perform appropriate emotion in turn to elicit an emotional response in their clients: 'the induction or suppression of feeling in order to sustain an outward

appearance that produces in others a sense of being cared for in a convivial, safe place' (1983: 3).

The exchange value of emotional labour extends beyond the airline industry to other kinds of service industry work, for example beauty therapy (Sharma and Black 2001), sex work (Oerton and Phoenix 2001; Sanders 2005) and funeral care (Hyland and Morse 1995). This emotional labour is also identifiable within those industries which, in the UK, do not involve the exchange of money directly between organisation and client, such as NHS healthcare (Theodosius 2008). In these contexts, the exchange value is not directly coerced by the employer but in the continuation of the worker's employment and more recently in the assessment of the standard of services by the government, for example the Care Quality Commission's regular reviews of NHS Trusts' performance.

Later work on emotional labour, particularly that of Sharon Bolton and her colleagues, have critiqued Hochschild's thesis for putting too much emphasis on the divide between the private and public performance of emotion work/labour at the expense of a more complex analysis (Bolton 2005a). Furthermore, Bolton and Boyd's (2003) own empirical research with flight attendants suggested that they may not experience as much distress from the management of the dissonance between their felt and enacted emotions as Hochschild proposed. This might, as Carol Wolkowitz (2006) has proposed, be because workers have become increasingly skilled at such emotion management since it has become a key requirement of

service sector work during the twenty years since *The Managed Heart* was published.

Emotions in Nursing

There has been extensive attention given to the emotional labour of nursing, (see for example Hutchinson 1984; Smith 1992; Lee-Treweek 1996; Phillips 1996; Woodward 1998; Bone 2002; Savage 2004; McClure and Murphy 2007; Evans, Pereira et al. 2008; Theodosius 2008). Deborah Bone's (2002) article on emotion work in nursing gives a good account of the particular emotion work experienced by nurses in the United States, which is applicable also to nurses and midwives in the UK. Her analysis considers the effects of working under increasingly tight time constraints on nurses' abilities to tend to the time-consuming emotional needs of patients. One nurse in Bone's study commented that:

> There's no substitute for taking time. Time is the key. You learn how to do a technique fast…but no matter how you have it down with meeting the emotional needs of a patient, it's paced by the patient (2002: 145).

This need for work to be 'paced by the patient' was in tension with Bone's observation that 'in institutional settings such as hospitals, patient care activities have long been organised into routines that manage the time or individuals, impose social order and privilege linear, clock time' (2002: 145). There is a dissonance here between the needs of the patient for emotional support and the needs of the

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institution to complete nursing tasks in the most efficient way possible. In most service sector employment, as Hochschild (1983) and others have noted, employers demand and expect emotional labour from their employees; Hochschild's flight attendants were 'constantly reminded that their own job security and the company's profit rode on a smiling face' (Hochschild 1983: 104). Bone's study suggests it is the first facet of care to go when time pressures are too great. It is distressing for nurses and midwives not to be able to perform emotional labour (or to be forced to do it efficiently but inadequately) because it is a fundamental part of their identity as professionals.

Whilst NHS hospitals will continue to function with or without the adequate emotional support of patients, the quasi market that has been imposed on the NHS through 'Choose and Book' may force Trusts to demand more emotional labour from nurses and midwives. A King's Fund Report (Dixon, Robertson et al. 2010) on patient choice in the NHS found that patients ranked 'friendliness of staff' and 'quality of care' before distance to travel, length of waiting list or 'the consultant of your choice' (2010: 70).

Emotions in Midwifery

Unlike nursing, relatively little attention has been given to emotional labour in midwifery. Penny Curtis' (1991) PhD entitled 'Midwives in hospital: work, emotion and the labour process' was an early account of midwives' emotional experiences at work but written before the rapid development of theory on emotional labour which

occurred during the 1990s and 2000s. Jane Sandall's early work on stress and burnout in midwifery (Sandall 1997; 1998; 1998a) helped to lay the foundation for the study of emotional labour in midwifery, by exposing the both difficult and rewarding emotional experiences of midwives managing relationships with colleagues and the women in their care whilst juggling shift work and their unpaid labour in the home. Similarly, other work on 'stress' (Davis and Atkinson 1991; Mackin and Sinclair 1998), has acknowledged the often invisible emotional facets of midwifery work whilst Deery has explored the paucity of emotional support available to midwives (2005).

Despite the significant body of literature on emotional labour in service professions and in nursing, until the early 2000s there had been little attention paid to how it is performed by midwives. In the ten years since, many more scholars have turned their attention to the emotional work of midwifery (Hunter 2010). Many academics have and continue to look specifically at midwives' and nurses' responses to grief at perinatal losses (Mander 1994; Downey, Bengiamin et al. 1995; Gensch and Midland 2000). However, 'normal' births are also emotionally demanding for midwives, either because normally labouring women may require or demand a significant amount of emotional support or because midwives may feel uneasy about being with women in pain (Leap 1997; 2000). Deery and Fisher's (2010) recent article has suggested that whilst the emotional labour involved in midwifery is draining and difficult for midwives, it may also be countered by 'philathropic emotion work' through which midwives express genuine emotions of care brought about through

emotional attachment to women. If the circumstances for such rewarding modes of emotion work are supported by employers, then midwives may seek fewer opportunities to avoid such demanding (if rewarding) interactions with women (Deery and Fisher 2010: 283).

Billie Hunter has provided the most comprehensive work to date specifically on emotional labour in midwifery (Hunter 2000; 2001; 2002; 2004; 2006; 2008a) although, as she notes, many other studies of service delivery and organisation have unexpectedly 'discovered' midwives' emotion work (e.g. Stevens and McCourt 2002; Dykes 2005; Hunter 2010: 257). Hunter's doctoral project (2002) explored the differences between the experiences of hospital and community midwives' emotional labour at work and of newly instigated 'integrated' team midwives who worked both in the community and in hospital. Hunter found different experiences of emotional labour amongst each group. Many of the hospital midwives found satisfaction in juggling the tasks needed to complete their work by the end of a shift. Others, such as novice and integrated team midwives were frustrated with such task-based hospital work. They experienced a tension between their ideals of practice (to be 'with woman' in accordance with the prevailing midwifery discourse) and the conflicting demands which were made on them by their employing institution (the requirement for them to be 'with institution'). The resulting tension between ideals and practice led to 'a variety of negative emotions, such as frustration, anxiety and anger, which required emotion work' (Hunter 2004: 266). The midwives deployed strategies such as 'finding emotional rewards in collegial relationships and doing

"real midwifery" wherever possible' (2004: 268) in order to try to restore emotional balance. The community midwives, on the other hand, felt better able to work in a way that was congruent with the midwifery discourse and so experienced less emotional distress and required less accompanying emotional labour in order to manage it. Although community midwives' work was emotionally demanding, it was not emotionally *difficult*. Hunter (2004) suggests that the ideological conflict in hospital midwifery could account for the tendency amongst midwives to divide themselves into ''us and them' groups on the basis of ideology' (Hunter 2004: 270).

Billie Hunter's findings mirror quite closely those of Ashforth and Humphrey (1993) who reviewed the occupational identity literature as part of a study of emotional labour in service roles. They proposed that:

> If emotional labor is consistent with a central, salient, and valued social and/or personal identity (or identities), it will lead to enhanced psychological well-being.

But

> If emotional labor is inconsistent with a central, salient, and valued social and/or personal identity (or identities), it will lead to emotive dissonance and/or a loss of one's sense of authentic self.

> (1993: 100-101)

According to this model, the emotional labour that is done by midwives in response to caring for women during normal labour would be an example of that which is consistent with a 'central, salient, and valued social and/or personal identity', whereas that which is done in order to manage the conflict between the 'with woman' ideal and the 'with institution' reality is inconsistent and therefore a source of 'emotive dissonance'.

Moral distress

The concept of 'moral distress' can further illuminate the relationship between discourse and reality in midwifery and the effects of 'emotive dissonance'. As I have suggested, the midwifery discourse presents midwives with a powerful and persuasive ideal of their work. It gives them a model and privileges certain practices, for example endorsing women's desires in order to provide woman-centred care. However, there are a number of reasons why fulfilling a woman's desires may be impossible for midwives, even if they would like to: a contraindication in Trust guidelines; a legal requirement to transfer the woman for medical care; pressure from other midwives to respond in the 'usual' way to a situation or a lack of facilities, for example a birthing pool which is out of service or a lack of epidural anaesthesia because the physician is busy.

The concept of 'moral distress' focuses on scenarios in which healthcare professionals cannot carry out what they believe to be the right course of action.

McCarthy and Deady (2008) define moral distress as the distress that comes about when:

> Individuals make moral judgements about the right course of action to take in a situation, and they are unable to carry it out. In short, they know what is the right thing to do, but they are unable to do it; or they do what they believe is the wrong thing (2008: 254).

Existing work on moral distress is dominated by accounts of nurses' experiences in different branches of the profession including psychiatric nursing (Lutzen and Schreiber 1998), general and acute care nursing (Wilkinson 1987-1988; Hylton Rushton 1992; Jameton 1993; Sudrin-Huard and Fahy 1999; Raines 2000; Corley 2002; Peter, Lerch Lunardi et al. 2004) and perinatal nursing (Tiedje 2000). McCarthy and Deady (2008) question why moral distress has such resonance for nurses compared with other professions and suggest that this might be because of their position in the clinical hierarchy, their status as a predominantly female group and, as Peter and Liaschenko (2004) have proposed, because they are the professionals in closest physical proximity to patients.

This analysis of distress in spatial terms may well shed light on the differences between midwives' experiences in different kinds of workplaces which give then different opportunities for emotional and physical proximity to women. Joan Liaschenko (1994; 1996; 1997; 2003), Peter and Liaschenko (2004) and Ruth

Malone (2003) provide an explicitly spatial analysis of moral distress. Malone's

premise is that the physical proximity between nurse and patient is the first of three

'nested' proximities between nurse and patient. Physical proximity and touch bring

about a 'narrative proximity' in which the nurse (or midwife) comes to know the

patient/birthing woman through listening to her story, which then leads on to a *moral*

proximity in which 'nurses encounter the patient as other, recognize that a moral

concern to 'be for' exists, and are solicited to act on a patient's behalf' (Malone

2003: 2318).

Malone (2003), Peter and Liaschenko (2004) and Fannin (2003) propose that nurses

have a moral obligation to act as advocates for patients in the face of competing

threats from biomedicine as represented by doctors. Peter and Liaschenko (2004)

argue that caring for patients in hospitals prevents nurses from carrying out this

obligation because they are obliged to be the eyes and ears of the doctor at the

bedside and are therefore required to prioritise biomedical surveillance. The presence

of nurses (and midwives) at the bedside allows doctors to be released from the

patients' side. Peter and Liaschenko suggest that shortages of time and space in

hospital:

> Decrease the energy nurses have for the emotional work of attunement and
>
> engagement. In such situations, proximity's capacity to engender moral
>
> sensitivity and action can be curtailed (2004: 220).

This offers another perspective on the connections between moral dilemma and retention in nursing, which can also be applied to midwifery. Corley (2002) writes that leaving nursing is a consequence of moral distress brought about by institutional constraints. Nurses who are left with little energy to fulfil their moral obligations to patients may avoid them by staying away from patients. The further they are physically from the patient, the less the emotional tie, which may inevitably lead to them leaving nursing:

> After all, leaving nursing can be viewed as an ethically and socially acceptable mechanism to escape from the demands of proximity the provision of temporary escapes, through more frequent breaks and quiet places away from patient care, may be ways to support less extreme responses to the distresses of proximity (Peter and Liaschenko 2004: 223).

Space: Midwifery within institutional spaces

Space and place in the midwifery, medical and sociology literatures

Midwifery scholars and social scientists have both addressed issues of space and place in birth. To date this interest has mainly been incidental to other concerns such as women's choice of place of birth (Campbell and Macfarlane 1994; Young, Hey et al. 2000) or the development of midwife-led services outside of obstetric units (e.g. Wax, Pinette et al. 2006; Walsh and Downe 2004; Hodnett, Downe et al. 2005; Mohajer, Hughes et al. 2009; Rowe 2010). Other work in this area has focussed on midwives rather than women and explored at the effects on midwives of working in

the community (Hunter 2002; 2004) or midwife-led (Ledward 1996; Hunter 2003; Kirkham 2003) as compared to consultant-led units. The relative personal autonomy of midwives in each of these workplaces has been a central concern for many, and the evidence from Hunter's work is representative of the findings from other studies, which have suggested that when midwives worked in consultant-led units:

> In addition to feeling geographically dislocated, as noted in other studies (Ball et al. 2002) ... their autonomy was compromised and it became difficult to maintain a natural, woman-centred approach. (Hunter 2004: 169)

In addition, much of the wider work in healthcare that has explored problems of space and place, has done so whilst focussing on workplace relationships, for example healthcare professionals' relationships with managers (Garelick and Fagin 2005) and midwives' relationships with junior doctors (Pinki, Sayasneh et al. 2007), support staff (Sandall, Manthorpe et al. 2007; Prowse and Prowse 2008) and labouring women.

Just as the research on inter-professional relationships has explored the power dynamic inherent in hospital hierarchies – and the extent to which midwife-led spaces overturn that hierarchy – so the literature on the midwife-mother relationship has also looked at the relationship between place and power. Shaw and Kitzinger (2005) and Davis-Floyd and Davis (1996) are among scholars who have suggested that women feel more in control of their birth at home or in home-like settings such

as birth centres. One reason given for this feeling of control is that at home the woman has the higher status of 'resident' and the midwife is constructed as a 'visitor', whereas in hospital these roles are reversed (Halford and Leonard 2003: 205). Following this, Gilmour writes that transforming hospital spaces so they are more home-like therefore challenges the dominance of biomedical values (2006), a claim which is disputed by Maria Fannin who argues that it is presumptive to assume that making a hospital space more like a home will fend off the controlling influence of biomedicine (2003). Others have also been critical of the assumptions which underlie the discourses of pro-homebirth academics and activists. The discourse of home = control assumes that women have agency in their own homes, which is not always the case: 'home does not signify autonomy and bodily control for all women, nor is domestic space always the safest place for women' (Mitchie 1998: 262). This discourse also tends to present power as if it was a zero sum game and could be possessed at any point either by the woman or by the healthcare professional.

Health Geographies

As it is the discipline of Geography that has put space and place into the social science agenda it is therefore central to any work, such as this, which itself privileges the effects of space and place on people's lives. There is little literature by geographers on maternity care but the literature on geographies of nursing, like that of health and medicine, is growing rapidly. Medical and Health Geography has addressed matters such as community access to health care services (Powell 1995), the spatial distribution of disease and the effects of space and place on health and

Health Geographers' turn towards the role of space and place in healthcare organizations has occurred alongside a change in the wider conceptualization of place from an 'unproblematized activity container' (Moon 2009: 39) to 'a socially constructed and complex phenomenon' (Kearns and Moon 2002: 609).

Andrews and Shaw (2008: 464) provide a comprehensive review of existing literature in geographies of healthcare and identify five areas of focus within the literature: community knowledge networks, the spatial distribution of people, disease and mapping; the effects of space and place on the development of professional specialties; the relocation and migration of healthcare workers both nationally (Radcliffe 1999) and internationally (Kingma 2006); the effect of space and place on professional-patient and inter-professional relationships; and the roles of space and place in the 'production and translation of clinical evidence' (Andrews and Shaw 2008: 464). Andrews has written a number of introductory 'manifestos' for the Geography of Nursing (Andrews 2002; 2003; 2006; 2008) which explore the role of space in healthcare organisations.

Work on the geography of healthcare organisations is particularly relevant to a comparison between spatially differentiated case studies. The concept of the 'therapeutic landscape' (Gesler 1992) has been central to the work of health geographers and begins to tease out the relationship between space, design, architecture and ideologies of health and healthcare. Therapeutic landscapes,

including for example spas, mountain retreats, a traditional healer's hut or a hospital ward, are defined as spaces that are:

> Those changing places, settings, situations, locales, and milieus that encompass both the physical and psychological environments associated with treatment or healing; they are reputed to have an enduring reputation for achieving physical, mental, and spiritual healing (Williams 1998: 1193).

Academic work on therapeutic landscapes has not only explored the way in which particular outdoor places are culturally imbibed with notions of healing, but also how, for example, hospitals are designed, decorated and built to promote health (Burges Watson, Murtagh et al. 2007). Contemporary interest in the design of hospitals has applied the principle that a therapeutic landscape is not only one that is outside, but may also be brought into an institution, and that 'the hospital, rather than being a place of scientific inquiry removed from everyday life, is conceptualised as the home place for its inhabitants' (Gilmour 2006: 19).

Hospital developers, fueled by the drive to build new hospitals though Private Funding Initiatives (Gesler, Bell et al. 2004) have sought to design hospitals that promote the healing and wellbeing of patients. Aside from the architecture of the hospital building itself, the introduction of visual art into hospitals (see Lankston, and Cusack et al. 2010 for an evaluation of its benefits) is one example of the way in which designers have attempted to make hospitals into therapeutic landscapes. These

interior designs have particularly focused on integrating 'nature' (see Conradson 2005 and Lea 2008) and 'home' (Gilmour 2006) into the institutional space because they are two arenas strongly imbued with the qualities of a therapeutic landscape.

This trend towards designing hospital wards as 'home-like' spaces assumes (problematically) that the home is a therapeutic landscape for all women, whilst also allowing them to birth within a hospital environment that is specifically *away* from the home: where those tools that are culturally assumed to improve safety, such as medicines, doctors and monitors are readily available. This 'hybrid space' (Gilmour 2006) is a manifestation of a wider cultural conception of childbirth as both a normal life event (e.g. Foureur, Davis et al. 2010: 521) *and* inherently risky and in need of medical assistance (see Hausman 2005 for a discussion of the discourse of obstetric risk).

Bodies: Caring for birthing women

Studies on body work have undergone a shift in recent years from looking at the work people do on maintaining and decorating their own bodies (Gimlin 2002), to work done on the care and maintenance of other people's bodies by trained body workers (Twigg 2000; Wolkowitz 2006). This change in focus to work done on the self, to that on other people has also introduced necessary analyses of the complex interplay of work and intimacy between worker and client. Whilst conventionally, intimacy and work have been seen as part of the separate areas of private relationships and employment (Wolkowitz 2006), those who work with bodies have

to negotiate constantly their relationships with others when doing work which involves intimate procedures on strangers.

Debra Gimlin's (2007) comprehensive review of the existing literature describes four definitions of body work:

1   Body/appearance work

2   Body work as labour

3   Body/emotion management, and;

4   Body-making through work.

In this section I will focus on the second of these definitions: 'body work as labour', which most closely represents the work of midwives, although other kinds of body work, for example 'body-making through work', e.g. the process of gaining embodied knowledge are also relevant (Davis 1995; Davis-Floyd and Davis 1996; Sternberg and Horvath 1999; Stewart 2005a). I will situate midwives within the existing debates on some key themes in the literature on body work: the concept of 'dirty work', touch and sexuality.

Dirty Work

Gimlin's (2007) discussion of 'body work as labour' focuses on 'dirty work', that is work dealing with unclean bodies and taboo bodily excretions such as faeces, urine and sweat (Lawler 1991). Such ideas of 'pollution' have implications for the status

of those who work with bodies. Julia Twigg (2000) discusses how the hierarchies of

work in nursing are built up with respect to the extent of an individual's contact with

dirt. Her argument is that as nursing staff's careers progress, 'they move away from

the basic body work of bedpans and sponge baths towards high-tech, skilled

interventions; progressing from dirty work on bodies to clean work on machines'

(2000: 1). The move away from body work with a rise in job status shows that body

work, particularly 'dirty work', is situated at the bottom of work hierarchies (Lawler

1991). This reflects wider cultural taboos surrounding contact with bodily excretions

(Douglas 1966) that stem from a fear of 'leaky bodies' whose permeable boundaries

can be seen as a threat to individual identity and integrity (Shildrick 1997; Sontag

2002 [1978]; Turner 2003).

Moves by midwives to delegate the most physically intimate, dirty and

time-consuming emotional work of caring for birthing women to Maternity Care

Assistants is an occupational strategy that may demonstrate both the desire of

midwives to move up the clinical hierarchy and the status of such work low down

(Witz 1992). Sharon Bolton's work with gynaecology nurses demonstrates an

example of resistance against such a hierarchy by those engaged in 'dirty work'. The

gynaecology nurses subverted the hierarchy by 'reframing the stigma of 'dirty work'

as ennobling' (Bolton 2005: 182). The nurses' pride in their work was founded on

the value of 'women's work', a rejection of its low status and a revaluing of the

particular (often emotional) skills required for gynaecology nursing. The value they

placed on their intimate body work is set against (and above) what they saw as the

clean and more detached work of midwives (Bolton 2005: 177). This is a similar strategy to that employed by midwives to raise the value of their work against medical professionals, by emphasising how they, unlike obstetricians, build intimate relationships with patients (Hunter 2001).

Touch

Touch is an important technique of midwifery practice. Touch is used to palpate the position of the foetus and to determine cervical dilatation, two skills which midwives hold in high regard. It is also used to comfort women in labour and relieve the pain of contractions through the application of counter pressure on a woman's lower back. These two kinds of touch are described by Van Dongen and Elema in their discussion of the role of touch in nursing work: one kind of touch which is used for 'cleaning, washing, medical actions or taking someone's temperature'; and another which is 'about emotions, care, relationships, gender, intimacy, age, and well-being' (Van Dongen and Elema 2001: 150).

Considering the importance of touch in midwifery, it has been less explicitly explored in midwifery than in nursing and care work (e.g. Twigg 2000; Kirsten, Agnes et al. 2005). References to touch in midwifery have mostly been made in teaching textbooks (e.g. Johnson and Taylor 2005), and not subjected to a critical analysis. Basic midwifery skills such as palpation are highly regarded within the profession and midwives have bemoaned the loss of hands-on skills (Jacobson 1993)

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in the age of CTG monitors and ultrasound, which can measure the strength of contractions and foetal position without the use of touch.

However, when touch which is painful or socially awkward, for example during vaginal examinations, the ability to assess a woman *without* touching has come to be seen as an advanced midwifery skill (Hobbs 1998; Stuart 2000). Sookhoo and Biott (2002) write that midwives' ability to 'read' the body in pain *without* touching (again for example avoiding a reliance on regular vaginal examinations) is an indication of both their professional expertise and their ability to cope with uncertainty. Professional discretion in judging progress in labour is 'enhanced by increased proximity with clients over time' (2002: 76), where 'higher levels of [physical] intrusiveness can be associated with…conflicting midwifery responsibilities that reduce proximity between a midwife and intrapartum woman' (2002: 82). There is a difference here between an intimacy between midwife and women built up through comforting touch and physically intrusive care procedures, such as vaginal examinations, which are seen as an effect of a lack of connection between the carer and cared-for.

Sexuality

The 'problem' of sexuality at work has been addressed by a number of nursing scholars as part of a wider nursing education project reflecting the 'new nursing' ethic of therapeutic intimacy (Williams 2001) between nurses and patients (Webb 1985; Savage 1987; Lawler 1991; Meerbeau 1999). Pregnancy and birth, however,

are uniquely embodied and sexualised experiences which challenge the core of the pregnant woman's bodily integrity and independent selfhood (Schmied and Lupton 2001). They also include the involvement of strangers in what is constructed as the personal, private, sexual and intimate act of birth, yet there is almost no literature on sex and sexuality in midwifery, apart from that addressing the specific needs of lesbian clients (Stewart 1999; Wilton 1999; Wilton and Kaufmann 2001).

This absence may reflect the de-sexualisation of acts of diagnosis or treatment which would be deemed sexual in other contexts (Meerbeau 1999). Ironically, de-sexualising such acts, while avoiding shaming the patient, may depersonalise them by isolating their constituent body parts in order to minimise any emotional/sexual response to the health professional's touch. Meerbeau suggests that 'treating the patient solely as an object is an indignity' (1999: 1510) and therefore unacceptable clinical behaviour. She describes a doctor juggling his performance of emotion with his body work, each with different effect:

> The doctor must treat both the patient as an object with his hands, whilst acknowledging her as a person with his voice. He may also need to soothe the patient in order to get her to relax, whilst trying to avoid sounding seductive (1999: 1510).

The doctor's hands and voice are performing separately: one fragmenting and one unifying the patient, in an attempt to perform two conflicting but 'appropriate'

performances of emotion. One of these is that of objective professional and the other of carer, whilst consciously denying the presence of sexuality within the encounter. Mary Stewart has written the only significant body of work to date on vaginal examinations in midwifery (Stewart 2004; 2004a; 2005; 2005a) and describes midwives' attempts to sanitise and de-sexualise the procedure through washing rituals and the use of abbreviation (VE) and euphemism (Stewart 2005). Aside from Stewart's work, the relative absence of discussions of sexuality in the midwifery literature signifies its status as a taboo in midwifery practice.

Other examples of the role of bodies in midwifery practice highlight the ways in which midwives manage, organise, categorise and restrict bodies, their functions and practices by asserting what is appropriate and inappropriate behaviour for women during labour. Niven's (1994) work on midwives and pain in labour shows that pain relief may be offered to women to alleviate midwives' distress at being with women in pain, rather than because women request or require it (Niven 1994; Leap 1997; Hunter 2001). Walsh also describes midwives' efforts to manage a woman's behaviour when she tried to move off the bed, against the rules, after being given an injection of narcotics (Walsh 2007: 228). Midwives participate in the dichotomous categorisation of women's bodies as 'normal' or 'abnormal' because having a realm of the 'normal' which is under their jurisdiction is important for their own professional project. Midwives may also enforce the regulations restricting what women can eat and drink in labour (Parsons 2004), uphold strict visiting hours and rules about where women and their visitors may go within the hospital. There is

some evidence that the scope of these kinds of rules may differ in different birth settings, for example on consultant units or midwife-led units (Parsons 2004; Walsh 2006), and this raises an interesting question of the impact of space and place on the control of women in labour which deserves further exploration.

Conclusion

This chapter has explored the intersection of the dominant discourse of midwifery and the reality of midwives' daily work. That midwives are autonomous and accountable professionals who work in partnership with women to provide responsive, tailor-made and holistic care for women is a model that is not consistently born out in practice. The difference between the ideal and the reality has been shown to be a source of frustration, stress and moral distress for midwives and demands a considerable amount of emotional labour from them.

A review of the midwifery and social science literature has suggested that midwives who continue to work within the NHS are likely to have devised strategies to manage these negative consequences. The midwifery discourse would suggest that the 'approved' strategy for managing the dissonance between the way midwives wish to work ('with woman') and the way the institution requires them to work ('with institution') is to take every opportunity to work more 'with woman': 'making the best that they can of their, usually brief, relationships with childbearing women' (Kirkham 2000b). Much of the literature suggests that close, caring relationships with women are pleasurable rather than difficult for midwives (Sandall 1997;

Kirkham 2000a; Hunter 2002; 2006; Kirkham, Morgan et al. 2006; Walsh 2007). However, there is other evidence that frustration, anxiety, anger (Hunter 2004) and moral distress may manifest in attempts by midwives to exert control over labouring women, rather than work more in partnership with them. Furthermore, the literature on personal autonomy suggests that cultivating a sense of control over their work environment (including the spaces they work with) maybe help midwives to ameliorate some of these negative emotions (Grandey 2000; Grandey, Fisk et al. 2005). The extent to which this occurs in practice is the central question of this thesis. From this review of the literature come the following research questions:

How do midwives negotiate current pressures in the workplace?

    i.   To what extent do midwives experience a dissonance between their professional discourse and the reality of their practice?

    ii.   How do midwives working in the NHS ensure that the benefits of staying in midwifery continue to outweigh the costs of leaving?

        a.   What coping strategies do they use order to manage any stress or distress?

    iii. To what extent do different work spaces also constitute different ideological places?

        a.   What effect do different work spaces have on midwives' experiences of a dissonance between discourse and reality and the strategies they deploy to manage it?

Chapter Three: Methods and Methodology

The evening of my first day at Millside hospital I had arranged to go out to dinner with a friend: part catch-up, part beginning-of-fieldwork celebration. I met her at the station and we walked through the dark streets of the city towards the restaurant. I talked about my day and, three hours later walking back, I was still talking. She listened and offered words of support whilst reminiscing herself of her first few days of fieldwork in a school three years previously. I told her about my feelings of anticipation and anxiety; about the midwife who had taken me into a room, shut the door and tearfully poured out her feelings of helplessness to me while I listened, feeling equally helpless. I had felt the relief of finally beginning after weeks of bureaucratic delays; the anxiety of wondering what would happen to the woman who had just walked in, in labour when there wasn't a single free bed in the place and the distress, which I hadn't anticipated, from being around people in pain. Without the ability to critically analyse such new and strange experiences, that first day I had simply *felt* them.

These emotions changed as the weeks went by. I learned that you can always find space somewhere and as the cries of pain gradually became background noise, I began to see patterns which I could begin to use to think analytically about what I saw, in a way that I hadn't had the emotional space to do earlier on. Despite finding my own coping mechanisms for managing emotion during my fieldwork, these

feelings, both the midwives' and my own, remained key to the experience of fieldwork. To write ethnography without them seems inaccurate and disingenuous, and yet finding a way of writing emotion into an academic text is a challenge. As social scientists 'we are unaccustomed to coming into contact with the personal life and vulnerabilities of the author, or with concrete details involving the human responses of particular, suffering people' (Ellis and Bochner 1999: 230). This is partly because of the traditional demands to maintain some kind of academic 'distance' in writing social science, but also because it is so difficult to articulate in words the complexity that emotion brings to a social context.

Despite these difficulties, the challenge is being embraced by those working within the Social Sciences (see for example the ESRC Seminar Series on *Emotion and Embodiment in Research* 2008-09[4]). Much of the work on emotion in social research in healthcare has concentrated on the emotional lives of research participants such as nurses (Hutchinson 1984; Smith 1992; Bone 2002), midwives (Hunter 2000; 2001; 2004; Hunter and Deery 2008a), psychiatric counsellors (Yanay and Shahar 1998) and care workers (Lee-Treweek 1996). However, the *Emotion and Embodiment in Research* seminar series reflects a growing interest in the emotional implications of research for *researchers* in health and social care (see for example Young and Lee 1996; Ellis and Bochner 1999; Savage 2004; Holland 2007), and beyond (Kleinman and Copp 1993; Williams and Bendelow 1998; Coffey 1999; Hubbard, Backett-Milburn et al. 2001). A recent issue of the *International Journal of Work,*

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[4] Further details can be found at: www.warwick.ac.uk/fac/soc/wbs/research/solar/researchmethods

Organisation and Emotion features a series of papers on emotions in reproduction (Deery and Fisher 2010; Hunter 2010; Smith and Cowie 2010) that demonstrates the interest which is developing over the role of emotion in midwifery work, of which this thesis is a part.

Selecting methods

Ethnography

The integration of my reflexive experience of fieldwork into the analysis and findings was something that was made possible by the methods and methodology used in the research. At the start of every research project, the researcher must choose a method which will best provide them with the kind of knowledge they need to answer their research questions. Different methods and methodologies also lend themselves to researchers with different ideological standpoints, for example: a desire for order vs. an ease with complexity; a belief in an objective single truth or an acknowledgement of multiple 'truths'. This study demanded a method which embraced both the requirements of the research questions and my own (feminist) epistemological standpoint.

Here is a reminder of those research questions:

How do midwives negotiate current pressures in the workplace?

i. To what extent do midwives experience a dissonance between their professional discourse and the reality of their practice?

ii. How do midwives working in the NHS ensure that the benefits of staying in midwifery continue to outweigh the costs of leaving?

    a. What coping strategies do they use order to manage any stress or distress?

iii. To what extent do different work spaces also constitute different ideological places?

    a. What effect do different work spaces have on midwives' experiences of a dissonance between discourse and reality and the strategies they deploy to manage it?

In my search for a method I looked for one that could help me uncover midwives' experiences in different contexts and enable me to observe their coping strategies. I wanted to be able to listen to the stories they told but also understand the context in which they occurred. I also needed a methodology that embraced complexity and allowed for the possibility of multiple truths and so I followed Donna Haraway in search of:

> Politics and epistemologies of location, positioning, and situating where partiality and not universality is the condition of being heard to make rational knowledge claims. These are claims on people's lives. I am arguing for the view from a body, always a complex, contradictory, structuring, and structured body, versus the view from above, from nowhere, from simplicity (Haraway 1988: 589).

Ethnography was both a method and a methodology that appeared to provide for all of these desires. Whilst Discourse Analysis (Weatherall, Taylor et al, 2001) may have seemed a method suited to such study of what midwives say about their work, this thesis aims to examine the manifestation of a professional discourse in practice and as such, I was not concerned with the midwives' narratives as units of study. Instead, unstructured qualitative interviewing allowed midwives to tell their own stories; participant-observation contextualised those stories and experiences where they were enacted and the writing of the ethnographic text situated me, the researcher, within the research process. It seemed that ethnography, rather than Discourse Analysis, would better allow for an examination of their narratives and discourse at work. Furthermore, my method needed to be flexible enough to manage a fast-changing environment and enable me to collect stories from people with little time to give a complete narrative within the context of their work. As Bev Skeggs describes, ethnography enables the appreciation of midwives' narratives *in situ*:

> Ethnography is probably the only methodology that is able to take into account the multifaceted ways in which subjects are produced through the historical categories and context in which they are placed and which they precariously inhabit (Skeggs 2001: 433).

In recent decades, ethnography has been a key player in a turn towards the subjective within the social sciences, driven by postmodern, poststructuralist and

feminist critiques of social research (see Strathern 1987; Stacey 1988; Bell, Caplan et al. 1993; Enslin 1994). This turn has moved ethnography from being what Martyn Hammersley described as 'an oppositional force confronting a dominant quantitative tradition to a position where it is now well established in many fields' (Hammersley 1992: 195); and this process has continued in the nearly two decades since Hammersley's article was published.

Despite its increasing popularity in the social sciences, ethnography has been little used as a method within maternity services research. There have, however, been a number of qualitative (and mixed methods) studies looking at the organisation of maternity services in general within the UK. Some of these have focussed on women's experiences (e.g. Machin and Scamell 1997; Stewart 1999; Hunt 2001; Shaw and Kitzinger 2005; Shaw 2007), some on midwives' experiences (most notably Kirkham 1996; Sandall 1998a; Kirkham 1999; Kirkham and Stapleton 2000; Hunter 2002) and some studies, focussing on institutional spaces, which have looked at both (e.g. Walsh 2004; Dykes 2005; Newburn 2009).

I have identified only six ethnographic studies of maternity care that are of particular relevance, either because they are situated in the UK (Walsh 1999; Hunt 2001; Hunter 2002; Stevens 2003; Newburn 2009) or are in midwife-led birth places elsewhere (Annandale 1988). Only Hunter's research (Hunter 2002) uses an ethnographic approach to compare the function and organisation of different work models (hospital and community midwifery) and only her study exclusively explores

the work of midwives, rather than the experiences of birthing women. Hunter's article entitled 'Emotion work and boundary maintenance in hospital-based midwifery' is particularly interesting because it expands on the difficult relationships between midwives within hospitals. Hunter writes that:

> It seemed that differing occupational ideologies were at the root of many of these intra-occupational conflicts, with midwives dividing themselves into 'us and them' groups on the basis of ideology. Put simply, the more junior midwives generally positioned themselves as advocates of a 'with-woman', non-interventionist approach, and contrasted this with the approach of many senior midwives, who were perceived as being 'with institution (Hunter 2004)' (Hunter 2005: 256).

There is evidence to suggest that midwife-led services may not only offer women the chance to birth with less medical intervention (Hodnett, Downe et al. 2005), but also offer midwives the opportunity to practise in ways more congruent with their 'with woman' ideology (Deery and Kirkham 2006: 132). This in turn suggests that an ideological distinction may arise between midwives working in consultant and midwife-led units.

There have been only two qualitative studies of alongside midwife-led units completed to date. Annandale's (1987; 1988) ethnography of an alongside midwife-led unit (one which was situated in a separate building on the campus of a hospital

with an obstetric service) explored midwives' balance of risk with enabling women's

control over birth. This study included a discussion of midwives relationships with

their neighbouring obstetricians and the reasons behind women's choices to birth

there over the hospital obstetric unit. This study is now over 20 years old and was

carried out within an American Birth Centre. Whilst many of the issues Annandale

identified are similar to those facing such centres and midwives in the UK, there are

significant differences in the USA's healthcare services organisation, funding and

maternity care culture which means the findings can not be easily applied here. The

second study is a Masters dissertation which reports on a small ethnographic study of

an Alongside Midwife-led Unit in England (Newburn 2009). Newburn's dissertation

explores the development of the unit and 'what the birth centre care meant to the

women and men who opted for it, and to the midwives working there' (Newburn

2009: 11). Despite its limitations of time and space, this study gives an interesting

preliminary account of the workings of the unit and the motivations of those who

choose to work and birth there. Neither of these projects compared midwives' work

within different institutional work spaces to explore the effects of different unit

models or locations on midwives' daily practice and their relationships.

The qualitative research on freestanding units is similarly sparse. Whilst there are a

number of studies which have explored clinical outcomes of what they term 'home-

like settings for birth' (See Walsh and Downe 2004 and; Hodnett, Downe et al. 2005

for a systematic review of existing research), Denis Walsh's doctoral work (Walsh

2004; 2006; 2007; 2007a) is the only ethnography of a freestanding midwife-led unit

to date, although an ethnographic study of the organisational culture of a freestanding Midwife-led unit in inner city London is currently underway (Rocca in progress).

For feminist social researchers in the 1970s and 1980s, ethnography offered the promise of a research method which was anti-positivist, contextual, personal and concerned with everyday reality and human agency (Stacey 1988). It appeared tailor-made for exploring a 'feminist objectivity' that was 'about limited location and situated knowledge, not about transcendence and splitting of subject and object. It allows us to become answerable for what we learn how to see' (Haraway 1988: 583). Ethnography was a method based on the essentialist 'feminine' qualities of mutuality and empathy, put to work in the pursuit of a subjective account which dismissed any attempts towards scientific objectivity or impartiality, which was seen as out of keeping with feminist ideals (Bell 1993: 6). As Stacey (1988: 22) wrote, 'an ethnographic approach seemed to resolve the "contradiction in terms" involved in interviewing women that Ann Oakley had identified in her critique of classical sociological interview methods' (Oakley 1981). In addition, ethnography allowed the researcher to engage participants (as opposed to 'subjects') in a way that was supposedly empowering, egalitarian and not exploitative. Some feminist researchers have criticised the way in which the insidious ethical problems with the method were ignored during the coming together of feminism and ethnography (Stacey 1988; Enslin 1994; Skeggs 2001) and I explore these in relation to my own fieldwork later in the chapter.

Ethnographic texts have been critiqued for being partial and subjective, and in response, certain practices have developed within the ethnographic community to ensure the validity of research findings. Ethnographers must be appropriately reflexive: they must make themselves visible within their ethnography (See also for example Roth, Buchowski et al. 1989: 555; and Koch and Harrington 1998) and write of their partialities that are informed by their own social and cultural background. Furthermore, the ethnographic text is also expected to include an account of the relationships between researcher and participant and how the participants responded to the researcher's presence in their world. The writing of the author into the text is an act which embraces those facets of social research, such as the Hawthorne Effect, which have traditionally seen as something to avoid. As Agar explains:

> Ethnographers think—at least this one does—that if you believe you've eliminated the Hawthorne effect, you have probably smoked too much for breakfast. An ethnographer has to accept that he or she is part of the data… Telling a story that you were part of makes more sense than telling a story and pretending you weren't there (Agar 2004: 20).

Instead, the Hawthorne Effect – the participants' response to the researcher's presence – becomes part of the research findings. For example, it was clear that midwives' interviews with me were some of the only opportunities they had available to talk about their work to someone they thought might have the authority

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to do something about it. This told me something about the extent to which they felt

empowered to influence their own working lives which was a crucial finding.

Case Study

Choosing to carry out ethnographic fieldwork meant that the scenarios I witnessed

and the stories I heard could be contextualised and interpreted within the very

particular, often banal minutiae of everyday life in maternity two units. What was it

about the perceived attitudes of the managers? Or the demography of the local

population? Or the way in which the unit was laid out? Or the resources that were

available, which made midwives' working lives more easy or difficult? The units

constituted the cases of my ethnographic case study. Case study has been defined as

'a detailed, intensive study of a particular contextual, and bounded, phenomena that

is undertaken in real life situations' (Luck, Jackson et al. 2006: 104) (and see also

Burawoy (1998) and Yin (2009)). Case studies are an integral part of ethnography, as

Brewer writes: 'while not all case studies are qualitative, all ethnographic research

involves case study' (Brewer 2000: 77). Whilst I was interested in their wider

geographical, institutional and political context, my fieldwork was carried out within

the bounded spaces of the Delivery Suite and two postnatal wards at Millside[5], and

the midwifery unit at Northway.

