

# **Discourses of unity and division: a study of interprofessional working among midwives in an English NHS maternity unit**

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A thesis submitted in partial fulfilment of the  
requirements of the University of the West of England, Bristol  
for the degree of Doctor of Philosophy

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July 2007

## **Abstract**

This thesis presents a case-study of interprofessional working in one English NHS maternity unit. Problematic interprofessional working in UK maternity care can contribute to poor outcomes for women using the services, as well as to difficulties for midwives. Relevant research to date has focused mainly on midwife-doctor relationships. Associated social factors, namely, issues of gender, power, professionalism and the medicalisation of birth, have been identified over the last two decades; however, there have been only sporadic improvements in this area. There has been no in-depth study of how micro-level discursive mechanisms affect midwives' interprofessional relationships. The aim of this study was to explore how midwives' discursive practices relate to the social factors listed above.

Critical Discourse Analysis (CDA) was applied to 17 midwife-authored research papers and four documents governing midwifery practice. Semi-structured interviews were conducted with 19 midwives, and 100 hours' observational data were collected over a period of one year. A sampling strategy of maximum variation resulted in the recruitment of interview participants of differing seniority, practice locale (hospital/community) and involvement in role extension. Additional interviews were conducted with four obstetricians and seven service-users. Interview and observational data were analysed following both thematic and CDA principles, in order to aid identification and examination of pertinent discursive practices.

Out of 17 relevant social practices identified, 13 involved midwives' discursive practices which reinforced traditional notions of professionalism, gender and the medicalisation of birth. However, most midwives in the unit expressed satisfaction with their interprofessional relationships; this appeared to hinge on the fact that their interaction with the obstetricians in the unit were grounded in the shared exercise of power. Midwives' relationships with some other occupational groups were more problematic, particularly where they had similar status in the occupational hierarchy. A key finding was that good interprofessional relationships between midwives and other staff did not necessarily enhance women's experiences of maternity care.

The thesis contributes to the knowledge base about interprofessional working among midwives by developing a theoretical approach concerning the relationship between communication and the operation of power in their working environments. It has also produced findings about midwives' relationships with both medical and non-medical colleagues. Implications are discussed concerning midwifery, women using the maternity services, and our society's approach to birth.

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## **Chapter 1. Introduction.**

One of the prominent developments in western society over the last 200 years has been the rise of medicine and the concomitant organisation and institutionalisation of health care (Foucault 1973, Nettleton 1995). This organisation has entailed different occupational groups marking out areas of practice as their own (Stacey 1988, Nettleton 1995). As long as these different groups have claimed ownership of discrete areas of practice, there have been, *de facto*, interprofessional relationships. Where ownership has been recognised as exclusive and appropriate, systems have existed which have allowed for different practitioners to work together as and when necessary (Stacey 1988, Nettleton 1995). However, where ownership has been contested, inter-practitioner rivalry has often been the order of the day (Moscucci 1990, Nettleton 1995). The establishment and development of organised professions between the middle of the 19<sup>th</sup> century and the latter part of the 20<sup>th</sup> century both consolidated ownership claims and determined the shape of interprofessional relationships in the western world, with the medical profession attaining dominance over related occupations (Witz 1992).

### **Healthcare in the UK**

In the first half of the 20<sup>th</sup> century, medicine dominated as healthcare services in the UK underwent increasing organisation, culminating in the establishment of the National Health Service (NHS) in 1948. The NHS was centrally funded, while control at a local level rested with representatives of the professions (mainly medicine) (Allsop 1995). However, the terrain has shifted over the last 30 years. In the UK, the power of medicine and other professions has been challenged by a move to care provision modelled on the principles and priorities of the market. With financial responsibility and accountability devolved to a local level, power in the NHS has increasingly been transferred to managers controlling budgets, rather than being in the hands of professionals determining practice priorities (Allsop 1995, Annandale 1998).

Over the same period, there has been a shift in the popular perception of appropriate relationships between healthcare professions and members of the general public. The rights of service users to exercise choice about some aspects of the care they receive have been promoted at official levels, notably in documents such as *The Patient's Charter* (Department of Health (DH) 1992). The concept of

choice for individuals in the western world is associated with wider social developments, including the widespread adoption of libertarian attitudes which prioritise the rights of both individuals and those groups who are perceived to have been disadvantaged by previous societal norms, among whom are included women, members of ethnic minorities, people with disabilities, and people with non-heterosexual orientation (Abercrombie et al 1994, Annandale 1998).

### ***Maternity care***

The history of maternity care in the western world is a story of conflict between two different approaches to birth: in one view, associated mainly with midwifery, birth is considered a normal physiological event located within the wider social context; in the other, associated mainly with medicine, it is seen as an inherently dangerous physical process which requires control and surveillance in order to be made safe (Donnison 1988, Witz 1992, Leap 2004). As medicine rose to power, midwifery practice was subsumed within the wider organisation of the healthcare system, and the medical perspective on birth became almost universally accepted (Donnison 1988, Witz 1992). By the late 1960s, childbirth within wealthy industrialised countries had become almost completely medicalised. The rise of feminism and the emphasis on choice for individuals in the latter part of the 20<sup>th</sup> century helped to fuel the movement that arose among women to wrest control of childbirth away from the medical profession (Annandale 1998, De Vries et al 2001, Edwards 2004). In the UK, the publication of *Changing Childbirth* (DH 1993) established the primacy of women's choice and control as a guiding principle for care delivery (Benoit et al 2005).

Many midwives in the UK and elsewhere allied themselves with women's campaigns for greater control over birth, seeing it as an opportunity to promote the midwifery perspective (Annandale 1998, De Vries et al 2001). Over the last twenty years, midwives have been implementing strategies to enhance their professional status (Sandall 1995). The alliance between women and midwives provided the latter with a legitimate justification for the promotion of their own professional agenda, which is to carve out an area of maternity care under their sole control. Ironically, some of the strategies midwives have employed to this end have resulted in their distancing themselves from the women whom they attend (Cronk 2000, Wilkins 2000). Key to midwifery's professional agenda is the renegotiation of relationships and power differentials between themselves and medical practitioners.

### ***Interprofessional relationships***

Other non-medical health professionals have also been promoting their own professional agendas during this period (Davies 1992, Annandale 1998). In conjunction with these developments involving different health-related occupations, health has been more widely conceptualised to include social aspects of life. There has been growing recognition that satisfactory care delivery entails co-ordination and collaboration involving a range of workers, both professional and non-professional, across a number of sectors, including social care (World Health Organisation (WHO) 1978). Over the last two decades, there has been a continuing emphasis on developing interprofessional working in health and social care services in the UK. Drivers for this development have included a perception that fragmented services and lack of interprofessional communication have been significant factors in high-profile cases of sub-optimal care (Dalley 1993, DH 1994a, Kennedy 2001, Laming 2003). However, the implementation of interprofessional working has been problematic in many areas, partly due to inconsistencies in inter-organisational structures, lack of resources, and lack of enthusiasm on the part of staff involved (Fowler et al 2000, Elston and Holloway 2001).

Research into interprofessional issues, both in the UK and elsewhere, has focused primarily on relationships between doctors and nurses and to a lesser extent, doctors and social workers, as well as those between different allied health professionals (see, for example, Fowler et al 2000, Blue and Fitzgerald 2002, Booth and Hewison 2002). Key factors determining the quality of interprofessional working appear to be power differentials (including decision-making processes and professional autonomy), communication issues, physical proximity, frequency of interaction, and managerial support, among others (Øvretveit et al 1997, Cook et al 2001, Barrett and Keeping 2005).

Exploration of interprofessional working in midwifery has focused almost exclusively on midwives' relationships with the medical profession (see, for example, Green et al 1994, Brownlee et al 1996, Lane 2005). However, routine interaction with a wide range of health and social care professionals and agencies is a key feature of midwifery practice in the UK, and includes practice across, as well as within, acute and primary care boundaries. It therefore seems timely to widen the research focus: this thesis entails exploration of midwives' interprofessional working across the range of professions with whom they collaborate, including non-professional staff.

## **The thesis**

Interprofessional working between midwives and medical practitioners in the UK is commonly portrayed as unsatisfactory (see, for example, Davies 1997, Meerabeau et al 1999, Pollard 2003). Moreover, poor working relationships in maternity care are associated with poor outcomes for women and their families using the service (Revill 2004, Robertson 2004). Social factors underlying problematic interprofessional working in midwifery have been clearly identified and debated for the last 20 years (see, for example, Oakley 1984, Kirkham 1986, Witz 1992, Kirkham 1996). While this body of work has been of enormous value in providing ways of thinking about relevant issues, awareness of these issues does not appear to have resulted in significant improvements in this area in practice. In this thesis, I have attempted to discover how micro-level social mechanisms contribute to the maintenance of the status quo in this area. There has to date been no in-depth micro-level exploration concerning midwives' relationships with colleagues from other disciplines.

In Chapter 2, I discuss factors affecting interprofessional working in healthcare generally and in midwifery in particular. I draw on research literature concerning interprofessional issues in midwifery in this regard. In a suggested approach for theorising interprofessional working in midwifery, I focus particularly on the relationship between power and communication, given their acknowledged contribution to the quality of interprofessional working in the wider healthcare arena (Øvretveit et al 1997, Cook et al 2001, Barrett and Keeping 2005). I argue that the incorporation of Critical Discourse Analysis (CDA) into an exploration of these issues can throw light on how current relationships between midwives and other professionals are shaped and maintained, since it focuses particularly on the representation and operation of power in society (Van Dijk 2001). In Chapter 3, I present an overview of the theories underpinning this field of study, and link it to interprofessional working in midwifery.

My topic cannot be isolated from the wider social context. In particular, most midwives are women (Nursing and Midwifery Council (NMC) 2005), and although they may give information, advice and support to male partners and relatives, midwifery practice directly targets only women and newborn babies. Moreover, the focus of midwifery practice is a process which defines women both biologically and socially. In addition, midwives consider themselves to be professionals, and have a particular location within the history and development of healthcare professions in

the UK (Witz 1992, Sandall 1995, Etuk 2001). Conceptions of gender and professional identity are therefore of prime importance when considering how relationships within midwifery are framed, and Chapters 4 and 5 are devoted to discussion of relevant issues, as well as consideration of how the wider social context impacts upon them.

When investigating my topic, I incorporated the CDA approach developed by Fairclough (1992, 1995, 2001a, 2001b), who introduced the concept of micro- and macro-analysis within one study. This enables a more sophisticated study of a particular topic, as it is consequently located within the framework of wider trends and influences which are impacting upon local conditions, even if only implicitly. This approach aligns with my own perspective, which does not view factors influencing interprofessional working in midwifery as being isolated from the wider social context. However, research methods commonly used in CDA did not appear to be entirely adequate for my purposes. Therefore, in order to explore the mechanics of midwives' relationships with members of other occupational groups, I adopted a hybrid research approach which was both congruent with my theoretical perspective (as outlined in Chapters 2-5) and with the need to collect data which could allow me to conduct micro-level examination of the issues at hand. I adopted, and extended, research methods that have been used in CDA, but also drew on case-study methods (Yin 1989, Titscher et al 2000, Fairclough 2001b, de Vaus 2001). In Chapter 6, I set out and discuss the methods I used in my study.

Chapters 7 to 10 comprise the findings of my study. Their presentation starts with the results of macro-analysis. In Chapter 7, I detail findings arising from the application of CDA techniques to midwife-authored research reports concerning interprofessional working, drawn from both international and national literature. Findings from analysis of the rules governing midwifery practice in the UK are also presented. I end this chapter by moving to micro-analysis, and report on the application of CDA to two local policies prescribing midwives' practice which were in force at the time of data collection in my selected research site.

In Chapters 8 to 10 I present findings from my fieldwork data, all of which constituted material for micro-analysis. I have attempted to contextualise the midwives' position within the research site, in order better to understand salient features of their interprofessional working. I therefore first present findings about how the research site operated in Chapter 8, with an emphasis on the general interaction between all

those working within it. I follow this with a report in Chapter 9 on the midwives' professional standing within the organisation, and their orientation to the provision of midwifery care. In Chapter 10, I focus on their interprofessional relationships with their colleagues from other occupations.

I end my thesis by discussing and summarising my findings in Chapters 11 and 12. In particular, I consider their implications for the midwifery profession, for women using the maternity services, and for the wider approach to birth in the UK.

## **Chapter 2. Research on interprofessional working in midwifery.**

### **Introduction**

A considerable body of work exists concerning the medicalisation and institutionalisation of childbirth and of midwifery: see, for example, Oakley (1980, 1984, 1993), De Vries (1982, 1993, 1996), Kitzinger (1984, 1989, 1991, 2005), Kirkham (1986, 1987, 1996, 1999, 2004), Donnison (1988), Van Teijlingen et al (1999) and De Vries et al (2001). This work has provided a comprehensive overview of how midwives, medical practitioners and childbearing women are, and have been, located in relation to each other in the western world. However, little attention has been paid to the micro-level of interaction between different maternity care professionals. Therefore, there has been little focus on developing theoretical understanding of how the relationships between midwives and other health and social care professionals are maintained in terms of the social and communicative mechanisms involved. It is my intention in this thesis to further the development of such an understanding.

Current social theories embrace the concept of 'discourse' as the articulation of knowledge through language and representation; discourse is then the framework within which knowledge, practice and values are constituted (Foucault 1972, du Gay 1996, Hall 2001). Over the last 200 years, the scientific discourse has dominated medicine; competing discourses have either disappeared or become peripheral to it (Smith 1998, Wicks 1998). Current midwifery practice has emerged through the victory of the scientific medical discourse (Donnison 1988). Put simply, medicine has developed through professionalisation strategies within a scientific discourse of cure (Foucault 1973, Witz 1992, Wicks 1998, Nancarrow and Borthwick 2005). Medicine's control of healthcare has resulted in its defining and regulating the scope of other related occupations (Witz 1992, Nancarrow and Borthwick 2005). Medically-supervised midwifery practice has accordingly been defined as a component of medicine's development, within the scientific discourse, while an alternative holistic discourse of care and support has been subsumed within it (Donnison 1988, Witz 1992, Nancarrow and Borthwick 2005). This alternative discourse has also persisted to some extent on the sidelines, maintained by midwives practising outside established healthcare systems. Control of midwifery remains controversial (Wagner 1997, O'Loughlin 2001, Leap 2004). The above is of course a highly simplified summary of the complex social processes that have led to

the development of modern midwifery. These issues will be discussed in more depth later in this thesis.

The control of birth is also controversial. There is conflict between paradigms of wellness and illness among competing discourses about birth. Traditionally, midwifery adopts a holistic perspective, viewing birth as a natural physiological process, which healthy, well-nourished women can usually accomplish with minimal intervention on the part of caregivers, other than emotional and social support (Leap 2004). By contrast, birth needs to be associated with illness to validate the predominance of the medical curative discourse in western maternity care (Oakley 1984). In many countries, including the UK, maternity care is only one of many activities undertaken within a medically-dominated healthcare system that focuses on the pathological. Maternity services are consequently provided within highly complex, hierarchically structured, medically-focused organisations, themselves embedded in and relating to wider society. The exploration of interprofessional working in midwifery in the UK is therefore exploration of a network of social structures and relationships which have arisen in these organisations following the demands and the assumptions of the dominant medical discourse, together with its wider social interpretation and application. In this context, 'interprofessional working' means collaboration between at least two different health or social care professions or occupations.

In this and the following three chapters, I shall propose an approach for theorising interprofessional working in midwifery, and outline its underpinning theories. I shall also draw on sociological theory in order to inform discussion of relevant issues, as well as research literature concerning interprofessional working in midwifery.

### **Research literature about interprofessional working in midwifery**

Searches on the Allied and Alternative Medicine (AMED), British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Excerpta Medica (EMBASE), MEDLINE and Midwives Information and Resource Service (MIDIRS) databases, using various combinations of the keywords 'interprofessional', 'relationships', 'midwifery', 'maternity' and 'midwives', yielded 32 reports published between 1989 and 2006, concerning 27 studies about midwives' relationships with other professional groups. Of these, 14 were conducted in the UK (Robinson 1989, Cheyne et al 1995, Brownlee et al 1996, Davies 1997, Fleissig et al 1997, Farquhar et al 1998, Symon 1998, Anderson 1999, Fraser 1999, Meerabeau et al 1999,



Symon 1999, Farquhar et al 2000, Redshaw and Harvey 2000, Farmer et al 2003, Hagelskamp et al 2003, Lumsden 2005), four in Australia (Haertsch et al 1998, Brodie 2002, Lane 2005, Adams 2006), three in Canada (Blais et al 1994a, Blais et al 1994b, Blais et al 1999, Katz and Katz 2001, Kornelson et al 2003), three in the USA (Miller 1997, Miller et al 1997, Harman et al 1998, Bailes and Jackson 2000), and one each in the Netherlands (de Veer and Meijer 1996), Taiwan (Gau et al 2002) and Guatemala (Hinojosa 2003). As the nature of relationships with other colleagues is pivotal to the exercise of professional autonomy, I have also drawn on two research reports concerning an exploration of midwifery autonomy in the UK which I undertook previously (Pollard 2003, 2005), together with six studies which informed that work (Green et al 1994, Robinson and Owen 1994, Hundley et al 1995, Meah et al 1996, Hosein 1998, Levy 1999) (see Table 1 on pp.10-11).

In 16 of these 34 studies, interprofessional relationships constituted a significant research focus. In the remaining 18 studies, findings about interprofessional issues were ancillary to the main focus, which was variously midwives' use of research in practice (Meah et al 1996); midwifery role, retention and autonomy (Robinson 1989, Robinson and Owen 1994, Brodie 2002, Pollard 2003, 2005); midwifery involvement in medical education (Harman et al 1998); general practitioners' (GPs) and health visitors' views of community-led maternity care and of team midwifery (Fleissig et al 1997, Farquhar et al 1998, 2000); women's choice and homebirth (Davies 1997, Hosein 1998, Levy 1999, Hagelskamp et al 2003); the provision of antenatal care (Haertsch et al 1998); women's perceptions of maternity care (Fraser 1999); the effects and extent of perinatal litigation (Symon 1998, 1999); the interface between lay and medically-oriented approaches to maternity care (Hinojosa 2003); the extension of the midwifery role in neonatal care (Lumsden 2005); and the use of complementary and alternative medicine (CAM) in midwifery practice (Adams 2006) (see Table 1).

The studies reflected the different contexts in which midwifery is practised in different countries. In the literature drawn from the UK, Australia and the USA, researchers focused almost exclusively on the relationship between medical practitioners and midwives. This is understandable, given the historical and current constraints imposed upon midwives by the long-standing hegemony of the medical perspective in these countries (Cassidy-Brinn et al 1984, Kirkham and Perkins 1997, Grehan 2004). Nevertheless, considering the wide range of health and social care

**Table 1. Studies concerning interprofessional working in midwifery.**

<i>Year</i>	<b>Author(s)</b>	<b>Country</b>	<b>Main focus</b>	<b>Methods</b>
1989	Robinson	UK	Midwifery role	Quantitative
1994, 1999	Blais et al	Canada	Interprofessional relationships	Quantitative
1994	Green et al	UK	Interprofessional relationships	Qualitative
1994	Robinson, Owen	UK	Midwifery retention	Quantitative
1995	Cheyne et al	UK	Interprofessional relationships	Quantitative
1995	Hundley et al	UK	Interprofessional relationships	Quantitative
1996	Brownlee et al	UK	Interprofessional relationships	Qualitative
1996	de Veer, Meijer	Netherlands	Interprofessional relationships	Quantitative
1996	Meah et al	UK	Use of research in practice	Qualitative
1997	Davies	UK	Homebirth	Quantitative
1997	Fleissig et al	UK	Community-led maternity care	Quantitative
1997	Miller (et al)	USA	Interprofessional relationships	Multi-method
1998, 2000	Farquhar et al	UK	Team midwifery	Quantitative
1998	Haertsch et al	Australia	Antenatal care	Quantitative
1998	Harman et al	USA	Midwives teaching medical students	Quantitative
1998	Hosein	UK	Homebirth	Qualitative
1998, 1999	Symon	UK	Perinatal litigation	Multi-method
1999	Anderson	UK	Interprofessional relationships	Quantitative
1999	Fraser	UK	Women's views of maternity care	Qualitative
1999	Levy	UK	Women's choice	Qualitative – grounded theory

**Table 1 (continued). Studies concerning interprofessional working in midwifery.**

1999	Meerabeau et al	UK	Interprofessional relationships	Quantitative
2000	Bailes, Jackson	USA	Interprofessional relationships	Qualitative
2000	Redshaw, Harvey	UK	Interprofessional relationships	Multi-method
2001	Katz, Katz	Canada	Interprofessional relationships	Quantitative
2002	Brodie	Australia	Midwifery role	Quantitative
2002	Gau et al	Taiwan	Interprofessional relationships	Quantitative
2003	Farmer et al	UK	Interprofessional relationships	Quantitative
2003	Hagelskamp et al	UK	Homebirth	Quantitative
2003	Hinojosa	Guatemala	Interface between lay and medically-oriented maternity care	Qualitative – ethnography
2003	Kornelson et al	Canada	Interprofessional relationships	Quantitative
2003, 2005	Pollard	UK	Midwifery role and autonomy	Qualitative
2005	Lane	Australia	Interprofessional relationships	Qualitative
2005	Lumsden	UK	Extension of the midwifery role	Qualitative
2006	Adams	Australia	Use of CAM in midwifery practice	Qualitative

professionals with whom UK midwives routinely interact, it is striking that so little literature exists concerning their relationships with non-medical colleagues. However, some attention was paid to the relationships between UK midwives and health visitors, obstetric physiotherapists and neonatal nurse practitioners (Farquhar et al 1998, Anderson 1999, Redshaw and Harvey 2000). Despite the frequency with which they are required to work together to provide comprehensive care for service users, no literature focusing on the interaction between UK midwives and social care professionals was found.