Most case studies involve only one or two cases and have been criticised over the

'feasibility of studying the general by means of the particular' (Brewer 2000: 77).

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[5] 'Millside' and 'Northway' are pseudonyms for two NHS trusts.

However, as Brewer also explains, empirical generalisations may be made from cases if the cases are effectively sampled. The cases I chose constituted 'instrumental' cases (Stake 2000) which Luck and colleagues describe as a specific case which is important because 'it uncovers knowledge about the phenomena of interest, which may not be the case itself' (Luck, Jackson et al. 2006: 106). I chose these cases because I hoped they would tell me about how midwives continue to remain satisfactorily in NHS employment. I was not so much interested in the cases *per se*, but instead they acted as contexts within which I could explore, and compare, midwives' work within different kinds of spaces and their relative strategies for coping with its demands.

Selecting the case studies

The choice of cases to study is an important part of the research process and has a significant impact on its outcome (Walford 2001). Millside NHS Foundation Trust and Northway Midwifery Unit were chosen as research sites because they provided a contrast with which to explore the effects of working within different models of care on midwives' experiences of their work. One is a large consultant-led unit and the other a small Midwifery Led Unit which was situated alongside, but separate from, the main Delivery Suite. A review of the literature suggested that perceived autonomy or lack of autonomy, at work had a significant impact on midwives' satisfaction with their practice (e.g. Ledward 1996; Sandall 1997; Pollard 2003; Kirkham, Morgan et al. 2006: 12-13). In order to explore this more fully it became clear that I needed to look across two sites which appeared to have different

opportunities for midwives' autonomous practice. I chose sites in different trusts in order to understand better the effects of different institutional cultures, norms of practice, guidelines and protocols, and the demographic characteristics of the local communities. A full description of the two sites and their local communities appears in Chapter Four.

Negotiating access

I first met the Consultant Midwife at Millside NHS Foundation Trust at a Maternity Services Liaison Committee Meeting in 2005. She had been friendly, approachable and interested in my Masters work at that time and offered a starting point to negotiate access. I re-contacted her and we arranged to meet in May 2007. She gave me a tour of the Unit and the contact details for other Midwife Managers and Consultant Midwives in the area, with permission to use her name when approaching them. I met the Directorate Manager for Obstetrics and Gynaecology in June 2007 to talk further about my plans and we agreed that I could begin observations at Millside as soon as my ethics and Trust Research and Development clearance came through.

Negotiating access in principle at Northway Midwifery Unit was also relatively straightforward. I met the Head of Midwifery at a local meeting of midwives and introduced myself. She asked me to email her my Research Protocol and eventually passed me over to the Consultant Midwife. I arranged a meeting with the Consultant Midwife in July 2007 and she was enthusiastic about research being carried out at Northway Midwifery Unit, since she was in search of any 'evidence' for the benefits

of their model of care. It was January 2008 before I met with the manager of

Northway Midwifery Unit. During our meeting, the manager poured her heart out to

me. She spoke with passion about being forced to compromise in order to keep the

unit running and of the fear of investigations by consultants and colleagues when

something 'goes wrong' with a woman 'on your watch'. After my meeting with the

manager of Northway Midwifery Unit, I wrote in my fieldnotes: 'she looks quite

upset at times whilst talking to me and wipes her eyes. I can't tell if this is tears or

just a watery eye, but the effect is quite intense' [Fieldnotes, 19.01.08]. The

manager's intensity of feeling came out frequently during my time at Northway

Midwifery Unit. She would launch into fierce debates with other midwives, assert

her opinions openly and speak to me in private of her hopes for Northway Midwifery

Unit and her fears for its future. Through many subsequent conversations over the

coming year she became a friend and ally.

Ethics

The NHS Local Research Ethics Committee

One significant distinction between ethnography in clinical settings and other kinds

of ethnography is that it is impossible to entirely separate the processes of

negotiating access from those of gaining ethical approval. Whilst negotiating access

through the Trusts was relatively swift and straightforward, applying for approval

from the Local Research Ethics Committee (LREC) to carry out the fieldwork took

around six months from start to finish and was fraught with a lack of information and

guidance, misunderstanding and bureaucracy. It was clear that the Committee lacked

experience of ethnographic research, particularly that involving healthcare professionals rather than patients. There was no guidance provided on the required standards for gaining informed consent from participants in ethnographic observation: would oral consent be enough or did I need to get everyone to sign a consent form for observations? Their written guidance contained only a passing reference to 'observation' as a method, to healthcare professionals as participants and made no mention of 'ethnography' at all.

I was called to attend the LREC meeting in August 2007 and sat around a large table in a small room with 12 committee members fielding questions. Their concerns were varied. For example, the Committee were concerned that my not being a midwife might cause distress in the midwives I was observing. Drawing on the literature on nurse-researchers' experiences of negotiating the dual role of nurse and researcher (e.g. Borbasi 1994; Goodwin, Pope et al. 2003), I replied that I thought as a midwife it would be more distressing to have a midwife observe your work than a lay-person. The bulk of the discussion, however, turned to the problem of where I would be carrying out my observations. The Committee was extremely protective of the women in the units. One member expressed surprise and concern that there might be any circumstances in which I could 'develop relationships with women' through which I could negotiate access to a room. They felt that these relationships would become coercive or exploitative and that they had no way of policing my behaviour. They wrote to me two weeks later approving my application on the condition that I did not enter rooms where women were labouring (see Appendix 8).

The Committee's decision contradicted those made by the key gatekeepers at the Trusts. The Consultant Midwife at Northway Midwifery Unit was open to the idea of my going into delivery rooms but wanted to wait until I had been in the Unit for a while; I assume in order to know me better and to assess my sensitivity to the goings on in the Unit. The Consultant Midwife at Millside was more hesitant but decided that I could enter rooms if I had built up a relationship with a woman outside of a room and she invited me in.

The experience of applying for LREC approval raised some of its own ethical problems. However much participants may choose to assert their opinions on the structure, substantive nature and practical processes and outcome of a research project within the NHS, they can be vetoed when the proposal comes before the LREC. The LREC further requires managerial consent in principle from participating Trusts, which means that access must be negotiated from the top-down rather than from the people who will be most directly affected by a researcher's presence in their workplace. Both of these factors contradict the received wisdom within the social sciences on ethical conduct during fieldwork.

Burgess (1984) and Mulhall (2003) have noted the ethical danger of negotiating terms of access from the top down. As Mulhall writes:

The first steps in negotiating access in health care settings often involve approaching the chief executive, consultant, director of nursing services or others in positions of authority and power. This is a pragmatic solution, but one that may override those further down the hierarchy. It might be argued that this problem is overcome by ensuring that informed consent is obtained from participants. However, in practice this is not that simple. Moreover, if one's manager has agreed to a study it is sometimes difficult to refuse to be involved (Mulhall 2003: 310).

Organisationally it proved difficult to negotiate consent with the midwives on the 'shop floor'. As I wanted to get consent in principle from as many midwives as possible, I asked to attend a Unit meeting at Millside. In the absence of a regular unit meeting with the midwives, it was suggested that I attended the next 'Nursing and Quality Meeting' which was the largest regular gathering of midwives in the Unit. In September 2007 I went to this meeting and presented my project to the midwives in attendance. Whilst I had expected to be able to speak to all grades of midwife who would be working on the unit whilst I was observing, it turned out that all the midwives at the Nursing and Quality meeting had managerial responsibilities. Furthermore, because of the delay between meeting the Directorate Manager, and the date of this scheduled meeting, my project had already been approved by the LREC and was almost certain to go ahead.

Whilst I remained uncomfortable about having gained initial consent only from senior managers, their support for the project helped smooth my path. They personally introduced me to other midwives and midwife managers in the units and publicly made it known that they were enthusiastic and supportive of the project. Whilst this helped to legitimise my presence, later in the fieldwork I uncovered a number of tensions between managers and staff which I'm sure had an impact on the way midwives received me at the very start of fieldwork. Midwives at Millside would complain, for example, that they only saw the Directorate Manager on the wards when she was coming to tell them off or nag them about something. Whilst midwives were pleasant to me from the start, there were times when it was obvious that their sense of my collusion with the managers made me a political tool. On my first day one midwife asked me to go and tell the Directorate Manager that the post-natal wards had not yet released a bed at 2.30pm. Bed availability was an ongoing battle and my position as an outsider in those early days made my word appear to have more clout than theirs. This was further exacerbated by my perceived friendliness with the managers and my 'access all areas' ID swipe card, which meant I could pass between clinical and administrative areas with ease.

Although I had planned on being able to observe midwives attending labouring women, in the end not having access to delivery rooms became a blessing. I was particularly interested on those aspects of midwives' work which are *not* played out in delivery rooms: the minutiae of life on the units and, most importantly, the discussions between midwives and their colleagues. Erving Goffman describes

differences between social actors' 'frontstage' and 'backstage' performances (1990 [1959]), describing an individual's behaviour in the 'frontstage' as 'an effort to give the appearance that his [sic] activity in the region maintains and embodies certain standards' (1990 [1959]: 110). In contrast, Goffman describes the performer's 'backstage' as:

> A place, relative to a given performance, where the impression fostered by the performance is knowingly contradicted as a matter of course…it is here that the capacity of a performance to express something beyond itself may be painstakingly fabricated; it is here that illusions and impressions are openly constructed. (1990 [1959]: 114)

The midwives' 'frontstage' performance occurred in the rooms with women as their 'audience'; their 'backstage' performance was around their colleagues (and me) in the staff rooms, handover rooms, offices or behind the desk. After the LREC's decision, this project became an ethnography specifically of midwives 'backstage' work; that is, an examination of the ways in which their relationships with colleagues, both supportive and adversarial, worked to construct a dominant way of speaking about their work in particular organisational contexts.

The midwives mostly worked alone with women in rooms but when in the private space of the ward office, staff room or even just behind the desk in the middle of the ward, they talked about the women in their care, relayed stories and swapped advice.

It was the discussions that went on outside of delivery rooms which contributed most to creating the *ideological* space in which the births took place. The activity that goes on in delivery rooms is only one part of a midwife's job and births are dramatic and distracting. Brewer (2000) writes that 'lone observers are particularly susceptible to focusing on the abnormal, aberrant and exceptional' (Brewer 2000: 62) and whilst of course births are not abnormal, aberrant nor exceptional for midwives, they were the aspect of midwives' work that was most different from my own usual daily experience.

Following approval from LREC, I also gained approval from the Research and Development departments in each of the two Trusts and was granted honorary contracts and approval to begin fieldwork.

The ethics of ethnography: Friendship and intimacy

Researchers in healthcare (e.g. Richards and Schwarz 2002; Goodwin, Pope et al. 2003; Anspach and Mizrachi 2006) and more widely (for example Burgess 1984; Stacey 1988; de Laine 2000; Murphy and Dingwall 2001) have acknowledged the insidious and often invisible ethical implications for participants of qualitative research. Pamela Cotterill (1992), Gesa Kirsch (2005), Ann Oakley (1981) and Judith Stacey (1988) all discuss the ethical problems around friendship and intimacy which often face qualitative researchers. Stacey (1988) writes that 'conflicts of interest and emotion between the ethnographer as authentic, related person (i.e. participant), and as exploiting researcher (i.e. observer) are…inescapable features of

ethnographic method' (1988: 23). The level of intimacy between researcher and participant, which is often considered a virtue of feminist research, can lead people to expose more of themselves than they might otherwise feel comfortable with. A willing, sympathetic ear and a desire to 'help' the researcher (Kirsch 2005: 2164, 2165) coupled with a 'research technique which encourages friendship in order to focus on very private and personal aspects of people's lives' (Cotterill 1992: 597) may well lead to a disclosure later regretted.

I am sure, as Cotterill (1992) warns, some disclosure was later regretted, although no one spoke to me directly about this. A couple of midwives asked me not to transcribe facts which would compromise their anonymity in interview and one asked to see a transcript and made some minor changes to wording. One midwife became very distanced and cold towards me in the final weeks of my time at Millside after disclosing her experience of pregnancy loss. I suspect she hadn't meant to tell me and was concerned as to what I would do with this knowledge. Her attitude towards me became increasingly frosty and I often felt unwelcome and anxious about going into the Delivery Suite when she was on duty. In other cases, I trod the line of friendship a little too closely which threatened my ability to critically analyse my research experience and maintain the boundaries between researcher, friend and counsellor. Fiona, a midwife at Millside, used our interview to talk about problems in her relationship and at home, as well as her frustrations with work. Her pleasure at finding a willing and sympathetic ear led her to ask me to record her own birth stories for posterity a few weeks later. She had made me a friend when I was trying

to remain a researcher and I hadn't anticipated how intimate and emotionally charged her stories would be.

My interviews with Fiona led me to consider more closely the ethics of friendship in research, not least that I have always thought of Fiona's interview as one of the 'best' that I carried out. Its virtue is in its intimacy and honesty – brought about by a burgeoning friendship sparked by our wider shared values (and supported by our common neighbourhood, ethnicity and class which most midwives at work didn't share with her). If interviews are improved by friendship and closeness between researcher and participant then there is a real risk of accidentally abusing (or at the very least performing) such a friendship in order to elicit 'better' stories. Whilst I genuinely enjoyed Fiona's company, my residual guilt at having gained a 'good' interview out of her at the cost of our potential friendship makes it clear that friendship in qualitative research is not as positive or straightforward an experience as Oakley (1981: 44ff) would have us believe.

Fieldwork

I spent approximately 200 hours, over four and a half months, from mid-November 2007 to the end of March 2008, observing daily life at Millside. I made observations on the Delivery Suite and the two postnatal wards. I interviewed eight midwives, at all levels and with different levels of experience, ages and ethnicities. I then spent 180 hours over four months at Northway Midwifery Unit, from early May until late September 2008, interviewing 7 midwives, again at all bands and ages, including

midwifery managers and the Consultant Midwife. At both sites I varied the days of the week and times of day I observed in order to gain as complete a picture as possible of life in the units.

Observation

Following precedents from similar research in nursing and social care contexts (Lawton 2001; Moore and Savage 2002) I gained oral consent to observe from everyone I could speak to within a ward whilst I was there. The process of negotiating access continued throughout the fieldwork period. Moving onto a new ward at Millside involved identifying and talking to the ward manager, explaining my project and asking permission to spend some time there. At the start of each shift I asked express permission to stay from the shift leader and introduced myself and my project to every new midwife, Health Care Assistant, Nursery Nurse and, when appropriate, domestics and doctors and gained oral consent to observe. This was demanding but necessary work. On Millside Delivery Suite it could involve approaching up to 15 people on a shift in the early weeks, but as more and more people knew who I was the numbers of new faces gradually reduced.

I visited on every day of the week, including weekends and stayed for a number of night shifts to see how things differed out of hours. I went to Millside at holiday times such as Christmas and New Year and at both units, I attempted as much as

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possible to follow the midwives' shift times[6] (see below) in order to be present at handover. I used handover to introduce myself to new faces; to seek consent for staying for the shift; to get a feel for what kind of day it had been; which women were on the ward and the collective mood of the midwives. It was not only a time when midwives received clinical and social information about the women they would be caring for, but it was also used as a space for a catch-up with colleagues, sharing gossip and banter and letting off steam about the frustration or drama of the day or night.

Midwifery Shifts		
	Millside	**Northway Midwifery Unit**
Early	7.30am – 3.30pm	7.30am – 3.30pm
Late	2pm – 9.15pm	1.30pm – 9.30pm
Night	9pm – 8am	9.15pm – 7.45am

I made notes as contemporaneously as possible, usually every hour or so during observations. These notes were written as a narrative, in complete sentences, and then typed up at the end of the day or as soon as possible after the event.

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[6] Some midwives at Millside chose to work 'long days' from 7.30am until 9.30pm which meant fewer midwives changed over at the afternoon handover than in the morning or evening. These shifts were discouraged at Northway Midwifery Unit, in part because it was difficult to find cover if someone called in sick to a long day.

Observation in a clinical setting

The intricacy of fieldwork roles has been an object of much attention. Whilst Gold's (1958) four-fold typology of research roles is well cited throughout this cannon of methodological study, authors such as Hammersley and Atkinson (1994) have exposed the model's limitations in expressing the complex nature of fieldworker/participant relationships. I made the decision early in planning my fieldwork that I would not take on a role of a volunteer in the units in order to facilitate access. This decision was made after considering the benefits and drawbacks to working in this way, and in particular after reading Julia Lawton's (Lawton 2000) account in *The Dying Process* of working as a volunteer whilst undertaking her fieldwork in a hospice. Whist I shared her concern that 'my presence within day care had the potential to be too cumbersome and distracting to patients and staff alike if I went in solely in a research capacity' (2000: 27), I was more uncomfortable with the possibility of role confusion which Lawton identified:

> We were…somewhat concerned that patients might find it too confusing if I wore two hats simultaneously: they might, for instance, be uncertain whether I was interacting with them in a 'volunteer' or 'research' capacity on any particular occasion (2000: 27-28 cf. 32).

The need for a clear and open consent process demanded by both the NHS Local Research Ethics Committees and my own ethical concern meant that I decided to risk being 'cumbersome and distracting' to ensure that staff were aware of my objectives

at all times. I know that at times my presence was distracting for staff and they often weren't shy to tell me so:

> [Millside: Delivery Suite] I walked into handover from Suzanne, who was welcoming and introduced me to three of the midwives who I didn't already know. They looked completely bemused by me until she explained that I was the woman off the poster (see Appendix 5): 'a researcher looking at midwives' stress'. 'It's weird when she's around like watching you. You're like "lalala"' (she mimes a fixed a grin and waves her hands; fake happy) [Fieldnotes, 21.11.07].

The pre-occupation with diagnosing researcher's roles within the structure of 'participant' or 'observer' presents particular problems for clinical ethnographers. 'Participation' implies taking part in the key activities of the institution, community or group and yet where the community's work is highly skilled, this kind of participation in identity-forming work (e.g. in the case of midwives, catching babies) is impossible. Rather than conclude that participant-observation in clinical settings will never be successful, it is instead useful to reframe it from the practical to the phenomenological.

Stephen Ball writes that 'the prime concern [of participant observation] is to share in a direct, immediate and non-presumptive sense the phenomenal givens of these actors in order to construct an account of their cultural setting' (Ball 1993: 72). In a

clinical setting, this kind of sharing of the culture and 'phenomenal givens' of a community must and can be achieved without abandoning all 'participation' or slipping into a traditional 'complete observer' role. Whilst opportunities for the 'usual' participation were limited, I didn't simply observe the interactions of midwives but constantly participated in discussions, debates and gossip; shared 'thank you' chocolates from women and countless cups of tea. These backstage activities took up a lot of the midwives' time, defined their community and structured the rules and knowledge with which they worked when caring for women. When working within delivery rooms, midwives were mainly alone with women and their accompanying friends or family, and whilst this is the work which appears at first glance to define their identity as midwives, it was only a part of the story. Midwives put into practice with women the taught and tacit knowledge which they developed through conversations with colleagues backstage, outside of the rooms. As I was primarily interested in the ways in which midwives used colleagues to provide support and to develop shared norms of practice, this aspect of participation was crucial.

In retrospect I am comforted by finding a theoretical and methodological place for the kind of fieldwork research I experienced, but at the time I felt a sense of doubt: was this 'real' participant observation? How could I do it right when not only was I not a midwife but I had been banned from entering rooms where women were labouring? I shared Gitte Wind's (2008) 'sense of uneasiness that I haven't been able to do 'proper' fieldwork and 'proper' participant observation because I didn't

really manage to become an active part of the on-going activities and events in the hospital settings' (Wind 2008: 81). Wind proposes a redefinition of 'participant observation' in clinical settings as 'negotiated interactive observation' which more accurately explains the kind of work going on in hospital-based ethnographic research. My notion of negotiated interactive observation respects the value of the particular kind of work that an ethnographer is able to do within a hospital setting: work that is more than merely observing, but that which cannot involve an active participation in the same work as healthcare professionals. Van Maanen (1982) describes the work of the ethnographer as 'hanging around, asking weird and sometimes even dumb questions, drinking coffee, taking notes, chatting' which accurately reflects my experience as an ethnographer.

Through talking with midwives, making the tea, fetching and carrying, once mopping up after a flood, and listening to their stories I became a largely accepted member of the community on both the units, albeit one with an unusual role. Finding a place within the strictly upheld, hierarchical relationships of a hospital is particularly difficult as a 'lay' person. Hospital hierarchies are set up around differing levels of clinical skill (i.e. staff grades), professional esteem and a continuum of clean to 'dirty' work. As Wind (2008) explains, hospitals are populated by three groups of people: healthcare professionals; patients (in maternity units that means pregnant and postnatal women and their babies) and partners and visitors. Ethnographers cannot be easily categorized as any of these. This means that negotiated interactive observation, or any kind of 'participant-observation', is

inevitably socially awkward as it has no precedent in any other part of social life. Social rules have to be negotiated as difficulties arise and its success relies on the researcher's flexibility in responding to situations as they arise.

Interviews

I began arranging interviews after I had been in each unit for some time. The benefit of waiting a while was partly a pragmatic one: that I was then known and trusted by the midwives and they were very willing to speak to me. It was also methodologically useful to have built up a relationship beforehand as this helped facilitate the conversation. As I knew the midwives well before interviewing them, the conversations were not only rich with emotion, but also with their own complex analyses of their working lives. Sophisticated discussions of this kind were possible because we weren't starting from scratch. Having spent a long time in the units, I shared with them an understanding of the basic workings of the hospital which didn't need explaining and this shared understanding and my sympathetic ear meant conversations were full of references to our shared subtle, complex, tacit knowledge of the work of the unit and their place within it.

I gained written consent from each interview participant and provided them with an information sheet (Appendix 6), which outlined the aims of the project and explained their rights, for example to end the conversation at any time without giving a reason. I attempted to interview a cross-section of midwives: senior and newly qualified, young and older, and those of different nationalities and ethnic groups. The aim of

the interviews was to give the midwives and me the time to reflect on what I had observed in the unit and to understand what they perceived as most important about their midwifery work. The interviews were loosely structured. There were only about four questions that I planned to ask each participant, with the other questions generated in response to the themes of the emerging discussion. These interviews often resembled therapeutic encounters (Birch and Miller 2000), which required careful negotiation. More than once I reminded a participant that I was not a trained counsellor. I began each interview with the question 'can you tell me how you came to be a midwife?', which gave me the opportunity to learn something of their history, education, home life and ideological standpoint before following them into new areas of conversation. Using 'unstructured' interviews means that the analysis can include those topics the participant chose to talk about the most, demonstrating their priorities, and also those issues they chose *not* to discuss, which were incorporated into the analysis and findings.

All but one of the interviews was digitally audio recorded and I transcribed them verbatim from the original audio files. The interview with the one participant who declined to be recorded was recorded using notes which I typed up and reconstituted into as faithful an account as possible. One midwife asked if she could see the transcript of her interview. She returned it to me with some minor amendments to wording, but had no major substantive comments to make. All participants were assigned pseudonyms.

Fieldwork Relationships

Impression management

Learning the language of maternity care was a key strategy to gain acceptance within the unit community. I came to Millside with a good working knowledge of the jargon, of the basic processes of pregnancy, labour and birth and the political structure of maternity services. My fluency and understanding grew apace in the first few weeks of fieldwork. My knowledge of the language of maternity care enabled me to follow and ask questions during discussions of cases and clinical decision-making, and it also engendered respect from staff. It was a central part of the game of re-negotiating access and consent throughout the 9 months I spent in hospital. I became a 'well-informed citizen' (Atkinson 1984: 180) whilst also using my lack of midwifery training to demand explanations of social, institutional/managerial and clinical situations, which might otherwise have been left unsaid (Atkinson 1984: 180). This kind of negotiation could be seen as a seduction, a performance and a game played with rules which were not my own. To some extent I played the game of the hierarchy: I dressed up in smart clothes which, coupled with my relative youth, meant I was usually mistaken for a junior doctor (until corrected). I used appropriately clinical language, and flattery (although I meant it) in order to ingratiate myself with participants (Daniels 1983; Mulhall 2003). This performance of language and dress or 'impression management' (Hammersley and Atkinson 1995: 83ff) was crucial to my finding a place in the community and neither felt excessively out of character. My genuine fascination with the process of birth made it a pleasure to learn its language in order to understand it better. The clothing was

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only that which I would wear in other contexts when I need to be smart and didn't stretch to a uniform or a suit, which would have made me feel more out of place.

Neither the midwives nor I could maintain a performance or present an ideal version of ourselves consistently over the months of fieldwork. Kate, a midwife at Northway Midwifery Unit, said more than once, 'Juliet's really seeing us warts and all isn't she'; and whilst I don't think she had serious concerns about the research, she admitted that she hadn't realised that having a researcher observing over such a long period of time meant that I wouldn't always see them in their best light. In the end we dropped our guard on both sides. In both units the midwives and staff began to relax with me. We would joke, laugh, swap stories, gossip, solve problems together, share cake, occasionally dance and fool around to pass the time. The need to maintain a serious, 'professional researcher' front became less as the midwives, care assistants and domestic staff allowed themselves to criticize their workplace in front of me.

In my early days in the field, an experienced researcher friend of mine advised me to develop the role of 'Fieldwork Juliet' in order that when tensions inevitably developed I could be safe in the knowledge that the midwives were only frustrated or angry with 'Fieldwork Juliet', rather than with *me*. This was an appealing option, but something I found impossible to keep up because I wasn't sure who 'Fieldwork Juliet' was. How would she behave? How would she respond to jokes, gossip or questions about her project? Would she refuse to participate in the silliness amongst

some of the midwives, born from a long shift and high levels of stress when the 'real' Juliet would gladly join in? Whilst I felt pressure to keep up the performance of 'Fieldwork Juliet', who in my head represented the ideal researcher: professional at all times, serious and someone who kept a clear distance from the participants (See also de Laine 2000: 38), I am no actor. Just as the midwives couldn't keep up with the image they wanted to portray for as long as I was there, I too couldn't stop being myself, particularly around those with whom I had become friendly.

My willingness to play: to join in with gossip and gentle teasing, to put up with endless jibes about my work (or often in their eyes, the lack of it) and to sympathise with the frustrations of the midwives' job had a number of effects. I was amazed at how trusting almost all the midwives became. After my initial introductions they appeared happy about, or at least indifferent to my presence. They opened up to me about their lives, their families, their work and the women in their care. In interviews they told me intimate stories of their vulnerabilities at work, of their fears and frustrations and hopes.

Social identities

My ability to cultivate friendships or at least working relationships with participants was guided by our respective responses to our social identities. I have explained how I chose to dress, talk and demonstrate my knowledge affected midwives' responses to me but my presentation of self was fundamentally guided by other things which I had less power to adapt to the demands of fieldwork. My personal collection of

social identities: female, queer, white, middle-class, feminist, university educated and in my mid-20s, among others, regulated the extent to which I could become a participant within the culture of Millside and Northway. The way in which I presented or exposed these identities was regularly (re-)negotiated in response to the participants and the culture of each unit.

Being female was clearly to my advantage in such a female environment. In both units all the midwives were women as were almost all of the other staff, apart from the doctors. The one young male domestic in Northway was enthusiastically mothered by the midwives and Maternity Assistants who praised him for his work and regularly referred to how 'sweet' he was, thus infantilising and feminising him. Gender was so pervasively feminine as to be almost invisible in both units and my gender helped integrate me so thoroughly that it was often difficult, as a woman, to maintain an outsider gaze with which to analyse the role of gender within the workplaces (See Walsh 2007 for an analysis of gender from the perspective of a man in a maternity unit).

However, whilst being female risked letting gender go under-noted, the gendered nature of the unit became all too clear when I looked at it from the perspective of a woman in a relationship with another woman. Maternity units are profoundly heteronormative spaces. Whilst lesbian women do, of course, use their services I was not aware of any lesbian clients, midwives or other healthcare staff during my fieldwork, although it is quite likely that they were some. The little literature there is

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on queer researchers' identities in the field is mostly focussed on the challenges

facing anthropologists when conducting fieldwork in homophobic societies abroad

(Blackwood 1995; Lewin and Heap 1996; Coffey 1999: 26-27). The experiences

retold in these texts were particularly difficult, exacerbated by living full time in

communities whilst trying to pass as unmarried and heterosexual or inventing

fictional boyfriends and husbands.

However, I too found myself in a situation in which 'the social rules of an

establishment have to be discovered and role relationships developed with other

people in situations which are strange' (de Laine 2000: 99), despite conducting

fieldwork at home. Talking about yourself is a key tool for developing friendships or

friend-like relationships with participants (Wolf 1996) and I was uncomfortable with

the irony of asking the Millside midwives to divulge detailed information about their

lives whilst being unwilling to talk about my own. I suspect my relative ease at the

second unit that I visited was partly because I was more comfortable with the

research experience by the time I arrived there but also partly because the midwives

were just more like me. The social identities we shared made it easier for us to

develop close relationships more quickly and for me to assess their likely response to

my own presentation of self. When these identities were not shared, the differences

became apparent. Whilst midwives from minority ethnic communities at Millside

responded in the same way to me as any other of the midwives and happily

participated in the observations and interviews, the only three midwives who

declined to be interviewed at Northway were the three of African-Caribbean origin.

Two of these midwives were suspicious of my presence throughout the time I was there. They had a wider reputation amongst the others for being 'difficult' and neither had invested in the ideology of the Northway Midwifery Unit as wholeheartedly as their colleagues. I suspect I was seen as someone who was 'keeping an eye' and who was openly friendly with the managers who embodied the philosophy of the Northway Unit (which I define and discuss further in Chapter Six). Thus I became part of the pre-existing ethnic and cultural divisions within the Unit.

Analysis

Analysis of ethnographic stories, as with all qualitative 'data', is an ongoing process (Brewer 2000). The process of typing up fieldnotes inevitably also involved reflection on their content and this then affected how and what I chose to focus on in subsequent visits to the units. Trying to recount such analysis, as if it were a step-by-step process, is extremely difficult and much of it occurred through continually writing, re-reading and re-writing chapters.

In order to even begin making sense of the huge amount of information I had amassed, I needed to organise it and so all the transcripts and fieldnotes were coded using Nvivo 7 software. I first coded the stories using open codes, which were elicited using the themes that emerged through reading and re-reading the transcripts and fieldnotes. The coding process allowed me to become familiar with the stories I had collected and organised them into a searchable filing system. In mid 2009, an Nvivo software fault jumbled my codes, which meant that I had to recode all the

stories once again. Whilst this was deeply frustrating at the time, it proved beneficial

to the end result as it forced me to focus my coding further through a second round.

Rather than replicate the codes that I had lost, I chose instead to recode using a

different framework. Having already elicited a structure for the substantive chapters

in the earlier coding and accompanying analysis, the second set of codes was built up

around the three themes of 'emotion', 'space' and 'bodies' and then sub-coded using

a network of related 'tree codes'.

As I became more familiar with the stories I began to recognise trends not only

within what midwives had chosen to speak to me about, but also what they did not

say. Of course, coded data only includes those themes that have been written down

or spoken so it was not until I became familiar with the texts through repeated re-

reading and writing that I could notice what was missing. These 'missing' parts were

very important to the story I came to tell as they suggested those topics which were

'unspeakable' within the confines of the midwives' professional discourse. In

addition to identifying the silences, I also identified those stories which did not fit the

dominant narrative within each site and finding a way to account for these negative

cases helps to ensure the credibility of the account (Tuckett 2005).

Emotions in ethnographic research

For many researchers, the emotional burden or pleasure of research is born from the

relationships they build or fail to build with participants. The difficulties of

negotiating access, of forging a role within the field and of developing and managing

friendships and relationships whilst undertaking qualitative fieldwork all affect

researchers' emotions (Coffey 1999). The emotional experience of the fieldwork has

informed every part of this ethnographic account. Firstly, my relationships with the

staff in the unit informed me about their expected way of interacting with others. For

example, whilst I have described the friendly and informal relationships I built with

midwives, most of the doctors, on the other hand, were more challenging towards

me. Senior Obstetricians asked me about my research: grilling me on my hypothesis,

methods and probable findings. They treated me as they would a medical student or

newly qualified clinician and I responded by answering their questions with as much

professionalism and scientific gusto that I could muster. They demanded from me a

different presentation of self than the midwives, Healthcare Assistants and domestic

staff.

Secondly, midwives' responses to my presence was also enlightening. During

interviews they had a tendency to only tell me about their complaints and frustrations

rather than what they liked about being a midwife. This was a methodological

problem that Paley (2004) also identified in Peter, Macfarlane and colleagues' article

on nursing. He accused Peter and her colleagues of encouraging their participant

nurses to indulge in 'professional gossip' (2004: 365) during which they (inevitably)

described 'not-being-appreciated, powerlessness, and oppression by medicine'

(2004: 364). However, Paley's problem with the article was that the authors treated

this account of nurses' suffering as if it were a *description* of the nurses' experience,

rather than an *interpretation* of it. The use of ethnography as a method helped me to

avoid such a pitfall. Whilst the method could not prevent participants from

presenting me with their stories of powerlessness and frustration, it did help me to

understand *why* they had developed such a negative script. Observation of the spaces

in which they worked and their behaviour whilst at work, suggested that the

complaining itself was a coping strategy, rather than simply a description of their

daily reality.

Thirdly, I compared my own emotional response to distressing situations, with those

of the midwives. My research questions address the ways in which midwives manage

workplace pressures, both practical and ideological, in order to continue working as

midwives when so many of their colleagues have left the profession. Coming into the

field with an interest in the emotional lives of midwives made me sensitive from the

outset to the emotion(al) work of being a midwife. Whilst this was a side interest at

the start, it grew throughout the time I spent in the two units. It became clear that

managing emotion (their own and that of the women in their care) was a fundamental

part of being a midwife and one that was rarely spoken about. In the opening story to

this chapter, I described the emotions I felt during my first day on the Delivery Suite.

The intensity of my own emotions in the early days of fieldwork made me curious

about the causes and effects of the silence surrounding emotions at work and the

ways in which midwives had learned not to have, or to better manage, the kind of

response that I had to emotionally distressing situations. What strategies did they

deploy to manage their emotions at work? Why did their chance to talk to me, both

formally and informally, so often come to resemble a therapeutic encounter which

they clearly needed but weren't getting elsewhere? These themes became crucial to the analysis of their stories and so the role which I played during fieldwork was not only pertinent to understanding the implications for case study as a model and ethnography as a method(ology), but also to developing an understanding of the substantive issues at stake in midwives' daily working lives.

Ethnography is an untidy methodology. For me, this is one of its virtues: it embraces the messiness of qualitative research, however much in the end we are required to turn the complexity of social life into an orderly narrative. The stories that appear in the three substantive chapters of this thesis emerged from the experience of my being 'in the field' as much as from the acts of collecting information and writing about it. Rather than perceiving the personal, subjective nature of this writing as a fault or weakness, instead I suggest that my awareness of it illuminated my analysis of the research findings.

Chapter Four: Setting the scene

This chapter will describe the two research sites in order to contextualise the later analysis of the data on midwives' work. The layout of the clinical spaces in which the midwives worked, their location within the hospital and the local area, as well as the characteristics of the surrounding communities all affected the midwives' experiences of their practice and their relationships with the women in their care (Puthussery, Twamley et al. 2008). The relationships between staff in different clinical areas and the midwives' relations with labouring and post-natal women are influenced and shaped by their geographical and socio-political context. In order to make clear the similarities and differences between the two Trusts, the first part of this chapter addresses Millside Maternity Unit: its history, local area, workforce as well as its geography and then moves on in the second part to look at the same characteristics of Northway Midwifery Unit.

Millside NHS Foundation Trust

Introducing the Trust

Millside NHS Foundation Trust maintained three hospitals and a specialist clinic in a large English city. It was one of the biggest employers in the city, employing 10,500 staff across its four sites. My fieldwork was undertaken at its original and largest hospital, Millside, which besides providing inpatient and outpatient services to the local area was a major tertiary referral unit for the wider region, which covered several counties, with a population of approximately 1.3 million people (Millside

NHS Foundation Trust 2008). A teaching hospital, Millside provided specialist care in a number of specialties, including Obstetrics and Neonatology.

The Trust had a long history of mergers and acquisitions with local hospitals. The Maternity Unit started life as a maternity hospital four miles from where it is now located. In 1992 it was acquired by a local District General Hospital and the services were combined at its current site along with another merged hospital to make a newly formed NHS Acute Trust. In 1995, the Trust merged with Longbury Hospital six miles to the south to become Millside and Longbury NHS Trust and achieved Foundation Status in April 2005. In 2007, shortly before I began my fieldwork, the Trust merged with another hospital in North Town, seven miles to the north. Whilst they are now administered under the auspices of a single Foundation Trust, the hospitals in Longbury and in North Town maintain maternity units of their own. Due to their history, Longbury and Millside had a close working relationship which manifested itself through shared medical staff, the rotation of midwives between the sites and Millside's use of Longbury as an overspill for low-risk women when they had no space for them on their own Delivery Suite. Their relationship with North Town was less well developed; they had had by that time little contact and tended to view each other with suspicion.

The local area and population

Millside Hospital sat in an area of significant urban deprivation. The geographical area covered by its commissioning PCT was ranked in the top ten most deprived

areas in England by the Index of Multiple Deprivation 2007 (Department of

Communities and Local Government 2007) and included almost all of the most

densely populated regions of the city. According to City Council statistics[7] taken

from the 2001 UK Census, the political wards covered by Millside Hospital (not

including those covered by Longbury and North Town) had an average

unemployment rate of 12% (May 2008) as compared to a citywide average of 8.32%

and a national average of 5.2% at that time. This is likely to have increased in the

past two years in line with the global economic downturn. 35% [range 6% - 73%]

people in the area were of Minority Ethnic communities compared to 9% nationally

and 30% city-wide. The population density was 1.3 times the City mean and over

twelve times that for the whole country. The largest and most well-established BME

community in the area was from Pakistan but there were also significant but more

newly arrived communities from Somalia and Eastern Europe.

The midwifery workforce

The diversity of the population was not reflected in the Millside Maternity Unit

midwifery workforce, which was predominantly White British with a number of

Black African and Caribbean midwives but very few of Pakistani origin. Of the

fifty-five midwives and student midwives I had close contact with during my

fieldwork, nine were of African Caribbean origin (both first and second generation),

four were British Asian, forty were White British and three were White European.

Most of the midwives lived away from the area and travelled there to work, some

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[7] In order to preserve anonymity, the website address for these statistics is not included.

from outside the city. This was partly due to the difficulty midwives were having in finding midwifery jobs at that time due to financial constraints on Trusts that had implemented recruitment freezes. Millside NHS Foundation Trust had remained financially solvent and so many midwives working for the Trust had trained elsewhere but had not been able to find employment on qualifying and moved to Millside for their first jobs after graduation or later in search of promotion. Furthermore, the local area was not considered a desirable place to live for those with skilled jobs who could afford to live elsewhere.

Social class is notoriously difficult to define and proxies such as occupation can only be rough substitutes for the real complexities of class identity. The midwives all had the same job and yet they were not an entirely homogenous group. Furthermore, their uniform disguised their dress as a class marker and in most cases I do not have information about their partners' employment. Any attempt to assign social class to the midwives is based on extremely subtle class markers such as accent, vocabulary and mannerisms, which are difficult to operationalise into class categories. At Millside, the midwives had relatively similar class signifiers although the younger midwives tended to appear more middle class, perhaps due to the introduction of university based, degree-level training, which may have been out of reach of those who would have been the first in their family to attend university. At the other end of the short class continuum, there were no midwives who appeared to be from upper-middle class backgrounds possibly because of the wider career choices available to women in recent decades, especially the availability of medicine and other higher

prestige healthcare professions, which might well draw potential midwives away from pursuing midwifery as a career. However, unlike the midwives, the domestic staff and Healthcare Assistants appeared to be more working class and did mostly live locally. High unemployment in the area and with only about 9%[8] of the local population holding a tertiary qualification meant local people were more likely to be employed in lower skilled work within the Trust.