Midwifery practice was legalised relatively recently in Canada, and the Canadian studies unsurprisingly concentrated on those professionals most affected by the integration of midwifery into the established healthcare system, namely, obstetricians, family physicians providing maternity care, and obstetric or perinatal nurses (Blais et al 1994a, 1994b, 1999, Katz and Katz 2001, Kornelson et al 2003). By contrast to many western countries, both midwives and family physicians in the Netherlands independently provide primary maternity care to women with uncomplicated pregnancies. The relationship between these two professional groups was of interest to de Veer and Meijer (1996). In Taiwan, midwives lack the professional education which their western counterparts enjoy, and consequently their role only entails assisting medical personnel (lay midwifery has virtually disappeared) (Gau et al 2002). In Guatemala, midwives are mostly non-professional women with knowledge and skills gained through experience and apprenticeship to other lay midwives<sup>1</sup>; they have some rudimentary westernised training, which allows them to be licensed to practise, but only work in domiciliary settings (Hinojosa 2003). These last two studies focused on how lay midwives interface with, and are regarded by, accredited healthcare professionals.

Various research approaches were used across the studies, encompassing quantitative, qualitative and multi-method designs. Nineteen studies involved the

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<sup>1</sup> It is sometimes stated that there is no such thing as a 'lay midwife', and that any birth practitioners without formal westernised midwifery education should be termed 'traditional birth attendants' (TBAs). This is irrespective of their actual knowledge and skills, their history and/or practice of attending birthing women, and whether or not they call themselves 'midwives', or are regarded by their communities as such (Daviss 2006). I personally think that this reveals an extraordinarily arrogant attitude towards other cultures, so I prefer to continue to use the term 'lay midwife'.

collection of quantitative data through the administration of questionnaires and surveys (see Table 1). These studies varied from large national projects with over 1000 participants (Robinson 1989, Blais et al 1994a, 1994b, 1999, Meerabeau et al 1999) to small studies with less than 50 participants (Cheyne et al 1995, Farquhar et al 1998, 2000). Some researchers did not provide readers with information about their response rates (Cheyne et al 1995, Hundley et al 1995, Davies 1997, Harman et al 1998, Brodie 2002). However, most of the other studies achieved a response rate of at least 60%, and only two projects reported rates lower than 40% (Gau et al 2002, Kornelson et al 2003). Only six (sets of) authors provided readers with details concerning the development of their study instrument, in which cases it was based on focus group (Kornelson et al 2003) and interview data (Blais et al 1994a, 1994b, Cheyne et al 1995, de Veer and Meijer 1996), a Nominal Group Technique exercise (Anderson 1999) and a literature review (Robinson and Owen 1994). In all the quantitative studies, the approach precluded in-depth exploration of relevant issues.

The 12 qualitative studies (see Table 1) also varied in size, ranging from the case study concerning two midwives and one obstetrician conducted by Bailes and Jackson (2000) to Green et al's (1994) study involving approximately 140 professionals in six NHS maternity units. However, between ten and 30 individuals participated in most of these projects, while two studies involved approximately 40 participants (Fraser 1999, Lane 2005). Data were collected through individual interview, except for Bailes and Jackson (2000), who drew on recollections concerning their own practice; Meah et al (1996), who conducted focus groups; and Hosein (1998), who collected written data through an open-ended questionnaire. Green et al (1994) also collected observational data. Methodological approaches were not specified, except for Levy's (1999) grounded theory study and Hinojosa's (2003) ethnographic research. Two qualitative studies involving approximately 20 participant interviews were conducted to explore issues arising from previous quantitative projects (Miller 1997, Miller et al 1997, Symon 1998, 1999). Redshaw and Harvey (2000) conducted a multi-method study, in which 190 questionnaires and ten shift diaries were completed.

Much of this literature is superficial and lacks a strong theoretical component. However, findings were generally consistent between the studies, and agreed with those from research into interprofessional working in other areas of health and social care (see below). For example, power differentials between different

occupational groups (Brodie 2002) and overlapping areas of practice (Farquhar et al 1998) could cause problems.

### **Interprofessional working in health and social care**

It is widely believed that effective interprofessional working is a prerequisite for the successful delivery of modern health or social care. This need has been discussed for at least 40 years, with early reports concerning collaboration between nurses and other healthcare professionals appearing in the USA (Henderson 1966). As long ago as the late 1970s, WHO identified interprofessional collaboration as an essential component in satisfactory service delivery:

Primary healthcare . . . relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

(WHO 1978, p.5)

Particular benefits for service users arising from effective interprofessional working are thought to be continuity of care, co-ordination of treatment and consistency of advice and information (Øvretveit et al 1997, Warde and Bunker 2001, Kesby 2002, Davis and Greenwood 2005). Interprofessional working has also been regarded as a strategy for maximising resources in increasingly stretched services (Fowler et al 2000).

The failure of care professionals to work together effectively can have serious consequences. In reports of high-profile cases in the UK, poor interprofessional collaboration has been identified as contributing to fatal outcomes for both service users and members of the general public (DH 1994a, Kennedy 2001, Laming 2003). Particular problems identified include lack of communication, inequitable relationships between different professional/occupational groupings, and misunderstanding of professional roles and spheres of responsibility.

Interprofessional working in health and social care is actively promoted at governmental level in the UK and elsewhere (see, for example, Romanow 2002, DH 2003a). In the UK, the drive for interprofessional collaboration in health and social care has been reinforced through the 'policy imperative of collaboration' (Meads and

Barr 2005, p.123). For example, nursing students are now explicitly expected to acquire relevant competencies as a condition of qualification and professional registration (NMC 2004a). One notable effect of this situation is that inter-professional learning opportunities are increasingly being included in undergraduate health and social care curricula, in order to equip the future workforce with such competencies (Barr and Ross 2006).

However, it is not only newly-qualified individuals who are required to develop these competencies. UK policy initiatives have promoted interprofessional working even more directly, through the introduction of National Service Frameworks (NSFs). Each NSF targets a particular area of care, and outlines agreed standards for best practice. NSFs are based on the concept of integrated care, in which professionals and other workers collaborate across different sectors in the interest of the target group (Meads and Barr 2005). Maternity care has been placed under the umbrella of services targeting health and social care for children (DH and Department for Education and Skills (DES) 2004).

Conflict between different approaches to birth, as described above, can lead to difficulties in working relationships involving different professionals involved with maternity care. Such difficulties are not, however, restricted to this area of healthcare. Despite the evident need for effective interprofessional collaboration and widespread commitment to its advancement, the process of developing satisfactory systems for its operation has proved problematic in many areas.

Initiatives have been diverse, ranging from the creation of inter-agency and cross-boundary groupings of professionals, carers and users in the community, to developing areas of common expertise among professions traditionally enjoying rigid role demarcation (Harris and Redshaw 1998). However, the implementation of interprofessional working has been fraught with problems in many areas, partly due to inconsistencies in inter-organisational structures, lack of resources, and lack of enthusiasm on the part of staff involved (Fowler et al 2000, Elston and Holloway 2001). Many health and social care staff, while in principle approving of the delivery of integrated care to service users, in practice appear anxious about changing their working structures, which they perceive may result in loss of power or status, erosion of professional role, and an increasing workload tied to decreasing resources (Biggs 1997, Elston and Holloway 2001).

There is evidence that effective interprofessional collaboration enhances the professional role, and increases job satisfaction (Cook et al 2001). However, a number of factors actively mitigate against effective collaboration. Individual professions and occupations have their own histories and their own values, which can cause problems when representatives from different professions try to work together, as they may disagree about which aspects of care need prioritising (Barrett and Keeping 2005). Overlapping areas of practice, combined with encroachment on, and/or blurring of, boundaries between different professional/occupational groups can lead to interprofessional tensions (see, for example, Booth and Hewison 2002, Rushmer 2005, Carmel 2006). Due to historical and other reasons, different professions enjoy different social status: this can make it difficult for the concerns of members of one profession to be heard by another. Nursing and medicine are an obvious case in point, and many authors have documented the effect of power differentials on the relationship between these two disciplines (see, for example, Wicks 1998, Cook et al 2001, Kennedy 2001, Coombs and Ersser 2004, Daiski 2004).

Power differentials also affect the way that professionals work with non-professional colleagues. An important factor that needs consideration is the role of support workers (such as healthcare assistants or nursing auxiliaries) and administrative staff in the provision of healthcare. Although the word 'interprofessional' implies collaboration between qualified professionals, a more flexible interpretation of this word is often needed. In most healthcare settings, the contribution of support workers and administrative staff is an integral part of care provision, and their inclusion in collaborative processes is essential for effective care delivery (Ketefian 2001).

The organisation of services can also impact detrimentally on interprofessional working. In particular, in NHS institutions, communication between different groups often depends on various complex and non-integrated systems of record-keeping, as well as unpredictable engagement in sporadic face-to-face encounters (Reeves and Lewin 2004, Pollard et al 2006). Work which has studied UK health and social care organisations from an interprofessional perspective has identified communication and power relationships as two of the most influential factors determining the quality of collaboration in a particular setting (see, for example, Øvretveit et al 1997, Cook et al 2001, Miller et al 2001, Coombs and Ersser 2004, Lingard et al 2004). In an exploration of concepts relating to collaborative working,



D'Amour et al (2005) identified the relevance of 'sharing', 'partnership', 'interdependency' and 'power'. The first three concepts all arguably depend on the nature of power relationships and the quality of communication between all parties involved in collaborative endeavour.

The degree to which individuals can participate in interprofessional working in a way which is meaningful to them is undoubtedly important. The concept of 'parity' (as opposed to 'equality') has been invoked in this regard:

Parity requires, and is fostered by, participation and involvement which ensures that people have some real say in decisions which affect their work. Meads and Ashcroft (2005, p.21)

These authors also argue that 'commonality' of purpose is required for effective interprofessional working, that is, the professionals involved must share a common aim, and must also agree about how these aims are to be achieved (Meads and Ashcroft 2005, p.22). These contentions carry obvious implications for maternity care: if professionals do not share a common perspective on childbirth or the appropriate delivery of care, the impact of power relationships and the quality of communication become even more significant.

### ***Factors affecting interprofessional working in midwifery***

There are reports in the research literature of midwives' enjoying good relationships with both medical and non-medical professionals (Green et al 1994, Brownlee et al 1996, Fleissig et al 1997, Miller 1997, Anderson 1999, Blais et al 1999, Bailes and Jackson 2000, Redshaw and Harvey 2000, Katz and Katz 2001, Kornelson et al 2003, Pollard 2003, Lumsden 2005). However, in some of these studies this only applied to a minority of participants (Green et al 1994, Fleissig et al 1997, Blais et al 1999, Katz and Katz 2001, Kornelson et al 2003, Pollard 2003). Problematic relationships between midwives and other healthcare professionals were far more commonplace, as was also illustrated elsewhere (Robinson 1989, Robinson and Owen 1994, de Veer and Meijer 1996, Meah et al 1996, Davies 1997, Farquhar et al 1998, Hosein 1998, Fraser 1999, Levy 1999, Meerabeau et al 1999, Symon 1999, Farquhar et al 2000, Brodie 2002, Gau et al 2002, Farmer et al 2003, Hinojosa 2003, Lane 2005, Adams 2006). Specific factors which influenced the way in which midwives' interprofessional working was framed included the dominance of the

medical profession, different approaches to childbirth, contested areas of practice and understanding of others' professional roles.

### *The dominance of the medical profession*

The dominance of the medical profession was plain in studies such as Davies' (1997) survey investigating factors affecting 248 booked homebirths in England. She found that obstetricians and GPs changed booked homebirths to hospital births without consulting midwives providing antenatal care. Another UK example came from Meah et al (1996), who gathered focus group data from 32 midwives about their use of research in practice. These participants complained that they could not implement midwifery-based research findings, due to their subordination to medical practitioners.

In a survey exploring the views of 563 Australian midwives about barriers to practising midwifery, Brodie (2002) found that many respondents felt unable to provide midwifery care because of the dominance of the medical profession. In particular, many of them reported being unable to provide antenatal care to women, as this was the preserve of obstetricians and GPs. Participants stated that midwives could only implement a midwifery model of care if they were supported by medical staff and management. Adams (2006) interviewed 13 Australian hospital midwives who were using complementary and alternative medicine (CAM) in their midwifery practice. He found that midwives believed that obstetricians opposed the use of CAM because it threatened the medical dominance of midwifery practice.

Conflict between certified nurse-midwives (CNMs) and physicians in the USA, arising from perceived power inequities, was also reported by Miller (1997). However, she also found examples of good interprofessional practice between CNMs and medical practitioners. Miller used qualitative methods to explore different models of collaborative practice with 17 CNMs and five physicians who provided maternity care. Contributing factors for success appeared to be a willingness to address power issues, manifested by creating non-hierarchical structures and establishing rotating leadership of the professional team. Similarly, in UK maternity units where the traditional hierarchical structures were altered, Green et al (1994) observed effective interprofessional collaboration between midwives and obstetricians. In these units, midwives were not expected to defer to junior doctors. The aim of this study was to examine midwives' and obstetricians' roles and relationships in the context of different staffing structures.

Problems associated with hierarchy can also be implicated when midwives experience difficult relationships with non-medical colleagues, as Kornelson et al (2003) found in their survey of 340 perinatal nurses in British Columbia. This study's aim was to examine relationships between this group of nurses and midwives. A source of discontent for the perinatal nurses was the lack of hierarchical clarity between themselves and midwives; there was confusion about who should be taking orders from whom.

#### *Different approaches to childbirth*

Lane (2005) found that issues of control over practice were central to how Australian midwives and obstetricians viewed each other. She interviewed 20 midwifery managers, 20 midwives and eight obstetricians to explore how different approaches to childbirth and to professionalism impacted on collaboration between midwives and obstetricians. Different approaches to childbirth appeared to be important in this context, as some midwife participants thought that obstetricians encouraged women using the service to opt for greater medicalisation than necessary (for example, choosing to have epidural anaesthesia).

Where midwives enjoyed good working relationships with other colleagues, underlying factors appeared at times to include acceptance of the midwifery perspective concerning childbirth. For example, in their multi-method study involving 190 NHS practitioners who delivered neonatal care, Redshaw and Harvey (2000) found positive perceptions of interprofessional relationships between midwives and neonatal nurse practitioners (NNPs). The NNPs reported positive relationships with the midwives, who considered that the NNPs offered them valuable support, particularly in at-risk and emergency situations. Of particular value was the fact that the NNPs were perceived to have a 'midwifery perspective'; the implication is that this contrasted with a 'medical perspective', as the NNPs' involvement in maternity care was in areas traditionally the province of paediatricians, such as examination of the newborn and emergency neonatal resuscitation.

Blais et al (1994a, 1994b, 1999) conducted a survey among approximately 1400 maternity care professionals prior to the legalisation of midwifery in Quebec. A main focus of the survey was to discover what representatives from different groups thought about the regulation and scope of midwifery practice. This study revealed that health professionals who supported the idea of woman-centred care, and/or

who were open to women giving birth in non-medicalised settings, were more likely to be favourably disposed towards midwives and midwifery practice. Similar findings arose from the studies conducted by Miller (1997) and Kornelson et al (2003). In the latter study, the converse was also found to apply, in that many respondents who were against women giving birth at home also mistrusted midwifery practice.

Different approaches to birth may also give rise to different professional priorities. Farmer et al (2003) surveyed 121 midwives' and 117 GPs' perceptions of their own and each others' roles in the provision of antenatal care in rural areas in Scotland. Most practices offered 'shared care' to pregnant women, that is, care delivered by both the GP and the midwife. GP respondents reported that the most important factors affecting the organisation of care were logistics and resources; in contrast, midwife respondents considered that the requirements of holistic woman-centred care, in which the women's wishes are paramount, should be the yardstick for care provision. This difference in priorities may have also depended on the professionals' differing levels of financial responsibility and accountability for the service delivery.

#### *Contested areas of practice*

As in the wider healthcare arena, problems concerning overlapping roles and areas of care can arise in maternity care. Midwives are supposed to be experts in the care of women experiencing 'normal' pregnancy and birth, only referring to obstetricians in the event of complications (the 'abnormal') (NMC 2004b)<sup>2</sup>. However, of the 333 obstetricians who participated in Robinson's (1989) national survey to determine the role and responsibilities of the midwife, and the 20 obstetricians who took part in Cheyne et al's (1995) study to discover their attitudes to working alongside a midwife-led unit, more than 80% insisted on participating in the care of all childbearing women (no more recent research concerning this topic in the UK appears to exist). Similar findings have come from other countries, including the Australian survey of 250 midwives and 250 obstetricians concerning involvement in antenatal care, conducted by Haertsch et al (1998), and the survey of 78 Taiwanese

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<sup>2</sup> This distinction between 'normality' and 'abnormality' will be discussed in more depth later in the thesis.

obstetricians conducted by Gau et al (2002), concerning their willingness to collaborate with midwives.

Obstetricians are not the only professional grouping with whom midwives share areas of care. Farquhar et al (1998) surveyed 42 health visitors' views about community-based midwifery teams. Some were unhappy that midwives were not giving women the same advice about infant care and breastfeeding as they were. In Farmer et al's (2003) study, GPs and midwives disagreed about who should be responsible for co-ordinating the 'shared care' model; moreover, in practices where both the GP and the midwife had responded to the questionnaire, there was often confusion about who was actually co-ordinating care, with both professionals reporting themselves as the main point of reference for their clients.

Interestingly, where different non-medical practitioners achieve competency in an area previously the monopoly of the medical profession, it appears that the relationships between them can be mutually supportive, even if their practice does overlap. Collegial relationships between midwives and NNPs were reported by both Redshaw and Harvey (2000) and Lumsden (2005), who interviewed ten midwives about their expanded role in neonatal care.

Where there are no contested areas of care, interprofessional interaction can be relatively straightforward. No conflict was apparent in a study of relationships between midwives and obstetric physiotherapists, in which Anderson (1999) surveyed 40 practitioners from each profession to discover how accurately they perceived each other's roles. Interaction between these groups appeared to be limited to referral requests.

#### *Understanding of others' professional roles*

Another factor contributing to interprofessional difficulties in midwifery may be a lack of knowledge about the midwife's role and scope of practice (Brodie 2002). For example, only 52% of the 432 nurses in Manitoba who participated in a survey about their perceptions of the midwife's role were aware of the nature and extent of midwifery practice (Katz and Katz 2001). Conversely, where professionals have this knowledge, they may be more favourably disposed towards midwifery practice (Miller et al 1997, Blais et al 1999, Katz and Katz 2001, Kornelson et al 2003).

Familiarity does not automatically appear to facilitate interprofessional knowledge in the UK. In research exploring the midwife's role and changing educational needs, in which data were gathered from approximately 1400 maternity care professionals, Meerabeau et al (1999) found that many obstetric registrars thought that midwives lack confidence, and many GPs thought that midwives are not willing to take responsibility, because they ask for medical assistance when problems arise. Despite regularly working alongside midwives, these respondents displayed ignorance about UK midwives' mandatory obligation to refer to suitably qualified professionals in the case of any 'abnormality'<sup>3</sup> (NMC 2004b). Similar findings came from Brownlee et al's (1996) study, where 20 midwives and 15 obstetricians were interviewed about interprofessional relationships on a labour ward in a large obstetric-led unit.

It appears that midwives too are ignorant of colleagues' professional roles and obligations. Of 22 midwives surveyed by Hagelskamp et al (2003) to investigate attitudes and practices regarding homebirth, 95% erroneously thought that GPs should attend a homebirth if requested to do so. Responses from the health visitors surveyed by Farquhar et al (1998) revealed some ignorance concerning the structures within which community midwives work; however, these respondents also felt that many midwives did not understand the health visitor role. In Anderson's (1999) study, neither the midwives nor the physiotherapists were aware of the extent of each other's role.

### **Power relationships and communication in midwifery**

While it is encouraging to see positive examples of interprofessional collaboration reported in the literature, the available research indicates that problematic relationships between midwives and other colleagues, particularly medical practitioners, is considerably more commonplace. The influencing factors identified above, namely, medical dominance, different approaches to childbirth, contested areas of practice and understanding of others' professional roles, all appear to be affected by local and wider power issues, as well as the quality and forms of communication used between the different professionals involved. The fact that so much of the literature in this area focuses on midwife-obstetrician relationships

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<sup>3</sup> See footnote on p.20

indicates the significance to midwifery of the power differential between these professions<sup>4</sup>.

Communication between midwives and other medical professionals can also be problematic. Fleissig et al (1997) found that fewer than 50% of the 102 GPs surveyed about community-led maternity care thought that they enjoyed 'good' communication with the midwives linked to their practices, and 17% did not realise that a midwife was linked to their practice. Slightly more encouraging results were found in a similar study conducted by Farquhar et al (2000), whose survey revealed that 60% of the 49 GPs who participated thought that communication from their linked midwives was adequate; however, 37% of them did not know the names of the midwives linked to their practice. It should also be noted that, in other studies, GPs considered their communication with midwives to be good, when the midwives clearly perceived problems within the relationship (Davies 1997, Farmer et al 2003).

In a study to explore views concerning interprofessional relationships in connection with perinatal litigation, Symon (1999) interviewed 24 maternity care professionals, four legal personnel and three representatives from service user groups. One of the latter spoke of a 'culture clash' between the midwives and the obstetricians. Fraser (1999) conducted a qualitative study to determine how competence in midwifery might be defined from the perspective of women using the service, of whom 42 were interviewed on three separate occasions. Three respondents in this study were disturbed by what they perceived as inappropriate attitudes between professional groups providing their care. Fraser found that service users expected a 'partnership' relationship between midwives and medical personnel, and were disturbed by evidence of interprofessional conflict.

Communication can also be difficult between midwives and non-medical healthcare professionals. In the study conducted by Farquhar et al (1998), all 42 health visitors had midwives linked to their practice: however, four reported that they did not know whether or not they had a linked midwife, while nine thought that they did not. The health visitors identified poor communication between the midwives and themselves as a major problem.

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<sup>4</sup> This issue will be discussed in more depth in Chapters 3-5.

The research literature therefore supports the view that unequal power relationships and poor interprofessional communication are commonplace in maternity care. Although there has been little analysis of relevant micro-level factors, resulting difficulties for midwives in their professional lives have been amply reported and discussed (see, for example, De Vries et al 2001, O'Loughlin 2001, Kirkham and Stapleton 2004). Of even more concern, poor interprofessional working within the maternity services is associated with negative and even fatal consequences for women and their families (Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) 2001, Confidential Enquiries into Maternal and Child Health (CEMACH) 2004, Revill 2004, Robertson 2004). Any exploration of interprofessional working in midwifery therefore entails exploration of a situation which is often socially problematic. It therefore seems appropriate to adopt a critical perspective when conducting research on this topic, so that contributing factors and mechanisms concerning its continuation may be both identified and better understood.

### **Developing a theoretical approach concerning the relationship between communication and power in midwifery**

The wider body of literature concerning interprofessional working in midwifery lacks a strong theoretical component. Despite the identification of power and communication as relevant issues in the wider context, there have been only sporadic attempts to locate their operation in midwifery within a broader theoretical corpus. Where this has been done, the focus has been on ethnographic or anthropological analysis (Kirkham 1987, Kitzinger 1989) or on social theories of gender and medicalisation (Oakley 1984, Witz 1992, Van Teijlingen et al 1999).

A complementary approach may be to explore the relationship between communication and power. It can be argued that methods of communication and language use reflect and maintain power relationships (Fairclough 2001a). This was clearly illustrated by Wicks (1998) in her ethnographic study of nurses and doctors at work. It has also been noted that where participants are not considered to have equal social status, asymmetric linguistic structures arise (Tannen 1994, 2001). So for example, some obstetricians and senior midwives refer collectively to other midwives who work in the same institution as 'girls' (Mander 1997, Kirkham 2000). There is no reciprocal term which midwives use to refer to obstetricians. In fact, in many maternity units, midwives still refer to senior obstetricians as 'Mr. So-and-so' (Pollard, personal observation). Both Mander (1997) and Wicks (1998) note how



difficult it is to challenge entrenched forms of communication which seem 'normal' to many actors involved in their use.

Anomalous opinions of GPs and midwives concerning their communication (Davies 1997, Farmer et al 2003) may be a product of the relationship between power and communication. Where members of a group feel that they are at a disadvantage, they may perceive communication issues differently from the members of the group appearing to wield greater power. In an evaluation of a post-qualifying module in communication skills, Tennant and Butler (1999) found that midwives' concerns with communication with medical professionals were focused entirely on assertiveness and confidence; conversely, their concerns about communication with women in their care hinged mainly around sensitivity and listening skills. There was no indication that the midwives considered the power differential between themselves and the women, nor the effect that this might have on the perceptions of their mutual communication. This again illustrates the asymmetric nature of communication when participants are not perceived as enjoying equal status (Tannen 1994, 2001). The more powerful actor in a communication exchange may be more likely to express satisfaction with it. Conversely, when this power is threatened, communication may be reported as unsatisfactory, as the case appeared to be with GPs having to adapt to restructuring of the community midwifery services (Fleissig et al 1997, Farquhar et al 2000).

A number of authors have highlighted the importance of language use in maternity care (see, for example, Kirkham 1987, Hewison 1993, Kirkham 2000, Hunter 2006). However, the focus has been mainly on communication between professionals and women using the service, or on how language affects the conceptualisation of birth itself. There has been no in-depth study of language use and communication between midwives and other professionals, particularly at the micro-level.

Social factors underlying problematic interprofessional working in midwifery have been clearly identified and debated for the last 20 years (see, for example, Oakley 1984, Kirkham 1986, Witz 1992, Kirkham 1996). While this body of work has been of enormous value in providing ways of thinking about relevant issues, awareness of these issues does not appear to have resulted in significant improvements in this area in practice. I would argue that to shed more light on midwives' interaction with other professionals, a key area for exploration should be the link between communication issues and prevailing power relationships. I suggest, therefore, that

development to existing work should include study of how identified social factors relate to one another from a critical perspective and, in particular, how issues of language and communication at the micro-level contribute to the maintenance of the status quo. In the next chapter I shall discuss the theoretical basis for such an approach.

### **Chapter 3. Applying Critical Discourse Analysis to the study of interprofessional working in midwifery.**

There is a growing trend among healthcare researchers, especially those engaged in nursing research, to adopt discourse analytic approaches (Trayner 2006). However, discourse analysis (DA) does not constitute a unified scholastic field. Different types of DA are based on different theoretical approaches (Titscher et al 2000). DA can be considered to occupy a continuum, on one end of which conversation analysis (CA) can be found, and on the other, critical discourse analytic approaches (Titscher et al 2000, Trayner 2006). While CA has a main basis in linguistics and focuses on the minutiae of language use within a defined speech event such as a conversation, critical discourse analysts are concerned with language use in the wider social context, and have drawn on critical social theory to develop their approaches (Titscher 2000, Wetherell 2001a).

#### **Language and critical social theory**

The central importance of language to the social world is now accepted within critical social theory (Chouliaraki and Fairclough 1999). Conversely, consideration of social action has been placed at the centre of critical linguistic theory (Kress 2001). Critical discourse analysis (CDA), in which these foci fuse, seems eminently suitable for a study which is concerned with the play of power and communication between different occupational groups. (There has recently been a move among critical discourse analysts to rename the field 'Critical discourse studies' (Van Dijk 2004). For the sake of clarity, I will use the term 'Critical discourse analysis' throughout this thesis.)

At this point, it is necessary to consider again the term 'discourse', which has a number of definitions, depending on the context and theoretical location of its use. In linguistic theory, 'discourse' has a narrower definition than that given to it by social theorists (see p.7 above). A basic linguistic definition of 'discourse' is 'extended samples of either spoken or written language' (Fairclough 1992, p.3). Discourse analysts attempt to combine definitions from both social theory and linguistics: for example, Wetherell (2001b) defines 'discourse' as both 'language in use' and 'human meaning-making'. Language usually has a social purpose, which may concern the interaction itself, for example, requesting or thanking; or wider social activities, like trading or teaching. Human meaning-making applies in all

these cases: understanding of language contributes to and depends on speakers' understanding of social context. Language is influenced and shaped by the social; the meaning and form of language undergo constant change to reflect speakers' perceptions (Kress 2001). However, discourse analysts view language as both referential (it conveys meaning about particular topics) and constitutive. This means that language itself shapes perceptions of the topic under discussion (Taylor 2001c). So the combination of language in use and human meaning-making both constitutes and influences social interaction; 'discourse' in this sense can therefore be considered to be social action.

Related to the idea of discourse as social action is the notion of a 'discursive event', considered by Fairclough (1992) simultaneously to comprise three distinct dimensions: the production of a 'text', the occurrence of 'discursive practice', and the influence of the local social context. A 'text' is understood to be a representation of social interaction. This may be purely linguistic, that is, the actual language used in speech or writing; or it may also involve other semiotic forms, such as non-verbal behaviours, silences and tone of voice. It may also include other media, such as music or visual images (Fairclough 1995). 'Discursive practice' is that element of the interaction which determines which wider discourses (in the sense used in social theory) have contributed to the production of the 'text'. The third element, that is, the local social context, also affects discursive practice, for example, the influence of the organisational context in which a discursive event occurs (Fairclough 1992).

For the sake of clarity, I shall follow the schema devised by Fairclough (1992) when referring to 'discourse'. 'Discourse' without an article will refer to the three-dimensional use of language and other semiotic forms as outlined above; while 'discourse' with an article, or in the plural, will refer to its wider use as defined in social theory.

CDA theorists consider that a 'transdisciplinary' approach is required to make sense of the complexity of the social world and its related behaviours (Chouliaraki and Fairclough 1999, Titscher et al 2000). CDA is therefore considered to operate in relation to a field of critical social research, rather than to be focused on, or contributing to, a particular social theory. It has accordingly drawn on an eclectic mix of theory during its development, including neo-Marxism, Bakhtin's linguistic theory of ideology, Halliday's system of functional linguistics and Foucault's concepts of power and discourse (Titscher et al 2000).

## **Theoretical underpinnings of Critical Discourse Analysis**

The development of CDA has been partially based on Marxist views of social inequality, in which a central notion is that idealised workers are prevented from realising their full potential as human beings, because those with greater social power (mainly economic) oppress and exploit them by controlling their labour (du Gay 1996). Proponents of CDA do not generally subscribe to this notion; however, they have been influenced by the idea that social/cultural factors shape power relationships and that social practices (established social behaviours or activities) are related to ideologies; and they have derived much of their political stance, that is, their concern with power and inequalities, from the Marxist traditions (Titscher et al 2000, Wetherell 2001a).

The structuralist tradition which held sway in linguistics during the early years of the 20<sup>th</sup> century regarded language as an abstract 'transparent' system serving merely to reflect speakers' perceptions of reality. In this conception, language simply provides a repertoire from which speakers choose, and which is unaffected by them. This assumption was challenged by later scholars who asserted the interrelatedness of language and social factors, and particularly the centrality of the latter (Kress 2001).

The Russian linguist Bakhtin claimed that all language use is ideological, always carrying social/cultural values and connotations. Moreover, he posited that there is ongoing tension within language use, as different social forces modify or re-assign meaning to words and the way that they are used. This implies that language in use always refers to previous or wider language use, a feature known as intertextuality. Bakhtin also maintained that speech is organised into patterns, which he termed 'genres', according to its social function. So, for example, the speech genre for a business transaction has its own accepted vocabulary, rhythms and patterns of speech (Titscher et al 2000, Maybin 2001).

Bakhtin insisted that language should be studied in context (as opposed to being viewed as an abstract system), arguing that the social forces operating within its use can then be revealed. CDA has adopted this principle and the concepts of intertextuality and genres, as well as subscribing to the idea that language always carries social/cultural connotations.

Halliday (1978) theorised that language in communication is structured according to at least three functions: the ideational, the interpersonal and the textual. The ideational function is that component of language which represents the speaker's experience of the external world, or of his/her own internal world. The interpersonal function is that component of language which pertains to the relationship between those participating in a communicative event. The textual function is that component of language which structures the way that the communication is actually expressed (Halliday 1978, Kress 2001). This view of language as being multi-functional allows for the conceptualisation of discourse as both linguistically and socially operational. This was a major consideration for its influence on the development of CDA, as it enables the investigation of both the way that language is shaped by social factors and, conversely, how it in turn shapes the social (Fairclough 1995). This is of key importance when considering the operation of power relationships within society from a CDA perspective.

In order to study the constitution and effectiveness of power relationships in society, CDA theorists turned to Foucault's concept of power (Titscher et al 2000). Broadly speaking, power has been conceptualised as either agentic, dispositional or facilitative over the last three centuries. A trajectory can be traced from Hobbes in the 17<sup>th</sup> century through to Lukes in the 1970s, during which a central, sovereign power was conceptualised in terms of causality and agency. This power was viewed as extending into all areas of its subjects' thoughts and consciousness, giving rise to the problem of hegemony. The concept of power located primarily in a central entity necessarily negates the power of its subjects (Clegg 1989).

Since the 1970s, an abiding concern for theorists considering power has been the relationship between agency and structure. Giddens (1984) developed a theory of 'structuration', in which social structures acted upon subjects (agents) who in turn acted upon them, thereby instantiating them. Giddens viewed power as dispositional, that is, he equated it with a set of capacities. In this perspective power is not necessarily repressive, but is a medium for possible liberation. Giddens defined power in terms of agency, and agency in terms of action, which in turn was defined as power (Clegg 1989, Wicks 1998).

Foucault embraced a facilitative theory of power, in which power is equated with the ability to achieve goals, and is productive of knowledge. A Foucauldian concept of power sees it as being located in a network of alliances and social practices. This

network varies along a continuum of stability/instability, depending on local conditions and actors. A key point of this conception of power is that a network always contains the potential for points of resistance to power (Clegg 1989, du Gay 1996).

Foucault's conception of power is commonly criticised as being too diffuse, and some scholars have been uneasy with his apparent relativism (see, for example, Sawicki 1991). However, the Foucauldian analysis of power has remained influential among social theorists. Clegg (1989) maintains that, rather than dissolving all fixed points, Foucault posits the dissolution of the idea that there can be any points which are fixed outside of discursive practices. The exercise of power is then seen to involve using knowledge to structure and fix representation, rather than there being one 'accurate' representation; the normalisation of knowledge is thus an accomplishment of power, which is then either maintained or resisted through discursive practices.

Laclau and Mouffe (1985) addressed the problem of the diffuse nature of the Foucauldian concept of power by focusing on the fixed nature of representation which arises through the consistent exercise of power; moreover, they insist that there are no fixed, real, hidden or excluded dimensions that are not apparent in such a representation. For these authors power is then equated with the overt normalised organisation of existence, which is fixed and represented through multifarious discursive forms and practices. This view is endorsed by Clegg (1989, p.184):

'. . . the central feature of power consists in this fixing of the terrain for its own expression.'

Crucially, Foucault contended that every discourse is historically situated: knowledge, language and social practice concerning a particular social issue depend on the historical context in which the discourse develops (Foucault 1972, 1973). This is a view which aligns with the CDA approach, which maintains that discourse (in Fairclough's three-dimensional sense) can only be understood within the wider social context (Titscher et al 2000). For CDA theorists, discursive elements of social practice constitute strategies whereby systems of social intercourse are maintained. CDA enables the examination of these practices with

the aim of revealing the strategies utilised, and the underlying power relationships that give rise to them (Fairclough 2001b).

### **CDA, power and interprofessional relationships in midwifery**

Interprofessional relationships in midwifery can be the site in which different professionals play out their desire to establish or maintain positions of power. This was illustrated by Blais et al (1994a), in whose study all the respondents suggested that the new body regulating midwifery practice in Quebec should be composed in such a way that their own profession gained the most power and control. Similarly, Meerabeau et al (1999) reported that obstetric consultants in the UK thought that midwifery autonomy would be detrimental to team working but medical autonomy would not, because they assumed that doctors would be the team leaders.

With their concern for social problems, CDA theorists focus on social situations as illustrations of the operation of power relationships (Van Dijk 2001). Their adoption of a Foucauldian theory of power allows for consideration of individuals' capacity to contribute to changing or reinforcing established power relationships. When considering power relationships in midwifery, a key issue to consider is the effect of the normalisation of the medical discourse concerning childbirth. This is apparent in the way that some midwives support this discourse, and subordinate themselves to it. In Lane's (2005) study, midwifery managers stated that 25-50% of midwives preferred to practise in a medically-dominated organisation, to avoid having to take responsibility for their own practice. Similarly, participants in Brodie's (2002) research reported that many midwifery colleagues were not eager to embrace a holistic approach to midwifery and birth.

More subtle illustrations of the effects of the normalisation of this discourse can be found in the way that midwives sometimes claim a degree of autonomy in their practice that is contradicted by other evidence. For example, Robinson (1989) found that midwives reported making independent clinical decisions, when in fact they were simply practising alone according to medically-determined policies. A similar finding arose in a study exploring midwives' perceptions of their professional autonomy, in which I interviewed 27 midwives (Pollard 2003). However, challenges to the normalisation of the medicalisation discourse are also apparent in the literature: relevant strategies include the promotion of homebirth as a safe option (Davies 1997), the support for women's choice of non-medicalised care (Pollard 2005), and the incorporation of CAM into midwifery practice (Adams 2006).



The literature also reveals how professionals have harnessed the current emphasis on placing service users at the centre of care as a discursive strategy either to reinforce or challenge the medicalisation of birth. So highlighting the danger to which women would ostensibly be exposed through midwifery practice or homebirth reinforces the medicalised 'controlling' discourse; while the need to respect women's wishes aligns with the holistic 'supportive' discourse. This does not mean that professionals deliberately deploy these strategies; rather, it illustrates how normalisation of specific discourses contributes to, and is reinforced by, discursive practice (Fairclough 1992).

It is also worth considering the concept of 'disciplining power', which Foucault (1977) considered to be one of the defining features of the 19<sup>th</sup> and 20<sup>th</sup> centuries. This is power that, through surveillance and assessment of individuals,

. . . disciplines the body, regulates the mind, and orders the emotions in such a way that the ranking, hierarchy and stratification which ensues is not just the blind reproduction of a transcendent traditional order, as in feudalism . . . (Clegg 1989, p.153)

These techniques of power arose in prisons, and spread through schools, the army, hospitals and factories, being constituted through discursive institutional and organisational practices. 'Disciplining power' is very close to 'hegemony' as a concept, but incorporates the normalisation of hierarchies and stratification through practices which result in members of the organisation actively 'policing' themselves and others, rather than merely accepting the status quo (Clegg 1989).

In the UK midwifery is officially allied with nursing through regulation by the NMC, and most midwives have been nurses at some point in their careers (Jowitt 2000, Wilkins 2000). Given the close links between these two occupations, it is useful to examine power relationships within nursing when thinking about power relations within midwifery. The organisation of nursing in the UK in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries combined aspects of the military model with the perception that nurses were socially comparable to domestic employees 'in service'; hence the wearing of uniforms and a hierarchical 'chain of command' (Dingwall et al 1988). If we consider nursing's relationship to the army, we can see that 'disciplining power' has been extremely effective – nursing internalised qualities such as tidiness and uniformity as being necessary for the effective care of the ill. This resulted in practices such as

producing 'hospital corners' and pillows all facing in the same direction, and prioritising the neatness of the environment above the wishes of service users, especially when authority figures such as medical consultants or matrons were likely to be present. Although this system is changing, as alternative discourses arise concerning appropriate environments for care, its remnants can be seen in everyday practice: for example, some staff in maternity units where I worked expressed distaste or irritation when relatives of service users from ethnic minorities brought food onto a ward. These staff appeared to view this practice in terms of contamination of the environment, rather than in terms of social support (Pollard, personal observation).