Midwifery employment in the Trust

The midwives had a large degree of freedom to choose which area of the Unit they worked in, once they had completed their compulsory two year rotation. For two years after qualifying, direct entry midwives spent a designated number of weeks working in each area of the hospital and in the community. After their two years were complete, some midwives applied for jobs in a community midwifery team but those who remained in the hospital moved regularly between the Delivery Suite, Antenatal Clinic and the two Postnatal Wards but with a regular pattern of work. All of the midwives I spoke to worked different rotations according to their preference. For example, some spent six months on the Delivery Suite followed by six months on the low-risk postnatal ward and back to Delivery Suite. Others worked one month on the Delivery Suite and one month on the postnatal wards, then went back to Delivery Suite, alternating between the two postnatal wards each time they moved. A few moved between the community and the hospital. The only midwives who

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[8] Taken from City Council statistics 2004. Refers to people with a First degree; Higher degree; NVQ levels 4 and 5; HNC; HND; Qualified Teacher Status; Qualified Medical Doctor; Qualified Dentist; Qualified Nurse; Midwife or Health Visitor. The statistic for England and Wales is 19.8% and just over 16% City wide.

remained in one area were those who held Ward Manager positions or who had been with the Trust for a long time and had managed to individually negotiate staying in one area.

The Millside Maternity Unit

Neonatal Unit

Theatres

Administration

Delivery Suite

Offices

Ground Floor

Antenatal Clinic

Gynaecology

Low Risk Postnatal Ward

Bereavement Suite

High Risk Postnatal Ward

First Floor
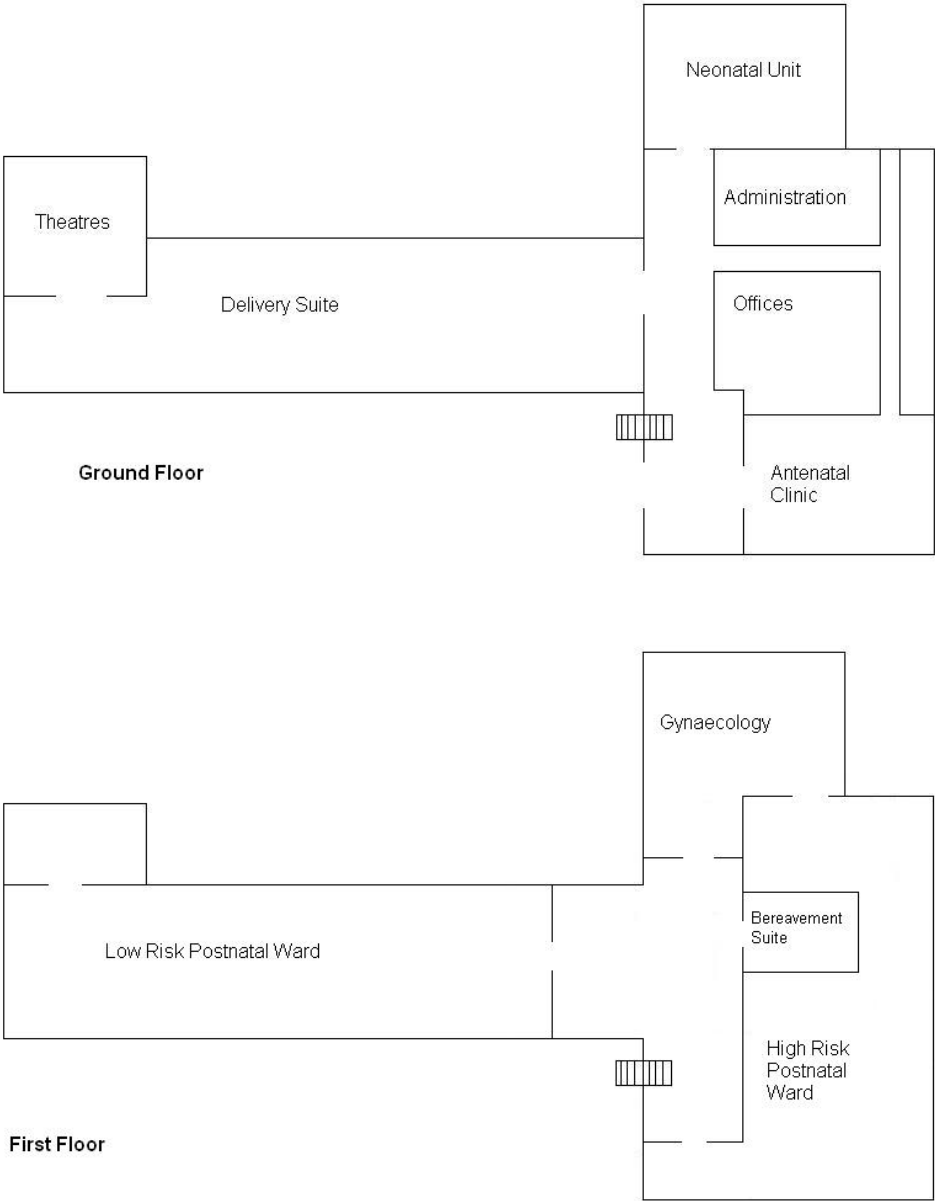
Millside Maternity Unit was a low, two-story building built in the early 1990s and separated from the main hospital block by a large car park. At the entrance on the ground floor was a small waiting area with a shop and café run by the WVRS and a reception kiosk with a glass window where women and their families lined up waiting to be sent through to the Antenatal Clinic. To the left was the short corridor that lead from the reception waiting area to the Neonatal Unit, the Delivery Suite and administrative offices.

The Delivery Suite

The door to the Delivery Suite was controlled by a swipe card system and so any visitor needed to ring the bell and intercom that was controlled from the desk, in order to be let in by a member of staff. The Delivery Suite was bustling and busy with the sounds of staff and visitors' talk, beeping machines, the swoosh of gas moving down pipes and the cries of pain of women in labour. It smelled of hospital antiseptic and was sluggishly warm. The only outside windows were in the delivery rooms and the lights in the corridor were kept on twenty-four hours a day which gave it an other-worldly feel. The Delivery Suite was a space which was influenced neither by the cycle of day and night nor the weather, something particularly striking during the winter months when my fieldwork was carried out. Only the clock gave any clue of the time of day and changes in weather were reported by incoming staff at shift changes. Unlike many other workplaces there was also little difference between weekdays and weekends, so a Sunday afternoon appeared much the same as

a Wednesday morning, although there were fewer medical staff on duty at night and at the weekends.

There were ten delivery rooms on the ward, set out on either side of the main corridor and clustered around the desk area. Eight of these rooms were in regular use, one was reserved when possible for women having a stillbirth or late pregnancy loss as it was quiet and the furthest away from the busy central area. Another was a High Dependency room equipped for those women who needed more intensive medical care. Both of these specialist rooms were used for normal labouring women if the unit was particularly busy. In the Assessment Room triage area, women waited to be seen by a midwife in a small, windowless waiting room. The door to this room was always propped open, giving a view across the corridor to the entrance to the Assessment Room opposite where the midwife sat. Women and visitors peered into the doorway and sometimes, after waiting many hours, came to stand in the corridor outside the door to the Assessment Room as if closer proximity to their destination might speed up their progress. I regularly observed women and visitors being sent back across to the waiting room and other visitors asked not to loiter in the corridor.

The Handover Room and the desk were the hubs of the Delivery Suite. Inside the Handover Room there was a trolley with mugs for tea and biscuits and chocolates left by women and their relatives as thanks to the midwives. A row of chairs were lined up in front of a notice board which was covered in notices such as notification of clinical trials and newspaper articles concerning the unit or wider maternity care,

often with scribbled handwritten commentary. In the far right hand corner of the

room was a whiteboard divided into spaces for each of the beds on the ward. In these

spaces were written the name and basic clinical information about each woman

present. This room was used for both midwifery and obstetric handovers and the

board was a crucial resource for quickly assessing how busy the unit was when first

coming into work. When midwives arrived for a shift they assembled in this room

and so it was also a meeting place to chat when waiting for someone to come and

hand over at the start of a shift. This map shows the central area of the Delivery

Suite, where I spent most of my time on the ward:
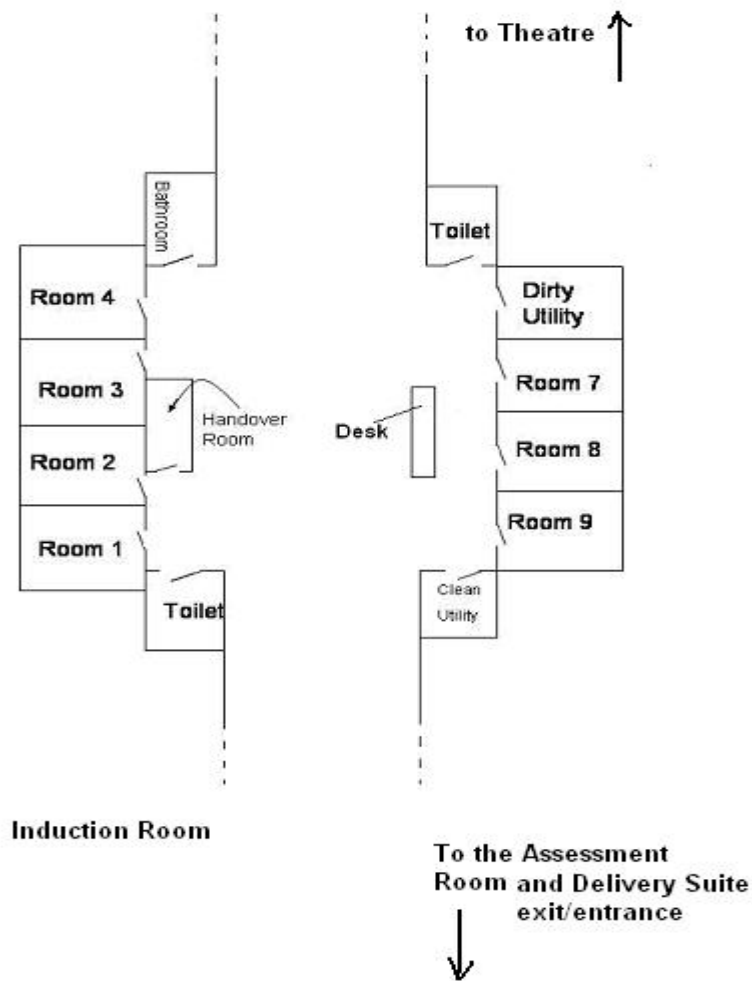
The midwives spent most of their time moving from the desk into rooms and back again. As almost all the delivery rooms were situated around it, the sounds of women crying out or shouting were audible from the desk area. The desk had a chest height border around it on which midwives and doctors leaned to write up their notes. The other side was at sitting height and covered in piles of patient notes, stationery, cups of tea, a CD player/radio and two computers. At one end sat the Ward Clerk when she was on duty. The desk was not only a work hub, but also a social hub for quick chats with colleagues about both work and home life. Midwives shared workplace gossip and stories of their partners and children whilst gathered around the desk, often when writing up notes or doing other work tasks at the same time. Other members of staff also used the desk to sit and write notes or talk. Junior doctors in particular wrote up their notes there and sometimes joined the midwives in conversation.

The Low Risk Postnatal Ward

The Low Risk Postnatal Ward was upstairs, connected by a stair case and lift to the ground floor. The ward was an extremely busy, noisy and frenetic place, filled with the sounds of staff and visitor talk and crying babies. Unlike the Delivery Suite, on the Postnatal Wards, the windows in the bays meant the ward was not entirely cut off from the outside world. At night the lights were dimmed giving clear indications of night and day and the meal trolley appeared at the same times each day, which also helped to mark the passing of time. As women usually stayed less than 24 hours after the birth of their baby, there was a high turnover, although women often waited

many hours to be discharged. The Ward held 26 beds, mostly in five, four-bed rooms

or bays with beds separated by blue paper curtains on tracks. At the far end of each

bay was a small bay window with a window seat and some fake silk flowers on the

windowsill behind. Within each bed area there was a bed, a bedside table, a sink, a

transparent plastic cot for the baby, a TV attached to the wall, and a telephone. Most

women stayed with their babies and visitors in their beds with the blue curtain pulled

around them and except for meals rarely came out unless they were asking for milk

or looking for their midwife at the desk.

Behind the desk in this post-natal ward was a wall separating it from the back

corridor and a long desk with a series of computers in a row. Some of the computers

were dedicated to the Audio Technicians or 'hearing ladies' who carried out hearing

tests on each newborn in the ward. The other computers were used by the midwives

to complete their notes. The ward also had a run of individual patient rooms which

were used for women whose babies were in the neonatal unit or were in for a

prolonged stay due to medical or social problems. The ward had a number of

backstage rooms which were out of bounds to women and visitors. The dirty utility

room contained cleaning equipment, the toilet for disposing urine samples, sharps

boxes and clinical waste disposal; the clean utility room housed the drugs cupboard

and clinical items such as bandages and instruments. There was also a Nursery,

where Nursery Nurses sometimes cared for and bathed babies. Changes in norms of

practice meant that this work was increasingly carried out at the woman's bedside,

with her participation. This mean the room was under-used as a nursery and so was

more often used as a kitchen and informal staff room. There was also a staff room for handover in which the Ward Manager had a desk. This handover room had a large board, similar to the one on the Delivery Suite, a notice board and chairs.

The daily work of the ward was managed by the Ward Manager, who was a midwife. Three other midwives worked on each shift and in addition, there were domestic cleaning and catering staff, two Nursery Nurses and a Healthcare Assistant assigned to each shift. Unlike the midwives, the auxiliary staff did not rotate, but remained working on the one ward. The doctors rarely came on to the Low Risk Postnatal Ward as the women there were considered low priority compared to those labouring or recovering from Caesarean Sections.

The High Risk Postnatal Ward

The High Risk Ward mostly cared for women who had had a Caesarean Section, but also housed high risk antenatal women who had been hospitalised, sometimes for long periods of time. It had a calmer feel than both the Delivery Suite and Low Risk Postnatal Ward because women stayed for longer to recover from surgical delivery and were also less mobile, meaning there were fewer people walking around. Like the Low Risk Ward, it too had outside windows, set meal times, visiting hours as well as an identical staff structure and similar working practices to the Low Risk Postnatal Ward. Again there were five bays identical to those on the Low Risk Postnatal Ward and a series of private rooms for longer stay patients, in addition to a small kitchen, a staff room with the board and a desk, a clean utility, a dirty utility,

an office for the Ward Manager and a nursery. Unlike the Low Risk ward, the High Risk ward was frequented by doctors who came in and out regularly throughout the day to examine women and babies.

Millside Maternity Unit was busy. It was noisy and bright; and whilst there were times of quiet, there were also periods of seeming chaos. The organisation of the Delivery Suite was dominated by trying to manage 5,000 births a year with 10 Delivery Rooms, where an average unit with the same number of births would have had about 18 rooms at its disposal (Commission for Healthcare Audit and Inspection 2008: 68). The postnatal wards, particularly the Low Risk Postnatal ward, had a fast turnover and such a transient population meant lots of coming and going of women and visitors. Such an atmosphere offered a contrast to the ambiance of Northway Midwifery Unit. In Part 2 of the chapter, I explain the history, staffing, lay out, demographics and geography of the Midwifery Unit at Northway NHS Foundation Trust.

Northway NHS Foundation Trust

Introducing the Trust

Northway was incorporated as an NHS Trust in 1998 and became a Foundation Trust in February 2008, shortly before I arrived to begin my fieldwork in May 2008. It maintained one hospital which was a teaching hospital for medical, midwifery and AHP students in the city and it had close links with the local university. The Midwifery Unit was opened in 2004 after £1 million funding was approved by the

Trust in 2002. During those intervening two years, many midwives working in the Trust and those employed in preparation for its opening, contributed to devising the lay out and remit of the unit.

The Midwifery Unit had strict criteria for entry for women, who must have had few or no complications during previous pregnancies or anticipated during birth. Clinical requirements for entry to the Midwifery Unit included having a 'normal' BMI, no gestational or pre-pregnancy diabetes, aged between 16 and 40 and no history of substance abuse. These criteria were regularly updated by the Consultant Midwife and had widened since the unit first opened. For example, the unit used not to admit 16 and 17 year olds or women with a history of even mild mental health problems, but by the time I was there it did. These changes were part of an attempt to increase the numbers of women delivering on the unit, which helped to keep it financially viable in the eyes of the Trust management. It operated an 'opt-out' system, whereby suitable women were expected to be automatically booked for labour in the unit by their community midwife, but could ask to go to the Delivery Suite if they preferred.

When the unit first opened, midwives were recruited to the Midwifery Unit both internally and externally through interview and those midwives recruited were chosen to fit in with the proposed ideology of 'women-centred', un-medicalised midwifery care. This continued to be the case. This strategy made for a very homogenous workforce. Almost all of the midwives who worked as core midwives on the Midwifery Unit shared a vocal commitment to birth with a minimum of

medical intervention. They prioritised alternatives to pharmacological pain relief and talked about their role in terms of trusting the birth process and employing what they understood as the traditional midwifery skill of 'watchful waiting'.

The local area and population

Northway NHS Foundation Trust had a diverse immediate catchment area. The area of the city covered by its commissioning Primary Care Trust included some of the most prosperous political wards and those with patches of urban deprivation. The local mean unemployment rate (in May 2008) was 5.9%, less than the city wide mean of 8.2% and significantly lower than the 12% in the Millside area. The Northway catchment area was home to a population of which 15.2% [range: 5.5% - 31.8%] was from BME communities (the City mean is 29.6%) and had an average population density of 4009 persons per km^2 [range: 2328 - 5177] which is only slightly higher than the City average of 3649 $ppkm^2$.

The midwifery workforce

During the time I spent doing fieldwork in the Midwifery Unit there were about fourteen core midwives on the Unit, working two per shift, accompanied by a midwife from one of the Trust's community midwifery teams. Of the fourteen core midwives, eight were White British, three were Black Caribbean, two White Irish and one of Chinese/White British origin. There were also students on short placements and newly qualified midwives who spent a few weeks of their first two years working on the Midwifery Unit.

The midwives in the Midwifery Unit appeared more middle class and more homogenous than those at Millside. One explanation for this may be that they were a self-selecting group who had chosen to work there because of their commitment to birthing practices which are traditionally associated with middle-class women (Crossley 2007). Many, but not all, of the midwives lived within the hospital's catchment area which had a far higher proportion (21.58%[9]) of tertiary-educated and professional residents, such as midwives, than Millside.

Midwifery Employment within the Unit

Unlike Millside, the midwives at Northway Midwifery Unit were almost all core to the unit and did not rotate between different clinical areas. There were a few midwives who split their time between the Midwifery Unit and the antenatal clinic doing scans or other specialist work and at each shift a community midwife came to work on the Midwifery Unit, but largely the midwives remained working in the Midwifery Unit unless they accompanied a woman to Delivery Suite when she was transferred for medical attention. The following page shows a map of the layout of the Midwifery Unit and its location next door to the Trust's main hospital Delivery Suite.

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[9] City Council education statistics (2004). Compares with an average of 19.8% in England and Wales and 16.6% across the City.

The Midwifery Unit

i   Children's play area
ii   Waiting area
iii   Office
iv   Reception
v   Store cupboard
vi   Visitors' toilet
vii   Breastfeeding room
viii   Staff shower
ix   Staff toilet

Sitting room

Retreat

Staff room

Changing room

viii   ix

kitchen

Main Delivery Suite

vii

bathroom

vi

Room E

Room D

Waterbirth room

Room C

Room B

MDS garden

garden

Room A

iii   iv

desk

Clean utility

ii   i

v   Dirty utility

Door to MDS   Door to Midwifery Unit

The Midwifery Unit was a specially built unit on the ground floor of the Northway hospital building, sandwiched into a space between two pre-existing buildings running parallel to the hospital's Delivery Suite. The Midwifery Unit and the Delivery Suite had adjacent main entrances as shown on the map above but were connected by a set of doors at the far end. These doors were used to transfer women in need of medical attention out of the Midwifery Unit onto the Delivery Suite and were also a staff shortcut between the two areas. The Delivery Suite at Northway was very similar in feel to that at Millside, although it was a bigger unit with sixteen delivery rooms, compared to Millside's ten. Despite the proximity to the Delivery Suite, the Midwifery Unit maintained a very different environment. The unit was bright, airy and calm. In contrast to the Delivery Suites at Millside and at Northway, the main corridor in the Midwifery Unit was flooded with natural light from the windows and a glass ceiling, which stretched, like a long conservatory roof, the length of the unit. The toilets were fitted with light pipes which brought daylight in through the ceiling and both the weather and the cycle of night and day were very much a part of the ambience.

Of course, the natural light in the unit was not accidental. The Unit was designed explicitly to provide a 'home-from-home' environment that was calming and different from the fluorescent Delivery Suite next door. Each delivery room had curtains, a sling hanging from the ceiling for women to hold onto, cushions, a floor mat, soft furniture, an en suite bathroom and little clinical equipment on view The aim was to make it look as little like a hospital as possible. At the Midwifery Unit

there were no restrictions on the number of visitors allowed in, with women and

visitors were free to come and go as they liked at any time of the day or night.

Women were encouraged to walk up and down the corridor during labour or spend

time in the retreat, which was designed with floor cushions and dimmed, coloured

lighting.

As at Millside Delivery Suite, the office, desk and staff room area was the hub of the

unit. The office and reception behind the desk were 'backstage' areas, but in view of

women and visitors who sat waiting to be seen in the reception. Conversations

behind the desk were hushed when women were waiting but loud and sometimes

raucous and heated when the waiting area was empty. The desk and office were used

as a social and work space by all the staff and this space was where I spent most of

my time whilst on the unit. It was the default venue for a cup of tea and a chat with

colleagues, with the staff room used for extended breaks and eating lunch. The office

housed the whiteboard, was used for handover and was the workspace for the unit

Manager, who attempted to work despite frequent interruptions and distractions from

staff talk in her office and at the desk just outside.

A lot of attention had been given to the interior design of the Midwifery Unit when it

was built but its location and shape was dictated by the availability of space within

the hospital campus. Compared to Millside, the Midwifery Unit at Northway was

quiet, with little noise filtering from rooms down the corridors. Its natural lighting

meant that it followed the cycles of day and night and with five delivery rooms for

just over 1000 births per year (over twice as many rooms per 1000 births as Millside). As an environment it was not shaped by a shortage of time and space to the same extent as Millside.

Conclusion

This chapter has sketched out the spaces within which my fieldwork took place. As I have shown, the locations of the two units and the local communities in which they are set were quite different. Thus the units differed not only in their perspectives on how childbirth should take place, discussed in Chapter Six, but also along social variables such as social class and ethnicity (e.g. Puthussery, Twamley et al. 2008).

The nature of the internal space was also fundamentally different between the two units. The attention given to the architecture and interior design at Northway Midwifery Unit was an attempt to provide a physical manifestation of the ideology of the unit which was intended to influence the practice of the midwives who worked there. Thus, despite this contextual chapter being entitled 'Setting the Scene', the space in which the midwives' work took place was not just background scenery or stage, but integrally related to their midwifery work. The workers in both units were preoccupied with the places and spaces in which they worked, and the ways in which they felt both freed and constrained in their practice. In the following chapter, Chapter Five, I explore the ways in which midwifery practice within these two settings was emotionally demanding for midwives and how their relationships with colleagues, women and visitors was played out within the two units.

Chapter Five: The emotional demands on midwives

Midwives work with women and their families around one of the most intensely emotional events of their lives. They work with women in pain and distress and the existing literature on their emotional labour suggests that they also work to reconcile the differences between the discourse of an ideal midwifery practice and the reality of working within a bureaucratic, under-resourced and constraining institution (Hunter 2004; 2005).

Drawing on the findings from fieldwork at Millside Maternity Unit and Northway Midwifery Unit, this chapter lays out some of the emotional demands on midwives: both in terms of how they experienced and described their own and others' emotions, and how they described the strategies they used to negotiate and manage those emotions when they were problematic and/or required emotional labour. The penultimate section of the chapter outlines the formal systems in place within the Trusts that aimed to support midwives, to promote their professional development, emotional wellbeing and communication with their employers. At Millside and Northway Midwifery Unit, these systems which included the Statutory Supervision of Midwives, as well as Trust provision of counselling and forums for feedback to senior staff, went some way to successfully supporting midwives, but were felt to be insufficient. The following two chapters, Chapters Six and Seven show how midwives devised and utilised *informal* coping strategies to better manage their

work's emotional demands, including the dissonance between the ideal and reality of their practice, and to try to make up for shortcomings in the professional and institutional support provided for them.

Unlike the subsequent two chapters, in this chapter I start out by analysing the emotional demands on the midwives in the two Trusts together, rather than taking each Trust in turn. This is because there were so many experiences that were common to both groups of midwives. Where experiences in each Trust were different, however, I analyse them separately in order to highlight the effects of different kinds of workplaces on their experience. This is particularly the case as regards how far the midwives felt they could depend on their managers for support.

Part I: The emotional work of caring for women

The midwife-mother relationship

The value of the midwife-mother relationship is central to the discourse of midwifery (Kirkham 2000a). The midwives at Millside and Northway Midwifery Unit spoke of their emotional relationships with women as if their emotions were inevitably very much intertwined. They managed their emotions at work in order firstly to present a positive, calm, communicative demeanour, and secondly to protect themselves from the adverse effects of the emotional intensity of birth. Much of the midwives' talk of their emotions was about how they went about performing emotions: those that they felt, as well as those that they did not feel. Jodie, a midwife on Millside Delivery

Suite, explained the reasons for expressing the 'right' kind of emotion when around women:

> A lot is about touch and I'm not talking - I'm talking putting your hand on someone and saying 'are you ok?' you know… When I did my training I did a massive thing on communication skills but non-verbal. You know you can walk in that room, real arsey face on you, and you'll change the mood. [Interview, Jodie, 19.04.08]

Similarly, Kate at Northway Midwifery Unit said: 'a smile, I think, is incredibly important: it sets the scene, doesn't it?' [Interview, Kate, 05.08.08]. Their desire to express the right kind of emotion was predicated on a taken-for-granted belief that a midwife's job was to provide not just clinical but emotional support for labouring women. When I asked her what made good midwifery, Veronica said:

> I suppose it's empowering women. And other characteristics that could be applied to any job really: it's being calm and organised and dealing with stressful situations and managing stress, just being an advocate [Interview, Veronica, 25.02.08]

Being emotionally sensitive was part of what made a good midwife because the midwife's and woman's emotions fed into each other and the midwife was obliged to

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sustain an environment in which women's positive emotions are maintained above all others. The 'feeling rules', that specified '*what* emotions people should express and *the degree* of that expression according to their social rules' (Theodosius 2008: 16 emphasis in the original), were learned in part by the midwives' training in non-verbal communication skills as well as what they observed in other more senior midwives during training placements.

Midwives' influence on women's emotions

As Jodie and Kate's comments illustrated, a woman's emotions during birth and postnatally were influenced by the expressed emotions of her caregivers. Midwives explained how they expressed particular emotions to provide an antidote to women's fear: for example being calm when with women who were particularly frightened or disturbed by the sensations of labour and birth. Fiona said, 'I just try to stay really, really calm' [Interview, 21.02.08] and Kate described her need for calm in order that problems could be detected: 'you're expecting it to be normal so anything that's not normal then it jumps out at you because it's peaceful, it's calm' [Interview, Kate, 05.08.08].

Whilst midwives aspired to be calm in both units, they differed in their capacity to achieve it. At Millside, it did not appear that midwives were often able to achieve this ideal around women. Midwives on Millside Delivery Suite often spoke loudly and insistently when working in rooms, particularly in the latter stages of birth. I heard their encouragements or instructions to women and partners from the desk in

the middle of the ward. On one occasion I could hear one midwife say to the partner of a woman who was not pushing effectively: 'the head will keep coming back and forward and if she's not pushing hard enough it won't come though' loudly and within earshot of the woman concerned [Fieldnotes, Millside, 17.12.07].

Those midwives at Millside who spoke to me specifically about being calm with women, Veronica and Fiona, were those who were particularly vocal to me about their commitment to 'normal' birth. Midwives have written of 'good' midwifery as the art of 'doing nothing well' (Powell Kennedy 2002). This is described in other contexts as 'watchful waiting' – that is simply *being* with women: being physically and emotionally present, often in silence, watching her behaviour, perhaps touching to comfort, rubbing her back during contractions, creating an atmosphere of calm: of being present and having the *potential* to act if necessary but not the need to fill the time with tasks. 'Being with' but not *doing* requires confidence that the process of physiological birth will mostly happen successfully without intervention and it privileges the 'normal' over the 'abnormal', both central tenets of midwifery practice. Fiona, a midwife on the Low Risk Postnatal Ward at Millside told me about her beliefs around working with women during labour when she is on the Delivery Suite:

> I think if a woman can say 'I've done it all by myself' that's the greatest
> compliment to the midwife. It doesn't exclude her, it completely includes the
> midwife because, yeah, that's what we're there for I think, to facilitate a

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normal birth. Some women need us completely in the front and very much in

their face and coaching and supporting; some women don't, but just to be

there in whatever way is necessary for them, for the woman to feel 'I can do

this myself and I've done it'. It's – really that sums it all up for me

[Interview, Fiona, 21.02.08]

Fiona's assertion that a midwife should facilitate but not 'do', closely reflects the

wider midwifery discourse. Whilst Fiona's ideology was in line with the traditional

midwifery model of care, her and Veronica were the midwives who appeared the

most alienated from their workplace community at Millside. Fiona described the

emotional labour involved in working with colleagues who she felt did not share her

views:

I really try to have – open as in a collegial, nice relationship to my colleagues.

I'm not hostile to anybody and I don't feel hostile to them, I'm not faking it.

But there's a lot of diplomacy as well because I really want to make sure that

the limited amount [of time] I've got I spend as pleasurable for everybody as

possible. [Interview, Fiona, 21.02.08]

At the time of my fieldwork, Fiona, as well as Veronica, was struggling with

reconciling her ideals of practice differing from the reality of work at Millside. Being

calm when working with a woman appeared to epitomize a part of the ideal to which

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they aspired, but which was difficult to achieve because of the chaotic environment of the unit. The difficulty for Veronica and Fiona was that they worked within an environment which they believed did not privilege the 'normal' over the 'abnormal' nor 'being with' over 'doing'. The sense of chaos at Millside stemmed from a number of factors including the chronic shortage of space, which meant women on the Delivery Suite and the postnatal wards were quickly moved on to make way for others. The situation at Northway Midwifery Unit was different, and led to a calmer atmosphere. Northway Midwifery Unit did not have the same restrictions on space and had fewer women on at any one time, so the care which women received was more leisurely. Women often spent at least six hours on the ward after they had given birth whereas at Millside they were usually moved on to the postnatal ward after about three hours. At Northway Midwifery Unit, the interior design of the unit was specially made to create an atmosphere of calm, which included hiding medical equipment out of sight and providing dimmed lighting. This contrasted with the medicalised environment of Millside, which persisted despite the Consultant Midwife's efforts, for example, substituting the clinical posters in the rooms with framed art [Fieldnotes, Millside, 15.05.08]. In Chapter Six I write more about the influence of space, including interior design, on clinical practice.

A third factor which sometimes made Millside feel chaotic was the attitude and skill of the different midwife Shift Leaders. The Shift Leader's job included dividing up the list of inpatient women between the midwives and balancing the workload

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between them, overseeing the care of women, offering advice to midwives and controlling the flow of women in and out of the wards. Each ward had a Shift Leader for a shift. On the Delivery Suite the Shift Leader was not supposed to take on the care of a woman but shortages of staff meant they usually did. They would, however, assign themselves a postnatal woman or a woman having an induction as they assumed these would be less demanding than a woman labouring, leaving them free to support the other midwives.

Jodie explained how the Shift Leaders influenced the feel of a shift for her, which in turn affected women's experiences:

> You know and it's like you look at who's in charge and think [pulls a miserable/hard-work/demoralised face]. You see what I mean though? As soon as you see who's on [the shift] that will effect how you – so if you walk in a room – lots of times I've had a woman and thought 'oh please have somebody nice come on'. [Interview, Jodie, 09.04.08]

Jodie wanted to protect the woman she was with from the negative effects of a Shift Leader midwife who wasn't 'nice', which suggests the extent to which she believed in the importance of a midwife's attitude on the woman's experience of labour. Jodie's explanation of the similarity between midwives' and mothers' experiences was supported by my observations of different Shift Leaders at Millside:

Caroline is in charge and is upset because she's had to cancel her holiday.

Someone groaned this afternoon when they found out she was in charge. She

doesn't have the authority of Suzanne or Miriam and sometimes looks like

she's floundering [Fieldnotes, 29.11.07]

And at Northway Midwifery Unit:

The Midwifery Unit manager is cool and authoritative. She decides which

midwife is going in which room, apologises to Joy who now has two women

and gives clear instructions to Abida [the Maternity Assistant] to do

observations, tea & toast and one-to-one T.L.C. to the woman in Room B.

Done. Dusted. Everyone goes off to start the shift… It makes *such* a

difference who is in charge. It's the same at Millside. The attitude of the

midwife in charge at handover sets the tone for the rest of the shift. They

need to be calm, confident and competent (or at least appear that way)

[Fieldnotes, 19.06.08].

Shift Leaders who appeared disorganised meant shifts felt disorganised. Regardless

of the number of women on the ward, confident Shift Leaders resulted in shifts

which felt more under control, with each member of staff aware of their duties and

roles. Under an organised Shift Leader, the staff had space to be calm because they

could trust that someone was in charge and could sort of the problems, such as finding bed space, as they arose.

The influence of the Shift Leader's performance on the midwives seemed almost exactly to mirror the influence of the midwives on the women. Midwives also explained other ways in which their own relevant experience, such as their own pregnancies and births and the emotions it had aroused, influenced how they behaved around the women they cared for. Miriam talked to me about the effect that her own miscarriage, many years before, had had on her care for women experiencing pregnancy loss:

I had a miscarriage when I was 18, 19 weeks [pregnant]. I learned a lot from that, funnily enough, because the girl next door was exactly the same gestation as me, pregnant wise and I lost this baby two days before Christmas… Losing the baby I could deal with, that was fine, got over it. But it was really hard, people's reactions when you got out. The girl came round from next door and asked to borrow some milk but never mentioned that I'd been pregnant or lost the baby. Same with everybody else, they just didn't know how to make the conversation. So I think I learned from it that you don't ignore and change the subject, you've got to you know, sort of talk to it with the woman. She might burst into tears but, you know, at least

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acknowledge that she's been pregnant and lost the baby and not just try and

change the subject. [Interview, Miriam, 16.06.08]

Similarly, at Northway Midwifery Unit, the birth of Virginia's son, two years' previously, had also had an impact on her work, particularly as the birth had not gone as planned:

My midwife was a friend and I saw how stressed she was and that had a

knock on effect with me so that's made me realise that I cannot show stress to

my ladies because occasionally I looked at her and I felt bad that we'd put her

in an awkward position to look after a friend. [Interview, Virginia, 22.09.08].

Many of the midwives believed that the way in which they expressed their emotions whilst with a labouring or postnatal woman had a profound effect on that woman. Some particularly desired to be calm because being calm during labour demonstrated a confidence in the physiological process of birth that was understood as a key skill of a good midwife.

Women's influence on midwives' emotions
Not only did midwives believe that their own emotional state significantly influenced a women's experience of birth, but they also described how they themselves were affected by being around women's emotions. The regulation of feeling was

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something common to all the midwives I spoke to, in one form or another. They all, without exception, explained ways in which this kind of emotional labour played a part in their work. The stories I told above were variously examples of surface acting and deep acting (Hochschild 1983: 33ff). The way Fiona spoke of how she 'stay[s] really, really calm' [Interview, Fiona, 21.02.08] when around distressed women, suggests that she also *feels* calm, that is, her expression of calmness is what Hochschild terms 'deep acting', during which 'the actor does not try to seem happy or sad but rather expresses spontaneously…a real feeling that has been self induced' (Hochschild 1983: 35). In contrast, Virginia's comment that she 'cannot show stress to my ladies' [Interview, Virginia, 22.09.08] is an example of surface acting, wherein we 'deceive others about how we are really feeling without deceiving ourselves' (Hochschild 1983: 33).

The midwives' emotional labour in the face of normal birth involved both the management of the expression of feeling, as well as changes in the feelings themselves. As midwives were reluctant to demonstrate what they saw as inappropriate emotions to women, they performed instead, in order to prevent negatively influencing women's emotions but also, importantly, over-exposing their own. Virginia, a Northway Midwifery Unit midwife, described a shift in performance between her backstage and frontstage performance that also illustrates what Goffman (1990 [1959]: 123) describes as the 'wonderful putting on and taking off of character' between the two:

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Virginia: Sometimes…we're outside of a woman's doors and we're

              having a bitch with another midwife over something that's

              happened on Delivery Suite and we look so livid and you go

              through the doors and you're all serene and you're like [smiley,

              calm] 'hi, how are you doing?' and that's how we do it, we're

              really good. It's bizarre how you can go from absolutely boiling

              to 'ok, now I'm back with my lady and it's fine'.

Juliet: You just perform it.

Virginia: Yeah and it is weird how you can be stressed about a million

              and one things and then…

Juliet: Do you actually feel calmer when you go back in?

Virginia: A lot of the time. Yes.

Juliet: Or do you just play calm.

Virginia: No, a lot of the time I do [feel calm]. It's like I walk through that

              door and it's like this is this woman's experience and I try and

leave any negative stress I've got at the door. So I'm completely

able to be with her. Because I think you can subconsciously pass

stress on to people. I really do think that. Yeah, so that's really

made me try and focus on going in as a – just a warm, inviting

blank canvas to help that woman. [Interview, Virginia, 22.09.08]

The difference here from Goffman is that Virginia describes her change in emotion

not only as a performance, but as something she felt. 'Hardening up' or performances

'on stage' (i.e. in rooms) resulted in midwives modifying their *felt* emotions, through

Hochschild's 'deep acting'. Midwives recognised that different women often wanted

different things of them: some women wanted hands on, active support whilst others

wished to be left alone. Being a blank canvas also enabled a midwife to hide her own

feelings when caring for women but also ran the risk of her being vulnerable to

soaking up those around her. Most of the midwives I spoke to had developed

strategies to resist against this, for example, rationalising bad experiences. However,

Fiona, a midwife at Millside, was unique in aspiring to such vulnerability in her

relationships with women:

I think what I really like about Midwifery is the in…I don't know if 'intense'

is the right word, not 'intense' like urgh, but like very close. You've got, if

you wanted, you've got the opportunity to get very close to the women and I

like…I do like to get close to people. I think that's what life's all about you

know, it's not worth just hiding oneself all the time, which is what one has to

do all the time in society. But in – as a midwife, especially in labour, you

have a chance to get close, especially if the woman wants it. It's fragile; you

really have to protect the woman because there is that window of her

closeness. And really women have to open up, they have to open up to give

birth so, you really get it usually [Interview, Fiona, 21.02.08].

Other examples showed how midwives performed the expected behaviour of a

midwife, for example, being welcoming:

When the phone call comes in - you know the way we say in clinic 'oh go

away!' before we pick up and say 'oh hello!' [smiley happy voice] [laughs]

[Interview, Majan, 14.12.07]

And calm:

The girls, my colleagues say, 'you never look harassed!' and I'll say 'no, but

I am inside', I am inside, because some people look obviously harassed

whatever, but I'll be harassed inside [Interview, Elizabeth, 19.02.08].

Death and loss

Working in the face of death seemed to require a different kind of emotional labour from caring for women during live births. During live births, midwives sought to influence the woman's emotional response to the situation by being, for example, particularly calm (i.e. 'deep acting'). However, during stillbirths or pregnancy losses, the work went into hiding their own emotional responses to what was happening (i.e. 'surface acting'). The midwives at Northway Midwifery Unit very rarely worked with women experiencing pregnancy loss, so most of the evidence I have around the emotional labour involved during death and loss comes from Millside. This is because, unlike the Midwifery Unit, Millside Delivery Suite midwives cared for women with serious complications, stillbirths, late terminations and miscarriages on a daily basis. Whilst we sat together on the Delivery Suite at Millside, some midwives explained to me how and why they disliked crying in front of women. It seemed to them that their expression of emotion and a woman's expression of emotion were mutually exclusive: that they would not be able to adequately support women if they themselves were upset. 'Excessive' crying, for example, was not within the feeling rules they had developed around death and dying. On 19th December 2007 at Millside, a midwife came up from clinic to fetch some drugs for a couple who had chosen to terminate the pregnancy of a foetus with Down's Syndrome:

"I didn't want him to be a nice man" she says of the father, "but he was

sobbing; and you know what it's like, I was welling up. You know how

you're swallowing [to hold back the tears]. It's terrible; you're supposed to be

caring for *them*" [Fieldnotes 19.12.07].

Again, Elaine described listening to the heartbeat, in-utero, of a baby with

hydrocephalus (see Glossary) who would not survive birth:

They had listened in at the woman's request and it had hiccups. Elaine said

the woman was quite composed but she [Elaine] got all teary. "Sorry" she

said to the woman; and then to me: "you're supposed to be supporting them

and you're blubbing" [Fieldnotes, 03.01.08].