Other effects of 'disciplining power' are evident in the way that some midwives restrict their practice and police each other and themselves in order to reinforce the norms of the dominant medical discourse concerning childbirth. For example, in a study exploring 28 midwives' attitudes to homebirth, Hosein (1998) found that, even if they thought that giving birth at home was a viable option for women, midwives did not offer them this choice when GPs did not support it. The same finding occurred when Levy (1999) interviewed 12 midwives in order to explore issues affecting their provision of information to pregnant women. Midwives who support women in receiving non-medicalised care can sometimes be treated with disapproval and hostility by their midwifery colleagues (Pollard 2005).

'Disciplining power' can be linked to the phenomenon of 'horizontal violence'. This is defined as behaviour associated with oppressed groups, whose members behave aggressively towards one another in reaction to their systematic exclusion from power (Robertson 2004). 'Horizontal violence' is increasingly mentioned in midwifery literature (Leap 1997, Kirkham 1999, Morison 2001, Dimond 2002, Robertson 2004). It is clear that some NHS midwives do identify themselves as members of an oppressed group (Davies 1997, Levy 1999, Pollard 2003).

The examples of midwives' behaviour given above reveal how individuals' discursive practice relates to the operation of power in both current and historical social contexts. CDA's chief interest is in how such power relationships are either challenged or reinforced through discourse, which is always related to social/cultural ideologies, and therefore always reflects a particular orientation to prevailing power relationships. I suggest that by incorporating this perspective into a study of interprofessional relationships in midwifery, it becomes possible not only to identify

and explain the operation of power within that context, but also to illustrate how communication issues (in the widest sense) contribute either to the maintenance or the changing of the status quo. This in turn can help to locate a theoretical understanding of the issues involved in interprofessional working in midwifery within the wider body of social theory.

### **Other underlying factors affecting interprofessional working in midwifery**

In this and the previous chapter, I have outlined some issues known to influence the quality of interprofessional working in health and social care, with a particular focus on power relationships and communication. I have also suggested drawing on CDA in order to theorise the operation of power and communication in midwifery in relation to each other. However, there are a number of other factors which also impact on relationships between professionals in the maternity services, in particular, gender, issues of professional identity, and the influence of the wider social context. In the next two chapters, I shall therefore broaden the discussion concerning the theorising of interprofessional working in midwifery.

## **Chapter 4. Gender issues and interprofessional working in midwifery.**

When considering the midwifery profession, it must be remembered that most midwives are women (NMC 2005), and although midwives may give information, advice and support to male partners and relatives, midwifery practice directly targets only women and newborn babies. Moreover, the focus of midwifery practice is a process which defines women both biologically and socially. Not all women give birth, but the social norm assumes that, in the absence of pathology, women possess the physical organs which bestow the potential for becoming pregnant, giving birth and nurturing offspring, and men do not.

In this chapter I shall therefore consider issues of gender, particularly in relation to professionalism and the historical development of midwifery. For this purpose, I have turned to feminist and post-modern sociological theory. By drawing on this theory in this context, I consider that I am continuing the 'transdisciplinary' tradition espoused by CDA scholars (Chouliaraki and Fairclough 1999, Titscher et al 2000).

### **Gender**

Gender is in essence a cultural artefact, a simplistic view of which equates it with the physical body. In this view, people are assigned to one of two genders and assumed to behave accordingly, that is, physical males are 'masculine' in behaviour, and physical females are 'feminine' (Adkins and Lury 1996). As the notion of gender is culturally determined, it has been assigned various attributes in different times and different societies: in the western world, these attributes have traditionally been conceptualised as binary opposites, for example, masculine/feminine, strong/weak, etcetera (Annandale 1998, Miers 2000). Moreover, 'masculine' attributes have generally been assigned positive social value, while many 'feminine' attributes have been distrusted as socially aberrant and leading to behaviour requiring male control (Annandale 1998). The belief that these attributes describe a natural order has been used to justify societal divisions, particularly in the world of work, both in the private and public spheres (Davies 1992, Adkins 1995, Adkins and Lury 1996, Annandale and Clark 1996).

A problem with this system is that it denies the reality that members of both sexes exhibit characteristics and behaviours traditionally denoting the 'other'.

Consequently, many writers now maintain that to think in terms of gender attributes is both unhelpful and unrealistic (Davies 1992, Annandale 1998, Miers 2000).

During the 1990s, the post-modern turn in sociology resulted in a broad reconsideration of the issue of gender, particularly among feminists. There has not been a unified approach to the problem of conceptualising gender in the feminist tradition. Positions have varied considerably, particularly with regard to the relationship between sex/sexuality and gender (Adkins 1995, Annandale 1998). For example, liberal feminists have tended to see gender as a purely cultural artefact, so that sex and gender are not intrinsically connected; whereas radical feminists have insisted on a strong connection between sex and gender, with a positive valuing of the female body (Oakley 1993, Annandale and Clark 1996). Post-structural feminist writers have suggested that, instead of reversing the hierarchy, as radical feminism does, it should rather be destabilised, so that particular values are not automatically assigned to fixed gendered characteristics. This approach studies gender in terms of gender relations, that is, in terms of how men and women interact in real situations; in these situations, gender becomes performance (Adkins and Lury 1996, Annandale and Clark 1996, Bradley 1999, Miers 2000). It is from this perspective that I prefer to conceptualise the issue of gender.

### **Gender and organisations**

Until the last decades of the 20<sup>th</sup> century, sociological studies of organisations regarded them to be gender-neutral; many analysts and theorists did not question the fact that most organisations are structured according to the Weberian ideal of abstract, neutral rationality, which was assumed to be the mode required to ensure that organisations achieve their purposes or carry out their functions (Witz and Savage 1992). However, there is a view that this mode is in fact gender-biased, and merely masks the fact that individuals' emotional and personal lives have an effect on the way an organisation functions:

. . . emotionality as an organizing principle is a dynamic that enjoys full citizenship in the life of organizations but not legitimacy in the organizational discourses either of organizations or of those that study them, because emotionality belongs to the symbolic universe of the female and is therefore devalued.

(Gherardi 1995, p.158)

In the gender-neutral perspective, disproportion between the numbers of men and women in powerful positions was seen as resulting from wider historical causes, rather than being an inherent feature of organisations themselves. However, writers from various feminist traditions have pointed out that, because the seemingly gender-neutral 'rational' ideal is in fact predicated on values associated with expression of the 'masculine', men set the standards through which success is defined (Davies 1992, Adkins 1995, Gherardi 1995, Witz et al 1996). In this view, as a woman is permitted access to higher levels of power, she becomes 'the outsider who enters an alien culture' (Gherardi 1996, p.190). Women often have to become 'honorary' men in order to maintain their position, that is, they have to adopt behaviours traditionally associated with being 'masculine', such as prioritising the public sphere over the private sphere and being unemotional in their personal interaction (Gherardi 1996). Many occupations have themselves been structured as 'masculine': for example, until recently, it was taken for granted that a normal part of a politician's role was to be available to attend sittings in Parliament until the small hours of the morning, with no intrusion from any domestic responsibilities. Another factor demonstrating the gendered nature of most organisations is that, in practice, the maintenance of 'masculine' roles and behaviours depends heavily on those in 'feminine' supportive positions. So the alpha-male behaviour found among many business executives, politicians, professionals and academics (men and women) relies heavily for its perpetuation on the support of secretaries, nurses and administrators, as well as domestic partners; these roles are, of course, most often (although not exclusively) filled by women (Davies 1992, Adkins 1995, Annandale and Clark 1996, Halford et al 1997).

Many post-structuralist writers insist that sex/sexuality should not be separated from the concept of gender, which they posit as being involved in the ongoing production of sexuality, and vice versa. So, for example, the subordinate position of women and the embedded sexualised nature of female-male interaction in many organisations can be seen both to contribute to, and to be based on, the eroticisation of women in the public sphere (Witz and Savage 1992, Adkins and Lury 1996, Miers 2000). One of the contradictions in the system which regards organisations as gender-neutral is that it presents human beings as disembodied, although it is actually predicated upon embodiment associated with the male body, that is, with little responsibility (other than possibly financial) for the domestic sphere and with a tendency not to display emotion. The concept of embodiment is used by post-structural feminists to explore the links between sex and gender. The focus

then becomes to discover how actual embodied men and women behave (Davies 1992, Adkins and Lury 1996, Witz et al 1996, Halford et al 1997, Miers 2000).

Witz et al (1996) maintain that a 'politics of the body' is played out in organisational practices involving gendered hierarchies in which men and women interact on a daily basis. So the organisation incorporates hierarchical spaces between bodies themselves, as well as between roles and functions. For example, midwives in many institutions wear uniforms, while medical staff do not (remembering the origins of these uniforms, as mentioned in Chapter 2). This view complements the CDA notion of discursive practices contributing to the production of a 'text', that is, wider discourses prevalent in society being linked to the semiotic elements of a discursive event (in this example, visual signalling effected by what individuals are wearing) (Fairclough 1992, 1995).

### **Gender and maternity care**

The traditional view of gender-specific attributes, which led to an assumption that men's domination of women was part of the natural order, underpinned the medical take-over of childbirth (Witz 1992). This applied both to practitioners and to those they attended. During the 18<sup>th</sup> and 19<sup>th</sup> centuries, the dualistic approach to medicine prevailed, whereby the body became the domain of the rational, while mind and particularly emotion remained the domain of the irrational. Obstetrics, along with the rest of medical practice, was shaped by 'masculine' values, which resulted in the female body and childbirth being pathologised; childbearing women were assumed to need the help of the 'scientific' male doctors (Annandale and Clark 1996).

The belief persists that birth is inherently dangerous, and that the way to deal with this danger is for childbearing women to be monitored and controlled by the medical profession. For example, despite well-documented evidence to the contrary (Anderson and Murphy 1995, Springer and Van Weel 1996, Olsen 1997, Allnutt and Smith 2000, Johnson and Daviss 2005), many obstetricians and GPs still assume that homebirth is unsafe (Davies 1997, Hosein 1998, Levy 1999, Hagelskamp et al 2003). An important consequence of this belief in childbirth's inherent danger, together with the accompanying focus on women's 'unreliable' bodies (Nettleton 1995), has been the assumption that non-physical aspects of childbirth, including the social, are of comparatively little importance. This attitude has persisted, despite evidence that social and emotional support are key factors affecting outcomes in pregnancy (Webster et al 2000). Consequently, western maternity care is based on

a primary perception of childbearing women as possessors of reproductive organs, rather than as social beings. It is worth noting that this perspective has been reinforced by recent policy initiatives in the UK. By including maternity care in the NSF for children's services, the importance of women as producers of children, rather than as individuals in their own right, has been clearly signalled (DH and DES 2004). This can be viewed as a variant of the eroticisation of women in the public sphere, with the focus being on their reproductive function, rather than their sexuality per se. This objectification means that women have only limited control over their own bodies (Oakley 1984, Davies 1992, Oakley 1993, Annandale and Clark 1996, Wicks 1998).

At the end of the 19<sup>th</sup> century, when obstetrics was being established as a speciality within the medical sphere, women were barred from medical education. In this heavily gender-biased schema, women were supposed to be 'caring', not intellectual, so were only fitted to supportive or caring (subordinate) roles. Midwives (women) therefore had to take on dual roles – they had to care for childbearing women, and support or defer to doctors (men). The organisation of maternity services and the wider healthcare system during most of the 20<sup>th</sup> century replicated this schema (Oakley and Houd 1990, Davies 1992, Witz 1992, Oakley 1993, Adkins 1995, Annandale and Clark 1996).

Behaviour that reinforces gendered roles within midwifery and medicine still exists. For example, the way in which midwives restrict offers and explanation of homebirth to pregnant women, because of the opinions of GPs and obstetric consultants, can be interpreted as gendered performance (Davies 1997, Hosein 1998, Levy 1999, Miers 2000). These midwives appear to be concerned with preserving the established hierarchy between medicine and midwifery, and/or have normalised the medical discourse concerning the dangers of childbirth. Brownlee et al (1996) found that junior doctors on a labour ward resented the fact that senior midwives were telling them how to practise. This can be read as reaction to the perceived violation of a gendered 'hierarchical space' (Witz et al 1996).

### **Gender and the professions**

In common with organisations, the concept of a profession has also assumed gender neutrality, which is not the case. Professions have been defined according to 'masculine' values: in particular, issues of autonomy and control, the hallmarks of



professions, do not stand alone, but require support and adherence from a range of subordinates. Professional autonomy is in fact a myth, particularly in medicine: no professionals work in isolation, all are dependent on the input and decisions of others (Annandale 1998, Miers 2000).

The rise of professionalism has been attributed to the rise of capitalism and the market culture, whereby the establishment of professions afforded protection for the commercial interests of particular occupational groupings (Witz 1992, Nettleton 1995). Witz' (1992) neo-Weberian analysis of professionalism and patriarchy, focusing as it does on differentiated power, is a useful foundation from which to study social problems from a CDA perspective. She identified a number of strategies employed by members of occupational groups wishing to establish themselves as professionals, including those of exclusion and demarcation. The credentialist tactic of exclusion restricted access to a profession in terms of education and possession of knowledge and skills; demarcation gave professionals control over the work of related occupational groups, in particular delineating and controlling the boundaries between them. These strategies were reinforced and entrenched through legalistic tactics, whereby lobbying of the state resulted in licensing for professions and their related occupational groups. This system ensured that control was placed firmly within the male professions, which were legally empowered to accredit and regulate both their own and related occupations.

These strategies of occupational closure were not gender-neutral (Davies 1992, Witz 1992). Women were not allowed to enter the professions and did not have direct access to state power. They were restricted to occupations which the professional groupings did not want for themselves; in the case of medicine, nursing as an essentially menial occupation was only considered suitable for women. However, it was also recognised as being a valuable support to medicine, so was duly brought under the control of the male medical profession (Davies 1992). The insistence on gender being a factor in the constitution of professions does not invalidate the class-based explanation for the rise of professionalism. Although there are contradictory views among feminists about this issue, many feminist writers maintain that capitalism is inherently patriarchal; there are also a number of other social groups, for example, ethnic minorities, who have traditionally been denied access to the professions, and a thorough analysis of the professions would need to take into account all of these interrelated factors (Davies 1992, Witz 1992, Adkins 1995, Bradley 1999).

As far as midwifery was concerned, the medical profession employed a demarcation strategy of de-skilling (Witz 1992). The pathologisation of childbirth allowed the profession to distinguish between 'normal' and 'abnormal' labour. Women in 'normal' labour were seen to require only care and support from their attendants, while 'abnormal' labour involved interventions requiring technical or surgical skills. Midwives were only allowed to care for women in 'normal' labour, while 'abnormal' labour was claimed by doctors as their exclusive domain (Donnison 1988). It should be noted that the debate about what constitutes 'normality' in childbirth is still far from resolved (Kitzinger et al 1990, Downe 2001, Robinson 2001-2002, Taylor 2001a, Anderson 2003).

Contributing to this situation was the fact that the medical profession was by no means unified. Battles for supremacy and control raged between gynaecologists and obstetricians as these professions sought to establish themselves (Moscucci 1990). At the end of the 19<sup>th</sup> century and during the first half of the 20<sup>th</sup> century, when midwifery was brought under medical and state control, it benefited the medical profession for midwives to be independent practitioners with their own clients, as long as the physiological process was 'normal'. There were too few doctors who wished to attend 'normal' childbearing women, especially where they could not afford to pay significant fees. So midwifery remained a distinct female occupational role under the regulation of the medical profession. Midwifery was a suitably cheap option, which allowed doctors to offer their services only to those women who were better financially situated (Donnison 1988, Witz 1992).

Over the last 40 years, issues of direct financial competition have not been that relevant to the UK, since most midwives have been NHS employees. However, the desire to protect financial interests can be seen in relationships between midwives and other healthcare professionals outside the UK. De Veer and Meijer (1996) surveyed 183 midwives, obstetricians and family physicians in the Netherlands, to determine the feasibility of co-operation between the providers of primary and secondary maternity care. A third of the family physicians felt they were in financial competition with midwives. In the study conducted by Kornelson et al (2003), 44% of the respondents feared that midwifery practice would threaten perinatal nursing posts. Gau et al (2002) found that obstetricians were unwilling to have to compete with midwives for patients. A similar finding arose from Hinojosa's (2003) ethnographic research conducted with 15 traditional Mayan midwives and an

unknown number of Hispanic members of the Guatemalan healthcare system over five years, in order to explore the relationships between them. Similarly, Australian obstetricians stated that they would be financially disadvantaged if midwives became involved in antenatal care (Haertsch et al 1998).

It appears that the de-skilling of Australian midwives continues, to protect obstetricians' professional interests (Haertsch et al 1998, Brodie 2002). Hinojosa (2003) observed the de-skilling of the Mayan midwives through the systematic undermining of their traditional knowledge, even where their practice followed current western recommendations. Many of these midwives gradually restricted their practice (often highly skilled) in deferment to the tenets of the medicalised training which they were obliged to attend in order to be licensed to practise. Significantly, steps were taken to limit the ambitions of any midwives who appeared to want to establish themselves in practice on terms of social equivalence with westernised professionals.

The ongoing influence of the historical strategy of de-skilling midwives and the concomitant ascendancy of the medical profession is evidenced by the fact that midwifery is still regulated according to medical frameworks and priorities in most western countries (Fleming 1998, Jowitt 2000, Grehan 2004), and that many maternity care professionals believe that midwifery practice is only safe when overseen by doctors (Blais et al 1994a, Cheyne et al 1995, Haertsch et al 1998, Meerabeau et al 1999, Katz and Katz 2001, Kornelson et al 2003).

In the first half of the 20<sup>th</sup> century, UK midwifery practice became increasingly medically regulated, and with the advent of the NHS after the second world war, both birth and midwifery practice became increasingly institutionalised (Donnison 1988). After the publication of the Peel report (DHSS 1970), childbirth moved almost completely into hospital settings, and midwives consequently were absorbed into the NHS, occupying the same niche in the hierarchy as nursing staff. Midwifery had already for some time been regarded as a nursing speciality, and most midwives were (and still are) nurses who had undertaken midwifery education after their nursing qualifications (Jowitt 2000, Wilkins 2000). In the case of nursing (and consequently midwifery), there has been a dual reinforcement of a gendered organisational system. No doubt it was thought that the organisation of nursing in relation to military and service models afforded the best opportunity for getting the required tasks done efficiently, and for maintaining control of the otherwise possibly

unruly and unreliable workforce. This resulted in a system, still in place today, in which the 'feminine' work of caring is controlled and regulated by the norms and constraints of an organisation devised and structured according to 'masculine' ideals of neutrality, efficiency and order. The gendered nature of the medical profession has assured that this system has been maintained by powerful pressure from those in positions of authority. A feature of this system is the emotional, sexualised work in which nurses (and to some extent midwives) engage with male doctors, in order to ensure that their relationships are productive in nursing terms – the 'doctor-nurse game' (Witz et al 1996, Wicks 1998, Miers 2000).

Of course, a sizeable proportion of women enter the medical profession today, but they are often treated by the organisation as 'honorary' men. Adkins (1995) revealed how the control of female employees' dress and appearance has been a feature of some organisations, and this has certainly been the case in the NHS. In Adkins' research sites, women were supposed to present themselves as sexually attractive to male colleagues and customers; conversely, in the NHS, nurses and midwives have traditionally been required to present a desexualised appearance, with little personal adornment and uniforms designed to be utilitarian rather than flattering. However, in both circumstances, the organisations have appropriated the right to determine how and to what extent women's sexuality is presented in their appearance. In a maternity unit where I worked, a memo was sent around addressed to all midwives, reminding them of the organisation's rules that hair was either to be above the collar, or to be tied back, in order to prevent the spread of infection and the contamination of wounds. This appeared to be a reasonable stricture at first glance; however, no such rules applied to medical staff, and it was not unusual to find female (and some male) obstetricians and anaesthetists working with fairly long, unbound hair (Pollard, personal observation).

Although I refer to the midwifery 'profession', neither nurses nor midwives fit the traditional definition of professionals, being neither autonomous in their own practice, nor wielding any control over other occupational groups (Oakley and Houd 1990). Nursing and midwifery are usually considered to be among the 'semi-professions'. Witz (1992) talks about their 'professionalisation projects', that is, their efforts to become full professions, and to be recognised as such. In many UK maternity units, medical control of midwifery persists through the imposition of medically-determined policies which guide midwifery practice. Robinson and Owen (1994), in their study of retention involving 86 midwives, found that their

relationships with doctors were often difficult because of the effect of restrictive medical policies governing their practice; this was also the case in my study of midwives' perceptions of their autonomy (Pollard 2003). It is not surprising therefore that midwives' current professionalisation agenda is pre-occupied with issues of autonomy and control.