Some performance of emotion was desirable – it made midwives seem human and

that they cared. These were very distressing experiences and crying would have been

an understandable reaction, however, open or 'excessive' crying threatened to turn

the tables on the caring relationship so that the woman might feel it necessary to care

for the midwife. It was more acceptable, although still embarrassing, for a midwife to

cry off-stage, out of sight of women. Lyn's comment that 'we all have our own place

where we cry at work' [Interview 30.01.08] suggests that crying at work, for

whatever reason, was common. I observed staff cry three times whilst I was on the

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unit at Millside and not at all at Northway Midwifery Unit, although these were all

tears of frustration rather than in response to distressing cases.

Most midwives had sought to 'harden' themselves against the effects of women's

intense emotions and of distressing situations such as the death of a woman or baby.

They demonstrated deep acting, through which they sought to change their emotional

response to a situation, as well as learn to manage their subsequent expression of that

emotion. Miriam, a very experienced midwife, explained this deep acting most

clearly:

> I think you've got to harden yourself, you know. I mean I can remember the
>
> first stillbirths I used to deal with, tears dripping down, you know. But you
>
> still feel that for that woman and the family but you don't show your
>
> emotions as much, well I don't as I did when I first qualified. [Interview,
>
> Miriam, 16.06.08]

She then told me about the death of a woman from complications relating to a

pre-existing illness and explained her strategy of rationalizing it as an unavoidable

death. In emphasising these aspects of the death, she manipulated her emotional

response to it:

Juliet: How did that experience [of the woman's death] affect you on a personal level?

Miriam: Er…I don't know that it did really. That sounds awful, doesn't it? I mean I've seen women die and this woman was ill and the disease that she'd got had a poor prognosis anyway. I felt upset that the family weren't with her, because they weren't. I felt upset that she hadn't been able to see her baby because she never came round to see it. But I also think that to the end she was chatting, she was fine and she won't remember anything [Interview, 16.06.08].

The skill involved in such self-protective rationalisation was especially evident when I spoke to a midwife who had yet to master it:

I speak to Lindsey, who hasn't been qualified long… She launches into a story of the first time she dealt with a miscarriage. It was a woman who walked off the street 23 weeks pregnant and 10cm dilated, before long the woman gave birth to a tiny foetus who lived very briefly and then died. She said it looked like a tiny bird that had fallen from its nest and it shocked and upset her. The theatre filled with people all being busy but, as a student, all she could do was stand there and watch, feeling helpless and 'like a spare

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part'… I asked if it got any easier since she was qualified. She said she gets

more used to seeing things like this but it's still upsetting [Fieldnotes,

Millside, 23.01.08].

Other midwives found ways to minimise their contact with upsetting situations.

There were two midwives I heard about who, following their own pregnancy losses,

chose not to work in the Bereavement Suite at Millside. Majan also avoided working

there since a shift in which she had been assigned to simultaneously care for a

healthy postnatal woman and another who had had a stillbirth. She had found the

emotional labour involved in this intolerable:

I had to work on the High Risk Postnatal Ward and suddenly there was a lady

in the Bereavement Suite right? This lady [on the Bereavement Suite]: I

delivered her baby, had to do all the handprints[10] and everything and got my

colleagues to care for my women on the High Risk Ward. But I had to finish

with her and come back to the High Risk Ward and care for women with

babies and that was awful. I had to smile, make them happy as if nothing is

going on and go back to the other lady and be solemn, meaning, 'I understand

your grief, I understand your pain' and it's not very easy. I have to switch on

and off, but we are human beings! You can't just keep switching on and off

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[10] After the births of stillborn babies, a number of rituals were undertaken to commemorate the birth
and death. Midwives made ink handprints and footprints of the baby for the parents to take home.
They dressed the baby and took commemorative photos and the parents were encouraged to spend
time with the baby before it was taken away for burial or cremation.

like that: going to women and being solemn and understanding, talking, supporting and coming back and saying 'oh what a wonderful baby!'. Oh come on! You know, you can't do that… I started building up defences; my reason why I don't want to go onto the Bereavement Suite because I can't be switched on and off. I don't want to be there. So that's what you get. People will start running away from it, finding excuses why they don't want to be there. [Interview, Majan, 14.12.07]

One midwife I spoke to on the Low Risk Postnatal Ward told me she particularly liked working on the Bereavement Suite. She enjoyed spending long periods of time with women without rushing, and gained pleasure from emotionally supporting women, or 'mothering them' as she described it, despite the distressing circumstances. Emotional labour like this could be very satisfying for midwives because it enabled them to provide the kind of holistic, woman-centred care they often looked for but failed to find elsewhere. The emotional labour involved was not distressing or difficult but a source of satisfaction. It became intolerable, however, for those such as Majan, who were required to rapidly shift their emotional performance back and forth.

Difficult relationships

Millside

The midwives in the two units differed by how much they were willing to speak about relationships with women and their partners that were characterised by aggression, violence, fear or prejudice. There was evidence from my observations at Millside that verbal or physical violence against midwives was reasonably common and there were episodes of racism against staff in both units. At Millside, negative relationships with women or their partners were often characterised by non-compliance, violence or difficulties in communicating. Verbal abuse of midwives and assistants was frequent and I noted five cases of verbally or physically abusive men being removed from the unit by Security on the days I was there. Midwives also told me stories of further incidents in interview. Midwives found both verbal and physical threats distressing. On my first day at Millside, I talked to Veronica who was in tears because that morning a man had threatened her and they had had to call Security to remove him [Fieldnotes, 16.11.07].

Most of the accounts midwives gave me of bad relationships with women or partners were countered, within the same narrative, by good examples. For example, Elizabeth told me about some encounters she had with parents she worked with:

> When I get from those parents 'thank you, thank you, thank you' I think 'this is why I do it. This is why I do it'. Honestly, this is all it is Juliet… the good

thing about it is you always get the positive thing about it, it's rare that you get, you know, that man who shouted at you two months ago. When you meet them, the funny thing is that they don't shout, they don't come at you negative again, do they. They don't. I actually met somebody like that. I was walking and I walked into a shop and they said 'hello, you don't remember me do you?'. And I went 'I remember you but I'm not going to tell you'. Because it was still a very fresh one and somebody we'd had an incident with and he'd been really – he just was unforgiving and he just was – and he said 'oh, do you want to see – this is a picture of the baby and they're doing well, mum and baby'. And I said 'oh I am glad they're doing well' and I came away thinking 'well, to think how he was that day with – !' But all these, the thank yous and whatever and it doesn't have to be…it is just that, 'thanks for being there with us' or whatever 'for bring our baby in' and it's not anything to do with any other gifts or anything, it is just the appreciation…they're hugging you and everything and you're like that's why you do the job really, it is, yeah [Interview, Millside, 19.02.08].

Her narrative about the man in the shop is placed between other examples of *positive* relationships with families. This strategy of minimising the negative incidents suggests that such poor relationships were unusual or may indicate a way of minimising their emotional importance to herself. Elizabeth refrained from using words to describe exactly what happened, instead using elusive phrases such as

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'somebody we'd had incident with' and 'he was unforgiving and he just was – ',
which contrasts with the verbatim quotes she gave of happy families who were
grateful for her support.

Jodie also used the same technique of masking her dissatisfaction behind a more
positive gloss:

> Visitors are horrendous. But I do love my job, I'm moaning now. [Interview,
> Jodie, 09.04.08]

This was a common strategy by midwives when talking about the negative aspects of
their work. Comments such as 'you could make it [the interview with me] a total
moaning session and this is crap and this is crap. But it isn't all' [Jodie, Millside,
09.04.08] and 'Sometimes actually it's alright working with next door [Delivery
Suite] and it's not that bad really' [Interview, Kate, Northway, 05.08.08] were used
to manage the midwives' concern at not appearing 'midwifely' in their manner.
Similarly, when interviewed, Kate and Jodie also demonstrated their anxiety after
revealing possibly controversial personal opinions by saying 'I've bored you silly'
[Jodie, 09.04.08] or 'you probably need to scrap all of that. I'm so sorry Juliet' [Kate,
16.07.08].

These examples demonstrate how midwives sought to maintain a public image to me in which they took pleasure in nurturing close relationships with women and partners. They were generally unwilling to talk openly to me about poor relationships because feelings such as impatience or disgust were not compatible with the discourse of midwifery professionalism. However, despite their desire to present a positive image about their relationships with families, they also wanted to use me as a sounding board for the negative emotions which often resulted from these relationships. The narrative strategy of framing negative statements with positive assertions allowed them to do both.

Northway Midwifery Unit

The influence of a midwifery discourse of positive relations with women and their partners was even greater on the Midwifery Unit midwives than it was on those at Millside. The midwives at Northway Midwifery Unit were far less willing to talk to me about poor relationships with families. The Unit's 'Philosophy' (See Chapter Six for further discussion of the Philosophy), which mirrored the midwifery model of care and the discourse surrounding it, emphasised the role of midwives in supporting and being with women. This made it less acceptable for midwives to talk about difficult relationships with families. I have only one example, from the Unit manager, who told me about a man who made the midwife attending his wife cry by shouting racist remarks at her. The midwife, who was Caribbean, left the room and refused to go back in. It was only after the man had apologised that the manager

persuaded the other midwife on that shift, who was also Caribbean, to go and care for them.

Frustration and Ideological conflict

Millside

Much of the distress the midwives experienced at Millside was down to the mismatch between their ideal, desired way of working and the daily reality. I observed this 'ideological conflict' (Hunter 2004) in practice most days in the unit and it was described in one way or another by all the midwives I interviewed. The ideological conflict was illustrated by manifestations of a tension between the midwives' belief that good, woman-centred care required spending time with women and the reality that the demand for efficiency from the institution allowed them little time with each woman. The perceived conflict was founded upon two taken-for-granted principles. First, that more care is better care: i.e. that spending more time with women would inevitably lead to women having higher quality, personally tailored care. Second, that midwives had a duty towards the women they cared for to provide such woman-centred care. These two premises were neither explained nor commented upon by the midwives neither to each other, nor to me, but they seemed to form the foundation of much the aspiration, frustration and the distress that midwives experienced on a daily basis.

The midwives adapted their working practices in order to do their best to fulfil the duty they felt towards women, whilst working within an environment which was time and space pressured. Midwives at Millside adapted to the restrictions of the workplace which prevented them from being 'with woman' by instead focussing on finishing a series of tasks throughout the day. This was most apparent on the postnatal wards because midwives cared for between three and seven (and sometimes more) women at any one time and each woman required similar basic observations at regular intervals. A number of midwives referred to this kind of care as 'conveyor-belt' care, a phrase used widely in maternity services to liken task-based healthcare work to factory work – with midwives performing the same identical task on each woman without adapting it to suit her individual needs. 'Conveyor-belt' care was a strategy which aimed to give equal (if inadequate) care to all women. Some midwives made disparaging remarks about those who took more than their 'fair share' of their time, for example, the private obstetric patients who used the facilities at the hospital. Jodie objected to private patients making demands beyond those of the NHS patients, particularly of the staff who were not paid any extra for caring for them:

> Juliet: How do you feel about the consultants who bring private patients into a public hospital?

Jodie: I think they should stay and look after them. I think that women

should realize they're having private obstetric care, they're not having

private - we get them come on the ward 'I want this, I want my own

private room, I want this' well they can't. They have to be aware

they're not paying for that. They're paying for the private obstetric

care from the consultant. So they'll come on the ward and say 'we

paid for a room' well tough, we haven't got one. You know, they're

not aware of that [Interview, Jodie, 09.04.08].

Miriam also objected to what she saw as one consultant's unequal treatment of his

private and NHS patients:

Miriam said '[he] drips all over his private patients. It makes you sick to see

it, at the expense of our women'. She claims he uses 'our [NHS] women' as

guinea pigs to experiment on – e.g. not taking them for c-section as quickly

as he would a private patient, when it's required [Fieldnotes, Millside,

19.12.07]

Whilst I have no evidence that this was in fact the case, Miriam's strong opinion

exposed her commitment to equity of care, even if that care was not always adequate

(Lavender and Chapple 2004). In this story, her term 'our women', despite its

patrician overtones, aims to ally the midwives with women as against the private-practising obstetricians.

The midwives appeared to struggle particularly to provide equal care to women who had diverse needs and demands. Jodie explained this with clarity, and her observations were representative of the wider concerns of the midwives. For example, some women had complex emotional or social problems, which required more than the usual attention:

> You kind of think, 'well, I did the best that I could today'. Particularly on the ward when you've got all these women and everybody hands over going 'I'm really sorry, I haven't done this, I haven't done that' but you sit there thinking 'but I'll be handing half of this over [too]'… Do you know what, I think that day I'd got - I think I'd got seven, eight women, no seven women. One, was homeless with two kids that she'd left with somebody she'd met yesterday. One her husband disowned her and sent her back to Pakistan [Interview, Jodie, 09.04.08].

Doing a good job on the postnatal ward included providing adequate care for women *and* keeping the organization running. Jodie was concerned both for the welfare of the women but also for her colleagues on the next shift who would have to take on the tasks she had failed to complete. In another example she gave, those particularly

demanding women were described by her as threatening the welfare of the other

women on the ward. Breastfeeding women took up a lot of midwives' time on the

postnatal wards and whilst all the midwives expressed a general attitude in favour of

breastfeeding, the reality of supporting newly breastfeeding women meant that their

limited resources were not spread evenly between the women in their care:

I think the breastfeeding thing is a big…which, I mean, yeah, great we all

know it's best and I breastfed mine. But it's not for everybody and I think

that bullying: 'you must breastfeed, you must breastfeed' and it isn't always

– and again time. If you're on a ward with 26 women and you've got one

breastfeeder, you could spend the night with her. And [then] she goes and

gives it a bottle [Jodie gives an ironic smile] [Interview, Jodie, 09.04.08].

Jodie's comments illustrate a tension between the institutional and professional

rhetoric (to support 'breast is best') and the amount of time breastfeeding women

needed from midwives who were then unable to give equal attention to women who

chose to formula feed. Midwives described the impossibility of attending equally to

every woman in their care as 'frustrating'. 'Frustration' was the most common

emotion expressed by midwives during interviews and informal discussions at work.

This single word described a multitude of emotional responses to situations. Like the

term 'stress', 'frustration' was used to try and explain very complex feelings which

the midwives found difficult, or did not want, to describe in detail. The sources of

frustration were many and varied and manifested themselves in different ways. For example, Elaine described as 'frustrating' a scenario in which a woman under her care had been left for long periods during labour:

> Elaine was supposed to be looking after her this morning but had two other woman delivering and so couldn't go in. The woman was getting increasingly distressed as the time passed and has just had an epidural. The implication was that she might not have needed one if she had had the support. Elaine talked about how frustrating that was, to know she needed attention but not be able to give it. [Fieldnotes, Millside, 17.12.07]

Fiona, on the other hand, described her frustration at having limited control over the outcome of labour:

> You tend to get given somebody who's so many centimetres dilated (see Glossary). It's like the damage – this might be a bit harsh, but the damage might already have been done by a various number of reasons so – it's like it's never completely in my and the woman's hands and it is frustrating. [Interview, Fiona, 21.02.08]

Whilst midwives were keen to tell me about the 'frustration' of not being able to give women appropriate care, there was also evidence that at times midwives avoided

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close relationships with women or spending a lot of time with them, in order to protect their own emotions. One young midwife said to me and some of her colleagues in the Delivery Suite: 'You know you're supposed to be in a room with a woman all the time, but I feel like I haven't got anything to do…I don't like it' [Fieldnotes, Millside, 12.12.07]. It was emotionally demanding to give one-to-one care. In an environment which favoured task-based work, it felt awkward to just *be* with a woman, without '*doing*' some clinical task.

The midwives in the two units experienced being 'with women' differently. This was because they had developed different norms of what constituted 'work'. At Millside it was unacceptable to sit and have a cup of tea during quiet times. Work was very much equated with doing and appearing busy. If they didn't have a woman assigned to them on the Delivery Suite they would go and find something else to do, such as strip a bed or restock the drugs cupboard. In contrast, when the unit was quiet, the midwives at Northway Midwifery Unit often spent time together drinking tea and talking about work or their home lives.

Northway Midwifery Unit

Unlike Millside, the midwives at Northway Midwifery Unit did not experience such a stark contrast between their ideals and the lived experience of their practice. In the main, the midwives there did not describe the tension, as the Millside midwives did. The only midwife who clearly spoke of a difference between her ideals and the

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reality of working in the Midwifery Unit the Unit Manager. The manager's tension manifested at the boundaries of her roles as midwife and as manager. Her job as Unit Manager frequently put herself in a position at which her 'midwife self' and her 'manager self' were set against each other. For example, her manager self was forced to find ways of increasing the numbers of women birthing in the unit in order to secure its future, which her midwife self knew would introduce new restrictions on the time she could be 'with woman':

> That's why sometimes I think I shouldn't be here. I have managed to almost double of the numbers of the women and the closures[11] - the downside of that is that when you get busy and you're stretched, people do become quite negative. So I don't know how to – I need to resolve that somehow [Interview, Midwifery Unit Manager 16.07.08].

and again:

> Manager: Sometimes they [the other midwives] make the odd comments which absolutely floor me and I'm gutted.

> Juliet: Yeah?

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[11] i.e. The frequency with which the Midwifery Unit is forced to temporarily close to labouring women. Since the Unit Manager had been appointed, the incidence of closure had dramatically reduced.

Manager: Things like um, that I'm trying to get women off really fast

and that care isn't the priority, you know, it's the numbers.

And somebody will just say that and I'm absolutely gutted

because that's not my priority. But I have to take it on the

chin. [Interview, Midwifery Unit Manager, 05.08.08]

She had to keep the Midwifery Unit open by considering economic factors which were invisible to the average midwife. At our first meeting, before I started fieldwork, she said to me that she struggled with the compromises that being a manager forced upon her. I wrote in my notes after the meeting:

She launched into a lengthy speech about how being a manager forces her to compromise all the time and she struggles with that… She thinks the Consultant Midwife has the luxury of being able to ignore reality some of the time, whereas she's been put in post to improve efficiency and cut costs [Notes from meeting with Midwifery Unit Manager, 29.01.08].

For the midwives on the Northway Midwifery Unit, their ideological conflict was played out between the ideology of the Midwifery Unit and the perceived dominance of the neighbouring Delivery Suite at Northway. In Chapter Six I explore the relationship between the Midwifery Unit and the Delivery Suite in detail, and

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examine the way in which their differences, both real and imagined, contributed to the midwives' experiences of a tension between how they wished to practise and how they were required to practise. At both Trusts, so much of this conflict was played out in spatial terms: that is, the contradictory influences on midwives' work stemmed from different clinical areas within the Maternity Units.

Part II: Coping strategies and systems

The first half of this chapter has given many examples of the difficulties produced for midwives by the effects of institutional restrictions. NHS Trusts and their employees have often been blamed for sabotaging, rather than facilitating, a midwifery practice which is flexible, woman-centred and conducive to generating positive emotions in all concerned (e.g. Pollard 2003; Hunter 2004). Whilst there is evidence that this is frequently the case, the NHS Trusts of Millside and Northway, like others, had a number of systems in place to manage midwives, which also aimed to emotionally and professionally support them at work. These systems sought to give midwives access to managers in order that they could make their voices heard; they aimed to campaign for better working conditions for midwives and other staff and to provide them with emotional support and professional development. Much of the emotional labour – the need for it and how to do it – was learned from other midwives. It was apparent that the midwives wanted more recognition from others (particularly those in authority) of the difficult emotional labour that their job demanded of them, and support so that their work created less emotional toll. In the

following section I explore the extent to which the midwives considered the

emotional demands and accompanying emotional labour to be formally recognised. I

also look at how far the 'shop floor' midwives considered the support work (as

opposed to the managerial work) of the managers, and institutional support systems

to be successful.

Institutional Support

Millside

Support from management

The middle managers in both units played a crucial role as intermediaries between

the 'shop floor' midwives and the Trust senior managers and as such were perceived

as potentially powerful allies by the midwives I worked with. However, there were

striking differences between the accounts given by the Acting Directorate Manager

of Millside of the kind of support she offered to the staff on the unit and the reports I

got from midwives. She told me that she always made sure, when the Delivery Suite

was particularly busy, to come down and tell everyone what a good job they were

doing:

> Sometimes if I'm called in in the night I will tend to walk round and talk to
>
> everybody and thank them really because that's all I can do sometimes, for all
>
> the effort they put in [Interview, Directorate Manager, 30.01.08].

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This contrasted with Miriam's complaint that the managers did not engage enough with the midwives on the unit:

If you talk to [the Acting Directorate Manager] in the corridor she's always doing this [looking at her watch] because she's got to go off somewhere else. Puts you off talking to her doesn't it? The person we had from the previous unit, who moved with us to [Millside]…she would do a round in the morning when she first came on. The girls used to think she was checking that they'd got their cardigans on when they were on duty and things like that. But I thought it was good because she was there to talk to and if there was a little niggle it could be ironed out then. Now you can get a really big niggle before it's ironed out because we never see them. If you ask a lot of those girls on Delivery Suite, they don't know what [the Directorate Manager] and [the previous Directorate Manager] look like. That's bad isn't it. I mean, even my husband, he was a director, he knew everybody on the shop floor because he'd do a walk round and see them. The only time you see the [Directorate Manager] and [the previous Directorate Manager] now is if they come round to criticise something we've done or show visitors round [Interview, Miriam, 16.06.08].

The Directorate Manager told me how she provided support to midwives. She mentioned one day how a Ward Manager had been in her office in tears [Fieldnotes,

16.11.07]. However, despite maintaining an 'open door' policy with a door that was literally open most of the time, it is likely that this was only of benefit to those midwives closest to her in the hierarchy.

Other managers appeared similarly distant to midwives. The Delivery Suite Matron acted as an intermediary between the Directorate Manager and the midwives and yet I rarely saw out of her office. On the two or three occasions that I did, she appeared harassed and rushing. My impression was supported by comments from some of the midwives on the Delivery Suite:

> Miriam: [The Matron] herself just seems to be hassled all the time, doesn't she? ... I'm not sure how approachable she is, I hear different comments. I think I just do my own thing because it never bothers me but I think the other girls find her that she's not always as approachable as she should be and she always seems to be hassled and rushing and but that's the whole unit isn't it, everybody hassled and rushing.

The Maternity Unit also 'put staff support evenings on which were quite well attended; an opportunity to have a chin-wag and a massage and a facial, this sort of thing' [Interview, Directorate Manager, 30.01.08]. Massage and facials are experiences women might usually have at a beauty salon or spa, perhaps with

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friends: an escape from the hassle and rush of daily life. Bringing this into the workplace is an explicit attempt by the management to construct an environment conducive to relaxation and friendship which may be limited during the usual work of the unit. However, no other midwives mentioned these evenings, which suggests they were not so important to them. Choosing such gendered activities for a 'staff support evening' suggests that it was designed for the female midwifery, support and domestic staff rather than the doctors. Hospital communities are structured around professional groups and so female doctors were more likely to ally themselves with the other doctors, whatever their gender, rather than the non-physician women.

Counselling

The Directorate Manager told me about the Midwife Counsellor who was available to see staff but who, she suggested, midwives rarely used. She seemed initially reluctant to tell me why this was so, claiming she 'didn't know', but in a way that suggested she did. This may have been because she herself felt disempowered to help the midwives who needed support and it was difficult to admit that there was such unease amongst the staff:

> Directorate Manager: People did go and see the Midwife Counsellor. She tells me she doesn't see so many staff now and I don't know why that is.

Juliet: You don't know?

Directorate Manager: I don't know, no.

Juliet: Do you think it's because they have less need for her or
                                do you think it's because they don't use her?

Directorate Manager: I suspect it's just because they're not utilising her.
            And, you know, they may be using other mechanisms, you know, to
            off-load or express their dissatisfaction. We do have an incident
            reporting system and that's online. It used to be a form that people
            filled in and staffing issues, or capacity issues, are the things that they
            can report and it's obvious to me – I read those, I get a summary of
            those and the Clinical Risk Coordinator is a midwife so, you know,
            she reviews each one of those and it's obvious to me that people
            sound off in a written way: 'and another thing – ' [miming writing].
            So we get those. And maybe when people are under pressure and they
            can do something about it they can report it and I have encouraged
            people to report these times because that gives me ammunition really
            to go and get more resources for us. But it sounds quite feeble as a
            response that I know my staff are under pressure that I'm not doing
            more for them in a way but I'm not sure what would be effective as a

mechanism for them other than what we've set up already [Interview,

Directorate Manager, 30.01.08]

She felt disempowered in the face of midwives' distress, which was a symptom of
the lack of resources in the unit. Midwives too, felt disempowered in the face of
women's distress for the same reason. The differences between the Directorate
Manager and the midwives' perceptions of her influence and actions appeared to
have come about because of a lack of communication between them. There were few
opportunities for midwives to contribute their ideas about how the unit should be run.

Communication between midwives and 'The Trust'

The only regular meeting at which midwives had an opportunity to formally
communicate directly with clinical managers, such as the Midwifery Matron or Lead
Obstetrician was the Labour Ward Forum. Only one Labour Ward Forum took place
whilst I was on the unit, although I turned up for a number of meetings which were
postponed at the last minute because of a shortage of staff available to attend. The
meeting I went to on 3rd December 2007 was attended by the Matron, one Consultant
Obstetrician, one Registrar (persuaded in from the ward to make the meeting
quorate), a Senior House Officer, two midwives and me. A piece of paper had been
displayed on the notice board in the handover room during the preceding fortnight
with space for midwives to write their requests or suggestions. At the meeting, each

query was addressed in turn. The questions, as written by the Delivery Suite

midwives, are listed below and the Matron's response has been added in italics:

1   Could we have individual bells for each of the Induction Room beds?

    'No'.

2   Why do midwives have to help clear up after the "doctors'" procedures, c-

    sections, instrumentals (see Glossary) etc but no one helps them

    'That's teamwork'.

3   Why, when the caesarean and induction rate has risen and the workload, have

    you cut staff on the unit?

    'She's wrong, we haven't cut staff'.

4   Why can't we fill in our duty forms ourselves as there have been errors?

    The Matron says 'oh, that's Julianne, it's been sorted'.

5   Why are there never enough Resuscitaires (see Glossary)?

    The Matron says there are six. She adds that staff do not report when they are

    damaged.

6   There have been some cases of FGM (see Glossary) that have been missed and not reported by midwives.

The Matron says the midwives should do an incident form and find out which midwife missed it so they can be reported to their supervisor for training: 'This just tarnishes us all, it might just be the same midwife each time'.

7   Beds are not being logged upstairs [on the Postnatal Wards] so that Delivery [staff] know how many there are.

S*taff have been taken aside and spoken to about their practice.*

8   Sometimes doctors change plans of care with a change of shift which is confusing for the midwives and the women, even when there's been no change in the obstetric situation.

The Consultant Obstetrician says that she wants individual consultants named and there is no point bringing such a question to the Labour Ward Forum. Midwives should confront doctors. She suggests that you can't do anything about this without addressing it at an individual level, adding that 'all clinicians, both doctors and midwives should be working as a team. It's not inappropriate for midwives to confront doctors'.

9   Could we turn the heating down? It's getting hot in rooms where women are

doubled up[12].

This comment is greeted with derisive laughter. Use your initiative! Open the

windows! The Matron brushes this complaint off, saying that this is just

midwives venting their anger on paper.

[Fieldnotes, Millside, 03.12.07]

The Matron and consultant's curt comments demonstrate an emphasis on individual

accountability and blame. Whilst I have summarized their responses, my summary

reflects how abrupt their speech was. It was easier to 'fix' an individual midwife than

it was to fix the faulty system (for example, the lack of beds) that caused or

contributed to the problem. There was a sense that the resource restrictions midwives

worked with had been around for so long that they had given up on ever being able to

change them. The Matron's dismissive attitude towards the midwives' concerns and

frustrations appeared in part to be a symptom of her own feelings of powerlessness in

the face of a large and dysfunctional hospital system.

Incident reporting

The feelings of powerlessness were passed up from each position level in the hospital

hierarchy. It seemed that whilst the midwives felt powerless, they believed that

Directorate Manager, would be capable of solving all their problems if only she was

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[12] During busy periods, postnatal women would sometimes share a Delivery Room whist waiting for a
free bed on the postnatal ward.

aware what they were. The midwives suggested that she was out of touch with the reality of every day practice and therefore didn't understand what she needed to do in order to make it better. Similarly, the Directorate Manager was required to make complex business cases to the Trust Board in order to persuade them to make the changes to the Maternity Unit she wished to see [Interview, Directorate Manager, 30.01.10]. She explained to me how she encouraged midwives to fill out formal 'Incident Forms' (usually used for reporting clinical incidents) in the event of staff or bed shortages, in order to provide her with ammunition when approaching Trust managers [Interview, Directorate Manager, 30.01.08].

In practice these forums had become one of the only ways in which midwives felt they could communicate with those who they thought potentially had the power to influence the Trust and had started to express their frustrations using these forms. Despite the widespread use of Incident Forms (and I observed them being used on a number of occasions), the midwives also believed that they were ignored by the unit management (including the Directorate Manager) and were therefore ineffectual: 'the midwives have been asked to fill in an Incident Form each time they have no beds. There have been comments going around that Incident Forms go into 'The Black Hole'' [Fieldnotes, Millside, 28.11.07]. There was no institutional process by which the progress of the midwife's complaint was fed back to the midwife who had submitted it. Implementing changes to processes, systems and staffing took a long time in such a large and bureaucratic institution, and as such there was no visible

evidence for the midwives that anything at all was done in response to them submitting the forms. Despite this, they continued to fill them in, which suggested the extent to which they had few other formal channels available to them with which to communicate their discontent to people they believed could act upon it.

Northway Midwifery Unit

Support from management

The midwives at Northway Midwifery Unit had very different experiences with managers from those at Millside. Unlike the Directorate Manager at Millside, the Midwifery Unit Manager was present in the unit every day, where she also did occasional clinical shifts. Her clinical practice helped level the hierarchy between her and the other midwifery staff, especially as she wore the same uniform as they did whilst on duty. Her office, where worked during her 'management days', was situated next to the midwives' desk and she engaged with the midwives in professional and personal discussions throughout their shifts. The Northway Midwifery Unit midwives spoke far less to me about their managers, or the formal support processes in place in the unit. The relative silence around the management of the unit at Northway suggests that the Unit Manager's managerial style was relatively successful. Unlike at Millside, disenfranchisement, powerlessness and frustration were not primary topics of discussion amongst the midwives.

Despite their apparent satisfaction, as at Millside there were hardly any functional institutional systems operating at Northway which worked to support midwives. The midwives had few outlets with which to feed back to the senior staff, such as the Unit Manager, the Head of Midwifery or the Head of Operations. In addition, I did not hear of a formal counselling service available to midwives, although some of them used their Supervisor of Midwives (see below) for this purpose. Like the Millside midwives, those at Northway Midwifery Unit utilised their Incident Reporting system for organisational 'incidents', but these were mostly about the Delivery Suite next door, which frequently summoned them to provide cover for staff shortages there, something I discuss in more detail in Chapter Six.

Formal midwives' meetings were scheduled regularly on the Unit but did not always go ahead. They were spearheaded by individual midwives and if those midwives were not scheduled to work on the day of the meeting, were busy with a labouring woman or called away to work on the Delivery Suite, then the meeting was unlikely to happen. A number of meetings were postponed whilst I was on the unit.

The Midwifery Unit manager's presence on the Ward appeared to compensate for the lack of formal institutional feedback processes in a way that was not possible at Millside. She was always available to speak to the midwives and they fed back to her every day through informal conversations. She had credibility in the eyes of the Unit midwives because she worked as they did and saw what the saw; the kind of practical

experience which was highly valued. The debates among staff, including the manager, were often fiery. The manager later disclosed in interview how they had become useful for her as a way not only to assess the midwives' feelings but also to instigate change:

> So when we have the heated debates on here I absolutely love it when we do because it tells me they're thinking. …I've got some right stroppy midwives on here [laughs] and I worry if they don't. I'd worry if they didn't say nothing. …I get a lot of knowledge from it so I know what needs to be addressed or as you say I use it, I drop things in like — also it's telling people, this is the side of the fence I'm on, you know, and being very open and it gets people to think I think really. So I use it. [Interview, Midwifery Unit manager, 10.08.08].

This is not to suggest that there was no discontent. Two midwives suggested to me that:

> [The manager] needs to stop being everyone's best friend as well as their manager. They think she would benefit from taking a harder line on midwives; for example, not being so completely unconditionally supportive and flexible about family difficulties [Fieldnotes, 14.07.08]

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The manager's consideration for the wellbeing of individual midwives was perceived by some as at the expense of the good of the unit as a whole. Such a position demonstrates an allegiance to the institution because it is considered as a service for the greater good of the labouring women, rather than a midwife allying herself with the institution in an effort to manage its excessive demands on her time over the women she cares for. The manager's own opinion was that accommodating midwives was simply an extension of being woman-centred in her practice and she told me in interview:

> I think that they still try and keep to this regimented idea of midwifery. It's a bit of a paradox. One minute they're saying to you it's about being with woman, and the next minute they're saying to you you can't drop your little one off at half past seven at the nursery because that's when it opens, you know, that you can't be on duty at quarter to eight [instead of half past seven]. [Interview, Midwifery Unit manager, 16.07.08].

At times there were discrepancies, and also between the unit manager and the Consultant Midwife, who was also regularly present in the unit worked occasional clinical shifts there. Whilst the Consultant Midwife did not have managerial responsibility, her role in founding the Midwifery Unit meant she had retained an interest in its day-to-day function. The Consultant Midwife enjoyed getting involved in the day-to-day running of the unit, however her and the manager's attitudes

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sometimes differed, causing confusion for the midwives. On one occasion I asked

Emma, a midwife, what had happened in the previous day's Unit Meeting. She

replied with a sigh and accompanied by others' laughter:

> Our manager tells us we're shit;
>
> We consider that we might be shit;
>
> The Consultant Midwife says that we're not shit;
>
> By the end of the meeting we feel like shit;
>
> By the time the night time comes we conclude we're shit.

[Fieldnotes, 14.07.08]

Professional support

The Statutory Supervision of Midwives

The statutory supervision of midwives is a system that dates back to 1902 when it

formed part of the Midwives' Act of that year. Since then, all midwives practising in

the UK are required by law to have a named Supervisor of Midwives. This obligation

on midwives is unique amongst healthcare professionals, although clinical

supervision is encouraged within some branches of nursing (Royal College of

Nursing 2002) and in medicine (Burton and Launer 2003). Supervisors of Midwives

are experienced midwives who have been nominated by their peers and have

completed a training course to become a named Supervisor of Midwives. The Local

Supervisory Authority (LSA), which coordinates the Supervision of Midwives,

explains that the statutory supervision of midwives as providing:

A mechanism for support and guidance to every midwife practising in the

United Kingdom. The purpose of supervision of midwives is to protect

women and babies by actively promoting a safe standard of midwifery

practice. Supervision is a means of promoting excellence in midwifery care,

by supporting midwives to practise with confidence, therefore preventing

poor practice (LSAMO National Forum (UK) 2009).

Alison, who worked on the unit herself, explained how she understood the role of the

Supervision of Midwives, emphasising its role in enshrining their professional

autonomy:

As midwives we've always worked as autonomous practitioners where nurses

work very closely with doctors and we work very much on our own. I think

that's a reason why we have Supervisory of Midwives. Also supervision was

brought in to ensure the safety of mothers and babies to make sure midwives

are fully trained and are not providing any care, even after they qualify, that

they're not actually trained to do. Obviously it's a midwife's duty to ensure

that they don't provide that care so because in the early 1900s there were

people calling themselves midwives providing care for women that weren't –

they weren't trained as midwives and women obviously, and babies were

dying, supervision was brought in to ensure the safety of mothers and babies [Interview, Alison, 30.07.08].

A midwife is legally obliged to have an annual review with her Supervisor of Midwives during which she discusses her midwives' professional and personal development. The Supervisors of Midwives in a geographical region are appointed by the Local Supervisory Authority and not by the NHS Trust, which aims to give Supervisors of Midwives independence from their employing Trust in cases of dispute:

> As a registered midwife you are professionally accountable to the NMC and, unless you are self-employed, you may also have a contractual accountability to an employer. There are occasions when this may give rise to a dilemma in your practice and it is at such a time that your supervisor may be a valuable source of support and guidance (LSAMO National Forum (UK) 2009: 6).

In order that Supervisors of Midwives may advise and represent their supervisees in the case of a dilemma, the roles of a Supervisor of Midwives and a Manager are carefully legally delineated, even when one person may have the job of being both. The table below shows how these often conflicting responsibilities are divided up:

MANAGER	SUPERVISOR
Trust employee	Appointed by Local Supervising Authority (LSA)
Accountable to Trust employer	Accountable to LSA and UKCC[13]
Has a Job Description and Conditions of Service	Undertakes a statutory course before taking up duties
Holds a budget	Holds no budgetary responsibilities
Must fulfil duties and responsibilities outlined in job description	Must ensure midwives are safe and competent practitioners for the protection of mothers and babies
Ensures a safe environment	Must monitor and audit the practice of individual midwives
Implements policies of employer	Promotes proficiency through supervised practice, education and Training, according to Rules and Codes of UKCC
Deals with poor performance/standards in accordance with Trust policy	Deals with incompetent practitioners by retraining and supervised practice
Deals with complaints and takes disciplinary action if required	Deals with issues of professional misconduct and negligence and reports to LSA if appropriate
Suspends from duty	Recommends suspension from practice to LSA
Must be conversant with Trust policies	Must be conversant with Midwives Rules and Codes of UKCC

Millside NHS Foundation Trust, 2008

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[13] UKCC is now the NMC – the Nursing and Midwifery Council

This table shows how the roles of Manager and Supervisor of Midwives are divided between representing the interests of the employer (Manager) and the profession (Supervisor of Midwives). The Supervisory system is in place in part to protect midwives from the negative effects of their employer on their professional practice, for example the requirement for efficiency over individualised care, or to practice according to guidelines with which they don't agree. Supervisors of Midwives also represent their Supervisees during formal disputes with the Trust.

In recent decades, supervision has come to involve more emotional support for midwives, as well as addressing their skills. As the remit of supervisors is to protect the public safety of women and babies, this change demonstrates how the profession is increasingly recognising that midwives' emotional health enables their good practice and therefore protects the safety of women and babies. However, despite all intentions, this level of emotional support did not always exist in practice. Majan, a midwife at Millside, spoke to me at length in interview about her own experience of the supervisory system:

> I work with mine [Supervisor] and I look at her and look at how busy she is.
> Sometimes I go to her; I go to her and say one thing and she'll talk and advise
> me standing [up]; [she's] not [even able] to sit down [and talk to me] ... I
> don't use her seriously. I think if we did it would be a very good thing. But I
> look at her, I look at the job she does and I'm thinking 'I'm not coming to

you! You're more stressed than I am! I'm not using you'. I need someone

who is sitting there, is relaxed, is not stressed, who can actually look at me

and see 'oh yes, I understand where you're coming from'. My Supervisor,

she's good, she's powerful, she's my friend… But I don't feel that I can

bombard her with that. …It is a good system, but I don't know, if it's

happening to me there are more people like me who are not going to see them

as well. I don't think I'm the only one. As long as it's happening [well] for

somebody, I believe [there are] about a hundred people more like me.

[Interview, Majan, 14.12.07].

Midwives work within a culture that privileges altruism. It is very difficult for them

to place a burden on others, particularly their colleagues, perhaps because this

threatens the collective support and community which they value very highly. Whilst

there had been increasing recognition of the emotional demands of midwifery work,

there was still a residual norm within the unit at Millside by which you get on with

your job and do not make a fuss. Adverse emotion was a sign of not being able

manage your job, as illustrated by those midwives I mentioned earlier in the chapter,

who admonished themselves for crying in front of women. Whilst it was in part the

job of the Supervisors of Midwives' to provide support for their supervisees, those

who were also clinical midwives were working under identical circumstances, which

also caused them distress (which they would in theory then take to their own

supervisors, and so on).

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The danger is that the profession tends to fall back on Supervision as the main source of support it provides to its midwives, despite the failings of the system. Midwives are particularly proud of the Statutory Supervision of Midwives. Alison spent almost all of her interview telling me about it in great detail. She explained that being selected as a Supervisor of Midwives by your peers was an honour. The Statutory Supervision of Midwives is bound up with promoting the professional autonomy that is also important in distinguishing midwifery from other healthcare professions, particularly nursing and thus the Supervisory system demands respect. The respect that is given to the Statutory Supervision of Midwives might be one reason why the profession has not gone further in providing other support systems which may function more effectively; for example, calls for the implementation of clinical supervision in midwifery (Deery 1999; Deery and Kirkham 2006) have not yet been heeded, despite the advantages which they may bring.