In order to advance their 'professionalisation projects', both nurses and midwives are employing dual closure strategies of usurpation and exclusion (Witz 1992, Sandall 1995). They are moving into areas of practice which the medical profession has claimed for its own, for example, conducting instrumental deliveries, prescribing drugs and examination of the newborn (Charles 2002, Lissauer 2003, Lumsden 2005). Nancarrow and Borthwick (2005) offer an alternative conceptualisation of usurpatory strategies, putting forward the notion of 'vertical substitution' to describe how occupational groups between whom there is a significant power differential take on each other's tasks. 'Vertical substitution' can work in either direction; so these authors argue that both medicine's appropriation of control over birth in the 19<sup>th</sup> and 20<sup>th</sup> centuries, and nursing and midwifery's current encroachment on the medical domain, can be viewed in this light.

Midwives' and nurses' exclusionary tactics involve increasing emphasis on tertiary academic qualifications as a minimum requirement for registration (Blais et al 1994b, Nursing Standard 2002). The creation of new posts, such as that of the consultant midwife, is also seen as enhancing midwifery's professional validity (O'Loughlin 2001). Some of these professionalisation strategies appear to be succeeding. For example, in Lumsden's (2005) study concerning midwives who were conducting the examination of the newborn, the participants reported that since they had expanded their role in this way, they had begun to be consulted by junior paediatricians when the latter required help or information with their own practice.

Despite problems concerning their claims to be full professions, the concept of being a 'professional' is central to contemporary nursing and midwifery. In most nursing and midwifery publications, both occupations are referred to as professions. They have codes of professional conduct, and members are expected to behave 'professionally' in their practice (NMC 2004c). Being recognised as a professional seems to hinge to some extent around social status and respectability. In a qualitative study in which 43 new students were asked to state why they had chosen

to enter midwifery, 21 intimated that the main reason was the enhanced social status and respect that they would acquire from becoming 'professionals' (Pollard, forthcoming).

In contrast to the professionalisation agenda outlined above, some writers have suggested that professionalism in healthcare should be reconceptualised (Stacey 1992, Davies 1995), in order for the act of 'caring' to be recognised and valued as a component in the professional panoply of skills. This would include explicit definition and recognition of individuals' interpersonal skills and their ability to engage with both service users and colleagues. Davies (1995) postulated that this would allow nurses to claim professional status on the basis of their full range of knowledge, expertise and skills, many of which have traditionally been viewed as 'women's work', and therefore of no consequence in the wider social context. Similar discussion concerning professionalism in midwifery has incorporated the same emphasis on valuing these hitherto unacknowledged skills (Kirkham 1996, Pairman 2000, Davis-Floyd 2005, Lane 2005).

An alternative approach is to reconceptualise 'women's work'. It has been argued that, in professions based on the performance of physical tasks, professionals can be categorised as those who both control and have unrestricted access to the relevant 'technologies', that is, the 'tools of the trade' (for example, obstetricians and forceps) (Croissant 2000, Lane 2005). A corollary to this argument suggests that where there is no recognised 'technology', there can accordingly be no 'professional'; and since 'women's work' has never been seen to involve 'technologies', but rather to be something that women 'naturally' do, associated activities do not confer professional status, no matter what levels of skill and expertise are involved (Croissant 2000). Croissant therefore suggests that many of these activities should be reconceptualised as involving 'technologies', in order to redress the situation.

Although some of the ideas concerning 'new' professionals have started to take hold, most notably in the drive to improve health professionals' communication skills (see, for example, NMC 2004a), the traditional notion of 'professionalism' still holds sway to a considerable extent. Where midwives have presented themselves as confident, assertive clinicians (for example, Brownlee et al 1996, Harman et al 1998, Bailes and Jackson 2000, Lumsden 2005), this often appears to be based on embracing (rather than rejecting) standards associated with the established order.

Midwives' professional ambitions have meant abandoning adherence to a holistic approach to childbirth to a certain extent, and adopting the values traditionally associated with the dominant medical discourse and with professionalism. For example, West et al (2001) suggested that midwifery should aspire to research paradigms such as the 'gold standard' of the randomised controlled trial, so that its knowledge base becomes acceptable to other disciplines; this despite the contention that other research approaches are more suited to the holistic midwifery ethos (Cochrane 1995, Taylor 2001b). Meah et al (1996) found that NHS midwives considered it their professional duty to conduct research, as a means of raising the profile of the profession. Similarly, in a study involving 176 midwives conducted by Harman et al (1998) to investigate the characteristics of CNM participation in medical education in the USA, respondents thought that their involvement in the education of medical students helped to enhance the status of midwifery. In Canada, midwives sought to join the ranks of professionals by moving into the established healthcare system (Blais et al 1994a).

Professions can no longer restrict entry to men; however, the emphasis now on acquiring research-based 'scientific' knowledge in healthcare is not gender-neutral, but is an extension of the ideology that values the intellectual and rational (the 'masculine') above the intuitive and irrational (the 'feminine') (Davies 1992). Moreover, in some circumstances, it can be seen that it is an ideology that simply values doctors' (men's) opinions above those of either service users or other occupational groups (women). This is illustrated by the fact that midwife-led research is given little credence or attention by the medical profession, as is any that reveals the harm arising from commonplace medical interventions in childbirth (Oakley and Houd 1990, Meah et al 1996). Conversely, midwifery practice is often constrained by organisational policies and regulations based on findings from medical research (Levy 1999, Pollard 2003). The research priorities of women using the service receive no attention (Campbell et al 2002).

The hegemony of the traditional professional ideal, based on 'masculine' values, has resulted in both nursing and midwifery putting themselves in danger of developing two-tiered systems, with some workers being valued more than others (Sandall 1995). So nurses and midwives who have acquired further academic qualifications and who devote themselves full-time to their careers are seen to be more valuable to the organisation, and are rewarded more in terms of status and remuneration, than those who have been satisfied with achieving the minimum required

educational competencies and who work part-time in order to prioritise their domestic obligations; this even though the functions and responsibilities undertaken by both types of workers may be identical. In midwifery, this has resulted in the curious position of an occupation that declares itself to be 'woman-centred' (whatever that actually means), and in which both workers and service users are overwhelmingly women, trying to reshape itself according to principles and standards that have been defined according to 'masculine' values. This becomes even more anomalous when one considers the target of midwifery practice, that is, the process of pregnancy and birth, which can only fit into the 'professional' medical model through constant surveillance and intervention in 'unreliable' female processes. Oakley (1993) notes that the term 'unprofessional' has acquired negative connotations: if something goes wrong during childbirth, no blame is attached to the caregivers where medical intervention has been deployed, even though the outcome and the need for intervention may be the result of unwarranted medical intervention at an earlier stage of the process; conversely, where no medical intervention has occurred, caregivers are often blamed for the outcome. This often means, in practice, that caregivers have trusted the natural process or respected a woman's wishes, and are consequently regarded as having acted 'unprofessionally'.

A critique of viewing organisations in terms only of the gender paradigm, where organising structures and processes are considered to be essentially patriarchal, is that it does not allow for the capacity of individuals to exercise their own power (Halford et al 1997). However, the exercise of power in organisations and professions is inextricably linked with gender relations. Within organisations, gender relations are enacted through daily practices which usually involve issues of power, dominance and authority (Davies 1992, Witz and Savage 1992, Adkins and Lury 1996).

### **Gender and power**

Foucault's conception of power is commonly criticised by feminists for not accounting for the repressive nature of patriarchy (Annandale 1998). However, Foucault and post-structuralist feminists share a concern with the embodied experiences of human beings. Moreover, a Foucauldian view of power can provide important insights into how femininity constructed as a disciplining discourse has contributed to embodied women maintaining and reinforcing patriarchal systems (Witz et al 1996, Annandale 1998, Wicks 1998, Westwood 2002).



An agentic feminist view of power sees the exercise of professional power in terms of the institutionalisation of men's domination of women (Witz 1992, Bradley 1999). However, if we reframe this concept in terms of facilitative power, the exercise of professional power can be seen to result in the normalisation of a body of knowledge which privileges a particular point of view (in this case, the 'masculine scientific'), and which is represented and maintained through discursive practices. So, for example, Foley and Faircloth (2003), in their study of 26 midwives' work narratives, found that their participants drew on midwifery discourses in order to differentiate themselves from the medical profession, but on medical discourses in order to legitimate their position as professionals. The extent to which a privileged body of knowledge is challenged is the extent to which resistance to professional power occurs. Moreover, the potential for resistance is inherent in the representation of power:

Thus the dominant discourse (of obstetrics, for example) *must* itself create the conditions, or discursive space, for a reverse or alternative form.

(Annandale and Clark 1996, p.31) (italics in the original).

There is evidence that midwives are attempting to challenge the power of the medical profession, through challenging the normalised medical corpus and promoting the concept of 'normality' in birth (Davies 1997, Harman et al 1998, Hagelskamp et al 2003, Adams 2006).

Witz et al (1996) maintain that the centrepiece of a feminist research agenda should be the relationship between gender and power in organisational settings. If we take the view that gender relations (embodied gendered interaction) in organisations represent the exercise of facilitative power, then rather than having to retreat to the concepts of gender attributes, and power centrally situated in some abstract 'other', it becomes possible to examine these issues as discursive practice. This approach is accompanied by a move away from the view that women in the NHS, both workers and service users, are inevitably both passive and powerless (Annandale and Clark 1996).

### **Gender and changes in the workplace**

One of the current concerns among theorists is the cultural feminisation of the workplace, and of the workforce. In this context, 'feminisation' implies not only a

greater proportion of the workforce being female than previously; but also the way in which issues of self-presentation and image at work now apply both to male and female employees (Tienari 1999, Adkins 2002). Implicit in this process is a shift in workplace semiotics that support more 'feminine' modes of communication and self-presentation, coupled with a recognition of the need for 'emotional intelligence' at work, that is, for individuals to be aware of their own and other people's emotions and sensitivities (Davies 1995, Rutherford 2001, Adkins 2002). An associated aspect of feminisation is the increasing privileging of what was formerly seen as essentially a female tendency, that is, the trend for individuals to make sense of their occupational roles through interpersonal communication and relationships, and to take opportunities to 'be themselves' at work (Rutherford 2001, Erickson and Pierce 2005).

There is a train of thought that the traditional binary structure concerning gender is being destabilised, and that gender can be viewed as a 'strategic artifice', which can be manipulated by individuals with a degree of fluidity in their social sphere. In particular, Adkins (2002) notes that the traditional concept of the rational, disembodied worker is no longer taken for granted. While the notion of gender fluidity has gained currency in recent years, some theorists express reservations about embracing it wholeheartedly, noting the continuing material differences between working conditions for many women and men (for example, pay differentials) (Wodak 1997).

Feminisation certainly does not imply a shift in power either from men to women, or from traditionally 'masculine' to traditionally 'feminine' roles and occupations (Tienari 1999, Riska 2001, Erickson and Pierce 2005). The reality of continuing medical control over both midwifery practice and childbirth belies the idea that roles based on traditional notions of gender attributes are yet fundamentally under threat in the maternity services (Kirkham 1999). Whatever the developments in the wider social sphere, the process of feminisation appears to have made little substantive impact on health professions. For example, men in nursing, despite their relatively small numbers, are disproportionately over-represented at senior levels in the profession (Whittock et al 2002). Conversely, although there are many women doctors, they are over-represented in medical specialities which are comparatively poorly paid and of low status within the profession (Riska 2001).

It is also important to recognise that the application of discourses of the market to healthcare, coupled with the increasingly powerful discourse of service users' rights, has effected radical change in the way in which power is constituted and represented in the NHS (Annandale 1998, Lissauer 2003). New managerial styles have resulted in internal stratification of the professions: even the illusion of autonomy and control is no longer available to many junior doctors, for example, due to increasingly complex organisational structures, managerial demands, budgetary constraints and calls for public accountability. In a bid to utilise the workforce more efficiently, many procedures and competencies previously monopolised by the medical profession have been opened up to other professionals. In this way, these procedures and competencies have been redefined as being technically, rather than professionally, based; that is, occupation alone does not determine who is taught how to conduct them (Cameron and Masterson 2003).

However, despite the apparent threat to its authority and influence, the medical profession still exerts considerable power at strategic levels. Economic factors dictate policy and procedures in most NHS Trusts; this includes adherence to evidence-based clinical practice, for fear of litigation (Samanta and Samanta 2004). The National Institute for Clinical Excellence (NICE) provides guidelines to clinicians to this end; however, these guidelines depend on who evaluates available research. Members of NICE committees and review panels are drawn mainly from the medical profession and NHS management (Thornton 2001, NICE 2007); in particular, it appears that NICE guidelines affecting midwifery practice are based on obstetric and paediatric principles and priorities, rather than on midwifery principles (Jowitt 2001).

Importantly for childbirth in the UK, this means that most midwifery practice is based on medically-defined categories of risk. The Clinical Negligence Scheme for NHS Trusts operates on general insurance principles and takes independent expert advice to determine levels of risk regarding clinical practice. At a recent conference on the future of maternity care in the NHS, the chairman of the NHS Litigation Authority hinted that a new model for midwifery insurance was being discussed. It became clear that there was no midwifery input into this process, and no awareness that there was any difference between midwifery and medical perspectives concerning childbirth (Walker 2005).

However, despite the ongoing dominance of medicine *per se*, the overall picture in the NHS is becoming increasingly complex. Usurpatory strategies of non-medical health professionals are challenging doctors' claims to exclusive areas of practice: the boundaries between these occupational groups are blurring and shifting (Sandall 1995, Annandale 1998, Pollard et al 2005). This raises the question of how professional / occupational identity is located alongside power and gender relations within the NHS.

### **Gender, identity and midwifery**

From the above, it can be seen that perceptions of gender and gender roles have had a major impact on the development of midwifery and of maternity care within the UK healthcare system. However, in order to explore factors relating to interprofessional working in midwifery, and in particular, individual midwives' discursive practices in this regard, it is also necessary to appreciate how their identity as healthcare professionals impacts on their perceptions and behaviour. Furthermore, any individual's identity is, of course, not limited to their professional persona; and as no individual is isolated from wider social influences, it is also necessary to consider the complex social context which affects people's orientation to birth and to the provision of maternity care. In the next chapter, I shall turn to a consideration of these issues.

## **Chapter 5. Midwives and professional identity; the influence of the wider social context.**

Although wider issues concerning gender and power undoubtedly influence all social interaction, it must be remembered that all social relationships concern individuals: so issues of identity are key to understanding how people interact with one another. Furthermore, healthcare professionals experience distinct and particular socialisation processes during their professional education and early orientation to their working environments (see, for example, Begley 2002, Mackintosh 2006). Therefore, it can be argued that how individual midwives see themselves in relation to the idea of 'being a midwife' has a direct bearing on how they engage with other people in their professional life. In the first section of this chapter, I shall therefore focus on midwives' professional identity.

I have already mentioned the poor outcomes for women using the maternity services associated with poor interprofessional working in midwifery (see p.24). It should also be noted that the relationships between women using the maternity service and professionals working within it are directly affected by how the professionals relate to each other, and by the organisational context of care delivery. For example, midwives who decide not to challenge colleagues' preferences, or who support the norms of the system, often do not offer women choices of care to which they are entitled (Levy 1999, Pollard 2003). Furthermore, women using the service sometimes make choices because they think midwives or obstetricians will find them acceptable (Johansen et al 2000). So in this chapter I shall also consider the wider social context influencing both individuals' health-related behaviours and the relationships between professionals and members of the public.

### **Professional identity**

As with so many other aspects of social life, identity is no longer regarded as something fixed and innate within an individual, but rather as something socially constructed and open to change. In this view, identity is always relational, and the reaction of others to the self is a critical element in its formulation. It confers a social category which is itself dependent on discursive practice (Barker and Galasiński 2001). While gender, class and ethnicity are intrinsically linked with identity, most current writers question the assumption that they confer collective identity on any group of individuals. Rather, they see a relational complex of these and other

culturally constituted dimensions (such as belonging to a profession) as affecting how individual actors are positioned within social practices. An actor's position in social practices is associated with a range of conceptual repertoires which themselves represent specific discourses, for example, the (female) nurse as 'ministering angel' (Clegg 1989, Gherardi 1996, Annandale 1998, Wicks 1998).

Some common repertoires available to midwives within the NHS are 'woman's advocate', 'employee', 'clinical expert', 'legally-sanctioned birth attendant', 'woman', 'friend'; the selection and deployment of a particular repertoire may or may not be consistent. Other repertoires available to actors may not be associated with a particular position; one would not expect midwives to use repertoires of sporting prowess, for example, in a working context. The idea of professional identity is therefore key to a consideration of how individuals behave within an environment which assigns a hierarchy of significance to possible roles: for example, in most work-related instances a midwife may present herself as a healthcare professional rather than as a woman. Exploring the dynamics of this situation becomes even more complex when one acknowledges the gendering of professional roles.

When considering nurses and midwives, the question then appears to be: how are they affected by relational complexes of culturally constituted dimensions in their occupational role? what repertoires do they use? what are the commonalities/differences in how they present themselves and are received in the organisation? Wicks (1998) found that the link between nursing and individual identity was particularly strong among her research participants. Certainly, the idea of someone having a 'vocation' is applied to nursing (and midwifery) in a way that does not occur with many other occupations; the premise appears to be that these 'caring' occupations require qualities such as altruism and dedication from individuals, and consequently a strong personal identification with the occupational identity. This then becomes one of the culturally constituted dimensions that affects nurses' and midwives' participation in discursive practices involving their occupational identity as they experience it. Hence power theory needs to address questions of identity.

Of course, not all nurses and midwives have a 'vocation'. Results from a recent survey of 775 students' motivation to enter a healthcare profession indicate that, while many student nurses had 'always wanted to be a nurse', others were motivated by the prospect of stable employment and a recognised qualification (Miers et al 2006). It may be that, not only do those nurses with and without a

'vocation' experience the reality of being a nurse substantively differently, but there may not even be any consistency in the way in which individuals with different orientation to their profession experience discursive practices involving their occupational identity.

Since midwifery practice in the UK is almost exclusively located within the NHS, the organisational context of the institution has had a major impact on midwives' professional identity, as have their claims to professionalism and the contested nature of childbirth itself. Before the wider changes in the healthcare system, it appeared that if midwives gained professional recognition in the traditional sense, they would enhance their ability to reclaim authority over areas of practice defined by doctors as 'abnormal'. The current picture is not so simple, since areas of practice in the NHS are no longer necessarily associated with particular professional groups, but rather with a range of practitioners who possess the requisite clinical knowledge and technical proficiencies (Cameron and Masterson 2003). However, there is no doubt that midwives' occupational identity is directly linked with the power relations which are represented and constituted through the discursive organisational practices in which they participate.

### ***Identity and discourse***

The post-modernists consider identity to be constituted through role-adoption and image construction which occurs within discourse. Axiomatic to this conception of identity is that it is most strongly delineated by contrast with the 'other', that is, with what it is not (Hall 2000). Maternity care practitioners' discursive strategies concerning their own professional identity have included the denigration of, and distancing of the self from, the 'other'. For example, obstetricians and nurses have promoted an image of midwives (in contrast with themselves) as untrustworthy and/or incompetent practitioners unnecessarily putting women and their families at risk (Meerabeau et al 1999, Kornelson et al 2003). Conversely, midwives have presented themselves as unfairly discriminated against and misunderstood by professionals intent on promoting their own agendas, rather than concerning themselves with the 'real' needs of their client group (Davies 1997, Farquhar et al 1998, Farmer et al 2003, Adams 2006). In this way, practitioners' professional identity has been presented in a manner that emphasises the qualities or characteristics which they themselves consider to be desirable.

A broader consideration of how midwives' professional identity relates to discourse requires a return to issues of gender. Feminist discourse analysts have focused on how linguistic structures and strategies have been used to maintain men's domination of women in western society. Feminist linguists have been particularly concerned with issues of women's representation in language, and with the way that men and women's linguistic strategies differ from each other (Wodak 1997). However, there has been a parallel process between the development of social theories and linguistic theories concerning gender. While earlier linguistic theorists focused on the acquisition of gender-specific ways of communication during childhood, and the representation of gender through these communicative genres, later theorists subscribe to the idea that gendered forms of communication are also constitutive of gender roles and perceptions about gender. This idea aligns well with the notion of gender as performance (Cameron 1997, Wodak 1997, Miers 2000).