Conclusions

The midwives in both units were required to negotiate emotionally demanding situations on a daily basis. This skill was a basic facet of their work. Whilst developing close relationships with women was a desirable and rewarding part of being a midwife, frequently this was emotionally difficult for them. Managing their emotions and those of the women in their care was a skill that they learned on the job by observing other, more senior midwives. The difficult demands this work made on

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the midwives required emotional labour. Midwives engaged in surface and deep acting in order to positively influence women's emotions and to protect themselves from emotional damage.

Part of becoming an expert midwife at Millside and Northway Midwifery Unit was becoming accomplished at manipulating and managing feeling and emotion in order to function within a highly emotive environment and to provide good care as a midwife. This was highly skilled work that took time to master. Newly qualified midwives were particularly susceptible to emotional vulnerability before they had developed the necessary skills to manage their emotions effectively, which demonstrated that this kind of emotion work was not inherent, but learned.

The existing literature suggests that not being able to be 'with woman' was a source of emotional difficulty for them which required emotional labour to negotiate and my findings support this. However, it appeared that successfully being 'with woman' was also emotionally demanding. The difficulties inherent in being 'with woman' were mostly spoken about by midwives in terms of working with women experiencing pregnancy loss. This is not to say that caring for women in 'normal' labour was not also emotionally demanding and the examples I describe above suggest that it was. However, few of the midwives I interviewed spontaneously chose to talk about the difficulties of working with women in normal labour, unless prompted. The lack of spontaneous talk was notable because it suggested, for

example, that this emotional labour was demanding, but not difficult (Hunter 2004), or that it had become invisible out of familiarity.

The midwives in both units turned to their managers for help in reconciling the tension they experienced between the way they wished to practise and the daily reality of their work. They wanted the managers to firstly recognise their difficulties and secondly, to ease the conflicting demands the institution placed on them by, for example, employing more staff or allowing them to cap the numbers of women admitted to the unit.

The midwives felt disenfranchised, but to an extent that differed between the two units. It appeared that the midwives at Millside, in particular, overestimated the capacity of the middle managers to affect significant change within the Trust. The middle manager at Millside, Lyn, felt disenfranchised herself when faced with the greater power of senior Trust management and the financial constraints and targets she was beholden to. There were some formal processes, for example the Midwife Counselling service and the Labour Ward Form, which were put in place specifically to support midwives or to allow for their input into how the Unit was run. Others, such as the Statutory Supervision of midwives and the managers' informal support were not specifically designed to support midwives emotionally, but did so as part of their function. However, these formal processes were largely dysfunctional. At Northway, the good communication between the manager and the midwives

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compensated to a great extent for the same lack of formal processes to support the midwives.

The key difference for the midwives between the two units was the extent to which they felt able to influence their working environment and the terms and conditions under which they worked. However, the formal institutional and professional systems did not adequately allow midwives to feel in control in neither unit. In order to compensate for these shortcomings, midwives in both units devised their own informal coping systems and strategies. The following two chapters explore these informal coping strategies. These strategies were largely directed towards managing and controlling their working environment and the people within it, in order to engender a sense of control which was otherwise lacking. The following chapter, Chapter Six, looks at those strategies which were specifically directed at the spaces and environments within the Units. The two units constituted very different kinds of workplaces. The midwives' differing coping strategies may therefore expose other differences between the units, particularly how far they offered midwives opportunities, or not, to work in ways which were satisfactory to them.

Chapter Six: Space and place at work on the Units

Geographers have long made a distinction between the concepts of 'space' and 'place'. Whereas 'spaces' are delineated by walls or other physical markers, 'places' are spaces imbued with meaning constructed by those who exist within them (Tuan 2003). In Chapter Four I described the spaces in which the midwives worked. They were spaces delineated by physical walls but they were more than just the 'activity containers' (Moon 2009: 39) within which babies were born or midwifery work was done. The spaces of the Delivery Suite and Postnatal Wards at Millside and the Midwifery Unit at Northway, were work*places*.

This chapter explores how space and place influenced the daily experience of the midwives in the two Trusts. It focuses particularly on how the midwives organised and manipulated those spaces, in an effort to negotiate and ameliorate the conflicting demands of the women, profession and Trust, and the difficult emotional labour that resulted. Space and place was as much a root cause of the midwives' difficulties as it was a solution. The first part of this chapter looks at midwives' relationships with space (and how the spaces influenced their relationships) at Millside and the second part explores those same issues at Northway Midwifery Unit. The previous chapter demonstrated how the midwives' work placed significant emotional demands on them that required emotional labour to negotiate adequately. Those demands were, in part, a product of the places in which they were exercised. The clinical areas which were the midwives' workplaces played a crucial role in shaping midwives'

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relationships with women and their colleagues. The previous chapter showed that many of the emotional demands placed on midwives stemmed from a discrepancy between the midwifery discourse and the reality of practising within a large, resource constrained and bureaucratic institution. Those support systems which were put in place by the profession and Trusts went some way to assisting midwives in managing these demands, but they remained inadequate. In part this was because they were initiated to promote the function of the Trust and the provision of safe and high quality care for women and babies, rather than the wellbeing of midwives. Midwives' wellbeing was understood as a way to promote these functions, but was not an end in its own right.

Millside

The Maternity Unit

The most obvious way in which space influenced the daily life of Millside Maternity Unit was through its shortage. Bed crises were an almost daily occurrence and quiet days were rare enough for me to note:

> 'It's quiet! Probably the quietist I've seen it. One induction; two rooms [occupied by labouring women]. Everyone's coming into the handover room to look at the board and expressing surprise, delight and disbelief' [Fieldnotes, 21.01.08].

The shortage of delivery rooms on the Delivery Suite meant women were moved up to the Postnatal Ward very soon after they had birthed their babies, often before they, or the midwives, were ready:

> [One midwife says to me] 'It's not good for the women to rush them'. She refers to a woman who gave birth at 10am this morning and now, at 2pm, they are trying to get her up and in the bath, 'she would be knackered after giving birth and she should be allowed to rest, but there's no time!'. She says she feels pressure to wake the woman up, get her bathed and upstairs 'ages ago', despite not feeling comfortable doing this [Fieldnotes, 08.01.08].

Veronica articulated explicitly how moving women on was incompatible with what she understood as the role of a midwife, which was to respond to that woman's individual needs:

> You weren't able to perhaps spend as much time with the women as you originally came into the job to do, really, which was sort of the role of being a midwife. It was more like see a patient, quickly try and get them out the door… The ward I was on was the Low Risk Ward so it was get them in, get them out. It doesn't matter how they're feeling or how if the care is adequate, it's a case of, it's a bit like a conveyor belt service of care really [Interview, Veronica, 25.02.08]

The demand for factory-like 'conveyor-belt' efficiency was deemed to come from the managers of the Trust's maternity service. Elizabeth spoke about how the managers pushed the midwives to use the space more efficiently at times of crisis. However, those actions that benefited the Trust left the midwives professionally vulnerable and denied women rights, such as privacy:

> I've been in a position where I've got no space, not a square centimetre or anything to put anybody and I've said to the manager 'um, I think I'm not going to have the induction ladies in; I think I'm not going to admit anybody' and … they go 'oh you can't do that, you can't do that. …Can you see if you can put two people in those rooms? Or if all else fails and you can't do that, come back to us, let's see what we can do'.
>
> It's not good for you as the midwife, or for the patient. You don't really get any job satisfaction really. It's as if it's like a conveyor belt like just move on, which is really bad but then you feel vulnerable because you think, well, if I make a mistake here, who is going to back [me up]? That's the other thing that you think about. You think if I make a mistake, who is going to be there for me? It just isn't any good for anybody: women, midwives – it can look good for the Trust if they're getting any money from it, maybe.
>
> [Interview, Elizabeth, 19.02.08]

The shortage of space in the unit profoundly affected the extent to which the midwives could work in a way that was acceptable to them. The impact of the

shortage was a part of their every day talk between each other whilst at work. However, there were other ways in which the unit's space shaped their experience that they did not speak of so explicitly because it had been normalized, and was therefore largely invisible. It was only by spending an extended period of time on the unit that I was able to see how the organization of the midwives' workplace worked to uphold these norms of practice, many of which also ran counter to the midwifery discourse.

Professional status

The relationships between women, midwives and doctors, as well as managerial and support staff was mediated through the hospital hierarchy. Unlike this shortage of space, this hierarchy was not talked about by staff during our discussions because it was so deeply ingrained in social order of the unit so as to be invisible. Learning the order, hierarchy, roles and scope of the different groups of staff was part of the process by which student and novice midwives (and researchers) were socialised into the institution.

This order was upheld by clearly visible markers, such as different coloured uniforms, which I discuss in Chapter Seven, but this was also measured by how free each group of staff was to move within and between the clinical areas of the building. Those with the highest status – the doctors and non-clinical managers – were freer to move between floors and in and out of areas than the midwives and support staff. Whilst the midwives chose their rotation pattern and moved between

areas every month or six months, for example, the Healthcare Assistants and domestic staff who had the lowest professional status worked permanently in one area, and neither rotated to work in different areas nor moved between areas within a shift as part of their work.

During a shift midwives largely remained in one clinical area, unless they were accompanying a woman up to the Postnatal Wards after she had had her baby. Unlike the doctors, who prioritised their own workload and accordingly chose where to walk, midwives' movement between areas was controlled by others. One example of this was that the Postnatal Ward midwives were frequently summoned to help out on a busy Delivery Suite. This was known colloquially as 'being pulled', a term which emphasised the lack of agency midwives had when they were sent, often reluctantly, to cover short staffing in other areas:

> I have had to go downstairs to labour ward to work and working down there, you know, I had to go back up because I felt I disappointed, or they're taking me away from what I want to do. And it was frustrating. And I told them about my shoulder and the fact I couldn't work downstairs but no one would listen would they because they needed someone downstairs and so it makes it a bit difficult [Interview, Majan, 14.12.07]

Midwives were also often forced to scour the unit looking for a doctor to sign off prescriptions for drugs, which they used frequently but did not have the legal authority to prescribe.

The organisation of the space within the unit not only illustrated, but also supported, this hierarchy of status. Doctors spent their time walking around the unit between all the clinical areas. Their specialist expertise was called upon only when required and as such was a desirable commodity which was in short supply. Often doctors walked onto the Delivery Suite to perform one task and were then unable to leave for over an hour as they were asked by midwives to do more and more things. In an attempt to combat this, they planned their time by waiting until they had a group of women to see and then came down to see them in one go. This meant they came to the Delivery Suite quite infrequently, which left them even more in demand. Everyone entering the Delivery Suite had to walk past the past the midwife's desk in the Assessment Room. Midwives in the Assessment Room pleaded, bargained or simply under-stated what was expected of the doctor by saying 'it's just two signatures' or 'just this one woman', in order to get the doctor through the door on their way down the corridor to see the labouring women. During a shift in the Assessment Room, I wrote:

> The doctor makes an appearance every hour and a half or so and each time is
> pounced on by Karen the midwife. The midwives down the hall are also
> desperate for him, as are passing midwives, sometimes down from the wards
> on the hunt for a doctor to sign off some drugs… 'He's all mine' says Karen,

grabbing the doctor's arm, 'I'm going to keep him'. She also tells the doctor

at one point that if he doesn't come back after being down the hall that she

will come after him with her baseball bat. [Fieldnotes, Millside, 08.01.08]

Pleading with doctors and using sexualized jokes and threats of violence against

them, emphasized their gendered power relationship. Whilst the doctors could

choose when to attend, the midwives were left to do the emotion work of placating

worried, frustrated and bored women who had been left for many hours waiting for a

doctor to see them. The delay in the doctor arriving exacerbated the anticipation and

again created a culture in which the doctors' expertise and knowledge was further

rarified.

The doctors' freedom of movement was dependent upon the midwives staying in one

place. Liaschenko (1994; and also Peter and Liaschenko 2004) describes how

doctors' freedom to move came about once nurses had been incorporated into the

hospital because 'the spatiotemporal positioning of nurses at the bedside 24 hours a

day, seven days a week allowed physicians to move away from the bedside' (Peter

and Liaschenko 2004: 219). Whilst midwives at Millside largely worked

independently from doctors, one part of their role was to look out for signs of

abnormality and call the doctor if required. This role required them close enough to

women to be able to check them regularly. However, the midwives also managed to

spread themselves across more women because they delegated tasks such as washing

or breastfeeding support, which required them to be physically present for longer

periods to Healthcare Assistants and Infant Feeding Advisors. The support workers

were thereby even more tightly confined to the bedside than the midwives. Each of

the professional groups in the unit thereby imposed occupational closure (Witz 1992)

on those below them in the hierarchy, which in part involved restricting the freedom

of movement of their subordinate group.

'Us and them'

One consequence of the relatively limited movement of midwives was that they

formed tightly knit groups of workplace friends within their clinical area. These

communities bonded by 'othering' those who worked outside of their immediate

clinical area. This was mainly done through blaming the 'others' for being inefficient

– for example, not discharging women fast enough from the Wards to prevent a

backlog on the Delivery Suite, or for not pulling their weight in shared tasks. During

the time I was at Millside, the Unit was drafted onto a clinical trial which assessed

the potential benefits of routine testing of babies' blood oxygen levels at birth to

diagnose congenital heart defects. The Heartbeat Trial[14] required babies' blood

oxygen levels to be measured, using a short, non-invasive test, between three and six

hours after birth. This was around the time the mother and baby were usually moved

from the Delivery Suite to the postnatal wards, which meant that the responsibility

for the test was shared between the two areas rather than the duty of the ward staff as

had originally been agreed. The postnatal ward staff began to complain when they

felt the Delivery Suite staff were shirking their obligations: ''They know how many

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[14] This is a pseudonym.

we have to do up here' Emily (Low Risk Postnatal Ward midwife) complains… I ask how they feel about the project, 'it's just another thing to do' they say, 'just more work'' [Fieldnotes, Millside, 26.02.08]. The culture of complaining that staff in other areas were shirking their responsibilities was sustained because the areas were so separate from each other. As midwives did not move regularly between clinical areas during shifts, the pressures on midwives in one area were hidden from those elsewhere.

Although most of the midwives rotated regularly between wards over the period of a year, I noticed that it took them very little time to ally themselves with their new ward once they had moved. Midwives who perhaps only a week previously been working on the Low Risk Postnatal Ward would join their new Delivery Suite colleagues in complaining about the Postnatal Ward staff. This was an efficient way to bond with the new group and complaining gave them a voice, if only to their colleagues. In fact, it was very unusual to hear a midwife say something positive about her work whilst in the company of colleagues and credibility within the community came from participating in collective complaining. Other than complaining about midwives in other clinical areas, complaints were usually directed at issues such as understaffing, midwives who repeatedly took sick days, the number of women on the Delivery Suite, being given 'bad shifts' such as being made to work Christmas Day, or being too busy to take a break. The complaints were a way of 'sounding off' but were focussed on the many conditions over which the midwives had limited control.

There was a notable discrepancy between midwives' talk about their work around their colleagues and how they described it to me in private. Whilst midwives did take the opportunity to complain to me, if I asked them why they stayed being a midwife, almost all the midwives were quick to tell me how much they loved it and comments such as the following were representative:

Loved it. Always have loved it; still do love it [Interview, Lyn, 30.01.08]

We're not doing like we want to and I still want to change the world. But no, I still love it [Interview, Miriam, 16.06.08].

I only met one midwife at Millside, Fiona, who I never heard complaining with her colleagues about her work. Whilst all the other midwives spent time talking through their frustrations, Fiona removed herself from the community on the Low Risk Postnatal Ward, got on with her work and ate alone at break times. Fiona felt excluded from the group because, as she explained it, 'they just talk about wedding dresses, which really bores me' [Fieldnotes, Millside, 02.02.08]. This was in part a class division between Fiona who was from continental European, well travelled and married to a doctor and the predominantly working-class or lower middle-class midwives. She also attributed her difficulties to working part time:

I think if you belong to the clique or you don't, and I don't. I don't dislike the midwives, I like them, but I think maybe I am a different person but it's definitely due to the fact that I am only working part time I don't think that – they might not take me seriously because of that [Interview, Fiona, 21.02.08].

Fiona was one of many midwives who worked part-time and it did not appear that all of the part-time midwives had the same experience. Working part-time made it more difficult for her to connect with her peers, but Fiona was also ideologically out of place:

Fiona: It's really nice to talk about it [to you] because I hardly ever talk about it… They [my colleagues] do know I've had homebirths, they might think I'm quite weird, certainly with the first baby. I wouldn't dare to tell them I've had them with an independent midwife – number 2 and number 3 anyway. I wouldn't dare to tell them I'm a member of the Association of Radical Midwives and no, I've – no I've never spoken about my beliefs at all, I wouldn't dare.

Juliet: Why wouldn't you dare?

Fiona: Well they might think I'm a little bit funny and that I don't comply with the system and that I'm dangerous and just to be viewed with suspicion. I feel quite insecure, quite vulnerable at Millside.

[Interview, Fiona, 21.02.08]

Fiona had developed a strategy of being benign, but distant, in an attempt to appear aligned with her workplace's ideological norms. The mis-match between place and ideology was emotionally difficult for her and made her feel vulnerable to victimisation. It also meant she could not rely on her colleagues for support in managing the ideological conflict between working at Millside and her dream of practising according to what she understood as the midwifery model of care.

Jodie also drew support not from her colleagues, but from non-midwife friends at home:

Jodie: I tend to keep myself to myself. I get on with everybody but I don't want to be anybody's best mate. Does that sound terrible?

Juliet: No, not at all… Why do you do that? Why do you keep that distance?

Jodie: Um…I dunno. I don't know if it's because I didn't train there that you haven't bonded – I mean I get on with everybody, it's not that. But I just think there isn't everybody – I've got my circle of friends and there ain't anybody [at work] that I've sort of thought 'oh yeah' [that I've 'clicked' with], you know. It sounds really – but I'm happy with how it is.

[Interview, Jodie, 09.04.08]

Whilst many of the different areas in the unit, particularly the Delivery Suite and Postnatal Wards constituted a continuous system through which women moved at different stages in the perinatal period, the midwives constructed the unit as a series of discrete areas which were seemingly unconnected to each other. One of the reasons behind the separation of the areas was that each area competed with the others for the limited resources available within the Unit as a whole.

The staff in each of these areas struggled daily with shortages of staff, time, beds and equipment. On 29th November 2007, a group of people in suits from the Trust's Board were taken on a tour of the Delivery Suite by the Directorate manager. They were taken to see the whiteboard which listed all the women inpatients and showed that the Delivery Suite was full. On a second occasion a management visitor was specifically shown the board on the Low Risk Postnatal Ward at a time when it too was full to capacity. Despite their misgivings about the effectiveness of the Incident Reporting System, which was termed 'The Black Hole' [Fieldnotes, 28.11.07], midwives filled out forms describing shortages of staff or bed crises which were then fed into the Unit Incident Reporting system. The forms were collated by the Clinical Risk Coordinator, a midwife, and then sent on in summary form to the Directorate Manager. Midwives (and medics) were eager that forms be filled in such circumstances. They encouraged and reminded each other to report in an attempt to drive the message of under-capacity home to the Unit managers. It appeared that the midwives believed that success in the competition for resources depended upon their

area appearing to be the most in need. As Jodie put it, 'everybody wants their bit to be worse' [Interview, Jodie, 09.04.08].

I did not witness any midwives volunteering to move to another area they knew was busy. Jodie noted how a colleague had dissuaded her from volunteering to help out on a postnatal ward:

> The other day I was on and Delivery Suite was quiet so I said 'shall I go and help the ward then?' and somebody said 'why don't you just enjoy the peace?' Well because I know that it's absolutely rammed up there; an extra midwife will make all the difference but then [the other midwives think]…'well, if they were quiet and we weren't, then they wouldn't come down' [Interview, Jodie, 09.04.08].

Jodie's experience illustrates a lack of cooperation between clinical areas. The altruism towards women, which is prominent in much of the discourse of midwifery practice, did not extend to colleagues. Favours required reciprocation, and this story suggests that midwives sought to protect themselves from exploitation of their goodwill. Furthermore, if midwives believed they were in direct competition for resources they would not wish to give the impression that they had spare capacity to help others. Such competition for staff and resources inevitably hampered relationships of cooperation between midwives in different areas. The competition meant that interactions between areas happened when they needed for clinical

reasons and not out of choice or voluntary efforts to help others out at times of need. As each area did this, it is clear that none of them were particularly worse off in practice, but constructing the midwives in other areas as inefficient or lazy meant they could claim the extra work load needed to compensate.

Policing space

Midwives' relative lack of control over their movement through the unit suggests that they had a lower professional status than the more mobile doctors. However, this immobility also had an unintended consequence, which provided midwives with an opportunity to assert a significant amount of authority. It was the midwives, not the doctors or managers, who ran the unit on a day to day basis. They outnumbered all the other professional groups, and spent more time on the wards than the doctors or the managers. Halford and Leonard wrote that 'nurses may be confined to the wards whilst doctors have the freedom to roam…[but] the constant and territorial relationship that nurses have with ward spaces constructs doctors as *visitors*' [emphasis in the original] (2003: 205).

The whole building was constructed (differently, by different groups of staff) as a series of spaces in which some people were 'home' and others were 'visiting'. The administration corridors were home to the administration staff, the Consultants and the community midwives (whose offices were also located there) but hospital midwives were visitors. The Delivery Suite was home to the Delivery Suite midwives, Healthcare Assistants and domestic staff, but doctors (particularly

Consultants), labouring women and their partners, Postnatal, Neonatal and community staff were constructed by the midwives as visitors. A 'visitor' does not have the same status as a 'guest' (King 1995) or a 'resident', and so the assignation of the label 'visitor' was a strategy to improve the resident's status.

In each of these spaces the status of 'visitor' was bestowed on people by those who thought of themselves as 'home'. I presume that the doctors would have thought of themselves as very much at home on the Delivery Suite, and yet the midwives' continual presence made it, for midwives, a midwife-organised area. The ownership that the midwives had over the wards gave them the capacity to control and organise the movement of people in and out of the spaces. Policing who was allowed to go where within the unit was one of the only things over which midwives took control. They could not control physiological events or people's emotions; they could not stop death and they could not always control clinical decisions. However, the midwives were able to make and police the rules about where people were and were not allowed to go.

Women, families and friends

The midwives policed the Delivery Suite on the basis that only essential people should be allowed in. During the winter months when a diarrhoea and vomiting virus went round the community, children were banned from visiting altogether. This rule was strictly upheld by the midwives. On 21st December I watched Aleesha, a Delivery Suite midwife, address a man who was walking through the Delivery Suite

with a group of children: 'Excuse me!', she shouted, 'Speak to me! Who are these people? No children on the ward, you all have to leave!'. Only two named supporters were allowed onto the Delivery Suite at any one time during a woman's labour and then only her partner, supporter and older children allowed after the birth.

The two per bed rule was also upheld on the Postnatal Wards by a system of pass cards for two visitors, in addition to the woman's partner. Partners were allowed in 8.30am-8.00pm and other visitors only between 3pm-5pm and 7pm-8pm. Every day on the Postnatal Wards, crowds of visitors gathered outside the doors at 3pm and again at 7pm. The Healthcare Assistants set up a table at the door to hand out passes and organize the crowd. The two-per-bed rule was challenged by visitors who I saw trying to argue their way in or sneak past the table before being sent back out to wait their turn. Visitors moved around the unit slowly and tentatively, as if they were waiting to be asked to leave and their movement contrasted with the fast and sure walk of the midwives, medics and other staff.

Staff

The rules about who could and could not enter different spaces were not only applied to women and visitors, but also to the doctors. The midwives on the Delivery Suite devised a system to manage the movement of doctors around the Ward. Inpatient women were listed on the board in red pen if they required medical attention and green pen if they were under midwife-only care. Instead of doing a traditional ward round at the beginning of a shift, the obstetric handover was done at the board. The

Registrar on duty presented each case to the oncoming Consultant or Registrar, with the midwife Shift Leader present. They skimmed over those women listed in green and then selected the women to visit from the board, choosing only those whose details were written in red ink:

> There is a lot of talk about how the doctors are 'well trained' here; how they do Board Rounds rather than Ward Rounds and this keeps them out of rooms that are midwife-led [Fieldnotes, 04.12.07].

> Lillian tells me that the doctors come in and they say 'we're going to do a ward round' and they [the midwives] say 'no, that's not how we do things here, you'll go and see the women who are under your care and we'll go and deliver this baby' and she says they sometimes have to physically stop doctors from going into rooms. The midwives just say 'we're here to deliver the baby and you need to stay out of it' [Interview, Lillian, 29.02.08].

> You get all the doctors from Northway and they all want to do ward rounds, you know, so you break their legs a few times and they get used to the fact they can do it from the board and see the patients that we say they can see sort of thing [Interview, Miriam, 16.06.08].

Miriam's joke about breaking the doctors' legs, whilst said in jest, exposed how the midwives sought, and had achieved, authority over the Delivery Suite as a space, and

therefore could limit doctors' roles by limiting their access to it. As the longest standing midwife in the unit, Miriam had worked hard to assert and defend midwifery interests in the Delivery Suite over many years:

Juliet: How do you try and make those changes happen?

Miriam: Just by chipping at it day by day … I was the witch and [they would say] 'god, what are you doing? But if you keep chipping at it and you get away with it then things start to change but I think a lot of midwives lose their initiative because it's hard work and it's not just going to happen in the next month or two months, it's going to take 5, 10 years before it happens and it's always…you get a new batch [of doctors] in so you've got to start again.

I did not see or hear of any dissent from the obstetricians about the board system or any other established midwifery initiative. The doctors respected the midwives' clinical opinion in discussions of difficult cases. I saw midwives openly challenge doctors' decisions if they disagreed with them and the doctors usually worked towards a consensus on a disputed plan of care as opposed to simply going ahead and administering an intervention.

However, despite their relative success in gaining professional authority, the midwives' status was vulnerable. Their professional esteem was, historically, hard-won and the difficulties that midwives had had in the past in gaining professional, as well as personal, autonomy in the face of doctors' professional power appeared to still influence their practices. They put a lot of effort into preserving and maintaining their authority over 'normal' birth, rather than taking it for granted. The midwives at Millside did not have the advantage of a separate physical space within which to promote midwifery interests but instead used systems, such as the red and green pens, to carve out their own professional place.

Northway

The Midwifery Unit

Unlike those at Millside, the Northway Midwifery Unit midwives *did* have their own space. Northway Maternity Unit was situated on the ground and first floors of the main hospital building. The Midwifery Unit was on the ground floor, running parallel to the main Delivery Suite and the two areas were connected by a set of double doors at the far end of the corridor. The Midwifery Unit at Northway was organised separately from the other clinical areas. It was mostly staffed by midwives who were 'core' to the area: that is they did not rotate regularly to work in other parts of the Maternity Unit. Every shift was staffed by two Midwifery Unit midwives and a community midwife from one of the local teams. The community midwives had chosen to spend one shift a month on the Unit and the integration of community

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midwives into the Midwifery Unit was not replicated anywhere else on the Maternity Unit.

Staffing the Midwifery Unit with community midwives had two explicit aims. It was an attempt to increase continuity of carer for women, as there was a possibility their community midwife may deliver their baby (although the odds of this actually happening were very poor). It gave community midwives the opportunity to keep up their skills in intra-partum care, as out in the community they would only attend home births. With the city-wide homebirth rate at about 1.5%, many delivered very few babies in their usual community work. However, the use of community midwives was not only a practical way to organise staffing, or a way to promote continuing professional development, it was also a manifestation of the Midwifery Unit's ideology. community midwifery has been particularly associated with the midwifery social model of care (van Teijlingen 2005; Leamon and Viccars 2010). Ruth Wilkins has suggested that it provides opportunities for a particularly 'special' relationship between mother and community midwife which is less possible in hospital practice (Wilkins 2000) and community midwives are also less likely than hospital midwives to experience an ideological conflict between midwifery ideals and the reality of their practice (Hunter 2002; 2004). Allying the Midwifery Unit with the local community practices was a way to emphasise its ideological similarities with the social/midwifery model of care (located within the community), as opposed to the medical model (located in the hospital). Despite its physical

position directly next door to the Delivery Suite, the Midwifery Unit was ideologically oriented away from the hospital.

A 'home-like' space

At a material level, the Midwifery Unit also looked different to the Delivery Suite. At Northway Midwifery Unit, the interior design of the unit was specially made to look as much like a 'home' as possible. Medical equipment was hidden out of sight and the lighting and furnishing were dim, calm and soft. This contrasted with the bright, medical environment of Millside. The Millside Consultant Midwife had tried substituting the clinical posters in the rooms with framed art [Fieldnotes, 15.05.08] and the midwives used the surgical lamps in the rooms as ambient lighting, instead of the fluorescent strip ceiling lights but this had had little effect.

Millside Delivery Suite was designed to make clinical care easier: for example all equipment was to hand, and the position of the clock behind the bed enabled midwives, but not women, to record the length of contractions or the passing of time. In contrast the design of Northway Midwifery Unit aimed to reflect its ideological aims to be woman- not institution-centred: 'it shouldn't look like an institution, it should look like a place where babies are born' [Interview, Midwifery Unit manager, 16.07.08]. Whilst they had been successful in many ways, the rooms at Northway Midwifery Unit still had an institutional feel about them. They each contained a delivery bed that cushions and burgundy throws could not entirely disguise. The midwives also discussed the frustration of only being able to purchase new chairs for

the rooms from NHS approved suppliers of hospital furniture in regulation pink or green. The walls and wood work in the reception area were starting to look tired and dated and as I was finishing my fieldwork, the unit received an instruction to replace their fabric curtains with paper ones to comply with Infection Control regulations.

Making the Unit 'home-like' was an attempt to influence the dynamics of the midwife-woman relationship through the spaces in which that relationship was played out. At a homebirth, the midwives would have been 'visitors' in the woman's home. This was because the home was assumed to be a place where women were in control, as opposed to a hospital, where the control was with the health professionals. Making the Midwifery Unit 'home-like' was a manifestation of the desire to give women control over their own births as part of providing woman-centred care. The Consultant Midwife explicitly made the connection between autonomy and being at home, demonstrating how she tried to make the Midwifery Unit as home-like as possible by allowing women to behave as they would at home:

> Eat and drink as you want to eat and drink. At home you're going to do that, why can't you do that here [Interview, Consultant Midwife, 02.09.08].

However, as much as the midwives believed this to be true, they were still in charge of the space. These rooms were, of course, not the women's homes. Women chose the Midwifery Unit over home, because they found comfort in medical assistance being very close by. There were many, largely unspoken rules about where the

women and visitors could and could not go, even though the midwives who designed the unit tried to break down many of these. Women did not move freely through the unit because, whilst there was an attempt to make the rooms 'home-like', they were still situated within a hospital. Hospitals, like all social spaces, have (spoken and unspoken) rules about where 'visitors' can and cannot go.

The midwives most commonly cited the shared kitchen as a unique feature of the Midwifery Unit. Unlike the other areas I studied, visitors were encouraged to help themselves to tea and coffee in a kitchen which was shared with the staff. The midwives explained this to me as a signifier of their relaxed attitude to the movement of visitors and women and their equal status with the women; as if the unit was not 'owned' by the midwives but shared, but in practice I never saw women or their partners help themselves from the kitchen. Similarly, I also rarely saw women use the retreat which was a room designed for women in early labour with cushions on the floor and dimmed, coloured lighting. Once, when I was there, it housed a woman in early labour but only as she waited for a delivery room to be free. Instead, this room was most used by midwives as a place for a nap during the night shift.

Not only was the Midwifery Unit not as accessible to women and their partners as the midwives might have hoped, but the construction of a 'home-like' birthing space in an attempt to give women more control over their birthing experience, presupposed a particular idea of 'home'. In her discussion of the evolution of these

'home-like' birthing spaces within hospitals, Fannin notes the limitations in assuming that home is an inevitable site of women's empowerment:

> In the hospital's references to domestic space, the home functions as an "enabling fantasy as a place of free choice over one's body, a context safe for the exercise of will, body, and desire" (Mitchie 1998: 261). This fantasy is historically specific and contingent on an understanding of a particular white, middle-class maternal subject (Fannin 2003: 521)

The development of a 'home-like' environment within the Midwifery Unit in order to empower women was somewhat presumptive. It also privileged a certain idea(l) of the white, middle-class domestic experience that was likely to be unfamiliar to many of the women who birthed there. Furthermore, those women who birthed in the unit had possibly declined to book a homebirth (if it had been offered to them), precisely because they wanted to birth in a hospital with doctors and medical equipment close by.

The Philosophy

Plans for the development of a Midwifery Unit in the early 2000s had been met with cynicism from some of those midwives working on the main Delivery Suite. The Trust's Consultant Midwife explained how midwives within the Trust had not believed that the Unit would ever be built:

Midwives didn't think it was going to happen and once the bricks and mortar went down there was interest in it or they began to believe it was going to happen. Lots of concerns about 'well, what are you gong to do differently?' What are we going to do differently? How are we going to nurture in this setting in this hospital that is known to be really medicalised and how are we ever going to be different? [Interview, Consultant Midwife, 02.09.08].

This aim to be different from the mainstream work of the hospital profoundly shaped the inception and function of the Midwifery Unit. The difference between the two units was cultivated by the staff, who prided themselves on working in a way which they explained as being almost antithetical to the operation of the main Delivery Suite.

The nature of the Midwifery Unit's intention to be 'different' was guided by its Philosophy. The Unit's Philosophy was a practical mission statement framed on the wall in the Unit reception. The written philosophy referred both to the physical environment of the Midwifery Unit and its aims to provide individualized care and emotional support for women, reflecting the social model of midwifery care:

The Midwifery Unit is a unique environment that offers women and their families the opportunity to give birth safely in a comfortable and relaxed home-like setting.

Committed practitioners, who work closely together to give high quality
evidence-based care, will support women through their experience, respecting
culture, religious beliefs and traditions.

The aim of the Midwifery Unit is to enable women and their families to
experience childbirth in a way that will establish a positive and enriching start
to parenting.

I asked the midwives I interviewed to define the philosophy for themselves and these
responses were representative:

I would say that it's a caring, nurturing environment where you are primarily
focussing on the woman and her pregnancy. The philosophy is to be with her,
is to be truly with-woman and to assist her by being physically present,
psychologically present, listening to her [Interview, Virginia, 22.09.08].

I think the philosophy is about giving women space and support rather than
trying to direct them and shape their labour for them; allowing them to shape
their own labour and birthing experience [Interview, Rose, 10.09.08].

We want to provide excellent care, high quality care for women on an
individual basis but also helping them to gain confidence really in normal

birth and having a really positive experience as a new parent [Interview, Alison, 30.07.08].

It is not surprising that these definitions so closely reflected the formal mission statement, as all three of these midwives originally helped devise it, although the midwives I interviewed emphasised being 'with woman' in a way which was not explicit in the written philosophy. Whilst the Philosophy existed in a written form, the midwives' operationalisation of it was in many ways more important. It is difficult to overestimate the prominence of the Philosophy in the day-to-day talk of the staff on the Midwifery Unit. The philosophy was imagined and spoken about by the midwives in the unit as an ideologically driven set of practices, but also if it had physical form as a kind of bullet-proof vest or container which protected them from the medicalising influence of the Delivery Suite.

A group of midwives from a trust elsewhere in the country had written to the Consultant Midwife at Northway, asking to visit to see how the midwives at Northway had kept their Midwifery Unit separate from the Delivery Suite [Interview, Consultant Midwife, 02.09.08]. The other Midwifery Unit was frequently being used as overspill for their busy Delivery Suite, a problem that the Northway Midwifery Unit midwives diagnosed as a disintegration of their protective philosophy:

[The other Midwifery Unit] diluted the philosophy a lot so they've got a lot of the postnatal women coming over, Sections [too], because they can't ward

them. You've got all that going on so it's not kept separate; so they wanted to

hear how we'd kept it separate [Interview, Consultant Midwife, 02.09.08].

The Unit Manager believed that it was the strength of their Philosophy which kept

their Delivery Suite at bay:

We're not being affected like other units being used as an overspill and I

think that's down to the philosophy being so, you know, entrenched on here.

[Interview, Midwifery Unit Manager, 05.08.08].

Policing Space

Women, families and friends

Norms of practice in the unit, as in other healthcare environments, were guided by a

set of guidelines, protocols and formalised processes. The Midwifery Unit was set up

to care for women who were not expected to experience any complications in labour

or birth and there were strict criteria for entry. Any woman who came onto the unit in

labour was required to comply with all of the following criteria (see Glossary for

further explanation):

- Women booked under midwife-led care
- Singleton pregnancy
- Cephalic presentation

- Gestation from 37 to 42 weeks + 0 days (i.e. Estimated Due Date + 14)

- Aged between 16–40 years

- Clinically well grown baby

- Placental site normal on ultrasound

- Haemoglobin > 9.5 g/dl + platelets 100 or more

- History of normal fetal movements

- A blood pressure of less than 140/90 mmHg

- Spontaneous onset of labour

The women who fulfilled these criteria were 'allowed' to labour with minimal intervention from midwives but these criteria were used to exclude women deemed 'unsuitable'. The strict entry criteria were formally in place to ensure the safety of women and babies, but they also protected midwives from being forced to practice outside their remit and professional capacity by taking the lead on 'high-risk' cases. The Midwifery Unit philosophy was predicated on not intervening in the natural process of birth, but the women had to be deemed low-risk enough for this (not) to happen (I discuss the low-risk/high-risk dichotomy in more detail in Chapter Seven). Trust guidelines dictated that 'high-risk' women required continuous foetal monitoring. They were also more likely to need analgesia, augmentation of labour or surgical intervention which required equipment that was not kept on the Midwifery Unit.

The exclusion criteria policed the border of the Midwifery Unit. Women who did not

fit the criteria were excluded and the 'opt-out' entry system meant that all women

who fell within the criteria were booked to birth on the Unit, unless they explicitly

requested to birth on the Delivery Suite. Women with individual preferences which

went against the guidelines had to negotiate their way onto (or off) the unit with the

Consultant Obstetricians, Consultant Midwife or Supervisors of Midwives, a process

that would require significant social capital. Some process to determine which

women were suitable to labour on unit was indeed necessary to ensure the safety of

women and babies and the professional wellbeing of midwives. However, these

criteria were medical and not women-centred. They represented a tension between

the desire amongst the midwives to promote the Unit Philosophy (of woman-centred

care), and the demands of both the Trust guidelines (however well intentioned or

appropriate) and the protection of midwifery professional interests.

Only one midwife, Rose, remained cynical about the existence of the Midwifery Unit

Philosophy and recognised the inherent contradiction between woman-centred care

and promoting one kind of midwifery care, regardless of women's wishes:

> Well it's like 'let's have a mission statement' – let's not! You know, it just
>
> doesn't do it for me, but I can see it does for other people which is why it
>
> wasn't for me to say to the midwives that we'd interviewed and appointed
>
> that they shouldn't have this thing because they felt it was something which
>
> would encapsulate [our kind of practice] – but it shouldn't ever be set in

stone… We now have anyone who's suitable which means that quite a few women have never considered doing anything but sitting on a bed and they want drugs and they want them now and they can't understand why we won't rupture their membranes [Interview, Rose, 10.09.08].

In the following chapter I explore this tension in more detail, looking in particular at the way in which midwives shaped women's choices about their labour and birth in ways which were both in line with, and contradictory to, the Unit Philosophy and the wider midwifery discourse.

Staff

The demarcation of midwife-led and consultant-led space at Northway led to the construction of midwives, doctors and other staff as 'visitors' to the Midwifery Unit, just as it did at Millside. The doctors, Delivery Suite midwives and Midwifery Assistants were all 'visitors' to the Midwifery Unit, but in practice they had different levels of informal access. Delivery Suite midwives and Midwifery Assistants visited the Midwifery Unit quite often. For example, they dropped in to borrow spare blank postnatal notes [Fieldnotes, 20.07.08] or came to hand over folders of women's notes and a few visited simply to say hello and stay for a cup of tea and a chat [Fieldnotes, 06.08.08]. This contrasted with the doctors who did not visit unless called to review a woman or if the emergency buzzer was sounded[15].