It has been noted that similar interpretations of linguistic events depend to a large extent on a shared cultural background. The use of linguistic strategies to achieve particular social effects is known to differ between different social groups, including between groups of men and women speakers (Gumperz 2001, Tannen 2001). Eckert and McConnell-Ginet (1992) posited the idea of 'communities of practice', defined as groups in which members adopt particular ways of behaving and communicating as part of a shared process which aims to achieve a common goal. One factor noted about such 'communities' is that men and women define themselves in relation to their own gender, and adopt different strategies to acquire greater status within the group (Wodak 1997). Interprofessional working in midwifery could be viewed as an area where different 'communities of practice' intersect: this intersection then becomes the focus of interest, to explore how communicative strategies and other behaviours are adapted or maintained to facilitate or hinder effective collaboration. Of particular interest is how gender roles and roles relating to professional identity, which have been established as normative within specific communities of practice, may or may not be reinforced in this intersection, and what impact this has on either challenging or maintaining existing power relationships between professional groups.

### **The influence of the wider social context**

The stated rationale for improving interprofessional working in health and social care is to improve the care provided to service users (Øvretveit et al 1997). Relationships between midwives and other professionals in the NHS do not only



involve and affect actors within the organisation, but also women using the service and the wider social sphere where birth is considered to be primarily a social, rather than a medical, event (Oakley 1993). However, wider social influences also impact on all these relationships.

Pollitt (1993) put forward the notion that the rise of managerialism in public services in the UK has resulted in the reality of individuals within organisations concerning themselves with accountability to 'accountability' itself, rather than to the communities which they are supposed to serve. Similarly, the effects of prioritising discourses of the market in the NHS appear at times to privilege the needs of the 'system' above those of the human beings either using or working within it (Annandale 1998). Other social changes have served to erode the power of professionals, notably in relation to the state. Over the last two decades, there has been substantial governmental encroachment on individual liberties, characterised by state identification, regulation and enforcement of standards concerning a wide variety of behaviours. A key feature of this trend is the requirement that professionals monitor individuals' activities for compliance with government preferences. So for example, it has become a punishable offence for parents to allow children to be late for school, or to take them on holiday during term-time (Heffer 2006, Lightfoot and Davies 2006). It is, of course, teachers and other school staff who are obliged to track and report these events. Similarly, health professionals, including midwives, are now expected actively to promote particular behaviours and screen service users for 'lifestyle' choices which are considered to be unhealthy (Dufty 2005). In a comparison of four national maternity care systems, Benoit et al (2005, p.727) speak about the 'public health model of midwifery' currently being promoted by policy-makers in the UK.

Even members of the medical profession are no longer free to determine their own professional priorities (DH 2003b, Exworthy et al 2003). However, despite the lessening of autonomy available to individual members of the medical profession, the medical perspective *per se* continues to be privileged. Most evidence supporting established views about health and behaviour comes from the scientific and medical communities. The power of medicine to regulate social behaviour in the wider context has been noted for over fifty years (Nettleton 1995, Riska 2003). The dominant scientific/medical paradigm exerts a major influence on how views of health, illness and risk are shaped (Annandale 1998, De Vries et al 2001). Moreover, medical discourses constitute a form of social control, as medical

perspectives are applied to situations which could be viewed as purely social in nature (Stacey 1988, Nettleton 1995, Riska 2003).

An illustration of the current application of medical knowledge to social situations is evident in the way that unruly or hyperactive children are often diagnosed with attention deficit hyperactivity disorder (ADHD). In this way, an essentially social situation (after all, why does an unruly, overactive child pose a problem?) is framed as being intrinsically a medical issue. The consequence is that it is commonly accepted that these children be medicated, rather than that they be involved in some other form of interaction or activity which might help them to develop socially acceptable skills and sensitivities. In 2005 nearly 400,000 children in the UK were medicated in order to improve their behaviour (Ragg 2006). Similar processes can be seen in the way that 'shyness' is now perceived in some quarters as a pathological condition, which can be treated using various strategies, including medication (Scott 2006). It should be noted that the medical perspective is often linked with the moral high ground (Riska 2003). So, for example, individuals who ignore medical recommendations regarding healthy lifestyles are increasingly presented as placing an unfair burden on other members of society (Grice 2006).

Medicalisation of social activities is itself a gendered process (Riska 2003). It can be seen as going hand in hand with the increasing technologisation of society. According to Croissant (2003), technology has been socially constructed as a 'masculine enterprise'. In our society, science and technology are associated with progress (Nettleton 1995). Discourses of science and technology have accordingly had a major impact on the wider social approach to birth. For example, in the Netherlands, where birth is largely under midwifery control, women have campaigned for unrestricted access to epidural anaesthesia (De Vries et al 2001). Midwives themselves have started to question whether the midwifery approach to birth is still relevant in our current society (Pollard 2003, Evans 2005). On the other hand, a recent survey conducted by the National Childbirth Trust (NCT) involving nearly 3000 women within one strategic health authority revealed that over 50% of them would choose to give birth in midwife-led birth centres (where medical 'technologies' such as epidurals are unavailable); and that 43% of them would consider homebirth if it was presented to them as a viable option (NCT 2006). There is therefore a question mark about what women want or expect from professionals within the maternity services. This issue gives rise to further questions as to how good a 'fit' there is between what childbearing women want, the

emphasis on various professional agendas, and interprofessional working and organisational priorities within the maternity services.

To complicate matters further, the relationship between users of healthcare services and the professionals within them are based on contradictory concepts. On the one hand, there is the discourse concerning service users' rights, enshrined in documents such as *The Patient's Charter* (DH 1992), and the increasing trend for them to be regarded as members of the interprofessional 'team' and to be involved in decision-making concerning their care (Thomas 2005). Rowe and Calnan (2006) differentiate between 'new' and 'traditional' professional-service user trust relationships: 'traditional' relationships entail 'embodied trust', that is, service users trust professionals purely on the basis of their occupational status and knowledge; while 'new' relationships are based on 'informed trust', where the service user is assumed to have access to a variety of sources of information. One of the characteristics of an alternative conceptualisation of a 'professional' is the ability to engage effectively with service users and to recognise that they too possess relevant knowledge (Davies 1995); in midwifery, this involves the notion of midwives working 'in partnership' with women (Davis-Floyd 2005, Lane 2005). The publication of *Changing Childbirth* (DH 1993) reinforced the primacy of women's choice and control as a guiding principle for the delivery of maternity care (Benoit et al 2005).

On the other hand, many health professionals and service users are still acculturated to a system in which the former are considered to be authoritative experts, and the latter merely passive recipients of care (Lane 2005). Furthermore, wider social practices involving perceptions of appropriate expertise linked to the authority of the state influence the way that individuals relate to those members of society who, by virtue of their occupation, have the power substantially to affect their lives and to influence, and sometimes actually control, their behaviour (such as teachers and health professionals). As mentioned above, pregnant women sometimes make choices because they perceive them to be in line with preferences expressed by the professionals (Johansen et al 2000). Although individuals in the UK in theory have the legal right not to comply with health professionals' recommendations, this is not always the case in practice (see, for example, Cahill 1999).

Another factor impinging on the delivery of maternity care is the question of resources within the NHS. Many of the woman-centred initiatives piloted in response to *Changing Childbirth* (DH 1993) foundered because of financial constraints, staffing problems and lack of managerial commitment to their maintenance (Benoit et al 2005). All these social factors contribute to the wider context in which the phenomenon of interprofessional working in maternity care is located, and need to be considered when thinking about midwives' relationships and interaction with their colleagues in the workplace.

### **Theorising interprofessional working in midwifery**

Modern midwifery has developed within the dominant medical scientific discourse in which the female body and childbirth have been pathologised. Over the last 150 years, midwifery practice has been increasingly governed by medical priorities and frameworks, largely as a result of perceptions concerning gender roles coupled with the rise of professionalism and the widespread medicalisation of life in western society. Current changes within the UK healthcare system, in alignment with the discourses of the market and of service users' rights, are contributing to the complexity of the system within which maternity care is delivered. Problematic interprofessional relationships continue to cause difficulties for midwives and for women using the service. The wider social context influences all these relationships in complex and sometimes contradictory ways.

Research into interprofessional relationships in the wider healthcare system has highlighted the importance of communication issues and prevailing power relationships. Work to date which has attempted to theorise interprofessional working in midwifery has focused on social theories of gender and medicalisation, linked to power. I would argue that the identification of these influential factors, while important, is not sufficient. A consideration of the constitution and influence of professional identity in this context should also be included in any analysis of the way that different health and/or social care professionals relate to one another. If we are to further our understanding of how the status quo in interprofessional working in midwifery is maintained, I believe we should investigate the relationship between all these factors, and in particular, explore the way in which issues of language and communication, particularly at the micro-level, contribute either to challenging or reinforcing established power relationships.

CDA appears to provide a suitable perspective from which to embark on such a study. Its simultaneous focus on the cultural influences affecting interprofessional relationships, the ideological intertextuality and multi-functionality of language, and the constitutive nature of discourse, all operating within a dynamic network of power relationships, provides a comprehensive theoretical framework for the complexities involved.

### **Terms of Reference**

The theoretical principle proposed in this thesis is that midwives' interprofessional working both influences and is shaped by the relationship between their ways of communicating with other colleagues and the exercise of power within their working environment. A key concept underpinning this principle is that individuals' discursive practices are both affected by and constitutive of discourses linked to the wider social context. The aim of this thesis is therefore to explore how NHS midwives' discursive practices, in the context of their interprofessional working, contribute either to maintaining or challenging discourses, dominant in the wider social context, concerning power, gender, professionalism and the medicalisation of birth. In the next chapter I shall detail the methods I have used in this study.

## **Chapter 6. Methods.**

### **Research approach**

In any project whose aim is to understand complex human behaviour, it is essential to adopt a research approach which will allow in-depth exploration of relevant issues. This necessitates the use of qualitative methods (Bryman 2001). My reasons for incorporating a CDA perspective into the investigative approach for my topic have already been outlined. My concern when selecting the methods for this project, therefore, was that, as well as facilitating in-depth enquiry into my areas of interest, they should also provide congruence with my chosen theoretical perspective with its emphasis on CDA.

In particular, I needed an approach which would allow me to concentrate on the multi-faceted context in which midwives practise, while also facilitating identification and exploration of the discursive practices involved in their interaction and relationships with other professions/occupational groups. I therefore turned to methods that have been used in CDA. CDA researchers have mainly explored the social implications of discourse as discernible in media presentations, public exchanges and verbal interaction (see, for example, Fairclough 1995, 2001b, Van Dijk 2001). A number of scholars have been prominent in the evolution of CDA. Although all are concerned with issues of power and communication (see, for example, Wodak 1996, Van Dijk 2001), I have chosen the approach developed by Norman Fairclough, which evolved over approximately a decade (Fairclough 1992, 1995, Chouliaraki and Fairclough 1999, Fairclough 2001a, 2001b). A particular reason for this choice is that Fairclough (1995) introduced the concept of micro- and macro-analysis to provide a comprehensive picture of what is actually happening in a given situation. This enables a more sophisticated study of a particular topic, as it is consequently located within the framework of wider trends and influences which are impacting upon local conditions, even if only implicitly. This approach appears to be particularly well suited to the analysis of the complex inter-relationships and social interactions that comprise interprofessional working in the NHS, given the increasing centralisation of control and the top-down nature of the collaborative agenda in the UK healthcare system (Meads and Barr 2005, Pollard et al 2005). It should be remembered that interprofessional working in health and social care is actively promoted at governmental level in the UK (DH 2003a).

Because of their focus on language, CDA researchers have usually collected data which have been easily translatable into a 'text', that is, 'a representation of social interaction' (Fairclough 1992). Despite the broad definition of 'text' within the discipline, CDA research methods often focus on documentary material, including interview transcripts (Titscher et al 2000). These methods were not in themselves adequate for this study, which also needed to capture semiotic detail of the physical environment and of interaction between different professionals. The notion of 'text' in CDA does extend to data such as photographic and video recordings (Fairclough 2001b); however, using cameras in maternity care and/or in the NHS is problematic, due to ethical considerations and stringent research governance requirements (Association for Improvements in the Maternity Services (AIMS) 2006a, DH 2005). I therefore also drew on methods which have been used in case-study research, which focus on naturally-occurring events and situations in order to reveal the particular features of a case. A particular strength of this approach is its ability to explore a case as a whole, with reference to its location in the wider social context (Hammersley and Gomm 2000, de Vaus 2001).

A feature of a heuristic case study is that it allows investigation with a focus on the operation of a general theoretical principle (Mitchell 2000). As stated in Chapter 5, the theoretical principle proposed in this thesis is that midwives' interprofessional working both influences and is shaped by the relationship between their ways of communicating with other colleagues and the exercise of power within their working environment. The case was identified as 'the interprofessional working among midwives in an English NHS maternity unit' (a case study of the unit *per se* was not appropriate, since my theoretical perspective dictated examination of discourse with regard to the relationship between power and communication). A case study is particularly suited to situations where there are only a few cases, but a large number of variables (de Vaus 2001). Factors shaping and determining the nature of interprofessional working within any environment are many and various. Adopting a case study approach allowed me to draw together and report on the many different aspects of actions and interactions that constituted interprofessional working within the unit as a whole, and within specific areas which served as sub-units of analysis for the study (Yin 1989), for example, the interprofessional working between midwives and specific occupational groups.

## **Study instruments and sources of data**

The use of documents and interview transcripts as data sources are common both to case-study and CDA research; however, CDA also uses transcripts of naturally-occurring speech, while case-study research includes recording observations of naturally-occurring events and situations (Yin 1989, Titscher et al 2000). The hybrid research approach chosen allowed for the incorporation of all these various types of data, which served to enhance the range of information contributing to the identification and understanding of discursive practices. Macro-analysis involved documentary data reflecting national and international conditions. Micro-analysis focused on unit policy documents, recordings of observations, and transcripts of interviews and naturally-occurring speech, that is, data illustrating local conditions.

Observations of interaction between staff members, naturally-occurring speech, physical behaviour and details of the physical environment were recorded in fieldnotes. The main aim of this process was to record details of actions, speech, body language, appearance, objects and sounds, rather than my interpretation of these phenomena. A priority was to record details of interactions between midwives and individuals from other occupations.

In order to aid identification of discourses concerning the midwives' practice and relationships in the context of the organisation, I wished to explore thoroughly their perceptions of interprofessional issues in the unit. However, my focus in this regard was not random, in that I set out to research issues concerning power, communication and identity, in accordance with my theoretical approach. I therefore decided to conduct semi-structured interviews with individual midwives. I anticipated that this method's combination of structure and flexibility would enable me to retain control over the direction of the interviews, while still allowing participants to raise any issues they considered relevant. This form of data collection would also be flexible enough to allow participants' responses to reflect their lived reality, which in turn would facilitate identification of their discursive practices (Fairclough 1992, Rees 1997).

The interview guide was accordingly developed to allow flexibility and a focus on power, communication and identity. As highlighted in previous chapters, there are numerous reports of difficult relationships between midwives and other healthcare professionals (Hundley et al 1995, Farquhar et al 1998, Meerabeau et al 1999, Farmer et al 2003, Pollard 2003). The guide therefore started with a general



exploration of the midwives' perceptions concerning interprofessional working in the unit. After their initial response, midwives were prompted to discuss professions/occupational groups with whom they collaborated, but whom they had not yet mentioned. Particular areas concerning power differentials in maternity care include observation of unit policies governing midwifery practice, and support for women's choices (Davies 1997, Hosein 1998, Levy 1999, Pollard 2003). So in order to investigate the midwives' discursive practices concerning their professional role within the organisation, issues surrounding decision-making in relation to two hospital policies and to women's choices were also explored. Role overlap is known to contribute to interprofessional tensions in healthcare (Farquhar et al 1998, Meerabeau et al 1999, Booth and Hewison 2002). Midwives were therefore also questioned about cross-boundary initiatives in the unit which involved their (and others') role extension. Care was taken to give informants the opportunity to raise other issues which they thought relevant; questions concerning these issues were then included in subsequent interviews. This was also the case where my observation of interprofessional interaction raised questions which I wished to pursue in more depth. So, in keeping with the principles governing qualitative research, the development of the guide continued throughout the period of data collection (Holloway and Wheeler 1996). The final version of the interview guide can be found in Appendix 1.

Since the stated rationale for enhancing interprofessional working in health and social care is to improve care delivery, I also wished to explore women's perceptions of the way that midwives interacted with other maternity care professionals. I conducted semi-structured interviews with women (for similar reasons as those given above). I planned to ask each woman about her current/most recent pregnancy in relation to the range of professionals she was seeing/had seen. As I anticipated that women's experiences could vary considerably, I decided that a pre-determined interview guide would not be appropriate for this sample. I therefore identified topics for exploration from the literature concerning interprofessional issues both in midwifery and in the wider health care arena, and asked about them if relevant for the woman in question. Issues identified included communication between the midwives and other professionals (Fleissig et al 1997, Farquhar et al 1998, Fraser 1999, Symon 1999, Farquhar et al 2000), consistency of information and advice (Farquhar et al 1998), liaison between the community services, the hospital services and other agencies (Cowley et al 2002, Hudson 2002, Van Eyk and Baum 2002), and responses and reactions to women's expressions of choice

concerning their care (Kirkham and Stapleton 2004, Pollard 2005). The interviews followed individual women's particular experiences in relation to these factors, allowing also for them to raise other issues.

I anticipated collecting data over the course of a year in three periods lasting a fortnight each. As members of some disciplines, particularly more junior medical staff, often spend relatively short times (approximately six months) in practice settings, I wished to ensure that the data collection period extended beyond such a time frame, so that the effect of any unusually dominant personalities would not skew the observed data concerning the unit as a whole; interpersonal issues are known to affect interprofessional working (Barrett and Keeping 2005). A characteristic of case study research is in-depth engagement with the unit of analysis (Cresswell 1998). Given that I have considerable experience researching interprofessional issues, and that I have also practised in a number of maternity units, and therefore am used to integrating myself into these environments, I anticipated that the time allocated for data collection would afford me sufficient opportunity for such engagement.

### **Ethical considerations**

The study was conducted following the principles set out in UK guidance on research governance (DH 2005). Ethical approval was gained from the University Ethics Committee and from a NHS Local Research Ethics Committee. Approval was also obtained from the Research and Development Department of the NHS Trust in which data were collected.

All individuals recruited to the study were provided with written information, and were asked to sign consent forms if they agreed to participate. Individuals who were not recruited were sometimes present during data collection; no observations involving them were recorded. Separate consent was obtained for interview. The information sheets and consent forms used in the study can be found in Appendix 2 (different forms were used for women recruited in hospital and those recruited elsewhere – see 'The sample for interview' below).

All the interviewees in the study were sent transcripts/notes of their interview for comment. There were two cases in which technical problems rendered interviews unusable. In both these instances, I wrote to the individuals involved, thanking them for their contribution and explaining why it could not be included in the study. A

summary of the findings was sent to all the interviewees, as well as to the relevant managers in the NHS Trust, with a request that they be made available for staff who had participated in the observational phase of the study.

In keeping with good practice concerning research in maternity care (AIMS 2006a), women were neither observed nor recruited to the study when they were undergoing any intimate physical examination, in labour, breastfeeding, or in discussion with staff about issues which were likely to be embarrassing or distressing for them. As the focus of the study was on staff interaction, I considered it unethical to involve women whose experience of pregnancy or birth appeared to be particularly traumatic. Therefore, women whose babies had died or were receiving intensive care were excluded from the study, as were those who did not have the capacity to consent to participation.

## **Setting**

The NHS maternity unit in which this research project was sited was chosen for a number of reasons. Firstly, its patterns of care provision were reasonably cohesive, for example, the community midwifery service followed only one model of care. Given practical restraints concerning time and resources, I did not feel that I could usefully explore mechanisms relating to power and communication if there were too many different models of service provision to consider. It was essential that the unit be consultant-led, since relationships between midwives and the full range of other professionals with whom they collaborate were pertinent for the study. In a midwife-led unit, where there would have been no medical presence, the opportunities for observing these relationships would have been severely limited. A third reason for selecting this particular unit was that it had a strong midwifery management with a history of supporting the extension of occupational roles. Since the blurring of professional/occupational boundaries can be a source of concern for individual professionals (Cook et al 2001, Booth and Hewison 2002, Rushmer 2005, Carmel 2006), I felt that this would allow me to explore issues relating to this phenomenon in appropriate depth. Lastly, the unit was geographically accessible to me, a factor which had to be taken into consideration given the resource constraints mentioned above.

The unit comprised a central hospital site and a community midwifery service. It employed hospital-based midwives, as well as community midwifery teams who practised in the hospital, in GP surgeries, in community health centres, and in

women's homes. Other relevant hospital personnel included administrative staff, anaesthetists, health care assistants, obstetricians, nursery nurses, paediatricians, physiotherapists and ultrasonographers. Liaison also occurred between both hospital and community midwives and other community-based professionals, in particular GPs, health visitors, community mental health teams and social workers.

The hospital had three main areas in which midwives practised: the delivery suite, the ward and the antenatal clinic. Areas selected for observation were the delivery suite and the ward. The antenatal clinic was not selected for data collection, as the pattern of care provision there would have made it very difficult to observe interactions between the midwives and other staff without my being present while individual women were actually receiving care. I felt that such intrusion upon the women was not warranted, as I was confident that access to the other two areas would afford me adequate opportunities for data collection.

Within the delivery suite, the area selected for data collection was the main administrative/reception area where women were admitted and where all the staff met to discuss and co-ordinate care. I did not pursue access to areas where I would be able to observe episodes of direct care delivery, as I felt that this would not be ethically sound, given the physically intimate and emotionally demanding nature of the women's situation (AIMS 2006a). All areas of the ward were available to me for data collection. Much of the interaction involving community midwives and other professionals occurred either in the hospital, where they had their office, or by telephone or e-mail. Their practice in the community was usually conducted on a one-to-one basis with the women, either in the latter's homes or in a community clinic. There would have been no advantage to observing the community midwives in these situations, which, once again, would have entailed unwarranted intrusion upon the women's privacy, so no observations were conducted in community settings.

## **Sample**

### ***Documentary data***

These data were selected to illustrate both wider and local conditions which impacted on the midwives' interprofessional working within the unit. Accordingly, data included documents concerning midwives' perceptions of the current climate concerning their interprofessional interaction, at both an international and national

level; the wider framework in which UK midwives' professional and legal obligations are located; and midwives' normal practice within the unit in relation to other professionals.

Perceptions concerning the midwife's professional role and standing in relation to other disciplines have influenced, and been influenced by, midwifery's professionalisation project for a considerable number of years (Witz 1992, Symon 1996, Stewart 2001). In order to elucidate the wider context in which this issue is framed, all bar one of eighteen peer-reviewed journal research papers on which a midwife was the sole or lead author were selected for analysis (see Appendix 3) from those which informed the discussion in earlier chapters<sup>5</sup>. A co-authored paper was omitted, as the lead author's orientation to the issues at hand was amply demonstrated in another paper on which she was sole author. Papers by non-midwife authors were not included, as the focus of interest was on midwives' representation of pertinent issues.

All UK midwives must practise in accordance with rules formulated by their regulatory body. Until 2002, this was the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), subsequently replaced by the NMC. These rules are currently set out in the document *Midwives rules and standards* (NMC 2004b), which came into force during the data collection period. Prior to that, they were detailed in *Midwives rules and code of practice* (UKCC 1998). Both sets of rules are based on the WHO (1992) international definition of a midwife (see Appendix 4). Since these three documents prescribed midwives' professional obligations during the data collection period, they were included for analysis.

As stated earlier, two unit policies were selected for analysis, one defining and governing practice in the case of dysfunctional labour, and one outlining procedures for the administration of Vitamin K to newborn babies (see Appendix 5). These policies were chosen because they concerned areas of care which involved other professionals, either directly or indirectly, and in which all midwives in the unit engaged fairly frequently. Furthermore, they were not uncontroversial, and therefore were suitable for discussion concerning midwives' practice regarding observation of unit policies and support for women's choices. Policy selection was restricted to these two documents, in order to preserve symmetry between analysis

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<sup>5</sup> See Table 1 on pp.10-11

of policies and discussion in the midwife interviews (see the interview guide in Appendix 1).

### ***The sample for observation***

All staff coming into an area during the three periods of data collection were eligible for recruitment to the study and where appropriate, women using the service. I approached people individually, told them why I was in the area, and gave them the information sheet to read. I subsequently asked them for written consent. If they agreed to participate, I included them in my observations. Observations recorded involved thirty-two midwives, four administrative staff, twenty-seven medical staff, five students, ten healthcare assistants, six other hospital staff and four women using the service. No individuals refused to participate in observation.

### ***The sample for interview***

#### ***Midwives and other professionals***

The structures and processes of midwives' interprofessional working differ according to practice areas, particularly dependent on whether they are hospital- or community-based. Given the hierarchical nature of the NHS, I wished to interview a range of participants in each area, so that I could explore perceptions of both junior and senior staff. I also wished to interview midwives who were particularly interesting in terms of interprofessional working or extended roles. I therefore selected the midwife sample for interview according to a strategy of maximum variation (Cresswell 1998), on the basis of work locale (community, delivery suite, ward), seniority and role.

It was anticipated that staff turnover and patterns of staff rotation, and the nature of the service, would preclude constructing defined cohorts of midwives for the purposes of the study. This was not considered problematic, since the research focused on the discursive practices which midwives employed in relation to interprofessional working, and not the psychological characteristics of individuals. The sample was accordingly drawn from those midwives working within a defined context during each period of data collection. This meant that midwives could be interviewed more than once during the course of data collection.

The final interview sample comprised twenty midwives: three senior midwifery managers (one responsible for the unit overall, one responsible for the ward, and one responsible for the delivery suite); three senior hospital midwives, based on the

delivery suite; four middle-ranking hospital midwives (two based on the delivery suite and two based on the ward); three junior hospital midwives (one based on the delivery suite and two based on the ward); and seven community midwives. One senior hospital midwife was interviewed twice. One senior hospital midwife and three community midwives were involved in cross-boundary initiatives in which they had taken on skills formerly only the province of medical staff, and a middle-ranking hospital midwife was responsible for organising education for the healthcare assistants which would enable them to take on some aspects of the midwives' role. During the observations, it became apparent that the midwives' role extension had had a significant impact on the obstetricians' role. For this reason, four obstetricians (two consultants and two middle-grade registrars) were also recruited to interview, to explore further this aspect of interprofessional working in the unit.

All the interviewees were identified and recruited while I was collecting data in the hospital. The consent form (see Appendix 2) asked participants to indicate whether or not they were willing to be interviewed. During sessions when I was observing interaction, I approached individuals who had already consented to interview in principle (through signing the relevant part of the consent form) and if they were still agreeable, we arranged a mutually convenient time. This always depended on individuals' workloads: sometimes it was possible to interview them on the same day, sometimes an appointment for another day had to be made. On two occasions, midwives agreed to be interviewed but their subsequent workload made it impossible to arrange a time when both they and I were available. No professionals approached refused to be interviewed.

### *Women using the service*

I initially planned to interview women who were admitted to the hospital during the data collection fortnights, so that my data set arising from observation and interview would pertain to the same time periods. The selection of women for interview was conducted in negotiation with senior midwives, following the criteria listed above. During the first fortnight, I recruited three pregnant women to the research, all of whom were in hospital due to medical complications. However, recruitment of women who had given birth was problematic as, unless they or their babies were experiencing significant problems (in which case they tended to meet the exclusion criteria), very few of them stayed in hospital for more than 48 hours. It proved very difficult to recruit them so soon after they had given birth. I therefore decided to recruit women in a separate exercise during the year after the completion of data

collection within the unit. After gaining approval from the University Ethics Committee for this change in recruitment method, I placed an advertisement in the local press and in the local NCT newsletter, stating that I wished to interview women who had given birth either in the hospital or at home attended by the community midwives during the previous year (see Appendix 6). By specifying this time frame, all the data collected for the study related to the same set of practices concerning interprofessional interaction in the unit. Simkin (1992) demonstrated that women's recollection of their birth experiences is consistent over a long-term period, so the length of time between data collection in the unit and the interviews with the women was not problematic. In this way, I recruited a further five women to the study, one of whom had given birth at home. Although these women were self-selected, and could all be categorised as white middle-class British, they had had a variety of experience, both positive and negative in their own perceptions, and so presented a varied picture of care provision and interprofessional working in the maternity services in the area.

## **Data collection**

### ***Observation***

During observation, I adopted the role of participant observer, in that I usually interacted with participants during periods of data collection (Cresswell 1998). I also occasionally participated in various activities in the unit (see 'Researcher reflexivity' below). To attempt the status of a non-participant observer would have been both unrealistic and inconsistent with my non-positivist approach to my topic (Smith 1998). Over each period, I went to the hospital for a number of days, usually timing my arrival with that of the changeover between the midwives on the night and the early morning shifts. I spent 21 days conducting observations, staying in the hospital for approximately 5 hours each day. Due to different levels of interprofessional interaction in the different areas, I spent approximately twice as much time on the delivery suite as I did on the ward.

I recorded my observations by writing fieldnotes, which I later typed up exactly as I had written them, including abbreviations, slang, etcetera. I adopted this procedure because I wished to scrutinise some of my fieldnotes using CDA techniques, for the purpose of clarifying my role in the research process (see 'Researcher reflexivity' below) (Taylor 2001c).



## ***Interviews***

An interview in qualitative research attempts to elicit information that is both genuine and comprehensive. The manner and environment in which interviews are conducted are consequently of great importance. Interviewees need to feel at ease; physical comfort, privacy, a lack of noise, and freedom from interruptions all contribute to successful interviews (Holloway and Wheeler 1996, Rees 1997).

My theoretical perspective and personal inclination align with an approach to interviewing techniques, common in feminist research, which frames the interview as a person-person encounter, incorporating self-disclosure and a two-way flow of information. This approach emphasises the importance of the quality of the interaction between interviewer and interviewee; it maintains that data collection is enhanced by the establishment of a genuine person-person relationship (Oakley 1981, Reinharz 1992). Verbatim transcription of such interaction not only allows research participants to speak for themselves, but also helps make the role of the researcher more transparent. In order to identify and explore discursive practices through interview data, my aim was to capture both content and style, that is, not only what the interviewees said, but also how they said it. I therefore also needed to have verbatim interview transcripts for analysis based on a CDA approach (Taylor 2001c).

In order to obtain data suitable for verbatim transcribing, I audio recorded the interviews. This method carries both advantages and disadvantages: the interviewer can focus on the informant, so that the interview feels like a normal conversation, which will hopefully enhance the quality of the data collected; however, equipment can be intimidating, and may also suffer from malfunction (Holloway and Wheeler 1996, Rees 1997). The equipment I used to record the interviews was small and unobtrusive, so most informants who agreed to this method of recording seemed to be able to ignore it once involved in thinking about the issues under discussion. Three interviewees (two midwives and one woman using the service) did not wish to be audio recorded. In these cases, I took notes during the interview, capturing direct speech as best I could.

During the data collection periods in the hospital, I was concerned to present myself as uncontroversially as possible. I accordingly dressed conventionally but comfortably, in clothes that would have been suitable for a relatively informal social occasion.

### *Midwives and obstetricians*

Most interviews took place in various settings within the delivery suite and the ward, including unused treatment rooms, the community midwives' office, and the coffee rooms in both areas. These were all places in which the staff were at home. I interviewed the consultants in their offices. All the interviews were conducted during periods when staff were officially at work, so it was essential to make the most of the time available, and to keep the interaction as focused as possible. There were interruptions on one or two occasions, but they did not significantly impede the flow of the interviews concerned. Two interviews with community midwives were audio recorded by telephone, since it was not possible to arrange a suitable time to meet. Unfortunately, technical problems rendered one of these interviews unusable. For analysis purposes, data were available from twenty midwife interviews and four interviews with obstetricians.

### *Women using the service*

When health professionals interview service users, an obvious concern must be the power differentials within the relationship, particularly in societies like the UK where superior status and authority are given to the former group. Two women whom I interviewed in hospital were staying in single rooms, in which the interviews took place. Both these women had been there for some weeks, so the rooms were very much their territory, as opposed to mine. They both wore street clothes, so the discourse of 'patient and professional' was not particularly evident. The case of the third woman interviewed in hospital was less satisfactory. She was housed in a bay within a four-bedded room, in which a small degree of privacy was afforded by drawn curtains. This was the only place available for interview, and the attempts on both our parts to maintain discretion resulted in an inaudible audio recording.

Subsequent interviews with women were conducted in their own homes, except for one woman who chose to be interviewed at her workplace. These interviews were generally conducted in an atmosphere of social equality and normality, often over a cup of coffee. All the women appeared to be keen to talk about their experiences, going into some depth in their answers to questions. Again, technical problems resulted in one interview being rendered unusable; however, in this instance, I was able to make notes from memory shortly afterwards, which I sent to the participant for verification. Data were available for analysis from seven interviews with women.

## **Data analysis**

A prime objective of CDA is to elucidate relationships between discourses identified within a text. To this end, Fairclough (2001b) has designed an analytic framework which involves three discrete steps:

- Location of the phenomenon of interest in context, with a focus on its problematic social nature. A particular concern is to identify the relationship between the phenomenon in question and other social practices.
- Identification and interactional analysis of appropriate texts. Interactional analysis aims 'to show how semiotic, including linguistic, properties of the text connect with what is going on socially in the interaction' (Fairclough 2001b, p.240).
- Investigation of how, and to whom, benefits are conferred through the maintenance of the status quo. An important part of this step includes suggestion of alternative ways of organising the social practice concerned, and reflecting upon the analysis process itself.

The choice of topic for this thesis and the completion of the research tasks associated with its exploration, as reported in Chapters 2-10, comprised the first two steps in this schema. The third step will be addressed in Chapter 11.

Case study analysis involves the identification of patterns across the different types of data collected, so that an understanding of the case as a whole may be achieved (Cresswell 1998). A key feature of analysis of a heuristic case study is to describe the case in relation to underlying theoretical principles (de Vaus 2001). My focus in this study was accordingly to elucidate patterns concerning the relationship between the operation of power and communication mechanisms within my identified case, that is, the interprofessional working in the unit.

## ***Documentary analysis***

The documents selected for analysis constituted 'texts', and as such, were subjected to interactional analysis (Fairclough 2001b). This includes analysis at both the global and local level. Global aspects of 'texts' are identified, for example, genre (the way that language is arranged into patterns) and organisation<sup>6</sup>, as well as interdiscursivity, that is, how they combine different genres and discourses.

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<sup>6</sup> See p.29

Analysis at the local level involves textual analysis of constituent parts, for example, syntax and vocabulary. Fairclough (2001b) suggests identifying four features within a 'text':

- Representation – the way that social practices are presented and contextualised.
- Relation – the way that social relations are constructed.
- Identification – the way that social identities are constructed.
- Valuing – the way that social values are put forward.

The first step in interactional analysis of a document was to identify the genre(s) used. Textual analysis was performed in a manner similar to thematic analysis (see below), in that each document was coded in terms of categories of social practice, relations, identity and value. These categories were then examined and grouped, in order to produce themes relating to these features. Finally, the text was examined for evidence of interdiscursivity. An example of interactional analysis applied to a section of a document can be found in Appendix 7.

### ***Analysis of interview and observational data***

Due to the hybrid nature of my research approach, both thematic analysis and CDA techniques were used to interrogate the fieldwork data.

#### ***Thematic analysis***

Both the interview data and the observational data were initially subjected to thematic analysis. Thematic analysis entails the organisation of data into categories and themes, with their subsequent integration into an overall structure explaining the relationships and patterns inherent in the phenomena under investigation. A number of steps are generally recommended (Huberman and Miles 1994, Janesick 1994, Polit and Hungler 1995):

- words and phrases used by participants are coded according to meaning, and through this process a number of categories are developed;
- themes emerging from the data are found by examining and grouping these categories;
- the researcher searches for patterns and relationships linking the emerging themes;

- the researcher constructs an integrated depiction of these patterns and relationships.

Analysis usually only begins with the data itself; however, in some cases the analysis style may be predetermined by the design of the study (Huberman and Miles 1994, Janesick 1994). Since this study had a focus on power, communication and identity, as expressed through the semiotics of a situation, I already had tentative themes in mind at the start of data collection, for example, the relationship between hierarchy and behaviour; however, I obviously needed also to be receptive to the existence of themes not already predicated. I therefore adopted an iterative approach to analysis, as suggested by Polit and Hungler (1995). The data were loaded into Qualrus Version 2.0.4, a qualitative analysis software package. The data were coded for categories; an examination and grouping of these categories produced a number of themes; with these themes in mind, I then went back to the material, searching for further/ alternative categories and/or themes. This process was repeated until I felt the results to be satisfactory. There was some overlap between the categories and themes identified from the observational data, and those identified from the interview data.

Codes developed included those for language use, particularly vocabulary and syntax. Data were also coded to enable identification of my input into the research process. Appendix 8 includes examples of fieldnotes and interview transcripts coded for categories, and a list of categories and themes.

#### *CDA techniques*

Following thematic analysis, appropriate data were subjected to scrutiny according to CDA principles, in order to identify the midwives' discursive practices. These comprised all the midwife interviews, and fieldnote data which incorporated direct speech and/or semiotic details of physical appearance and non-verbal behaviour. As stated earlier, the focus of analysis in CDA is a 'text', which in this context is understood to be a representation of social interaction (Fairclough 1992). For data to be accessible to CDA techniques, they must therefore constitute 'text' within the parameters set by the discipline.

Although there has been debate about whether only naturally-occurring speech should be considered data in discourse analysis, verbatim interview transcripts are now accepted as legitimate data in many discourse analytic approaches (Silverman

2001, Wetherell 2001b). This is less common in CDA, but they can certainly be regarded as representations of social interaction. At an obvious level, the main social interaction in interviews occurs between the interviewer and the interviewees. However, it can be argued that interviews also allow insight into, and therefore representation of, social interaction at other levels, in that they allow access to the interviewees' presentation of their own position with regard to a range of social issues.

The case for considering fieldnotes as legitimate data for CDA is more complex. Fieldnotes are used to capture data concerning naturally-occurring events. An alternative way to collect these data would have been to use video recordings. CDA researchers include video recordings in their range of data (Fairclough 2001b, Wetherell 2001b), so this would have been consistent with this approach; the use of fieldnotes is not usual in CDA. However, as stated above, using video within an NHS setting is problematic, not least because it becomes impossible to exclude non-participating individuals from observation if necessary.

When using fieldnotes for data collection, the researcher selects items for recording, as opposed to capturing an entire sequence of behaviour or events. Therefore, at first glance fieldnotes appear to constitute an interpretation of social interaction, rather than a representation of it. However, further examination of this situation reveals that the difference between fieldnotes and video recordings is actually one of degree, rather than of kind. Ashmore et al (2004) have argued that an audio tape should not be treated as a 'found object', whose status and nature need not be questioned. They coined the phrase 'tape fetishism' to convey the idea that a listener can directly access an event by listening to a tape recording made of it. By extension, these ideas can also be applied to the use of video tape. Goodwin (1994) speaks of 'professional vision' and Ashmore et al (2004) write about 'professional hearing' with regard to tape recordings of events. These authors assert that the act of looking at/listening to tapes requires an act of deliberate seeing/hearing, and so cannot be equated with seeing/hearing the event itself. They argue that there is thus no inherent benefit in using audio or video recording, as compared to data collection by other means.

Intuitively, the use of taping appears to offer an 'accurate' representation of interaction. However, if one subscribes to a post-modern view, one must question whether such a representation can ever be realised (Smith 1998). It can be argued

that, no matter the method chosen, the selection of data and the choice of recording method require similar processes in which the researcher exercises discretion and subjective judgement in order to decide what to record. In this regard, Ashmore et al (2004) suggest that, rather than judging how accurately interaction is represented by data, a more useful stance is to make transparent the work of building the correspondence between interaction and its representation in data. This stance appears to align satisfactorily with the ethos of much qualitative research, which accepts the inevitability of subjective interpretation of the social world (Smith 1998).

So it can be argued that both interview transcripts and fieldnotes can be regarded as representations of social interaction. A later definition of a 'text' in CDA describes it as 'a contribution to communicative interaction which is designed for travel, so to speak - which is designed in one context with a view to its uptake in others.' (Chouliaraki and Fairclough 1999, p.45). It can also be argued that both transcripts and fieldnotes satisfy this definition, in that they are designed to convey information about a specific topic in a specific context in a manner which allows it to be examined and understood in a range of other contexts. Considering all the above, I conclude that both interview transcripts and fieldnotes can be considered to be 'texts', and therefore constitute legitimate data for the application of CDA techniques.