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[15] Each delivery room was equipped with an emergency button which sounded a loud alarm throughout the unit, and the Main Delivery Suite. When it was pressed, every member of staff from

The midwives tried to control the doctors' access to women and were able to do this easily, compared to those at Millside. Millside midwives had invested a lot of effort into designing systems, such as the red and green pens, and 'training' the doctors. Northway Midwifery Unit had the advantage of a pre-existing physical separation between it and the Delivery Suite which made it easier for the midwives to police the space. Keeping doctors out of the area was a strategic move by the midwives to retain, for them, a feeling that they had control over the space. Like the Millside midwives, those on the Midwifery Unit spoke about the doctors as if they were well-behaved children, reinforcing the midwives' perceived higher status within the space:

> They're actually usually very good and they'll say "I know we're not usually allowed on here" [Interview, Alison, 30.07.08].

'Us and them'

Not rotating helped maintain a stable and cohesive workforce within the unit. However, at Northway it also had some unintended consequences. As rotation was often used to try and minimise the culture of difference between clinical areas, the lack of regular movement between the Midwifery Unit and the Delivery Suite may also have contributed to the suspicion and intolerance between the two groups. The

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the Midwifery Unit and the available medical staff from Delivery Suite ran to assist. Only those staff actively catching a baby were excused from attending.

midwives on the Midwifery Unit told me that they felt scrutinized and judged by the midwives next door:

The whole hospital is critical of the Midwifery Unit with regard to following guidelines and so on. If anything does happen that isn't a good outcome, every little thing does get pulled apart; every little thing. We're very much under scrutiny. We still are under scrutiny, probably as much as at the beginning [Interview, Elise, 27.07.08].

I think Delivery Suite still think we're a little bit dilettante, especially if we say we don't think it's appropriate for a woman to come here. 'Well why?', 'because I say so'. So there's always that bit of nark going on between us [Interview, Rose, 10.09.08].

I think sometimes they think that we're all rubbish and that we send them problems and I hear them criticise us a lot and it's really sad and you think 'no, it's not right' [Interview, Kate, 16.07.08].

Many midwives described what happened when they were asked to cover short staffing on the Delivery Suite when they rarely worked there. Alison's comment was representative:

I used to work on Delivery Suite; I was a core member before I went to work

in community, 13 years ago now, but sometimes I feel lost on there looking

for things…you can ask, but for somebody who's not familiar it can be very

stressful [Interview, Alison, 30.07.08].

Alison felt discomfort on the Delivery Suite because she was out of place. As a very

experienced midwife, Alison was used to being highly skilled at work but she was

de-skilled by not knowing her way around the space. Similarly, Elise described being

de-skilled by the actions of the Delivery Suite midwives when she transferred a

woman to their care:

It's like ER sometimes. It's quite interesting to watch... You transfer them

over and suddenly the lights go on, it's very bright, everybody runs in,

nobody says, 'hello, I'm such and such'… You almost feel stunned by it. You

get pushed out the way, they just get on with it and [at the end they say]

'everyone well done' and they leave. They just leave this kind of 'oh my god'

[feeling]; and you hear them saying 'you know, those Midwifery Unit

midwives just stood back' and it's not that you've stood back, it's that you've

literally been pushed out the way [laughs] [and they say] 'oh they've brought

the crap around again' and ugh – you just can't win, you can't win

[Interview, Elise, 27.07.10].

In Elise's story, the Delivery Suite staff played the slick, skilled, medical heroes. The rush and bright lights followed by the congratulatory 'everyone well done' was reminiscent, as Elise said, of an episode of a TV medical drama. Elise's expertise was in a different kind of midwifery, which belonged on the Midwifery Unit and not on the Delivery Suite. For example, the skills in emotional labour which were privileged on the Midwifery Unit did not have as much currency as speed and technical clinical skill, next door on the Delivery Suite. Despite Government and Trust support for the Unit, its midwives still felt themselves the underdogs compared to the Delivery Suite's 'sexy side of midwifery or obstetrics or that's where gets the most money or the most input from government, you know the NHS's money' [Interview, Kate, 05.08.08].

The manager of the unit was particularly attuned to the role the Unit had within the wider Trust. She was responsible for representing the unit in organizational negotiations and defending it from becoming an overspill facility for the Delivery Suite. She often spoke of the Unit's status as underdog, which suggested this perception impacted on her interactions with the representatives from other clinical areas. I also found that it spilled over into the general attitude amongst the community on the Unit. The Consultant Midwife was particularly keen to point out to me how she felt their practice was scrutinized. After a meeting on 24th July 2008 to discuss a case in which a baby had been born in a poor condition, I noted in my fieldnotes:

The Consultant Midwife came up to me after the meeting to make sure I had 'got' that external scrutiny was an issue. She hopes that I can pick up on this key problem. 'They' [the Trust's executive managers] don't pay any attention if things are all good but are watching like hawks for bad things – there was a fresh stillbirth one month into the life of the Midwifery Unit and it stopped her from being able to develop anything new for a year. [Fieldnotes, 24.07.08]

Much of this scrutiny occurred after poor outcomes or reported clinical errors. Whilst the Trust formally investigated such events, the midwives suggested to me that they were particularly stringent in investigating the Midwifery Unit:

Mistakes are made then that gets highlighted and here it's polarised isn't it. It feels worse when you're over here. Over there it'll just be hidden; it just hides amongst all the bigger figures. Over here it looks terrible. [Midwifery Unit manager, Interview, 16.07.08]

The sense of being under scrutiny tended to make the Midwifery Unit staff retreat into protecting themselves, rather than reaching out to the other midwives and managers on the Delivery Suite. For example, when I asked the Unit manager what single thing she would do to most improve her working life, she replied:

Manager: I'd move us [laughs]. I mean it's not in my power to do that of

            course.

Juliet: Where would you move you to?

Manager: I'd move us away from Delivery Suite because the fact that

            we're next door I'm fighting a losing battle really [Interview,

            Midwifery Unit manager, 16.07.08].

The separation of the areas allowed the Midwifery Unit midwives to entrench,

ideologically, away from those on the Delivery Suite. The spaces in which the

midwives worked were both constructed as particular kinds of work*places*, which

then helped to form the next generation of midwives:

Manager: Maybe Midwifery Units grow confident midwives, I don't

            know. I would say so on here. I do see a lot of confident

            midwives in community. That's probably why I miss them.

            They're all quite stroppy out there as well…

Juliet: Do you think it's the Midwifery Unit which attracts certain

            kinds of midwives or does it create certain kinds of midwives

            here?

Manager: I'm hoping it creates them [Interview, Midwifery unit manager, 05.08.08].

However, this separation also polarized the midwives' ideologies, further exacerbating the division:

Juliet: You said the effect of working next door [to the Delivery Suite] was that you kind of found yourself on a continuum and as a reaction to it you became super, super normal.

Manager: Midwifery Unit

Juliet: Super, super Midwifery Unit

Manager: You have to do that. I think you have to do that for midwifery because, as I've said before, they [the medicalised, Delivery Suite midwives] are so powerful, that I honestly see that's the dominant culture. [Interview, Midwifery Unit manager, 05.08.08].

Despite their desire to make the Midwifery Unit different from the Delivery Suite, the Midwifery Unit manager lamented the lack of cohesion between the two areas:

Manager: There's just tension between the two areas and my job actually is

            to get rid of some of that tension.

Juliet: Is it? Is that in your job description?

Manager: Yeah, how do you do it? [smiles, incredulous]. I have, to an

            extent but you know, it's traditional that the areas do not get on.

            How do you make communication better? How do you resolve

            those issues? I don't think I have that power to do it. [Interview,

            Midwifery Unit manager, 16.07.09]

The manager spoke about the 'tradition' of animosity as if it was essential to the two

areas and not constructed or upheld by the actions of the midwives working there.

There was a general unwillingness amongst the midwives to speak about their role in

upholding such a culture within the Maternity Unit. The Consultant Midwife, too,

was adamant that the culture of 'them and us' had only negative consequences for

midwives:

Juliet: What's useful about 'them and us'?

Consultant Midwife: What's useful? Nothing's useful at all, it's very

                     destructive! It is destructive, completely destructive!

                     [Interview, Consultant Midwife, 02.09.08].

However, for this division and suspicion to be maintained over many years required the active participation of the midwives from both sides. This suggested that it was to their advantage to maintain this culture of separation, rather than try to reconcile. In practice it helped the Midwifery Unit midwives to preserve their model of midwifery care. The professional remit of midwifery is expertise in normal birth. When working with normal birth, midwives felt themselves to be autonomous professionals in a way that they are not when they are working in partnership with doctors, caring for women with abnormal labours. Keeping women with 'abnormal' pregnancies away from the Midwifery Unit made them feel like they were practising autonomously, despite working under restrictions such as Trust guidelines, the Delivery Suite's resource constraints (which spilled over to them through 'pulling') and close scrutiny, whether real or perceived.

Conclusions

This chapter has outlined the role of space, proximity and inter-area relationships on midwives' working lives. I have explored the influence of the location of different clinical areas and the mobility of staff on their relationships with other staff. In both sites, the spatial separation of clinical areas (for example them being on different floors) helped them to develop separate communities, but it also meant that the lived realities of the staff in other areas were largely hidden. The midwives articulated problems with the space in terms of its effects on the women, and on their individual

autonomy and capacity to do *be* midwives. This was a script which was congruent with a midwifery discourse which privileged altruism and woman-centredness.

At Millside, the way the workplace was used by different professional groups both diminished midwives' status and allowed it to be reclaimed. The power dynamic between midwives and those with ostensibly higher status: the doctors and the managers, continually fluctuated. At a micro level, actions such as policing the borders of the delivery rooms were a way of protecting midwives' sense of personal autonomy. Within the wider field of midwifery, they can be understood as strategies deployed to protect midwives' vulnerable professional status. In the absence of their own space, the midwives at Millside carved out territory in the unit within which they felt able to practice according to their professional ideals. They bonded with colleagues by complaining about those factors of their work: staff shortages, inconvenient shifts, or other midwives' laziness, which were perceived as out of their control. Managers and midwives in other areas were a common enemy or a convenient 'them' against which to define 'us' (who were also those who could be relied on for emotional support). Those midwives like Fiona, who were ideologically out of place could not rely on colleagues for such support and so adapted their presentation of self, which required emotional labour.

The midwives at Northway Midwifery Unit had different experiences. The spatial, social and cultural division between the Midwifery Unit and the Delivery Suite next door provided the midwives with homes for their differing ideologies. Despite

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Government and Trust support for the Midwifery Unit, the midwives on the Unit felt scrutinised and under threat of closure. They articulated this feeling of difference and the culture of 'us and them' to me as if it hindered their work. I came to believe that this separation of the two groups was in fact useful to the midwives. It gave them space to develop (and indeed strengthen) their sense of an ideological apartness. A more collegial relationship with the midwives on the Delivery Suite might have resulted in the unit being used to take their overspill of excess postnatal women, becoming under the control of the Trust's management and doctors, or further scrutinised on a daily basis, rather than just after the (occasional) adverse event. The Midwifery Unit was a spatial manifestation of an ideological distinction. It was built in order to provide a space for a particular type of midwifery practice that was based on the ideals of woman-centred, individualised care, although the strong influence of the Delivery Suite meant this was not always played out in practice.

Had it been adequate, ideal or simply incidental, the space in both units would have been invisible to midwives. Judging by the amount of time spent discussing it, this was clearly not the case. Exploring the geography of the units has begun to expose how the midwives worked with(in) the space they had and the complexity of their professional status. The midwives' dominant script was that they worked to promote woman-centred care in the face of contrary institutional restrictions. However, the evidence suggests that their strategy of occupational closure against support workers, for example, promoted their own professional interests whilst moving them *away* from women. In the following chapter I discuss in more detail the extent to which

midwives in each of the units experienced this contradiction between their discourse of a social and woman-centred model of midwifery and their occupational project to promote their own interests. The literature suggests that intimate body work, such as that often carried out by midwives, involves a complex negotiation of power relationships and the discussion in Chapter Seven focuses particularly on the strategies midwives deployed in relation to the bodies they worked with.

Chapter Seven: The bodies of midwifery work

The review of the literature suggested that body work involves a complex interplay of power between body worker and client or 'patient'. My own findings and that of other midwifery researchers suggest midwifery is no different. The guidelines and policies of maternity care require healthcare practitioners to use intimate body work, such as vaginal examination. The existing literature suggests that midwives use strategies to manage that intimacy in order to depersonalise and desexualise procedures, such as vaginal examination (Stewart 2005), whilst still cultivating a professional friendship (Kirkham 2000b) for which the discourse values emotional closeness, altruism and love (Oakley 1999).

This chapter explores the apparent tension that the literature suggests between avoiding or depersonalising intimate procedures out of respect for women's privacy and bodily integrity, whilst aspiring to the kind of emotional intimacy that the discourse privileges. Midwives are also required to adhere to Trust guidelines and policies regarding the clinical measurement of cervical dilation and vital signs. This chapter explores how the midwives negotiated such guidelines in ways that were complicit and ways that were resistant, and the extent to which their actions reflected their stated aims to be woman-centred versus upholding their own professional interests. The different policies of the two Trusts suggest that midwives' experiences between them may also differ. Like the previous chapter, the first half of this chapter

addresses the midwives' work at Millside Maternity and then proceeds in the second half to look at the same issues at Northway Midwifery Unit.

Millside

Touch

The body work of midwifery is dominated by the use of touch. Van Dongen and Elema (2001) defined two kinds of touch in healthcare: that for 'cleaning, washing, medical actions or taking someone's temperature' which I have termed 'clinical touch'; and another which is 'about emotions, care, relationships, gender, intimacy, age, and well-being' (Van Dongen and Elema 2001: 150) or 'social touch'.

The Millside Trust guidelines required midwives to perform vaginal examination on admission to the Unit in labour, and then every four hours once the woman had reached 4cms dilated. Women could therefore expect to have a number of vaginal examinations during the course of their labour. Performing a vaginal examination involved placing the index and middle fingers into a woman's vagina, inserting the tips of the fingers into the cervix and spreading them apart to assess the dilation of the cervix in centimetres. The position and thickness of the cervix also gave an indication of the stage of labour as the cervix would thin and move anteriorly during labour in conjunction with dilation. These examinations were clearly painful, as I frequently heard women cry out during them and others have written of how women often find them embarrassing and awkward (Devane 1996). Two midwives at Millside: Miriam and Jodie, spoke in an interview about how distressing women

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found vaginal examinations and how midwives therefore needed to give women time and allow them to feel in control of the procedure:

> You put her heckles up [sic] from the minute she comes in through the door. Then you're doing all sorts of these procedures that…oh god…with somebody you don't know; although I don't know if that's a good thing or a bad thing [Interview, Miriam, 16.06.08].

> [You need] just that little bit of compassion and a little bit of – don't be in a rush. Which again comes down to time. If I do a VE it's like "you're in control: if you tell me to stop, I'll stop" [Interview, Jodie, 09.04.08].

Vaginal examination could be very disempowering for women, not least because vaginal examinations were used to diagnose abnormality in labour such as 'slow progress', which would be likely to result in intervention in accordance with the Trust's guidelines. Miriam and Jodie described how, despite this, they attempted to make the procedure as 'woman-centred' as possible by allowing the woman a degree of control over how and when it was carried out.

Miriam, a senior midwife on the Delivery Suite, suggested that performing the minimum possible number of vaginal exams was desirable, but required confidence. She described one of the other midwives on shift to me as 'a bit VE happy' [Fieldnotes, 12.12.07], explaining how vaginal examinations acted as a safety net for

inexperienced midwives, as they provided them with the security of numerical evidence for the progress of labour. Miriam made the distinction between more junior midwives' reliance on vaginal examination and the skills developed by experienced midwives, such as herself, to assesses intuitively the progress of labour through observation.

Not performing vaginal examinations might spare women (and midwives) distress and embarrassment, but it also put midwives in a vulnerable position as employees. Midwives were expected to add their findings from vaginal examinations to the patients' notes and failing to do so could result in retribution from the Trust if there was a subsequent investigation due to a poor outcome to the birth. I discuss the role of Trust guidelines and midwives' relationships with them in more detail later in the chapter. The dominant medical discourse demanded quantification of the progress of labour, which could be recorded in centimeters by vaginal examination. However, midwives' intuitive knowledge of the progress of labour, based on observations of a woman's behaviour was not quantifiable. The practice of undertaking vaginal examinations was guided by the dominant paradigm of medical over midwifery knowledge (Davis-Floyd and Sargent 1997).

Observations of progress also required physical proximity to a woman over a long period of time. The shortage of space and therefore time available to midwives (owing to the pressure to move women on) may have also increased the pressure on

them to perform quick vaginal examinations, rather than rely on the slower development of intuitive knowledge of an individual women's labour.

Cardiotocograph (CTG) monitoring was used widely at Millside to measure the strength, length and frequency of contractions against the foetal heart rate, in order to detect foetal distress. Women were usually monitored on admission to the unit and if it was deemed necessary, either continuously during labour or the foetal heart was auscultated at intervals using a hand-held Sonicaid machine. Traditionally, midwives would have used a Pinard stethoscope (see Glossary) to listen to the foetal heart, but the younger midwives especially, lacked the skill and confidence to use it. During a night shift I wrote:

> A young midwife came into the handover room looking for a Sonicaid. 'I've
> got a Pinard's in my bag if you want it' said Olive (senior midwife) with a
> glint in her eye. This was taken as being a bit of a joke, 'oh, shall I be brave?'
> said the midwife, 'no! Where's the Sonicaid?' [Fieldnotes, 04.12.07].

The machines used to detect the foetal heart rate and measure the strength of contractions were considered more reliable than the Pinard stethoscope. Jenny, a midwife working on the Low Risk Postnatal Ward at the time of my fieldwork told me that midwives: ''should' use Pinard's but don't' and that she avoids using them because 'she doesn't trust her hearing' [Fieldnotes, 12.02.08]. Jenny trusted the CTG or Sonicaid machine more than her own fallible body. Jenny (and the midwife who

declined the loan of the Pinard) perceived the electronic machines as more accurate

and reliable, as well as easier to use, but not all midwives shared her view. Jenny got

into a discussion with a student midwife who had been taught by her tutors that

machines, too, could not always be trusted:

> Sara (student midwife) was saying that CTGs can sometimes be unreliable
>
> because they can pick up the maternal heart instead [of the foetal heart]. It has
>
> been known that the maternal heart can appear 'doubled' on a CTG which
>
> then shows up as if it were a foetal heart [Fieldnotes, 12.02.08].

Students were taught to check the findings from the CTG using a Pinard stethoscope,

but as this was rarely done by their mentors[16] in practice, they often failed to develop

the necessary technique. Mentors were influential on the development of students;

norms of practice, but this influence varied depending on the mentor. Whilst some

mentors were keen on CTG monitoring, another mentor at Millside advised her

student to always (or only) do as much monitoring as to make her feel safe about her

practice and not be swayed by what other people did, as it was a 'controversial issue'

[Fieldnotes, 11.01.08]. Current evidence suggests that continual electronic foetal

monitoring in labour does not increase foetal wellbeing for 'low-risk' women, but

does increase the likelihood of interventions such as caesarean section or

instrumental delivery, because foetal distress is frequently over-diagnosed (Alfirevic,

Devane et al. 2006).

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[16] Mentors are practising midwives assigned to work with (and tutor) student midwives during their clinical placements.

Like vaginal examinations, CTG monitors provided quantifiable information on labour, which was deemed more reliable than bodily assessment; for example observing a woman's behaviour or palpating the strength of the contraction by hand. The tendency to trust machines over traditional midwifery skills involving touch is also evident in the use of ultrasound scanning to determine the position of the baby when this would previously have been diagnosed by palpation. In both cases, the paper print-out from the machines also gives a record, which could be persuasive when trying to determine the cause of a poor outcome and protect a midwife from litigation.

For some, the use of monitoring as opposed to touch represented a fundamental difference between midwives' and obstetricians' practice. Miriam also saw this division as gendered, and her explanation played on the stereotype of masculine technology vs. feminine proximity and touch:

> When we first went there [to Millside] we had one of these central computer things where you could see all the traces (see Glossary) and the doctors used to sit there glued watching all these traces. I hid it in the end [laughs]. Because if a woman has got a bad trace, you shouldn't be sitting at the desk, should you? You should be in looking at the woman! But then that was another bit of technology that the men thought was fantastic.

[Interview, Miriam, 16.06.08]

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Despite Miriam's insistence that good care involved being physically with the woman, there was also evidence that monitors were used by midwives to 'babysit' women and relieve midwives from spending extended periods of time with them. On New Year's Eve 2007, a particularly busy day at Millside, a woman came in to the unit in advanced labour and as there were no midwives available to care for her she was placed alone on a monitor until a midwife became available: 'put her on the monitor for half an hour' a midwife said, adding sarcastically, 'I think continuous monitoring for this one, due to high risk, don't you think?'.

This evidence of the use of monitors to baby-sit women during busy times was supported by a further comment from Miriam:

> Miriam: Can't lose the monitors, tried and tried and tried but they're very reluctant to do the quarter-hourly observations[17] of an established normal labour.

> Juliet: Who are reluctant?

> Miriam: Most of the midwives. They like to have the excuse to put her on the monitor: 'I'll just put her on for 20 minutes because there's a bit of a decel (see Glossary), I'll just put her on for

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[17] Observations included measuring the woman's pulse, temperature, pressure and the foetal heart rate.

this because there's that'. And I have to say I've been a bit

lapse myself in that it's so blooming busy. But it's the wrong

reason to put her on the [CTG] monitor. If you put them on the

monitor you should be watching that woman and doing

one-to-one [care] but you tend to do it so you've got time to do

the flaming computer when you're in the Ass[essment] Room

[Interview, Miriam, 16.06.08].

Miriam attributed her actions, as well as those of other midwives, to a shortage of

time within the Unit. This reflected a wider tendency amongst the midwives to blame

acts of which they were ashamed on factors that were out of their control, as if to

absolve themselves of responsibility for not upholding the midwifery model of care.

This is not to suggest that the institutional resource constraints on midwives were not

significant nor real; they were both. However I suggest that they constituted only one

reason why midwives avoided regular contact with women, particularly when that

contact involved intimate body work.

It was evident that midwives sometimes used the monitors to avoid giving women

one-to-one care, performing intimate examinations or simply spending time. Body

work is often difficult work to negotiate, and minimizing opportunities for touch

could be understood as an act of self-preservation. Many of the midwives negotiated

a tension between wanting to preserve traditional the midwifery skills that privileged

proximity and touch, and protecting themselves from the difficult emotional labour it

required. The tension was never resolved. Instead they constantly reassessed the optimum balance between fulfilling the two sides. Other factors, such as busy ward, tended to push the midwives into avoiding intimate and/or time-consuming contact with women, but managing the large numbers of women was not necessarily their only motivation.

Acceptable and unacceptable bodies

Midwifery work involved close contact with lots of different kinds of bodies. The way midwives spoke about dealing with women's bodies belied their preference for certain kinds of bodies over others. 'Difficult' bodies: those women who did not behave 'appropriately' or who were unacceptable in other ways presented particular challenges for midwives. They spoke frequently about the strategies they used to try to organise or manage women in bodily terms.

The body in pain

One of the key themes of their talk about bodies was women who behaved 'inappropriately' during labour. On a number of occasions, the midwives complained of women's poor behaviour, for example kicking, scratching or grabbing midwives when in pain. Jodie described, on the Delivery Suite and again in an interview, how she had developed the confidence to tell women to stop hurting her:

> You get tough, you know like, I'm trying to think of some examples. Women trying to grab you is a good one. I mean whereas as a student you're like

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[gently saying] 'yeah yeah, let's do this' and now it's like, 'no, don't do

that!'. That's a confidence thing. [Interview, Jodie, 09.04.08].

Women who made a lot of noise during labour were also treated with dismay and I

regularly witnessed midwives rolling their eyes, to each other and to me, at screams

coming from delivery rooms. On 9th January 2008, Maria was caring for a woman

who had been shouting loudly through early labour contractions, refusing to sit up,

take a bath or otherwise comply with her suggestions to relieve the pain. After

spending some time with the woman, Maria came out of the room to the desk, sighed

and said 'my "with woman" has gone' indicating both that she was aware of the

expectation for her to support the woman emotionally in labour but also that this was

tiring and difficult. Her response to the woman's non-cooperation also demonstrated

how the pain relieving strategies preferable to her as a midwife (such as changing

position or taking a bath) were deemed more appropriate than the woman's strategies

of shouting and writhing in pain.

Pain relief was a particular area of concern for midwives. On one shift, the midwives

made clear their relief when a woman who had been shouting during contractions

had an epidural because it quietened her [Fieldnotes, 17.12.07]. The use of epidural

(see Glossary) and opiates (see Glossary) to, in effect, quell the midwife's as well as

the woman's distress at being with pain, echoes Nicky Leap's findings in a study on

midwives' experiences of being with women in pain. Leap writes that 'several

midwives commented on how the pressure to offer 'pain relief' is exacerbated on

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labour wards by reactions to the noise that women make, particularly when they are frightened or alienated' (Leap 2000: 50).

Caesarean Sections were sometimes pre-empted by midwives, particularly for women who were uncooperative or loud. On one of the busiest days I spent on the unit, one midwife said 'just you wait, when this one goes for a section, the other one'll be fully [dilated]' [Fieldnotes, 29.11.07] well before a clinical decision about a Caesarean Section had been made. Comments such as these were usually made on days when the unit was particularly busy. Vocalising frustration with women was a coping strategy for not being able to give women the kind of one-to-one support that was known to increase women's abilities to 'cope with the stressors of labor' (Hodnett 2002: S170). After one such experience Elaine, a midwife on the Delivery Suite, described the emotional consequences of being unable to support adequately a woman in labour:

> The woman in Room 9 is shouting during contractions and demanding an epidural. She's crying and distressed … Elaine was supposed to be looking after her this morning but had two other woman delivering and so couldn't go in. The woman was getting increasingly distressed as the time passed and has just had an epidural. The implication was that she might not have needed one if she had had the support. Elaine talked about how frustrating that was: to know she needed attention but not be able to give it. She said she had asked Miriam to look in on her while she was away and she hadn't… When she

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challenged Miriam, she said 'well, there's nothing we can do about it'. Elaine said you have to develop a thick skin here. [Fieldnotes, 17.12.07]

Both the woman and the midwife were inadequately emotionally supported. Not only was it emotionally demanding for midwives to be with women in pain, but it was also distressing for them not to be able to be with women, because that was what the discourse around what was deemed 'good' midwifery required of them. The line between what was appropriate and inappropriate behaviour in response to pain behaviour was also defined relative to how much midwifery input the women had. The women who shouted, writhed, kicked or scratched but had had little support from a midwife were treated with sympathy, in comparison to those women who behaved in the same way despite the attentions of a midwife. Although they were physically 'with woman', midwives who spent time supporting women were not always *emotionally* (or ideologically) with them, privileging the midwife's own preferences for the woman's care over the woman's wishes.

Making sense of unacceptable bodies

Midwives sometimes resorted to racial stereotypes in order to try and find a way to make sense of women's 'difficult' or 'unacceptable' behaviour. Polish, Somalian and Pakistani women in particular were easy scapegoats for a number of midwives' difficult work experiences. On my second visit to Delivery Suite, two midwives blamed the overcrowding of the unit on 'immigration from Poland and Somalia' [Fieldnotes, Millside, 18.11.07]. Jodie also told me that 'if we didn't have the

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immigrants, the unit would be a lot quieter'. At one level, their comments were understandable being as migrant women constituted a large minority of the women attending the unit. However, they also suggested that the midwives saw these women as less deserving of (NHS) care than (White) British women. Jodie was careful to make a distinction between those 'truly in need' and those she perceived as taking advantage of the British economic and healthcare systems:

> I'm not talking about your persecuted people because I'm absolutely one hundred percent for those ladies. I'm talking about people that come in... Should they have to pay for their maternity care? Would they? Should they – if we reduce family allowance to only two children, would they have as many? You know, their culture is no birth control [Interview, Jodie, 09.04.08].

Various ethnic minority groups were also characterized by particular health issues or behaviours that complicated their labour or midwifery care: for example South Asian women with diabetes or Somalian women who had undergone genital mutilation. Young South Asian women (especially those who were physically small) were frequently referred to as 'little primips' (See Glossary): an infantilizing term. They attracted the most eye-rolling by staff in response to their cries during labour. Women deemed 'obese' had similarly unruly bodies and were objects of spectacle. During one shift, a midwife on the Delivery Suite suggested I went to look at a young woman who had come in, just to see how large she was.

Low breastfeeding rates in the Trust were attributed to 'very different cultural feelings about breastfeeding'. According to a Breastfeeing Support Midwife this included Healthcare professionals who had their own prejudices and family experience of breastfeeding [Fieldnotes, 06.02.08]. Midwives also blamed low breastfeeding rates on the attitudes of particular cultural/ethnic groups in the unit, most particularly White British working-class women, who did not have a culture of breastfeeding. They also talked negatively about the practice of discarding colostrum, which they attributed to Muslim women but which is practiced in diverse ways by many cultural and religious groups (Liamputtong 2007: 12-13).

These prejudices helped some of the midwives to explain and understand women's behaviour that they found unacceptable or difficult. The midwives were not always able to provide adequate emotional support to women during labour, which may have exacerbated behaviour such as screaming, biting or non-cooperation. Essentialising such behaviour to a woman's ethnicity, culture or body size, relieved the midwives from some of the responsibility, and as such a part of the midwives' behaviour was a strategy for coping with their own distress. However, these attitudes were not at all woman-centred or in line with the midwifery or social model of care and no doubt themselves impacted on the quality of care available to some women from prejudiced caregivers.

Movement

Midwives exerted a significant amount of control over women's movement. Women at Millside were supposedly encouraged to mobilise during labour. The unit had a reputation, according to the midwives, of being good at allowing women to move around. Lillian, a midwife on the Delivery Suite, explained how before the unit had moved to its current site, 'mobilising' was just a matter of women going to the toilet, coming back and being put on the monitor, whereas at Millside the midwives were much more inclined to leave women to give birth however they chose [Interview, Lillian, 29.02.08]. In practice, I rarely saw women leave their (very small) delivery rooms. If they had wanted to walk, there was nowhere for them to go apart from across the car park to the main building or through the corridors. These areas afforded them no privacy and, as I explained in Chapter Six, were very tightly policed, so women and birth partners were unlikely to feel free to spend time there.

As well as influencing women's movement outside the Delivery Rooms, midwives also had a significant influence in the Delivery Rooms over women's position at birth. Jodie spoke about gradually losing her confidence in assisting women into alternative birth positions[18]:

> They would go on their back and I'd be thinking: 'I didn't do this in my
> training, why am I doing it now?' And then somebody would say 'I want to

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[18] 'Alternative' positions referred to any position other than lithotomy, in which the woman is supine, with or without her legs in stirrups.

go on my knees' and you'd go [gasp] because you've lost that confidence [Interview, Jodie, 09.04.08].

The ideals of practice that were taught to them in the class room faded during the first years of work, as the influence of the Unit became stronger than those of their tutors.

Midwives' bodies

Not only were women's bodies organized within the unit, but midwives' bodies were too. Uniform (or blue theatre 'scrubs' on the Delivery Suite) was compulsory and there were strict regulations about what kinds of shoes, tights and jewellery midwives were allowed to wear. Different groups of staff wore different coloured uniforms. Most midwives wore a white dress or top and trousers with a blue trim (or blue 'scrubs' on the Delivery Suite); clinical midwife-managers (e.g. Ward Manager or Matron) wore navy blue with a white trim; student midwives wore pale grey pinstripe with red epaulettes; Healthcare Assistants and Nursery Nurses, white with no trim and cleaners or 'Domestics' a mauve uniform or 'scrubs'. The doctors and non-clinical managers did not wear a formal uniform, although doctors were often seen in scrubs, or a white coat worn over plain, smart casual clothes which were part of an expected, if not formally enforced, dress code. In part uniforms had a practical use to protect clothing from bodily fluids but, like white coats, their cultural status was crucially important. Ostensibly wearing different colours was a strategy to help women distinguish between health professionals, but there was no particular way

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women would know which colour meant which type of staff. Instead the uniforms did more, in practice, to mark out the professional hierarchy between the healthcare professionals. The staff who did no clinical work, or who had the least contact with women, were those who did not wear uniform.

Midwives' bodies in the unit were marked not only by what they wore, but mostly by what they did. Midwifery is a very physical job. Midwives complained frequently about the occupational hazard of bad backs and shoulders. Women choosing to birth standing up were deemed a particular problem for a midwife as she would be forced to kneel on the floor in an awkward position during the birth. Jodie suggested that some midwives encouraged women to give birth on their backs in order to protect their own bodies:

> Why are we putting these women on their backs? Worst position possible.
> But a lot of the older midwives say well "I'm protecting my back". Fair play
> to them, you know [Interview, Jodie, 09.04.08].

NICE guidelines, which have been adopted by most NHS Trusts, advise maternity staff to encourage women into upright positions (NICE 2007: 162). However, some midwives identified a tension between the bodily wellbeing of the woman and that of the midwife where only one could be achieved at the expense of the other.

Clinical guidelines

The issue of birth position was only one example of midwives' interaction with clinical guidelines and protocols. Observation of midwives' talk about guidelines and their use exposed a complex relationship. Midwifery is a profession which prides itself on its relative autonomy: a discourse which argues that midwives are independent practitioners that are able to make autonomous clinical decisions in a way that nurses and Healthcare Assistants, for example, are not. This autonomy is fundamental to the discourse and yet it is one that is organised within the institutional (and professional) structure of a large number of rules, codes of conduct, clinical guidelines and protocols which govern and constrain, as well as facilitate, their practice. The academic and professional literature on clinical guidelines has preoccupied itself on the effect of these guidelines on clinical autonomy (see for example Berg 1997 for a discussion of the relationship between guidelines and professional autonomy). Therefore, the ways in which midwives complies with and/or subverted guidelines can explain much about their own attempts to uphold their professional autonomy.

Most of the clinical guidelines and protocols had been developed by NICE and passed down to the Trust. Representatives from the Trust workforce then adapted and wrote their own set of Trust-wide guidelines for different clinical areas and conditions. These guidelines constituted a set of 'if…then…' scenarios which midwives were advised to follow, whereby if a woman demonstrated a particular clinical sign then a specified action should be carried out within a specified amount

of time. Clinical guidelines were meant to provide midwives with guidance on appropriate courses of action in response to different events.

Sabotage of the guidelines was evident at Millside, but only through midwives' private reports. Miriam and Fiona both gave examples in their interviews of how midwives often resisted diagnosing women as 'fully dilated' in order to give them more time for the second stage of labour, which was time limited by Unit policies. This meant that if a woman had not birthed her baby within a certain period of time, doctors would be requested to expedite the birth:

> We've always cooked the books in midwifery. I mean we've always known there's a latent phase and an active phase of second stage (see Glossary) but when it was very medicalised you told them there was an anterior rim (see Glossary). I mean she was fully and you knew she was fully but you just cooked the books and we're back doing that a bit now [laughs] [Interview, Millside, 16.06.08]

> Another thing I do, and I've heard this is quite common amongst midwives, that I tend to not tell the dilatation straight away and I tend to try to stretch the [time between the] VEs a little bit, even if it's a quarter of an hour, a half an hour, do them a little bit later and start the partogram (see Glossary) a little bit later… Just start them as late as possible and just not telling when the woman is fully dilated (see Glossary) because she might not have the urge to

push and but then the clock starts to click. Just do things like that; and I'm

sure other midwives do the same, I'm sure they do [Interview, Fiona,

21.02.08].

Strategies such as stretching time intervals was a means for midwives to promote

their autonomy in terms that supported women's autonomy, within an environment

where it was not always supported. The autonomy existed both at a personal and a

professional level. At a personal level, the midwife was able to utilize her intuitive

knowledge of the progress of birth whilst providing the record of cervical dilation

that was institutionally required. At a professional level, it kept the woman within the

realm of 'normal' for longer than might otherwise have been the case. The midwives

manipulated their findings and records to try and protect a woman from going 'over

time' in the second stage of labour, after which they would have to call a doctor to

intervene. The midwives told me they did this in the interests of the woman as it gave

her more time in the second stage of labour before undergoing potentially traumatic

interventions such as instrumental delivery. These strategies also had the potential to

work in the midwives' own interests. As the midwives had jurisdiction over normal

birth, keeping a woman 'normal' kept her under midwifery care. The midwives

spoke about these strategies as if they were deployed to help *protect* women from the

assumed bodily pain and trauma which would come with medical intervention.

Whilst the midwives' role in protecting women from doctors is a common feature of

the midwifery discourse, this is very rarely described in terms of its benefits to the

professional project of midwives. It is another example of the way in which other

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(perhaps unconscious or secondary) motivations are silenced by the effects of the discourse which privileges the needs of women over the needs of midwives.

Northway Midwifery Unit

Unlike at Millside, there was a clear distinction at Northway between clinical and social touches. This is not to suggest that these two types of touch were not also practised at Millside, but the midwives at Millside did not speak to me or to each other about the social touch involved in midwifery and so I have no evidence of how it was used in the Millside Unit. This contrasted with the attention Northway midwives' gave to developing expertise in social touch, which I discuss here.

Touch

Clinical touch

Clinical touch, such as vaginal examination (VE), was an ordinary task of every day midwifery work. Women were not routinely examined vaginally on admission to the Midwifery Unit as they were at Millside (and on the Northway Delivery Suite). Avoiding vaginal examinations was viewed as part of woman-centred practice as such examinations were difficult and often painful for women. Virginia explained:

> Can you imagine going to the doctor's surgery and the first thing the doctor saying 'ok, can you take your knickers off, let me just examine you'. You're going to freak out. So you know, you try and make it…you've got to make the woman completely relaxed and often when they relax they get on and do

what they've come in to do which is to have their babies [Interview, Virginia, 22.09.08].

In order to decrease the number of vaginal examinations carried out on women, the midwives at Northway Midwifery Unit had developed an alternative scoring system based on the work of Susan Burvill (2002) to assess the stage of labour. The 'Modified Burvill Scale' instructed midwives to assess a woman's progress based on her behaviour in response to pain and the experience of being in labour. Symptoms of early labour were given a score of 0; early active labour, a score of 1 and active labour, a score of 2. Scores were given for each of six categories of assessment: Breathing; Mood; Energy; Movement and Posture; Descent of Presenting Part and Contractions Without Palpation. The findings of the Burvill Scale assessment determined whether a woman was advised to go home to wait until labour was further established, or admitted to stay on the Midwifery Unit. A Burvill Score of 5 indicated established labour; that she should receive 'one-to-one' care from a midwife and a partogram started. An example of the scale for 'Energy':

Early labour		Early Active Labour		Active Labour	
Wants to sort out practicalities.	0	Becoming still, Inward – focuses on self.	1	Still. Withdrawn into self.	2

And for 'Mood':

Early labour		Early Active Labour		Active Labour	
Excitement/Anxiety. Happy. Slightly agitated.	0	Ceases to worry about external concerns.	1	Withdraws – focuses on self.	2

Kate, Virginia and the Consultant Midwife talked about the time it took for them to assess women without using vaginal examination but also of the benefits of avoiding them. The Consultant Midwife's comment was representative; she spoke of how the Burvill Scale helped them to be woman-centred in their practice, but at the cost of Unit resources:

> It's very much easier for me to look at a woman, examine her vaginally, say 'you're not doing anything' and send her home. I can do that in 10 minutes and she's gone out the door. It takes me a lot longer, it takes me an hour or two, to make an assessment without doing that and I think it's what that we've done as well. So although we may be criticized as well, and we are; [they say] 'how can it take you that long to do an assessment?' Well, because we're doing a woman-centred approach, rather than a conveyor belt approach [Consultant Midwife, Interview, Northway, 02.09.08].

Using observation to measure progress was time consuming and only really possible in an environment without the time and space pressures of the Delivery Suite. However, whilst I was on the unit the Burvill Scale was in the process of being

implemented for all 'suitable' women birthing on the main Delivery Suite at Northway. Whilst its benefits were clearly recognised by the Trust, this is not to say that the Burvill Score was universally liked in practice by the midwives. One midwife on the Midwifery Unit pointed out to me how the word 'still' is used both in the 'Early Active Labour' and 'Active Labour' scores and 'withdraws/n' in both 'Mood' and 'Energy' and explained how this cross-over meant it was often difficult for her to know what score to give. The difficulty lay in quantifying things which were difficult to quantify. It seemed that the intuitive measurements of observations were made pseudoscientific by quantification which in effect replaced one set of numbers – the measurement of cervical dilation – with another.

Encounters of clinical touch, such as vaginal examinations and perineal suturing were ordered by strict but unspoken rules of engagement. I wrote an account of Kate describing suturing a woman's perineum:

> [Kate says] she's so focused on getting this bit to join that bit that she forgets the rest of the woman is there. 'That's terrible isn't it?' she says to me. [Fieldnotes, 17.06.08].

Disembodying the woman from her perineum can be understood as a coping strategy when carrying out such a procedure on a part of the body only usually seen by a lover. The strategy of disembodiment also dehumanized the woman: a strategy in evidence when midwives were (rarely) required to do procedures such as episiotomy:

Kate says she hates doing episiotomies on her 'own women'. She doesn't

mind so much walking into a strange room and doing it, but when it's 'your

own woman' you feel traumatized [Fieldnotes, 17.06.08].

The women in 'strange rooms' were in effect simply bodies waiting for the

procedure. On the other hand, Kate had developed empathy with those women she

had spent time with in 'familiar' rooms which humanized their relationship.

The main difference between vaginal examinations and the Burvill Score was that

there was not any 'clinical' touching involved. In the Midwifery Unit, good

midwifery practice was set up as one which had minimal clinical touch. Doing fewer

vaginal examinations was implemented ostensibly out of respect for women's bodily

autonomy because of the emotional and physical difficulties of doing such intimate

kinds of body work, both for women and midwives. However, whilst clinical touch

was to be kept to a minimum, for the midwives at Northway Midwifery Unit, good

midwifery practice did require what I have termed 'social touch'.

Social touch

Almost all the midwives on the Midwifery Unit had, or were being, trained in

aromatherapy massage and they were enthusiastic about its benefits. Rose described

aromatherapy as something 'which I love. Because that's another area where you feel

you're doing something positive for a woman' [Interview, Rose, 10.09.08] and other

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midwives' comments also demonstrated how this kind of touch was pleasurable for the midwives as well as for the women: 'it's nice to give as well as to receive' [Interview, Consultant Midwife, 02.09.08]. Giving massage was very much a physical pleasure for midwives, which was not easily acknowledged explicitly by most of them.

Instead they spoke of their own pleasure, obliquely, during a long conversation between the Consultant Midwife, the midwifery unit manager, midwife Elise, student midwife Meg and I. During the conversation the Consultant Midwife talked about her experience of the aromatherapy training course: 'I was struck by how intimate it felt to have your hand stroked' she said, taking my hand and stroking it as illustration. One of the course delegates had cried during the course, overcome by the intensity of the experience of being massaged. I wrote in my fieldnotes that day that:

> The Consultant Midwife said it [being on the course] was the first time she had had a real understanding of why some women don't want an aromatherapy massage. She never understood it before, but suddenly 'got' that it was such an intimate experience and from a stranger might seem awkward or difficult [Fieldnotes, 17.06.08].

The midwives in this conversation all recognized that social touch was sometimes disturbingly intimate. Kate explained how she instinctively touched women only during contractions but not between them and others agreed that they did the same.

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Kate had created rules around touching women in order to construct boundaries around the intimacy and prevent any sexual overtones. Rubbing a woman's back during a contraction had a clinical role – to help relieve pain – whereas touch between contractions did not. Thus she reformulated social touch as clinical touch, in order that it was deemed appropriate.

Acceptable and unacceptable bodies

The body in pain

I have no record of midwives making comments about women's behaviour in pain at Northway. The lack of comments about noise might be because the layout of the unit meant that most rooms were out of earshot of the desk but also because the attitude towards pain relief differed there from Millside. The use of pharmacological pain relief, apart from Entonox (see Glossary), was far less common and epidural was unavailable. Midwives were therefore more likely to be comfortable around women with normal labour pain. However, during a very busy day on the Unit, I wrote in my fieldnotes:

> Kate was saying earlier that she hates the way some midwives dose women up on Pethidine (see Glossary) 'almost to keep them quiet'... She grimaces as Diane gives the handover and explains that the woman in Room A had Pethidine at an early stage of labour [Fieldnotes, 19.06.08].

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The midwives appeared less likely than those at Millside to perceive women's body or behaviour as 'unacceptable' or 'unruly'. In part this was likely to be because the entry criteria for women onto the unit (which excluded, for example, women with particularly high or low BMIs), meant that the women's bodies were less variable than those at Millside.

The only critical comment I heard about a woman's body came from a visiting Delivery Suite midwife, well-known and liked by the Midwifery Unit midwives. She commented that she thought a woman on the Unit had 'section legs', that is legs shaped in a way which somehow increased her likelihood of a Caesarean Section. This was used by the Unit Manager to illustrate to me the difference between the Midwifery Unit midwives and those on the Delivery Suite:

Unit Manager: [The Midwifery Unit] does attract a certain kind of
                      midwife.

Juliet: And who's that?

Unit Manager: That would be somebody who actually does have that
                      confidence in a woman giving birth naturally, does not
                      predict that somebody has got Caesarean Section legs
                      as soon as they lay eyes on her. I mean that's just
                      incredible, comments like that come out. You know

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'section legs', 'she's got "section" written all over her'. Somebody who wouldn't just say that. Why do midwives say that? So that isn't somebody who naturally wants to work on a Midwifery Unit [Interview, Midwifery Unit Manager, 10.08.08].

The relative silence amongst midwives about noise or women's behaviour in labour reflected the dominance of the Philosophy, which upheld an ethos of woman-centredness which precluded complaining about women or voicing a mistrust of the process of birth. The visiting Delivery Suite midwife was not beholden to the same (unwritten) rules as those midwives core to the Midwifery Unit.

Making sense of bodies

Unlike Millside, Northway midwives were very reluctant to talk about women in ethnic or classed terms, even when prompted. They self-consciously attempted to appear ethnicity and class-blind. In a discussion with Kate on 25th August 2008, she only grudgingly acknowledged that 'I guess it is the White, middle-class women who are more informed' and secondly, when I asked if there were different kinds of women on the Midwifery Unit than on the Delivery Suite, replied 'yes, I guess there is'. Kate attributed that difference not to health discrepancies between minority and majority ethnic groups but to 'certain groups of women' who asked about the Midwifery Unit whilst others waited until their midwife recommended it, which not all community midwives did. Despite their efforts it seemed significant that women

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who were referred to as 'stars' or 'lovely' at handover were White, middle-class, well educated and had uneventful births. I suspect these women were easier to care for because they spoke English, were well-informed and were more likely to have birthing ideologies about birthing position and analgesia in line with the midwives', something I discuss in more detail below.

Movement

Like Millside, women at Northway tended to stay in the rooms, but did also go out for walks in early labour. As I discussed in Chapter Six, the midwives were careful to point out to me that one of the key principles of the unit was to allow women and their visitors free movement in and out the unit at all times. Giving women freedom of movement was seen as central to the philosophy of the Midwifery Unit and something which distinguished it from the Delivery Suite. The Consultant Midwife illustrated this to me in terms of allowing women to go home in early labour if they wished:

> The Midwifery Unit philosophy is I think essentially woman-centred.
> Nurturing the natural process, whatever that is for that woman and her family.
> Some women feel that they've got to sort out their child and are four
> centimetres [dilated] and need to go home. They're not going to labour 'til
> they've sorted out their child and come back in. I'm not going to be the one to
> say you can't go [Interview, Consultant Midwife, 02.09.08].

The freedom to birth in any position was also something held up as an example of the unit's best practice. Midwives laughed as they told me anecdotes in which women had chosen to birth in a position that was difficult for them, recreating the contorted positions they got into in order to listen to the foetal heart.

Virginia, who was particularly passionate about educating others on alternative birth positions, told me of an encounter with a doctor which for her highlighted both the differences in ideology between the Delivery Suite and the Midwifery Unit and the power dynamics between doctors and midwives:

Virginia: You know, I remember once I was delivering a lady standing and the Reg[istrar] came in and said 'get her into a proper position' and I went 'what on earth do you mean a "proper position"? She is in a proper position!'. And I made him watch her deliver standing, you know. And he didn't believe it at all.

Juliet: What happened after that?

Virginia: Well it was fine. He was like [sheepish] 'ok'. He didn't believe we could get a decent trace (see Glossary) on a woman standing up on Delivery Suite and I just proved that you could

or even if you couldn't you could just put a clip (see Glossary)

on if you need to.

Food

Similarly, the midwives on the unit were careful not to restrict women's food intake

in labour. Accompanying Elise who was showing Meg, the visiting student midwife,

around the Midwifery Unit, we reached the kitchen and Elise explained to Meg how

women could eat and drink as they chose throughout labour and how they made

banana smoothies for women in the second stage of labour. Meg was stunned and

said 'if I think back to the fight I had in my Trust to allow a woman a slice of toast at

5cm!' [Fieldnotes, 17.06.08]. Allowing women to eat in the latter stages of labour

when other units did not was a strategy that not only had clinical benefits, but was

also helped to maintain the 'home-like' environment the Midwifery Unit strived for.

The provision of food is a central domestic task. In making smoothies for women,

midwives demonstrated a kind of care which differed from that given by those paid

specifically to prepare the food (for example hospital catering staff). In the hands of

the midwives, food became like a gift, which stood them out as particularly different

from those who exerted control over women's bodies by denying them food in

labour.

The midwives self-consciously facilitated women's freedoms of movement and food

in the unit as part of a strategy to make their Unit more 'home-like'. The midwives in

the Midwifery Unit took particular pride over this because it marked out their

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difference to the Delivery Suite. However, Virginia's story of defying an order from a doctor to get a woman into a 'proper position' illustrates how she conceptualized this kind of strategy as a victory not only for women but of a social model of midwifery over a medical model of care. These strategies were discussed by the midwives in terms of their benefit to women, but they also had significant benefits for the midwives themselves. Marking out the Midwifery Unit's difference, in contrast to the neighbouring Delivery Suite (and more generally the model of care represented by all Delivery Suites), helped the midwives to carve out their own ideological space. The midwives did not consciously choose to talk about their practices in terms of the benefit to them, but many of the stories they chose to tell me belied this aim. The midwives' discomfort with talking about women in negative terms does not inevitably suggest that they did not find the women difficult to work with. The strength of evidence from the midwives at Millside suggests that it would be unlikely that the midwives did not have similar experiences. They were, rather, reluctant to talk about those experiences and also the extent to which women did *not* engage with their ideologies.

Midwives' bodies

As I have explained, the midwives often had difficulties encouraging women to engage with the freedoms they were offering. Women and visitors appeared reluctant to use the kitchen, for example, or to walk around the unit in early labour. Their strategies to create a 'home-like' space could not disguise the fact that it was a unit

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within a hospital, whose (unspoken) rules influenced women's behaviour as visitors within the space.

It was not only the women's bodies who were influenced in this way; the midwives too abided by certain institutional restrictions on, for example, their dress. Like those at Millside, the Midwifery Unit midwives were required to wear a uniform: navy blue with a white trim. The Maternity Assistants wore white with a blue trim and the domestic staff wore their contractor's uniform. The manager of the unit only wore uniform when she worked clinically and wore her own clothes on 'management' days, as did the other midwife-managers. The different uniforms upheld a hierarchy within the unit between midwives and managers and between midwives and other workers.

The Manager spoke to me at length about the political and social rules of uniform. She recounted how at university she had refused to wear the coloured epaulettes (a different colour for each year of study) that were a part of her student uniform, because of their hierarchical and military connotations. Whilst she saw the benefits of presenting a professional image, to her, uniform evoked an image of a kind of professional that was unlike a midwife:

> I have this kind of old fashioned idea of a midwife, somebody with long grey
> hair and a plait or something just very friendly and very strong. And the fact
> that you put them in a uniform isn't quite what my image is of a midwife. …I

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don't like the fact we're grouped with nurses because we're a very distinct

profession. …I'd like it distinct from a nurse's uniform. I won't win that one

though. I was told that [by my tutors] when I was at university [that] I won't

win that one. [They said] 'do not be doing an assignment on what nurses and

midwives wear'. You know, I thought that one isn't worth [it], so I decided

not to do it [Interview, Midwifery Unit Manager, 16.07.08].

Uniform was another way in which midwives lost their distinctiveness in the face of

nurses. Furthermore, The Manager's story provides an example of how she was

advised to choose her battles when challenging the status quo. She saw the uniform

as an example of a largely random rule, put in place simply to uphold a social order:

I didn't jump through the hoops but it [the hoops] could be anything. It's like

it could be your uniform, it could be your hair [Interview, Midwifery Unit

Manager, 16.07.08].

Despite their manager's cynical attitude to uniform, all the midwives in the unit wore

their uniforms correctly. Wearing uniform was a taken-for-granted part of being a

midwife, into which they were socialised from the very start of their training. Even

the Manager spoke about the pride she took in wearing uniform when on duty,

acknowledging the contradiction between her thoughts about uniform more generally

and her feelings when wearing uniform herself:

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I don't like the fact we're grouped with nurses because we're a very distinct profession but putting a nurse's uniform on – strangely, you feel proud when you put it on. You're part of this whole. You do feel proud when you put it on. [Interview, Midwifery Unit Manager, 16.07.08].

Midwives were selective about which rules they adhered to and uniform appeared not to be worth the fight. The only uniform rules that were not always adhered to were those demanded by the woman from Infection Control who was widely viewed as being overly fussy. On one unannounced visit she told one of the midwives off for wearing a bracelet. After a second visit I wrote:

The Infection Control woman comes over. A midwife [the same as before] hastily takes off her rings and bracelet and stuffs them in her pocket, only to slip them on again when she is out of sight. The woman from Infection Control immediately notices that the Registrar who has come to suture a woman is wearing a watch. She's like a hawk. They all pull faces behind her back; it's quite funny and brings out everyone's disregard for the rules [Fieldnotes 27.08.08]

Clinical Guidelines

The midwives worked under a large number of other rules, with which they also had a complex relationship. Like all NHS Trusts, Northway had lengthy guidelines and protocols in place that guided the midwives' clinical decision-making

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At Northway, the development of guidelines in the Midwifery Unit was headed by the Consultant Midwife in conjunction with medical staff and others. The midwives saw a lot of the Consultant Midwife who would consult them, if informally, about guidelines and there was a sense of ownership within the staff community over the guidelines.

The midwives at Northway Midwifery Unit referred to the folders of written guidelines or asked their colleagues about them significantly more frequently than those at Millside. The midwives appeared comforted by guidelines and protocols that informed their decision-making about particular cases. They were safety nets that many of the midwives appreciated. The guidelines and protocols were explained to me as being in place to 'keep that woman safe' [Interview, Midwifery Unit Manager, 10.08.08] – as if keeping to the guidelines guaranteed a good outcome. Some guidelines were also written in response to adverse events. Elise, a Northway Midwifery Unit midwife, described the consequences of a stillbirth that occurred on the unit shortly after it opened:

Elise: Of course what happens is they scrutinise all of that, they pull it apart. Who was where? With whom? What time? What staff were on? How many women were in labour? Why didn't you do this? Why didn't you do that? And then all of the things that came out - they had a - what's called Root Cause Analysis which resulted in things like:

here's one, if you can't find the baby's heart rate you call the

emergency bell.

Juliet: Straight away, first time?

Elise: Yeah, like we do that. You'd be doing it five times a day, wouldn't

you? Do you know what I mean? Because how many times does it

take you a little while if the woman's in a funny position [Interview,

Elise, 27.07.08].

When those 'why didn't you do this?' questions were asked, keeping to the guideline

would have almost guaranteed a midwife could defend herself against an accusation

of having acted negligently. Elise's scorn towards those guidelines produced as a

knee-jerk response to an adverse event was in contrast to the midwives' explicit

engagement with those guidelines they had helped to develop.

The use of guidelines on the Midwifery Unit was supported by the Integrated Care

Pathway (ICP): a 32 page booklet used by midwives to document the care they gave

to labouring, birthing and immediately postnatal women. The ICP was used in place

of conventional patient records in which midwives would record the woman's labour

using detailed contemporaneous notes. The ICP worked on the principle of

'documentation by exception' which meant that rather than writing continuous

narratives to explain the care given to women, midwives used a series of tick-boxes,

which prompted her to carry out measurements, for example, of a women's temperature, pulse, blood pressure, behaviour and length and strength of contractions. Any deviation from the 'norm' or a decision to deviate from the standard procedure had to be justified using the 'variance notes' pages at the back where there was space for longhand explanations.

Other researchers have written of the problems with such a 'tick-box' approach to record keeping, claiming that ICPs promote standardisation at the expense of midwives' clinical autonomy and the flexibility to respond to the individual needs of different patients (Hunter 2007; Whittle and Hewison 2007; Rycroft-Malone, Fontenla et al. 2008). In contrast, the midwives at Northway Midwifery Unit universally spoke about the ICP in terms of how it *facilitated* their professional autonomy. The manager at the Northway Midwifery Unit said:

> Our Consultant Midwife is so clever in a way because she's put that ICP [in place] and it gives us that kind of leeway to use our own discretion and that's so important that needs to be protected [Interview, Midwifery Unit Manager, 16.07.08].

Rose, a senior Unit midwife clearly explained how she understood the relationship between professional autonomy and institutional rules:

I'm always cautious when people start talking about autonomy because it's

within parameters…not only our professional parameters but downscaling

that to hospital parameters… I wouldn't do anything that I thought I wasn't

supported by, you know, by what I know of the guidelines and policies of the

Trust as appropriate for a midwife to do. Now if I was an independent

practitioner I would be truly autonomous because I would be making my own

guidelines, other than the biggest ones, the professional guidelines. But

because I work within an organization, autonomy is always going to be

limited by the policies and the accepted norms. And even in the community

you've got to develop your judgment but you've still got to have that

awareness of where it's appropriate to stop and those aren't going to be you

making those decisions, they're going to be your understanding of the

organisation you work with [Interview, Rose, 10.09.08]

Abiding by institutional guidelines was an accepted part of being an NHS midwife

but this is not to say the midwives did not interpret or adapt the guidelines according

to their own ideology of practice.

The midwives at Northway Midwifery Unit often worked according to the rule that

'what you don't measure, you don't know': that is, if a protocol or guideline required

them to take an action in response to a measurement in many cases they would not

measure to avoid taking the action, if they felt the labour was progressing normally

and the action would be unnecessary. In doing this, the midwives implied that it was

the measurement which made a woman's labour 'abnormal' and not the actions of her body. Furthermore, they also suggested that they would be forced to act in response to the measurement, as if the guideline compelled them to act, despite their clinical judgement suggesting otherwise. The midwives interpreted the guidelines as inflexible, once they had been implemented. Their strategy for avoiding guidelines or policies was to avoid implementing them in the first place. I recorded three anecdotes which illustrate this more clearly:

Northway Midwifery Unit, 5th August 2008

Joy is in Room C caring for a woman in advanced labour. She comes out of her room into the reception area where I am sitting with the manager and Ros, a midwife from Delivery Suite who is working on the Midwifery Unit today. Joy looks both frustrated and amused: 'I saw some hair when I looked' she blurts out as we laugh at her annoyance with herself. She explains how she had looked at the woman's vagina and seen the top of the baby's head. 'I wish I hadn't looked because now I have to start on that bloody time limit'.

Joy claims that the other day was the first time she had ever confirmed the second stage of labour and moved onto the second partogram[19]. Usually she doesn't bother which means she can leave the woman to birth in whatever time she does, and I assume use her own clinical judgement of abnormality.

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[19] The 'second partogram' here refers to the partogram used to measure progress in the second stage of labour, as opposed to the first stage.

Northway Midwifery Unit, 10th June 2008

One woman who has just been transferred to the Midwifery Unit has been put on a partogram on the Delivery Suite a bit early by Midwifery Unit standards. She's four centimetres dilated but is also quite comfortable during contractions and could be considered to be in early labour. Partograms are not usually started here until 'active' or 'established' labour is diagnosed. Virginia and Sara, a student, are going in to see her to do a 'top to toe' assessment. 'We might just find her to be three centimetres' Virginia says, in a tone that suggests that they might write that she is three centimetres so they can stop the partogram and let her get on with it for a while without formal time constraints. Otherwise, they suggest, it is very difficult to stop a partogram once it has begun.

Virginia says it's going to look to the woman like they've cocked it up if she has to go back to Delivery for slow progress. The only thing they've done to 'cock it up' is start the partogram too soon. The physiological process of labour is unaffected and unchanged, it's merely the way it's recorded which is different.

Interview with the Consultant Midwife

When you go into a boundary where you're [thinking] 'ok, I've got another two hours to work with this or we're going to have to transfer her' you're thinking you're trying to do everything before she has to go because once

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she's gone, you know, you need to have done everything you can to nurt – to

have kept her within those boundaries if you like.

All the midwives in these stories recognized the arbitrariness of the guidelines and

how their measurements and the categorization of women's bodies as 'normal' or

'abnormal'. Although 'abnormality' in the progress of labour was often posited as a

physiological risk to the welfare of the women and baby, the boundaries of 'normal'

or 'abnormal' progress in pregnancy or labour were not absolute. They were instead

social and clinical constructions which were frequently under review, most notably

in the Midwifery Unit. Whilst I was observing at the Midwifery Unit, the Consultant

Midwife was in the process of trying to change the criteria for entrance to the

Midwifery Unit to include women with conditions such as mild psychiatric

problems, those who were over 40 years old or who had a known Group B Strep

infection which can cause postnatal complications in babies. The Midwifery Unit

provided care for women who were expected to have 'normal' labours and so any

changes in the parameters for entry were indications of changes in the parameters of

'normal' and of a widening of midwifery practice to accommodate more

abnormalities.

Being flexible with guidelines helped the midwives to feel with-woman rather than

with-institution because it involved manipulating institutional guidelines in order to

provide personalised, woman-centred care. The Midwifery Unit manager explained

this in an interview by, again, contrasting the work of the Northway Midwifery Unit

with the Delivery Suite next door:

> [We give] women that time over here and being with them and really
>
> understanding how birth works. I really don't think that they do over the way
>
> because they stick to this very regimented one centimetre an hour[20]. You get
>
> to four centimetres, ok, you can stay; one centimetre an hour, if they don't
>
> progress they do an ARM. You know, it's very regimented. We're all
>
> individuals, we don't all work like that. [Interview, Midwifery Unit manager,
>
> Northway, 16.07.08]

Virginia's desire to 'find the woman to be 3 centimetres' is an example of the ways

in which some of the midwives at Northway (as they did at Millside) ensured these

guidelines did not override their personal autonomy by mis-measuring women to

protect her from what the midwives saw as unnecessary intervention. Another

example explained to me was that it was expected practice for midwives to measure

a woman's fundus (see Glossary) with the tape facing down so that she could not

manipulate the findings to make them fit into the boundaries of normality. Rose

corrected a student she had observed doing it wrong, but added that she thought it

was common practice for midwives to get someone else to check and 'then if their

number is better than yours, go with that one' [Rose in Fieldnotes, Northway,

09.06.08].

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[20] The protocol stated that if the cervix did not dilate at a rate of one centimetre per hour then
intervention to increase the rate of dilatation was indicated.

Despite insisting that guidelines were flexible: for example, 'a guideline is a guideline it's not actually a rule' [Interview, Alison, 30.07.08], the midwives' appeared to try to prevent getting into a situation where they were forced to use a guideline, rather than adapting the guideline itself. They worked with the guidelines as if they were inflexible: compelling them to start a partogram, or transfer a woman who was labouring 'too long' or refer her for a scan to check the growth of the baby if the fundus measured too large or too small. The midwives were unreflexive about this approach to guidelines, despite their significant insight into most other aspects of their work. During discussions with each other about guidelines they mostly tried to ascertain what the guideline said, consult colleagues on a plan of care in accordance with the guideline or strategise about keeping women 'normal' so they would not be forced to implement it.

Choice

Midwives at Northway spoke about choices for women exclusively in terms of her choice to adopt different birthing positions and use non-pharmacological pain relief. These practices were fundamental to wider campaigns for 'normal' birth and autonomous midwifery practice and the midwives used them to highlight the Midwifery Unit's difference to the Delivery Suite. They were set up within the Midwifery Unit as antithetical to the practices of the Delivery Suite where midwives used analgesia differently and were only starting to 'allow' women to adopt different birthing positions.

However, like Millside, the choices available to women on the Midwifery Unit were also constrained. There are other choices which women might make, for example to have an epidural, which were not available on the Midwifery Unit and honouring that choice would mean transferring her to the Delivery Suite, something that the midwives had spoken to me at length about wanting to avoid unless clinically necessary. Rose brought up the issue of choice for women in interview and her seemingly contradictory comments reflect the complexity of offering choice to women and empowering them when you disagree with their choices:

> If every woman who came through you asked, 'well did our philosophy work for you?' they'd say 'no it didn't because I wanted you to rupture my membranes (see 'ARM' in Glossary) and you wouldn't' you know? It – respecting people's choice – it's all those things get mixed up with it [the philosophy] [Interview, Rose, 10.09.08]

> It's changed a lot really but even those women who can't quite get where we're coming from when we say we want them - we find it helps labour if they're upright and things, will still quite often shock themselves by either kneeling to deliver or actually going into the pool at some stage. So it's small steps. But I think if you've got to sum it up it's more about hands off, less directive style and giving women, as I say, this space in which they can get on with things really [Interview, Rose, 10.09.08].

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In the first quote Rose recognised the problem with not respecting women's choice for the kinds of interventions avoided on the Midwifery Unit. In the second quote however, she spoke instead about 'small steps' towards changing women's minds about birth to align them with her own and also about them having a 'less directive style' which seems at odds with midwives refusing to rupture a woman's membranes. The midwives' refusal to perform interventions such as Artificial Rupture of Membranes might well be in the woman's best interest. It is a challenge then for midwives to weigh up the woman's clinical best interests (or their belief of her best interests) with their desire to provide her with choice and control over her labour whatever those choices might be.

Conclusions

Categorising women according to constructions of 'normality' and 'abnormality' was in effect a way to organise women's bodies, by deeming them clinically compliant or non-compliant with the expectations of a normal birth. Midwives spoke of the categorisation in terms of its benefit to women and babies because identifying abnormalities, both clinical and social, enabled them to be treated, thereby reducing the risk of mortality and morbidity. The midwives did not speak explicitly about the professional benefit to midwives of identifying 'normal' women although so much time and effort was invested in activities such as increasing the remit of midwifery practice at the Northway Midwifery Unit and keeping doctors out of midwifery rooms at Millside. These were clearly practices which helped midwives maintain a

professional role within the Trust and yet they were spoken about in terms of helping women to achieve a birth attended by midwives with minimal medical intervention as if this was only to the woman's advantage and not the midwives'.

This chapter has shown that midwives spent a lot of time promoting their professional autonomy in the face of institution control. Their work in both units was a continuous interplay of intuition, measurement, adhering to rules and bending them; upholding clinical autonomy whilst referring to others for advice and assistance. They negotiated these tensions every day. Midwives worked with the institution, under its controls, because it made their working life easier within an environment in which they experienced sometimes conflicting demands from women and from the Trust. It is clear that their relationship with women was very much influenced by the Trust and as such the dynamic was more like a midwife-woman-institution triad than an intimate one-on-one relationship. The intimate body work of midwifery is used to fulfil the demand of the institution to keep record of the progress of labour, and to fulfil women's expectations, influenced by the culture of birth in the UK, that cervical dilation will give her a reliable indicator of how long labour will last. Even the body work which I have named 'social touch' is to some extent reframed by midwives as a clinical act in order to manage its emotional intimacy.

It was very difficult for the midwives in both units to reconcile a need to be a midwife: which for them meant providing a flexible woman-centred service

employing expert, autonomous, clinical judgement and meeting the demands of the institutional rules and guidelines. Until now, the midwifery tenets of 'choice, continuity and control' have been used to describe those qualities midwives should give to women in their care. Perhaps they should also apply to midwives. It seemed that most of the midwives' strategies for coping with working under difficult situations involved them trying to gain choice over their working practice, continuity in their relationships with women and control over their environment and the people within it.

Chapter Eight: Conclusions

The occupation of midwifery has developed a particularly strong professional identity that is constructed by a way of speaking about midwifery that privileges a notion of midwifery as a woman-centred, holistic, emotionally sensitive, caring and altruistic practice. This discourse is pervasive throughout the midwifery literature, as was discussed in Chapter Two of this thesis and its strength and ubiquity has come about in part as a defence mechanism to assert the independence of midwifery against the neighbouring and more powerful professions of medicine and nursing. The effect of this discourse is that midwives have developed a particularly strong idea of what it means to be a 'good' midwife or to practice 'good midwifery'. The review of the literature presented in Chapter Two suggested that midwives are often prevented from carrying out such 'good' midwifery practice because they work within resource constrained institutions. The institutional demands on midwives: for example the need for speed and efficiency, are in tension with the necessary requirements of a woman-centred, responsive and flexible maternity service. Billie Hunter (2002; 2004) described this tension in terms of an ideological conflict, with midwives at the centre being pulled in opposite directions by the women and by the institution. Hunter identified this conflict as a key source of emotion work amongst midwives but one that was experienced very differently between hospital and community based midwives.

Her comparison showed that those midwives who were able to practice according to a 'with-woman' ideology, for example the community midwives, experienced less of the tension and required less emotion work to ameliorate its effects. This thesis has extended Hunter's work by exploring the ways in which midwives articulate that ideological tension and its causes in two very different *spaces*. Furthermore, the thesis is original in its comparison of midwives' *backstage* talk, capturing thereby the ways midwives rehearse and construct their professional identity and frontstage performance. The analysis of such talk within the context of the workplace has helped to highlight how the talk or discourse is restricted by a number of different factors, including:

1. The geographical and spatial context of midwives' work, for example:
   a) Midwives at work in one clinical area compete with those in other areas for resources and are therefore reluctant to discuss their experiences favourably;
   b) Individual units are physical manifestations of ideological difference that are polarised against each other by proximity. These ideological differences influence the taken-for-granted rules by which people work there.
2. The legacy of the historical fight for *professional* space between midwifery and obstetrics that has left professional groups defensive towards each other and protective of their own practice and social status as well as the boundaries of their clinical workplaces within the hospital. This professional

tension manifests itself separately from the (often good) personal

relationships between individual obstetricians and midwives.

In the following sections I discuss the findings from the previous three chapters and

go on to explain some of the limitations of the study and suggest future areas of

research.

Emotional difficulties and emotional labour

As I have explained, my findings in this thesis reflect the existing evidence from the

work of Hunter (2002; 2004), Kirkham (1999) and Ball and her colleagues (2002):

that midwives were frustrated at not being able to practise the kind of midwifery

enshrined in the discourse, which can be described as an ideal of midwifery, or

'good' midwifery or a midwifery model of care. The role of emotion in midwives'

work was one of both problem and solution, as explained in Chapter Five. The

discrepancy experienced by NHS midwives between their ideals of practice and the

reality caused them to experience a range of negative emotions, particularly distress

and frustration, and required them to use emotional labour to try and ameliorate its

effects. In Chapter Five I identified three sources of midwives' emotional difficulties,

which were experienced by the midwives on both sites, but to different extents:

1   An ideological conflict between the ideal of midwifery enshrined in the

    discourse and the reality of their practice;

2   Being with women in pain, during times of death and loss and when negotiating intimate bodywork;

3   Midwives' feelings of disenfranchisement in the face of poor communication with managers and dysfunctional institutional systems for midwife feedback.

On both units studied, Millside Maternity Unit and Northway Midwifery Unit, midwives' emotional labour when working with women took two forms. The midwives believed that theirs and the women's emotions were closely connected. Their emotional labour closely reflected the two types, 'surface' and 'deep' acting, that were originally introduced and described by Arlie Hochschild (1983). Midwives used 'surface acting' to express 'appropriate' forms of emotion whilst caring for women in normal labour. Alongside this they sought to protect the women from the potentially negative effects of their own stress or anxiety, much of which stemmed from their inability to provide continuous, flexible and woman-centred support for women during labour and in the immediate postnatal period. Similarly to Hunter's (2002) findings that those midwives who were able to practice more in line with the midwifery model of care experienced less demanding emotional labour, the midwives at Northway did not need to put so much effort into dealing with the gap between desired and actual practice. In contrast, the midwives at Millside were less able to provide what they considered adequate support to women than those at Northway Midwifery Unit because of the significant constraints of space and time that limited the amount of time they spent with women, and thus had to expend more effort on managing the dissonance.

Midwives' emotional labour was not only necessary to protect women, but was also used to protect the midwives themselves. 'Deep acting' or 'hardening' themselves in the face of distressing experiences protected midwives against the ill-effects of working with stillbirth, pregnancy loss or, in extremely rare instances, the death of a woman. This strategy was more commonly used by the midwives at Millside because, unlike those at Northway Midwifery Unit, they frequently cared for women at times of death, illness and loss. 'Deep acting' or 'hardening' enabled midwives to care for women through these distressing experiences in the way they felt they should. An expression of an extreme of emotion was understood by the midwives to hinder their capacity to care appropriately. The findings from this thesis show that emotional labour was a skill that midwives took time to perfect. Those midwives who were yet to acquire the skill, because they were new to midwifery, were particularly susceptible to distress in response to difficult situations.

Unlike the Northway Midwifery Unit, at Millside there were many midwives who did not appear to aspire to provide a midwifery model of care. They practised what Judith Purkis has termed 'medwifery' (2006: 112): that is midwifery in alignment with the biomedical model, and measured their job satisfaction in terms of organizational goals (Hunter, 2004: 268). This was in itself a coping strategy as it would have been almost impossible for them to reconcile their day-to-day reality with the ideals of the discourse, if they unquestionably aspired to it. Those who did persist in aspiring to practise in accordance with the midwifery discourse, such as

Fiona, were vulnerable to isolation, emotional distress and frustration. However, with this exception, the midwives rarely spoke to me or to each other about the emotional demands and difficulties of the job, unless they were prompted. The collective silence about difficult emotions within the midwifery community was reflected in the paucity of formal systems in place that adequately emotionally supported midwives in either unit.

The third key source of emotional difficulty for midwives was their feeling of disenfranchisement at work, although this differed between the two units. Institutional processes, such as the incident reporting system and the goodwill of managers went some way to providing midwives with a forum to voice their experiences. Similarly, the Supervisors of Midwives provided counsel to midwives, but their efficacy depended on their skill and capacity and the quality of the supervisor-supervisee relationship. The midwives at Millside looked to their managers for recognition that the institutional constraints prevented them from working in the way they desired. Their reasoning was that if only the managers understood the circumstances well enough then they would act to provide better resources: especially more midwives or more delivery rooms. The manager was in fact very much aware of the situation, but also found herself constrained by those higher up the institutional hierarchy.

The systems that helped to support midwives, such as the Statutory Supervision of Midwives and the Incident Reporting System, were each designed to fulfil another

role: for example to ensure the safety of women and babies or record adverse events. Supporting midwives was not their primary focus. The Midwife Counsellor at Millside, too, was in post to provide counselling for women, as well as midwives and the midwives' reluctance to see her may have been related to the wider lack of acknowledgement within the midwife community that emotional difficulties deserved attention. At Northway, the shortage of formal systems for midwife feedback, in particular, was compensated by a skilled manager who created many opportunities for informal consultation on the running of the unit. The midwives at Northway Midwifery Unit had a sense of ownership over the space, brought about through their involvement in the design of the unit, the planning in the run-up to its opening and drafting of clinical guidelines. The Northway Midwifery Unit midwives' sense of relative enfranchisement was central to their greater satisfaction with their work.

Despite the marginal successes of the institutional and professional systems available to support midwives in both units, these remained inadequate. In order to compensate for this inadequacy, midwives in both Trusts deployed informal coping strategies to ensure their working lives remained tolerable. These strategies focussed particularly on cultivating a sense of control over their daily working lives and centred around what I identified as two foci of their practice: the 'management' of the body work with women their job required; and their organisation of access to clinical spaces.

Space

My analysis of midwives' experiences using space was the most original contribution of this thesis because it highlighted, firstly, the importance of context on differentiating different midwives' experiences; secondly, the influence of space and place on the construction of organisational practices and professional relationships and thirdly, that the midwives' professional project and strategies of occupational closure manifested themselves spatially.

Spatial factors shaped and reflected many aspects of the midwives' practice and coping strategies. The findings from this thesis showed that higher status was bestowed upon those who were physically the furthest from women and had the greatest freedom to move away from the bedside. The midwives deployed a strategy of occupational closure (Witz 1992) that aimed to free them from the routine activities such as washing and examining women that tied them to the bedside. The use of clinical techniques such as electronic monitoring in place of hands-on assessment e.g. palpation, and the use of a Pinard stethoscope, moved midwives physically *away* from women. The Burvill scale reduced the number of vaginal examinations they had to carry out which, as Stewart (2008) wrote, midwives find difficult to negotiate. As Malone (2003) described, this distance excused them from a moral obligation to hear women's stories and advocate for them. The findings from this thesis suggest that midwives working in the contemporary NHS work within ideological and material circumstances that make it very difficult to advocate for women in this way. This inability to advocate is at the heart of the tension Billie

Hunter describes (2002, 2004), which she identifies as a key source of their emotional labour. The tension is particularly great in midwifery because of the prevailing discourse that still tends to position midwives as protectors of women in the face of obstetric intervention.

Moving away from women can be understood firstly as a personal strategy through which midwives protected themselves from the emotional demands of caring for women, particularly those in labour; and secondly as a professional project to improve the status of midwifery. This occurred in both units despite the discourse's insistence that good midwifery meant being more 'with woman'. With the exception of Finlay and Sandall's (2009) article on street-level bureaucracy in midwifery, there is little acknowledgement within the midwifery literature of midwives distancing themselves from women in self-preservation. Whilst such behaviour is well described, for example in task-oriented work on the labour ward (Hunt 1995) and 'checking not listening' (Kirkham et al. 2002), it is attributed to institutional constraints on resources and staffing.

This strategy of distancing themselves from women, physically and emotionally, was a side of the professional project that midwives in both units found very difficult to articulate. Strategies such as these, which were antithetical to the discourse of midwifery, were discussed within the confines of a restrictive discourse. For example, the use of electronic monitoring and the Burvill Scale were talked about only in terms of their benefit to women: ensuring their safety or sparing them from

intrusive and painful vaginal examinations. While this was undoubtedly true, they also held benefits for midwives, which were left unspoken. Goffman (1990 [1950]) identifies such behaviour when he writes:

> In addition to secret pleasures and economies, the performer may be engaged in a profitable form of activity that is concealed from his [sic] audience and that is incompatible with the view of his activity that he hopes they will obtain. (Goffman 1990 [1959]: 52)

These silences formed part of the performance of 'midwifeliness' that the midwives hoped to portray to women, other professional groups, members of the public, each other and me. Those practices that were not consonant with the discourse were either not spoken about at all, or blamed on the institution (and other factors out of their control such as staff shortages) and described as bad for the profession of midwifery. I argue that midwives' strategies were not necessarily inevitable, nor bad for the profession. Whilst there is no doubt that the constraints on midwives' practice made these understandable responses, the midwives were active in upholding these norms of practice and teaching them to new generations of midwives. Furthermore, they had positive consequences for the status of the midwives within both trusts and the status of midwifery more widely.

Strategies such as policing the movement of doctors protected midwife-only space: the entire Midwifery Unit at Northway and individual delivery rooms at Millside. A

territorial attitude towards their workplaces gave the midwives the authority of 'residents' over 'visitors', whether women, their families, doctors or managers. The collective complaining about managers and midwives in other areas helped midwives develop support networks with colleagues. Each of these strategies, as with others, helped them to function as workers, as well as midwives, within the each Trust. Having a space of their own was crucial to them being able to retain control over the conditions of their work, and the terms with which they engaged with women. This was much easier for the midwives at Northway Midwifery Unit and this was reflected in the Northway midwives' greater satisfaction. The midwives in both units drew support through bonding with colleagues within their clinical area and at Millside in particular, this compensated for a perceived lack of support from managers.

The midwifery unit midwives' work to make their unit a therapeutic landscape was central to their identity. The physical spaces within the unit: the 'home-like' interior design, soft furnishings, larger rooms, opportunities for women to prepare their own food as they would at home and the garden and presence of natural light and cycles of day and night were all ways in which the founding midwives had attempted to bring the 'home' and 'nature' into the unit, in a manner similar to those described by Conradson (2005), Lea (2008) and Gilmour (2006). This environment was different from the environment both next door in their neighbouring Delivery Suite and at Millside and in creating a 'home-like' space that welcomed 'nature', the midwives were making it congruent with their model of childbirth. The philosophy of the

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midwifery unit promoted the social model of midwifery that positions birth as a natural and normal life event. Making the hospital midwifery unit a 'home-like' space can be understood as an attempt to make it an extension of the everyday space of the home – a perpetuation of normal life. Similarly, bringing 'nature' into the space seemed to be an attempt to connect the event with the outside world in contrast to the 24 hour artificial light of the Millside Delivery Suite.

The 'natural' landscape of the midwifery unit represented a manifestation of an ideological difference from the Delivery Suite next door. However, it also closely mirrored Fannin's (2003) description of an ambivalent, hybrid space:

> Indeed, the homelike hospital room can be read as the "domestication" of a formerly public and institutional space that produces a *hybrid* space, ambivalently situated as a site of domestic comfort and technological sophistication. This ambivalence is evident in the concern many midwives express over the homelike hospital room's potential as "deinstitutionalized" space still firmly situated within an institution (2003: 520).

The midwifery unit was therefore not only a physical manifestation of an ideological difference played out across the wall between the two spaces, but also a manifestation of the midwives' own conflict between their desire to work within the social model of midwifery and the demands on them of their employing institution; a tension that occurred *within* the walls of the midwifery unit.

In practice, the midwives' aims could never truly be realised because the unit was still within an institutional space. The women who birthed there specifically chose not to give birth in their real homes, in all likelihood because of its difference from home: the proximity of medical assistance and an opportunity to take a break from the demands of every day life, for example the care of small children at home.

Bodies and body work

The body work of midwives in each unit differed because the midwives dealt with different kinds of bodies. The strict criteria for women's entry onto the Midwifery Unit meant that the women's bodies there were less variable than those at Millside. The midwives' body work in both units involved a complex interplay of their management of space and emotion.

Touch was a key feature of midwives' body work at Millside and at Northway, and I identified two types of touch at play: what I termed 'clinical touch' and 'social touch' (after Twigg 2000). At Millside, the midwives did not talk about the role of social touch, or touch-as-comfort in their practice. At Northway however, such touch, for example the use of aromatherapy massage was commonplace and the midwives engaged in reflexive discussions about the role of touch in their work. Whilst social touch was described as a pleasure for midwives at Northway, as I described in Chapter Seven, I also found that they legitimised its use by reformulating social touch, as clinical touch. Acts such as rubbing a woman's back in labour were in some cases done only during a contraction to relieve pain, and not

between contractions when they would simply be used as a comfort. Strategies to make such touch less intimate and therefore easier to negotiate also included depersonalising the woman during painful procedures such as episiotomy and perineal suturing.

Touching women required midwives to be close to them, sometimes for extended periods of time or involved intimate body work. Being with women was also often emotionally demanding for midwives and so midwives' use of touch was mediated by their desire to be with woman, and also their desire for emotional self-preservation. I found that midwives on the Millside Delivery Suite used CTG monitoring, for example, to release them from being 'with women'. Monitors were predominantly used to 'babysit' women during busy times. The midwives explained how they used the monitors to help them get the work done and provide equitable care to all women (not just those in active labour). However, their use can also be understood as a strategy to distance themselves from women in order to relieve themselves of the emotional demands of being 'with woman'. The midwives at Northway Midwifery Unit, however, were less likely to be asked to care for many women and therefore were less likely to experience the frustration that resulted. In addition they did not have access to CTG monitors and therefore had to manually palpate contractions and use hand-held methods of auscultating the foetal heart which required them to be physically proximate to women.

Examining midwives' talk about their body work exposed an inherent tension

between the discourse of 'with woman' practice and midwives' strategies for

self-preservation. At Millside Delivery Suite, the midwives expressed frustration at

women's unacceptable behaviour, including the way women responded to labour

pain. It was taken for granted that women should follow their midwife's advice to

take a bath or change position in order to relieve pain and women's alternative

strategies of shouting or writhing in pain were difficult for midwives and deemed

unacceptable. In both units, there was evidence that women's choices of behaviour,

birth position or analgesia were restricted and guided by the midwives' preferences.

This was particularly apparent at Northway, where the unit philosophy promoted

non-intervention and non-pharmacological pain relief. The midwives were explicit

about the value of promoting women's choices but, apart from Rose, they never

spoke of the unintended consequence of the philosophy to potentially limit women's

choice.

The midwives in both units demonstrated particularly complex relationships with the

clinical guidelines that mediated their body work. The historical debate about clinical

guidelines has been long and complex. Much of the discussion has focussed on the

impact of the introduction of clinical guidelines and protocols on healthcare

professionals' autonomy (e.g. Berg 1997; Lawton and Parker 1999; Rycroft-Malone,

Fontenla et al. 2008). In particular, the practice of medicine, unlike nursing for

example, has been traditionally constructed as relying on extensive experience, in

addition to the scientific knowledge, on the basis of which doctors make assessments

and diagnoses. This model of intuitive as well as scientific knowledge was advantageous to the medical professional project because it made the acquisition of such tacit knowledge a mysterious and exclusive process that was inaccessible to ordinary people, as Friedson (1988) wrote:

The profession, we must remember, gains special occupational autonomy on the basis of its claim that its work is guided by knowledge too esoteric and complex for the layman to even evaluate, let alone share' (1988: 341).

The suggestion that doctors' clinical decisions may be guided by and indeed encapsulated within a guideline or protocol indicated a de-professionalisation that 'cut to the core of professional monopoly over esoteric medical knowledge' (Timmermans and Kolker 2004: 180). As Eddy (1990) writes:

One of the basic assumptions underlying the practice of medicine is being challenged. This assumption concerns the intellectual foundation of medical care. Simply put, the assumption is that whatever a physician decides is, by definition, correct. The challenge says that while many decisions no doubt are correct, many are not, and elaborate mechanisms are needed to determine which are which. (1990: 288)

The challenge made to the 'rightness' of medical decisions has helped to open the arena for other forms of knowledge and practice, including midwifery, that could (in

theory) be justified through the use of evidence on equal terms with medicine. In practice it was difficult to unpick midwives' relationships with their guidelines. On one hand, guidelines enabled the expansion of midwives' roles by legitimating the separation of midwife-led spaces from medical control, as reported in Rycroft-Malone, Fontanela et al's evaluation of the use of protocol-based care on nurses' and midwives' roles (2007: 91-92); but on the other hand they seemed to be perceived as restricting midwives' autonomy.

The effort that midwives put into to working around, rather than with, guidelines provides evidence that suggests they felt constrained by them rather than enabled. For example, midwives in both units confessed to delaying vaginal examinations to diagnose the second stage of labour or noting the presence of an 'anterior rim' when there was none. These strategies subverted the authority of the clinical guidelines. They allowed the midwives at Millside to use their intuitive knowledge of the progress of labour which was not formally valued. They also helped prevent the woman's labour becoming prematurely 'abnormal', according to Trust guidelines, and thus move her out of the care of the midwives to the doctors'. The midwives appeared to be functioning as 'street-level bureaucrats' (Lipsky 2010 [1980]) – those on the front line of a large and bureaucratic institution who are required not only to implement the guidelines passed down to them from above in their interactions with clients, but also to use their discretion in ways that bureaucratic norms do not specify. Lipsky describes three reasons why worker discretion can never be entirely eliminated, as it can actually improve the effectiveness of the bureaucracy:

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1   'Street-level bureaucrats often work in situations too complicated to

       reduce to programmatic formats…

2   Street level bureaucrats work in situations that often require responses to

       the human dimensions of situations…

3   Street-level discretion promotes workers' self regard and encourages

       clients to believe that workers hold the key to their wellbeing' (2010

       [1980]: 15).

Midwives' day-to-day function as street-level bureaucrats was in tension with their

collective identity as autonomous, independent professionals. The manipulation of

guidelines was a way by which they could promote a personal sense of autonomy

within a highly constrained working environment. Such use of guidelines not only

promoted this autonomy at an individual level but also at a collective *professional*

level and it is this that was rarely spoken about by individual midwives.

Guidelines such as those embodied within the Integrated Care Pathway (ICP), that

the midwives themselves has helped to develop, were also seen in some cases to

facilitate midwives' autonomous practice. The ICP was designed to keep women on

a path to normal birth. The ICP supported women during normal childbirth and there

was evidence that midwives 'steered' women to make choices that promoted normal

birth, for example to choose non-pharmacological pain relief. This steering was more

pronounced at Northway Midwifery Unit and was supported by the ICP, the Unit's

Philosophy (both written and unwritten) and the wider midwifery discourse and

reflected the particular way of practising midwifery that they all promoted. This kind of steering can be seen as 'midwife-centred', but introduces an interesting question as to how far it is *woman*-centred when working with women who might wish to make other choices, for example to have an ARM or epidural anaesthesia when they are not *clinically* in the woman's best interests. The concept of 'woman-centred care' is often used synonymously with midwife-led care that avoids medical intervention at any cost, but is in practice extremely complex as is shown in Phillips' (2009) thesis on the topic.

The findings from this thesis do not seek to provide evidence that the midwives in either unit were not practising woman-centred care; instead, an analysis such as this of the dissonance between the midwifery professional discourse and some examples of its practice raises questions about how woman-centred care and other central tenets of midwifery are manifested in practice. Midwives appear to be very reluctant to have this discussion at all, because the philosophy of low intervention is held so very dear, and in many ways rightly so. However, again, the findings from this research about midwives' very complicated relationship with clinical guidelines, highlight how midwives' use (and subversion) of guidelines work to empower them as professionals but this empowerment is not inevitably passed down to women, as might be assumed in some cases.

Giving specific attention to the body work of midwifery has exposed more ways in which emotional labour, the organisation of space and bodywork intersect in the

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work of midwives. The findings highlight how many midwives used strategies to physically distance themselves from women in an effort to avoid the emotional demands of working with women. This finding is reflected in the literature on proximity and emotions (e.g. Malone, 2003; McCarthy, 2008; Peter, 2004), which suggested that proximity to women brings about a moral obligation to advocate for them. Within Millside, midwives had little spare capacity to advocate and so it would be an understandable strategy to avoid proximity to women in order to avoid feeling this obligation to support the women in their care. Feeling a moral obligation to advocate but being unable to do so resulted in further ideological conflict and emotional distress.

Exploring the dissonance between ideals and practice in terms of space, bodies and emotion has exposed how the emotional difficulty of midwifery is found at its borders: ideological and physical. Contrary to much of the literature on the history of the profession of midwifery (for example Donnison 1988, Murphy-Lawless 1998), the professional borders, particularly those with doctors, were not a significant problem for the midwives at Northway and Millside. The midwives had developed effective systems to organise and control the movement and influence of doctors, to both professional groups' satisfaction. At Millside, the ideological borders defined the physical space of the unit. The Millside midwives' ideology divided them from the institution, as represented by the managers and the drive for speed and efficiency in the face of profound resource constraints. At Northway Midwifery Unit, these differences were played out across the Unit's border with the Delivery Suite. Within

the unit the midwives had a space in which they could, in theory, provide the kind of midwifery care enshrined in their Unit 'philosophy'. Its guidelines, spaciousness and physical environment were all conducive to providing what they understood as a 'woman-centred' service. However, their frustration stemmed from the ideological difference between them and the midwives in the Delivery Suite next door, and the effects on them of the Delivery Suite's staff shortages, for example being 'pulled' across to cover. The midwives worked with a feeling that they were constantly being scrutinised, judged and their skills found wanting. This was in part because the Delivery Suite midwives only saw them working on the Delivery Suite, where they were ideologically 'out of place'. The midwives' skill was more apparent when they were working within spaces which promoted and valued their way of working; and with which they were familiar. In response to this feeling of alienation from the Delivery Suite, the Midwifery Unit midwives became increasingly aligned to the midwifery model of care.

This suggests that whilst Alongside Midwife-led Units may in many ways succeed in promoting a midwifery model of care and a good working environment for midwives, their proximity to consultant-led services compounds the ideological conflict the midwives experience. The strength of their philosophy may have the unintended consequence of silencing open discussion about the negative influence on women of the strategies the midwives use to compensate for ideological conflict and a lack of institutional and professional support.

Methods

I chose ethnographic case study as a method for this project because it enabled me to explore the context in which the midwives worked. This context became central to the analysis and shed new light on midwives' daily working lives as experiences of dissonance and conflict at the borders. The thesis is an organisational ethnography in so far as it is an ethnography situated within an organisation, whose borders constitute the boundaries of the case study. Its identity as an organisational ethnography is important because it places a particular emphasis on the bounded *spaces* in which maternity care occurs. This is a key way in which it extends on other, previous, similar research (e.g. Hunter 2002) by exploring ideological discourses, practices and tensions as they are manifested *within and between the physical spaces* of an institution, instead of through different forms of midwifery work (for example community and hospital practice).

Conducting an organisational ethnography also allowed for an explicit analysis of my being 'in the field'. For example, my own distress in the face of death and loss during the early weeks of fieldwork suggested that the midwives had developed coping strategies to protect against similar experiences. Extended unstructured interviews gave the midwives space to tell their own stories and exposed what they chose *not* to speak about, as well as what they did. Furthermore, they used me as a sounding board and counsellor in a way that suggested they had few other opportunities to talk about their frustration, but clearly wanted to. These findings

were of central importance to the thesis and would not have been so easily uncovered without spending extended periods of time with the midwives in their workplaces.

Despite these advantages, the use of case study as a method limits opportunity for generalisation. It is difficult to generalise from the very specific ways in which midwives engaged with emotional difficulties, emotional labour, space and body work at Millside and Northway. However, the use of 'instrumental' case studies (Stake 2000: 445) does offer some possibilities to extrapolate to possible findings elsewhere. The two case studies were chosen specifically to illuminate the effects of different workplaces on midwives' emotional difficulties and coping strategies. The Trusts, units, wards and midwives were not the focus of the research *per se*. They were undoubtedly unique, and differ in many ways from other units in the country. However, it is likely that differences may also occur between midwives' experiences in other work spaces: such as Consultant Units or Midwife-led Units, regardless of where they are in the country. This again emphasises the centrality of space to midwifery practice.

The breadth of the issues addressed in this thesis mean that there are, inevitably, a number of methods and analytical frameworks that could have been used to explore them. The most relevant of these were Discourse Analysis and Communities of Practice and here I evaluate the benefits they each would have brought to the process of fieldwork and analysis of the stories collected.

Discourse Analysis

Discourse Analysis would have provided an opportunity to explore in more detail how the dominant writing and talk about midwifery constructs their particular worldview. This construction of a professional identity is made through the performance of individual midwives, and the use of Discourse Analysis and the work, for example, of Judith Butler (e.g. Butler 1990) would have focussed the analysis on the ways in which midwives' identity is constructed through their performance to each other, to women and to myself. Furthermore, Discourse Analysis may have opened up interesting avenues to further explore midwives' political struggle (both at the national and institutional level) in terms of their use of language. As Barker and Galasiński write:

> Change is possible because we are unique inter-discursive individuals about whom it is possible to say that we can 're-articulate' ourselves, recreate ourselves anew in unique ways by making new languages (2003: 47)

Instead of Discourse Analysis, this thesis uses ethnography as its predominant methodology and method because of the priority ethnography gives to the physical context of the discourses and their deployment. The thesis has focused on the ways in which this 're-articulation' of identity can also occur through the other means: the midwives' physical defence of boundaries, performance of emotion and practice (in the form of body work). Language was a crucial tool in the midwives' defence of their professional identity. However, as the analysis of the Philosophy of the

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Northway midwifery unit, for example, has shown, they articulated this use of language as a defence as if it were a defence not only of their ideology, but also of the physical barrier between themselves and the Delivery Suite next door. It was a use of language that was very much situated in the material environment in which they worked.

Communities of Practice

Communities of Practice (see for example the work of Wenger 1998) is one example of a body of literature that also examines how a group of people work together to construct and better understand the world around them. The groups of midwives in this study are an excellent example of a community of practice. Wenger's checklist for a Community of Practice includes criteria such as:

- [T]he absence of introductory preambles, as if conversations and interactions were merely the continuation of an ongoing process …
- local lore, shared stories, inside jokes, knowing laughter …
- jargon and shortcuts to communication as well as the ease of producing new ones … [and]
- A shared discourse reflecting a certain position on the world (Wenger 1998: 125-126)

All of these criteria and more were clearly in evidence amongst the midwives of Northway and Millside and Communities of Practice would have been a valuable

analytical tool, focussing as it does on groups of expert practitioners who share common knowledge, norms and understandings about their practice. Using the literature on Communities of Practice as a foundation would have enabled me to explore midwives' socialisation and on-the-job learning in more detail. It may also have highlighted the role of the development of tacit or intuitive knowledges (Duguid, 2005) on midwives' professional identity in relation, for example, to medicine and the role of storytelling in the upkeep of professional identities (Seely Brown and Duguid 1991). Both of these elements: the roles of intuitive knowledge and of storytelling would make interesting foci for future analysis of the stories recorded for this thesis.

These constituent concepts within Communities of Practice have permeated the literature in other ways and are all evident within this thesis (although with a different emphasis). This has occurred despite my choice not to have an overriding theoretical framework. The absence of a single theoretical framework facilitated the wide-reaching nature of the study and helped me to bring together theories of emotional labour, body work and space and place in new ways to explore the manifestation of a professional discourse (as also described in the Communities of Practice literature) in practice.

Limitations of the study

The most significant limitation to the scope of this study was its confinement to midwives 'backstage', rather than 'frontstage' work. Whilst this benefited the project in many ways, as I explained on p. 96, it meant that the analysis of midwives' body

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work, in particular, was restricted to their *talk*, rather than their action. The study may also have benefited from the consideration of the organisational context within which the units functioned, which could have been explored through interviews with and/or observation of the work of obstetricians, Trust managers and local service commissioners and this could be the subject of future research.

Further Research

Midwives' frontstage work

Considering the limitations of this study, future ethnographic research that compared the differences between midwives' frontstage and backstage performance would be valuable. A future research project could involve observation of midwives' bodywork to examine the extent by which their talk is manifested in practice and explore the boundaries between frontstage and backstage: the putting on and taking off of character that Goffman recognises as being of particular interest (1990 [1959]: 123) and that I described briefly in Chapter Five.

Professional boundaries

This thesis has exposed the importance of researching working lives at the boundaries of the profession: whether spatial, ideological or, indeed, professional. In the light of the government's drive for choice of place of birth, further ethnographic research could be undertaken on the experiences of midwives working in Freestanding Midwife-led Units, particularly during the transfer of women to the Consultant Unit: the main interface with midwives in other areas. Other boundaries

in maternity care also warrant further investigation using ethnographic methods, for example the professional boundaries between midwives and support workers in the light of changes to the deployment of support workers in maternity services (Sandall, Homer et al. 2011). Observation of these working patterns would be particularly important to differentiate between the policy, theory and talk and the implementation of these changes. The same questions may also be asked of other professional groups who have well developed professional identities and/or share boundaries with other occupational groups: for example nurses and nursing auxiliaries; teachers and teaching assistants or police officers and Community Support Officers.

The experiences of women

The experiences of women and their partners were outside the scope of this study, but an understanding of women's experience is crucial to improving the provision of care. Of particular interest would be an exploration of women's experiences of moving between units with different ideologies: for example during transfer between Alongside Midwife-led Units and Consultant Units when complications develop in labour. It would also be important to gain an understanding of women's experiences at the receiving end of midwives' coping strategies, particularly to examine the extent to which midwives' articulation of their practice in terms of its benefit to women holds true for those women.

Further analysis of existing stories

Further analysis of the stories collected for this thesis could be made using, for example, the framework of Communities of Practice. Such an analysis could facilitate a study of, in particular, the role of 'local lore, shared stories, inside jokes, knowing laughter' (Wenger 1998: 125) amongst midwives and how these helped to consolidate accepted norms of practice that were extremely difficult to challenge.

Recommendations and concluding remarks

The findings of this research have exposed a number of problems facing midwives working in NHS hospitals. Whilst the midwives in the two units experienced the emotional difficulties of their work differently, they deployed unexpectedly similar coping strategies. These similarities were not immediately obvious. The way the midwives spoke about their work, and the atmosphere and pace of the two units were so different that they disguised the ways in which their experiences and actions were similar. It was only during analysis of the research findings that similar themes appeared in both sites. It became apparent that the similarities were hidden by the strength of the distinct midwifery discourse on the Midwifery Unit.

This 'philosophy' held many advantages for these midwives: it bonded them together with a common ideology. They also believed that it kept them distinct from the Delivery Suite and prevented them from being asked to care for women who needed medical attention. However, it also tended to polarise them from the Delivery Suite and contributed to their poor relationships with the staff next door.

The findings from this thesis have implications for a number of stakeholder groups. Amongst midwifery professional groups and midwifery managers there is a danger of relying on professional processes (especially the Supervision of Midwives) and potentially dysfunctional institutional systems to reduce midwives' emotional difficulties. The findings from this thesis show that these are inadequate to support midwives in recognising and ameliorating the emotional consequences of not being able to practice in a way the dominant discourse expects of them. There is a need within the community of practising midwives to openly acknowledge the emotional demands of midwifery practice and not just in relation to death, illness and loss. Midwives would benefit from a change in culture to one which recognises that such emotional demands deserve support, and resists normalising (and therefore ignoring) them if they are problematic.

Cultivating channels through which midwives can influence their work environment (for example informal discussions with a skilled facilitator) can significantly compensate for shortcomings in formal institutional processes. Failing to do this effectively has consequences not only for midwives' wellbeing, but also for the quality of midwifery services, as midwives' informal coping strategies are often detrimental to the care of women.

In the midwifery academic community there is a real reluctance to critique the dominant midwifery discourse. This is because the discourse originally prevailed as a

border defence against the influence of medicine and nursing, which means that any critique is perceived as a threat to the profession. I argue, however, that promoting critical engagement with the discourse may do a lot to support midwives struggling to practice according to its tenets.

Methodologically, this thesis has demonstrated the benefits of promoting the burgeoning interest in the emotional experiences and emotional labour of fieldwork researchers. Analysis of the emotions of the researcher can enhance the understanding of participants' experiences within the same field. The methods used in this project have also demonstrated how observation of the daily work of midwives allowed me to recognise how midwives' 'approved' way of speaking about their work restricted what they talked about, despite good relationships with the midwife participants. The silences within the discourse would have remained invisible without witnessing how the talk manifested in practice.

The midwifery discourse would suggest that the 'approved' strategy for managing the dissonance between the way midwives wish to work ('with woman') and the way the institution requires them to work ('with institution') is to take every opportunity to work more 'with woman'. I found that this was not always the case in practice, particularly at Millside. *Avoiding* being 'with woman' was just one example of a number of strategies midwives used to protect themselves emotionally by physically distancing themselves from women. In more extreme cases, such strategies included working part-time or, ultimately, leaving the profession for good.

Examining the emotional difficulty and emotional labour of midwifery alongside their body work and within the context of their workplace has exposed its extraordinary complexity. Those midwives who remain working in NHS hospitals face enormous challenges in ensuring their working lives remain satisfactory. The strategies they use to cope with the often contradictory demands of their profession, the institution and the women in their care are diverse and complex. Their coping strategies are all understandable and intelligent responses to the emotional distress their work causes them and the lack of formal recognition and support available to them to deal with it. The midwifery discourse, which remains so strong in defence of midwives and the profession of midwifery, may in practice make it even more difficult to sustain midwives' and women's wellbeing. Midwife-led spaces situated within hospitals show promise in providing midwives with a room of their own in which to better influence the terms and conditions of their work. However, the difficult inter- and intra-professional relationships they appear to engender makes them not without their problems. The midwifery discourse can withstand critical engagement without damaging the hard-won status of the profession of midwifery. If midwives can speak of their difficulties without fear, the profession can then regain strength, look after its members, promote the wellbeing of the women in their care and move into the future.

Appendix 1: Glossary

'A line'   Arterial Line: catheter placed in an artery, used in intensive care medicine.

Anterior rim   The last bit of the cervix which can still be felt during a vaginal examination

ARM   Artificial Rupture of Membranes or 'breaking the waters'

Blood pressure   Excessively high blood pressure can be a symptom of
(pre-eclampsia)   pre-eclampsia which in severe cases can necessitate immediate birth of the baby.

Cephalic   A baby directed head down into the pelvis
presentation

'clip'   Colloquial term for a Foetal Scalp Electrode, placed under the skin of the baby's scalp before birth to monitor its pulse.

CVP line   Central Venous Pressure line. Catheter placed in a large vein, used in intensive care medicine.

'Decel'   A deceleration in the foetal heart rate

Dilation   The extent to which the cervix has dilated (in centimetres)

Entonox   A mixture of Nitrous Oxide and Oxygen, commonly used in the UK as pain relief in labour.

Epidural	A regional anaesthetic used in labour, which numbs the lower half of the body
FGM	Female Genital Mutilation
'Fully'	Colloquial term for fully dilated: the cervix is dilated to 10cm
Fundus	The woman's pregnant abdomen
Gestation	The duration of the pregnancy to date
Gestational age	The number of weeks since the baby was conceived
Grand Multip	Abbreviation of 'grand multiparous': a woman who has birthed four or more infants beyond 24 weeks gestation.
Haemoglobin	A low haemoglobin level indicates a woman is anaemic.
Hydrocephalus	An abnormal accumulation of water in the skull.
'instrumentals'	Instrumental delivery of a baby using forceps or Ventouse
IUGR	Intra-Uterine Growth Restriction
IV syntocinon	The 'hormone drip' used to promote uterine contractions.
Multip	Abbreviation of 'multiparous': a woman who has previously birthed a baby which passed 24 weeks gestation.
Opiates	Pain relieving drugs used in labour, including Morphine, Diamorphine and Pethadine.

Partogram	A chart plotting cervical dilation and contractions against time. Started once a woman is deemed over 4cms dilated and/or with strong regular contractions.
Pethidine	An opiate pain relieving drug used in labour.
Pinard Stethoscope	A trumpet-shaped stethoscope used to listen to the foetal heart. Its use is considered a traditional midwifery skill.
Placental site (placenta praevia)	Where the placenta is growing within the uterus. A low-lying placenta which partly or wholly covers the cervix is called 'placenta previa'.
Primip	Abbreviation of 'primaparous': a woman who is birthing a baby over 24 weeks gestation for the first time.
Resuscitaires	Machines used to aid the resuscitation of newborn infants.
Second stage	The stage of labour starting when the cervix is fully dilated (10cms) and ending with the birth of the baby.
Singleton pregnancy	A pregnancy of one foetus
Spontaneous onset of labour	A labour which starts without the use of drugs or other interventions.
Stillbirth	The death of a baby in the womb after 24 weeks gestation

Appendix 2: Named Participants

Millside Maternity Unit

Aleesha	Midwife	Delivery Suite	Early 30s	Black Caribbean
Christine Harvey	Head of Nursing	Management		White British
Elaine	Midwife	Delivery Suite	Late 30s	White British
Elizabeth	Midwife	Delivery Suite	52	Black African
Emily	Midwife	Low Risk Postnatal Ward	Late 20s	White British
Fiona	Midwife	Low Risk Postnatal Ward	38	White European
Irene	Midwife	Delivery Suite	60s	White British
Jenny	Midwife	Low Risk Postnatal Ward	Mid 30s	White British
Julianne	Midwife	Delivery Suite	40s	White British
Karen	Midwife	Delivery Suite		White British
Katharine	Consultant Midwife	Management	Late 40s	White British
Lillian	Midwife	Delivery Suite	Early 50s	White British
Linda	Midwife	Low Risk Postnatal Ward	Late 50s	White British
Lindsey	Midwife	Delivery Suite	Late 30s	White British
Lyn Mackay	Directorate Manager	Management	Mid 40s	White British
Majan	Midwife	High Risk Postnatal Ward/Clinic	50	Black African
Maria	Midwife	Delivery Suite	Mid 30s	White British
Miriam	Midwife	Delivery Suite	60s	White British
Olive	Midwife	Delivery Suite	Late 40s	Black Caribbean
Pauline	Matron	Delivery Suite	Early 50s	Black African

Sara	Student Midwife	Low Risk Postnatal Ward	early-20s	White British
Sarah	Midwife	Delivery Suite	28	White British
Susan	Midwife	Delivery Suite	60s	Black Caribbean
Suzanne	Midwife	Delivery Suite	Mid 30s	White British
Veronica	Midwife	Delivery Suite	28	White British

Further observation participants, who are not explicitly named in the thesis include:

30 Midwives

2 Student midwives

5 Domestic and support staff

12 Doctors, including obstetricians and anaesthetists

Northway Midwifery Unit

	Manager	Mid 40s	White British
	Consultant Midwife	Mid 40s	White British
Joy	Midwife	50s	White British
Kate	Midwife	Mid 40s	White British
Eleanor	Midwife	50s	White Irish
Diane	Midwife	40s	Black Caribbean
Patricia	Midwife	Mid 40s	Black Caribbean
Rose	Midwife	Early 60s	White British
Emma	Midwife	30s	White British
Virginia	Midwife	30s	White British
Elise	Midwife	Mid 40s	White British
Alison	Midwife	50s	White British/Chinese
Meg	Student Midwife	Early 20s	White British
Abida	Maternity Assistant	Early 30s	South Asian

Further participants not explicitly named in the thesis, include:

11 midwives

1 Healthcare Assistant

1 Infection Control Manager

Appendix 3: Participant Information Leaflet: Staff

THE UNIVERSITY OF
WARWICK Sociology

Research Project

Midwives' strategies for managing disagreement and distress in the workplace

Information for staff

Department of Sociology
University of Warwick
Coventry
CV4 7AL

j.rayment@warwick.ac.uk

Academic supervisors:

Dr Hannah Bradby:
h.bradby@warwick.ac.uk

Dr Carol Wolkowitz:
carol.wolkowitz@warwick.ac.uk

Hi, my name is Juliet Rayment and I am a PhD student in the Department of Sociology at the University of Warwick.

This leaflet provides further information about me, my research, what this project means for you and how you can get in touch with me if you have any questions.

Key information

Researcher:

Juliet Rayment
PhD Candidate
Department of Sociology
University of Warwick.
Email: j.rayment@warwick.ac.uk
Mobile:
Telephone:

Research funded by:

The Economic and Social Research Council

www.esrc.ac.uk

What is the research about?

This research will provide information about how midwives cope with the pressures of being a professional and an employee in NHS maternity services. I am interested in the ways in which midwives adapt their practice in order to compensate for shortages in resources and to maintain their own dignity, professional autonomy and minimise any distress they may experience at work.

What will it involve?

I will be spending approximately five months observing the every day work of midwives in the Unit.

All the information that I record in my notes, including the names of both the Unit and staff, will be anonymised.

In addition to the observation, I would very much like to talk to some midwives one-to-one about their work. These interviews will be voluntary and confidential. Again, all names and identifying details will be removed.
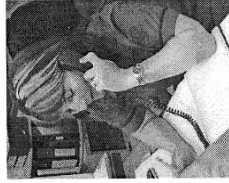
If you have any questions at all about the research or do not want to participate in the observation, please contact me. I will be very happy to talk to you. I always like chatting about my work and I very much value your input and opinions so please get in touch!

Who will be doing the research?

My name is Juliet Rayment. I began researching midwives around four years ago and gained an MA in Social Research with Health in 2005. My MA dissertation was about midwives involved in campaigns for one-to-one care. Since then I have worked as a Research Associate at Warwick Medical School and have taught a number of courses in Healthcare, Sociology and Gender Studies.

Who is funding this research and what will happen to the results?

This research is funded by the Economic and Social Research Council and the results will be written up as a PhD thesis. It is not an audit and has not been commissioned by the Trust.

The findings will be presented to you and to the Trust in order to spread good practice and may also be presented at conferences or in journal articles. No names or contact details will appear in the final reports.

Appendix 4: Participant Information Leaflet: Women & Partners

Research Project

Midwives' strategies for managing disagreement and distress in the workplace

Information for women and their partners

This leaflet will give you some more information about a research project being carried out in the Unit. If you would like to ask any further questions about the research, please use the contact details below.

Researcher:

Juliet Rayment
PhD Candidate
Department of Sociology
University of Warwick.

Email: j.rayment@warwick.ac.uk
Mobile:
Telephone:

Research funded by:

The Economic and Social Research Council

www.esrc.ac.uk

Department of Sociology
University of Warwick
Coventry
CV4 7AL

j.rayment@warwick.ac.uk

Academic supervisors:

Dr Hannah Bradby:
h.bradby@warwick.ac.uk

Dr Carol Wolkowitz:
carol.wolkowitz@warwick.ac.uk

Hi, my name is Juliet Rayment and I am currently doing some research in the Maternity Unit here at

What is the research about?

This research is about how midwives cope with working in busy and stressful situations. Hopefully the results of this project will help to improve the working conditions of midwives and the care that women and their babies receive.
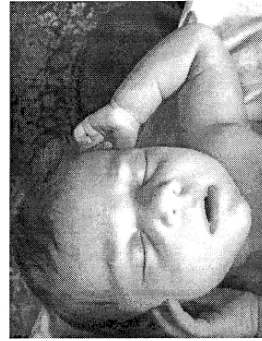
What does it involve?

I am spending around five months from August 2007-January 2008, observing the every day work of midwives in the Unit.

All the information that I record in my notes, including the names of the Unit, staff and patients will be anonymised, so no one will be able to be recognised.
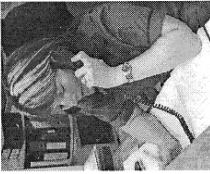
I will also be talking to some midwives individually about their work.

If you see me around the Unit, please come and say hello. I will be very happy to talk to you about the project and answer any questions you may have.

Who is funding this research and what will happen to the results?

This research is funded by the Economic and Social Research Council.

I will be collecting the stories of midwives working in the Unit and these will be written up as a PhD thesis.

The results of the study may also be published in a report for the hospital, an article in a journal, and be described at local research meetings and conferences. Your name or contact details will not appear anywhere in published documents.

Appendix 5: Participant Information Poster

THE UNIVERSITY OF
WARWICK   *Sociology*

Research project

*Midwives' strategies for managing disagreement and distress
in the workplace*

My name is Juliet Rayment and I am a PhD student at the University of Warwick. I am doing a project in the Maternity Unit at ▮▮▮▮▮ beginning in late summer 2007.

I am interested in how midwives manage the pressures of being a professional and an employee in NHS maternity services and how they cope with working in stressful situations on a day-to-day basis. I have left some leaflets in the unit which give further information about the research.

All of the information and stories I collect will be entirely confidential.

If you would like to ask me anything at all about my research please email me on j.rayment@warwick.ac.uk or drop me a line on ▮▮▮▮▮ or ▮▮▮▮▮ any time.

Appendix 6: Interview Participant Information Sheet

05.07.2007

Midwife Interview Information Sheet

UK midwives' strategies for managing disagreement and distress in the workplace

I have been observing midwives' work in the Unit over the last few months in order to find out more about how you manage the specific pressures on you as employees and professionals in the maternity services. In order to gain some more specific information on the day-to-day experience of being a midwife at Heartlands, I am inviting midwives from the Unit to talk to me in more detail about their work.

I would very much like to talk to you, in confidence, about your experiences as a midwife. Before you decide if you would like to talk to me, please take time to read the following information carefully. Talk to others about the study if you wish.

Please ask me if there is anything that is not clear or if you would like more information. Find me in the Unit or feel free to telephone or email me at any time. Take time to decide whether or not you wish to take part.

Juliet Rayment

Juliet Rayment
PhD Candidate
Department of Sociology
University of Warwick
Coventry
CV4 7AL

Tel: ███████████
Mobile: ███████████
Email: j.rayment@warwick.ac.uk

Academic supervisors:

Dr Hannah Bradby
Email: h.bradby@warwick.ac.uk

Dr Carol Wolkowitz
Email: carol.wolkowitz@warwick.ac.uk

Why have I been chosen?
You have been invited to take part in an interview because you are currently working as a midwife at Heartlands. You have not been chosen for any other reason.

Do I have to take part?
No. It's entirely up to you. Even if you say yes, you can change your mind without giving a reason or decline to have your interview included.

What do I have to do?
This part of the research project involves you taking part in two one-to-one interviews with me. If you decide to take part then I will contact you to arrange a suitable time for the first interview. I will invite you to sign a form to give your consent to the research. You will be given a copy of the consent form and an information sheet about the research and be able to ask as many questions as you want.

During the first interview I would like you to take me on a tour of the Unit, during which we can talk about the work which is going on there. The second interview will take place in a private room either at Heartlands or at a venue of your choice. If you would rather take part in only one of the two interviews then please let me know, I would still like to talk to you.

The direction of the interviews will be guided by you and therefore you do not have to discuss anything you do not wish to talk about. You do not have to give a reason if you choose not to answer any of the questions or to end the interview early.

The interview will be audio recorded with your permission.

Ethical issues

The information gained from this study will be fed back to the Trust in order to help improve the experiences of midwives in the future.

What are the possible disadvantages of taking part?

It is very unlikely that you will be caused any problems by taking part in these interviews. Many people find it helpful to talk about their work to an outsider. If for some reason you get upset during the interview you can stop the interview whenever you like without giving a reason. If you want to complain about any aspect of the ways you have been approached or treated in this study, free, impartial, independent advice on making a complaint is available by phone by ringing 0845 120 3748. . If you wish to make a complaint directly

to the University, this should be addressed to Head of Department, Department of Sociology, University of Warwick, Coventry, CV4 7AL.

What will happen if I don't want to carry on with the study?

If you decide before, during or after the interview that you do not wish any or all of the information you give to be used in the final thesis or report then it will be deleted from the project records. You do not have to give a reason to withdraw from the project at any time.

Will my taking part in this study be kept confidential and anonymous?

Yes. Information which is collected about you during the course of the research will be kept strictly confidential. You will be invited to give yourself a pseudonym. Your real name and the name of the Trust will never appear with your story so you cannot be recognized.

The only circumstance in which information about you may be disclosed is if you indicate a level of ongoing distress which is of significant cost to your health or if circumstances suggested ongoing harm to patients. In that case I may inform Sue Dennett, who is acting as my clinical supervisor during the research period. If I felt this was necessary then I would discuss this with you at the time and would not disclose any information to anyone other than Sue. This protocol has been put in place in order to protect you.

All recorded information including your name and the name of the Trust and Unit will be anonymised on transcription. It will be stored on a computer owned by me and will only be accessed directly by me as the key researcher. I may also share parts of the (anonymised) information with my academic supervisors at the University of Warwick. The information will be handled in line with the Data Protection Act 1998.

What will happen to the results of the research study?
I will collect your stories along with those of other midwives in the Unit. Your story is unique and I am interested in its special features as well as its similarities with the stories of other midwives. The results of the study will be written up as a PhD thesis for submission in September 2009. They may be published in a report for the Trust, in journal articles for academic or professional audiences, and be described at local research meetings and conferences. I will be happy to provide you with copies of the published results. Your name or contact details will not appear anywhere in published documents.

Who is organising and funding the research?
The research is being carried out as part of a PhD in the Department of Sociology at the University of Warwick. It is funded by the Economic and

Social Research Council. If you would like any more information about any part of the research please contact me:

Tel:
Mobile:
Email: j.rayment@warwick.ac.uk

Appendix 7: Interview Participant Consent Form

Midwife Interview Consent Form

UK Midwives' experiences of managing disagreement and distress in the workplace

Name of Researcher: **Juliet Rayment**

Please initial box:

1. I confirm that I have read and understand the information sheet dated.................... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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

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

_____   _____   _____

Name of Midwife   Date   Signature

Juliet Rayment   _____   _____

Researcher   Date   Signature

Appendix 8: Local Research Ethics Committee Approval Letter

NHS
National Research Ethics Service

27 September 2007

Ms Juliet Rayment
PhD candidate
Department of Sociology
University of Warwick
Coventry
CV4 7AL

Dear Ms Rayment

Full title of study: UK midwives' strategies for managing disagreement and distress in the workplace.

REC reference number: 07/H1206/28

Thank you for your letter (undated) responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the research site(s) taking part in this study. The favourable opinion does not therefore apply to any site at present. I will write to you again as soon as one Local Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at sites requiring SSA.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

This Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

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Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	5.4	04 July 2007
Investigator CV		04 July 2007
Protocol	1.0	05 July 2007
Covering Letter		05 July 2007
Interview Schedules/Topic Guides	1.0	05 July 2007
Advertisement	1.0	05 July 2007
Participant Information Sheet: Leaflet - women/partners	1.0	05 July 2007
Participant Information Sheet: Leaflet - staff	1.0	05 July 2007
Participant Information Sheet: Midwife Interview	2.0	05 September 2007
Participant Consent Form: Midwife Interview	2.0	05 September 2007
Response to Request for Further Information		
Supervisor's CV - Dr H Bradby		
Supervisor's CV - Dr C Wolkowitz		02 July 2007
Statement of Student Status		04 July 2007
Statement of Indemnity		02 August 2006
Statement of Indemnity		02 August 2006

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm .

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

07/H1206/28	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

▮▮▮▮

Yours sincerely

▮▮▮▮▮▮

Chair

Email: ▮▮▮▮▮▮▮▮▮

Enclosures: *Standard approval*

Copy to: ▮▮▮▮▮▮▮
                       R&D office for ▮▮▮▮▮▮▮ Trust &
                       ▮▮▮▮▮▮

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