However, interactional analysis at a global level (see above) did not appear to be appropriate for the fieldwork data. Firstly, global aspects applied across the whole data set: the genre 'interview style' applied to each interview transcript and the genre 'notes' applied to all the fieldnote data, so that no insights were to be gained from their identification. Secondly, the interview transcripts were the result of discussion and questioning, and therefore jointly produced by me and the midwives. Furthermore, research participants had no part in constructing the fieldnotes. Any resulting interdiscursivity in either the interview transcripts or the fieldnotes was liable therefore to depend on my own perspective and contribution to the process of data collection. For these reasons, I concentrated mainly on conducting local, that is, textual analysis of the interview transcripts and fieldnotes. Appendix 9 includes examples of interview transcripts and fieldnotes coded for the four features (see above), and a list of categories and themes for each.

## **Researcher reflexivity**

The possible effect of the researcher's role on the research process has been well discussed, particularly in ethnographic research (Spencer 2001). As should be obvious from the exposition of my theoretical perspective, I do not subscribe to a positivist/empiricist view, nor do I think it possible for a researcher to be a neutral gatherer of information. Moreover, I believe the mere presence of a researcher unavoidably affects the dynamics of the research setting (Smith 1998). This is particularly the case where methods involve collection of qualitative data over significant periods of time, as in this study.

This process begins with the way the researcher represents herself in order to gain access to the setting, and continues as she inevitably starts to form relationships with participants. So although her stated role may be that of 'researcher', she may find herself moving in and out of other roles as the way she interacts with individuals in the setting evolves. One aim of qualitative research is to attempt to 'see through the eyes' of the participants (Bryman 2001). However, the degree to which any researcher is really able to do this, is questionable. After all, when involved in any interaction or observation, researchers are unavoidably seeing through their own eyes.

Streubert Speziale (2007) recommends that researchers 'bracket' their own opinions and attitudes to their research topic; that is, make them explicit, and then attempt to put them on one side. I am sceptical about the degree to which an individual can render herself 'value-free' in this way, not least because one cannot know how many unconsciously-held opinions and attitudes still remain hidden; nor do I think that this is necessarily an appropriate way to proceed if one recognises the futility of striving for an 'objective' stance. My preferred stance incorporates a recognition that every researcher brings to a situation her own history and personality, and that the entire research process will depend in some measure on these factors (Smith 1998). Current accepted practice entails recognising and acknowledging these factors whenever possible, so that any report of process, findings or recommendations is clearly framed within the awareness of the researcher's influence (Bryman 2001).

I started this study knowing that I carried certain beliefs and values which are a product of my own history and personality. Firstly, I am a mother and a midwife and my own experiences of giving birth and of assisting birthing women have had a



profound effect on my own attitude to birth, which I believe to be a process best left undisturbed as far as possible. So my attitude towards midwifery is that midwives should practice with the minimum of intervention (medicalised or otherwise), and should always be led by the feelings and wishes of the women whom they are attending, rather than by professional or organisational priorities. I found that this stance made it almost impossible for me to practise midwifery within the NHS without suffering from considerable cognitive and emotional dissonance on a daily basis.

My experience of practising as an NHS midwife left me with the impression that the wishes and feelings of the women using the service often came last, this being justified by the rhetoric (and usually the apparent sincere belief) that what was happening to them was for their own good. I observed, in both others and myself, the insidious nature of socialisation into the institution, so that behaviours that would be unacceptable in ordinary social settings were regarded as normal (such as ignoring unknown newcomers entering a room)<sup>7</sup>. My impression of interaction between staff members was that, although influenced by occupation, it was particularly dependent on individuals' personalities and interpersonal skills. However, a major consideration for me as a midwife was my ability to exercise my own (mandatory) professional autonomy: it was in this context that I became acutely aware of the organisational dynamics between midwives and other professionals, and experienced first-hand how this impacted (negatively, in my perception) upon my own practice and my own professional standing.

I was raised in apartheid South Africa, which, compared to the UK, was fairly anarchic in its conception of the relationship between citizens and the state. In particular, when I was growing to adulthood, there was no expectation that the state had any role to play in regulating individuals' health-related behaviours. Medicalised approaches to healthcare were (and are) not universally privileged: many black South Africans prefer to consult their own traditional healers, rather than westernised healthcare professionals (Setswe 1999, Puckree et al 2002). During the apartheid era, most white South Africans accessed healthcare through privately-financed organisations, so that the relationship between service user and health professional was that of client and vendor: if a health professional did not provide a

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<sup>7</sup> Observations concerning NHS staff's lack of social niceties have also been made by other authors. See, for example, Reeves and Lewin (2004).

service satisfactory to the client, the latter simply changed provider. So while health professionals were valued for their expertise among white South Africans, they did not exercise any authority in the wider social sphere; and the social norm was for individuals to decide for themselves how far to follow any health professional's recommendations. The situation seems to me to be quite different in the UK, where members of the public appear to invest a great deal of authority in health and social care professionals as representatives of the 'establishment', who not only know what is best for them, but who also seem to have the social influence to enforce compliance, despite the lack of legal authority to do so (Harcombe 1999). The difference between the two countries may be attributable to the fact that, during the late 19<sup>th</sup> century, at a time when many parts of South Africa were still being settled by European immigrants, in Britain increasing medicalisation of life, and in particular, the development of public health as a specialism, had already resulted in the implementation of an explicit agenda of social control (Stacey 1988, Nettleton 1995).

To summarise, I began this study with a strong belief that birth is a natural process that usually does not need intervention in order to be safe; but also with the feeling that as a midwife, I and my beliefs do not 'fit' within the prevailing system of NHS maternity care. I also thought that midwives' professional stance in the UK is inevitably compromised by the privileging of the medical profession's perspective and priorities and the hierarchical structures of the NHS. Previous research I had conducted had revealed that many midwives were not aware how precarious this situation rendered their position, both as employees and as professionals (Pollard 2003). From a more general perspective, it seemed peculiar to me that individuals would so often invest power and authority in health professionals, and would so often appear to be anxious to comply with the system, even to their own detriment, despite the absence of any real need to do so.

It did not seem to me that these beliefs and attitudes were ones that I could easily set aside during this study, nor, indeed, did I particularly want to. However, I did attempt to keep an awareness of them alive during the process of data collection and analysis, so that I could have some control over the extent to which they influenced my observations and interpretation. To this end, I kept a reflective journal during the period of data collection, in which I tried to capture my own thought processes about some of these issues. What I had not expected, was how the inclusion of CDA in my research approach served to aid the process of reflexivity. In particular, analysis of my journal, my fieldnotes and my own contributions to

interviews has allowed me to see how my role as a researcher changed and developed during the course of data collection, and how my own mental framing influenced data collection.

### ***Researcher role***

#### *With staff in the unit*

When I decided to begin this research, there were certain factors operating in the wider context which I knew could aid me in gaining access to suitable settings. Over the last fifteen years, strategies in midwives' professionalisation project have included their gaining higher degrees and conducting research grounded in midwifery perspectives (O'Loughlin 2001, Osbourne 2001). Therefore, in my estimation, my chief asset was that I was a midwife. I was fortunate to be living in an area where most of the heads of midwifery in the various NHS Trusts were progressive in their outlook, and those I approached were keen to give me their support.

Once I had received permission to go into my selected unit, my main concern was to gain access to the midwives, my main focus of interest. I deliberately presented myself to them as another midwife, not just as a researcher, as my own experience led me to believe that I had a far better chance of their accepting a fellow midwife in a research role, rather than an academic with some midwifery knowledge and experience. Although this was a conscious strategy, I did not feel that I was misrepresenting myself: indeed, throughout the period of data collection, I found that I was drawn into clinical discussions through the strength of my own interest in the topic:

IOL (*induction of labour*) ctg (*cardiotocograph*) reviewed by consultant.  
Makes decision to carry on – midwife is happy to go along with it. I ask  
her if I can look at the ctg, as it sounds interesting.

*Excerpt from fieldnotes*

I was also particularly careful to keep the senior midwives informed of my activities, making sure that they knew when I was going to be collecting data. This was another conscious strategy on my part to optimise my acceptance into the setting, but it was only the exercise of common courtesy, as these midwives were responsible for the integrity of the areas in which they were in charge.

Before starting data collection I was invited to attend a midwives' meeting, so that I could introduce myself to them and explain what I wished to do in the unit. Despite this preparation, my first encounter with staff at the beginning of data collection, which took place in the delivery suite coffee room at 7.30 one morning, was disconcerting:

No social graces whatever. No greeting, no offer of a drink, no acknowledgement. None of the midwives knows why I'm here, other than the 2 who were at the meeting the other night.

*Excerpt from research journal*

Fortunately, I recognised this behaviour as following a pattern which I have experienced in many maternity units in the UK. As mentioned above, social norms within maternity units do not conform to those in wider UK society. This is one illustration of how my professional background and experience allowed me to interpret individuals' behaviour in a way that facilitated my integration into the unit.

As a participant observer, over the course of data collection I moved from being an 'outsider' to being an 'insider' (Cresswell 1998). After being initially ignored, I gradually started to become accepted, so that I almost became part of the furniture. As staff got used to my presence, I was frequently included in social conversations with individuals from a range of occupations – midwives, doctors, theatre staff, healthcare assistants and administrative staff:

Midwifery manager says she's had some chocolates. Midwife asks why she hasn't brought any down. Jokes with me about senior managers, and how they treat the others. Lots of laughter.

Have a conversation with receptionist and midwifery manager about Christmas decorations.

*Excerpts from fieldnotes*

The extent of my social integration into the unit became clear to me when I returned there after an absence of some months for the second period of data collection. I was greeted by some staff as if I belonged there and had simply been away for a while. I had no qualms about becoming socially involved in this way. I felt that the more I was included by the unit staff, the more likely they were to behave normally in my presence. However, I was aware that this could have an effect on my own

observation and interpretation of events. I developed genuine liking for many of the midwives, and I could see that at times this influenced the data I was collecting:

I'm conscious that I want to respect the access that I've been given here, and although I may not agree with their views on birth and midwifery, I like the midwives here, and want to present them in a good light. Impossible for me to be anywhere for too long without forming relationships.

*Excerpt from research journal*

So as data collection progressed, I recognised that I continually needed to check the balance between due and proper consideration for the participants, my own tendency to become socially involved in situations, and the technical requirements of the research process.

My inclusion into the unit at a social level was not the only factor operating with regard to my role there. As time went by, I found myself occasionally being treated as one of the workforce. This was particularly so when I was asked to pass on information between members of staff in the absence of anyone else. Sometimes, however, this was on my own initiative, when someone required information, and I realised that I was the only person present who was able to help, having previously been party to other events:

Consultant sits down to try to ring the social workers – I tell him that the unit social worker has already phoned them, and that the midwife is waiting for them to ring back.

*Excerpt from fieldnotes*

However, there were also occasions when I was asked to perform a particular task:

Student asks me to look after baby, I sit down next to cot.

*Excerpt from fieldnotes*

Again, I had no problem about my involvement at this level, as long as I felt that it was appropriate, both in terms of the research and my professional obligations. One of the clearest indications I received that I was accepted in the unit, both socially and professionally, is demonstrated in the following interchange, which occurred during my final period of data collection:

The manager has been on the phone, they're all still discussing trying to find a midwife to work tonight.

Midwife: 'We need two.' They laugh.

Manager: 'But one would be nice.' She looks over to me: 'You don't want to work tonight, do you?' I laugh, don't answer.

*Excerpt from fieldnotes*

Although the manager was not asking this question seriously, I felt it signalled her acknowledgement of me on a number of levels.

The fact that staff accepted me into the unit did not mean that they had forgotten why I was there. There were numerous occasions when they demonstrated their awareness of what I was doing:

A senior midwife and another midwife come in, talk about a woman. The registrar says to me: 'Now we're all being really nice to each other, because you're here – when you've gone we'll be horrible again.'

General laughter.

*Excerpt from fieldnotes*

However, I do not believe that this awareness often extended to occasions when staff were involved in work-related interactions. By their very nature, maternity units have a constant flow of unknown people coming and going, including other professionals, employees, students and members of the public. Staff are consequently used to operating in the presence of, and ignoring, strangers and individuals not directly involved in the delivery of care in that setting (this may, in part, account for some of the peculiar social norms that prevail in these environments).

There was, however, some evidence that staff were at times concerned to present themselves to me in a way that accorded with 'politically correct' discourses. For example, they sometimes took care to highlight or downplay aspects of their role and working conditions so that their 'professionalism' was emphasised. There were also times when it appeared that interviewees changed the language they were using when referring to the women using the service. Some of the data were undoubtedly affected by these strategies. However, as CDA techniques were applied to all the data where direct speech was involved, these strategies were

discernible and therefore served to illustrate some of the wider social influences impacting on the midwives.

#### *With women using the service*

In order to promote ease of communication, when I interviewed women service users my self-presentation emphasised points of similarity with them, for example, being female, or being a mother; however, I only made my own views about childbirth explicit if the woman concerned was expressing views that were congruent with my own. While not emphasising it, I did not hide my professional persona, and at times I drew on my professional knowledge to help women complete pictures they were constructing concerning their experiences.

#### ***Mental framing***

Although I knew that during the study I could not set aside the effects of my own midwifery experience, I was still surprised to realise to what an extent they affected the process of data collection. Firstly, on reviewing my journal and fieldnotes, I saw that there were certain exchanges that I could not have understood without that experience, for example:

Midwife (to young female registrar): 'Oh, can I speak to you? I've got a lady who's been prom now for 96 hours, and she's had 2 prostins, but isn't really doing anything.'

Registrar: 'What does her ve show?'

*Excerpt from fieldnotes*

Because I am a midwife, I knew that this conversation was about a woman whose waters had broken without her going into labour. Due to fear of infection, staff were attempting to induce her labour, apparently without success. The registrar was asking whether or not her cervix was dilating, something that can only be confirmed by a digital vaginal examination (ve). When looking at this excerpt after I had recorded it, I realised that a researcher without midwifery or obstetric experience would have had no chance of understanding it, never mind recording it accurately. So the fact that I am a midwife greatly increased my capacity to interpret and record observations within the unit.

Of course, it also increased the likelihood that I might fail to notice events or aspects of interaction simply because I was so familiar with the norms of the setting. Further examination of my data and my journal revealed frequent use of abbreviations and

terms commonly used by midwives, for example, paed (paediatrician), reg (registrar), ctg (cardiotocograph), station (the central desk within a clinical area). So it became apparent to me that my observations were being conducted through a midwifery lens, so to speak.

However, this was not the only lens in operation. As I mentioned above, my views about childbirth do not agree with those of many NHS midwives and other maternity professionals. Analysis of my interview data made me realise how cautious this sometimes made me when asking midwives about their orientation to midwifery and birth:

Researcher: So what about women who sort of want weird and wonderful things . . . that you would, as a midwife would probably not consider safe?  
*Interview with senior midwife*

This was particularly the case with those midwives whom I liked and respected, but who I felt would consider my own views to be bizarre and/or dangerous.

There were, however, occasions when I found that my response to midwife interviewees demonstrated tacit understanding of a common cause or attitude:

. . . some (GPs) are a bit more paternalistic than others, but that has its pluses as well, they're very caring (*laughs, also researcher*).  
*Interview with community midwife*

My own personality and history undoubtedly affected the course of my research. However, I believe that their influence was offset to some degree by my systematic approach to data collection and analysis, which incorporated an awareness of factors shaping my relationships with the research process. I would argue that my attention to my research journal, my choice of data collection instruments (semi-structured interviews and observation) and my approach to data handling (recording what I saw, rather than my interpretation of it, and verbatim transcription of interviews) helped to minimise the extent of my own influence. During analysis and writing up of my findings, I maintained an awareness of my own bias, and relied on feedback from my academic supervisors to act as a counterbalance in this regard.



## **Evaluation of the research process**

Research findings only have value if the study has been conducted with appropriate rigour. In this regard, qualitative research should meet four criteria for trustworthiness: credibility, transferability (fittingness), dependability (auditability) and confirmability (Guba and Lincoln 1989, LoBiondo-Wood and Haber 1994).

Credibility requires the accurate representation of data: the researcher must therefore be capable of understanding the culture being studied, and of discriminating between relevant and irrelevant information. Guba and Lincoln (1989) recommend the researcher's 'prolonged engagement with, and 'persistent observation' of, the culture under scrutiny. I am both a registered midwife and an academic who had already spent three years researching interprofessional issues in education before embarking on data collection for this study. I was therefore thoroughly conversant both with the culture of NHS midwifery and issues concerning interprofessional collaboration. My data collection methods aided accurate representation (inasmuch as this is possible – see discussion of this point above). Involving participants in data verification can also promote credibility (Rees 1997). Interview transcripts were sent to participants for verification and comment. I also asked midwives and other staff during interview about particular events/issues noted in observation.

Qualitative research aims to understand phenomena, rather than to predict and control outcomes, so is not designed for the generalisation of findings from the sample to the wider population. However, transferability implies that the understanding and insights gained from a study may be applied to similar situations (Streubert Speziale 2007). Transferability is not determined by the researcher, who needs to supply a comprehensive picture of the sample and context of the study, so that readers can decide whether or not the findings are transferable for their purposes (Guba and Lincoln 1989, Holloway and Wheeler 1996). To satisfy this criterion, a detailed picture of the sample, as well as the sampling and data collection methods, has been presented.

For a study to be dependable, it must be credible, that is, have credible findings. The onus is on the researcher to show that the process of arriving at the findings is stable over time. This infers that the researcher must make explicit the rationale for the theoretical stance underpinning the study, as well as for the choice of methodology (Guba and Lincoln 1989, Holloway and Wheeler 1996). In this study, I

have attempted to explain the importance of interprofessional working to midwives and to women using the service. My theoretical perspective has been explicitly stated, and the methodology has been chosen accordingly. The research has been conducted following the principles governing this methodology.

Confirmability requires that findings can be linked with raw data. The reader should be able to follow the activities and thought processes which have guided analysis and interpretation of the data, as well as the development of the conclusions drawn from them (Guba and Lincoln 1989, Streubert Speziale 2007). This 'decision trail' is crucial to confirmability: sufficient information should be provided about how data have been collected and analysed, what decisions have been taken during this process, and why (Holloway and Wheeler 1996, Clarke 1999). In this thesis, I have attempted to present a clear 'decision trail' by making explicit the process which has led from the raw data to the findings: a detailed account of the analysis process has been presented, illustrated by specific examples drawn from data.

I am not attempting to present this thesis as a work of objective truth. However, I believe that I have met the criteria for conducting qualitative research sufficiently for it to be considered a useful contribution to the knowledge base concerning interprofessional working in English maternity care. In the next four chapters, I present my study findings.

## **Chapter 7. Findings from the documentary analysis.**

In this chapter, I present findings from CDA applied to three sets of documents:

- research papers which present midwives' perspectives concerning interprofessional working;
- the rules governing UK midwives' practice;
- policies guiding midwives' practice in the research site.

### **Research papers which present midwives' perspectives concerning interprofessional working**

In order to identify midwifery discourses concerning interprofessional working in the wider context, and in keeping with the CDA notion of macro-analysis (Fairclough 1995), I present findings arising from the application of CDA to midwife-authored journal articles drawn from the literature which informed earlier chapters of this thesis<sup>8</sup>. These comprised 11 papers written by UK midwives (Cheyne et al 1995, Hundley et al 1995, Brownlee et al 1996, Meah et al 1996, Davies 1997, Hosein 1998, Fraser 1999, Levy 1999, Symon 1999, Pollard 2003, Lumsden 2005); three papers by Australian authors (Haertsch et al 1998, Brodie 2002, Lane 2005); and three papers authored by midwives from the USA (Miller 1997, Harman et al 1998, Bailes and Jackson 2000). I have undertaken this analysis to explore midwife authors' representation of midwives' orientation to interprofessional issues, both through the language they use and the data they select for presentation:

. . . the role of textual researchers is not to criticize or to assess particular texts in terms of apparently 'objective' standards. It is rather to analyse how they work to achieve particular effects – to identify the elements used and the functions these play.

(Silverman 2001, pp.121-122)

The 17 studies all belong to the genre 'peer-reviewed professional journal paper'. The widespread use of this genre by midwife authors and the editors of midwifery journals is consistent with midwifery's drive towards professionalism.

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<sup>8</sup> See Table 1 on pp.10-11.

Unsurprisingly, all the authors adhered to the conventions ruling this genre; it is highly unlikely that their work would have been published in the relevant journals if they had presented their material in a different format. Following these conventions, the research reports are mostly written in the third person. Authors develop an authoritative voice through declarative sentences, stating their position on a subject for which they cite evidence, either from their own research or from other published work in the field. On the basis of these position statements, they develop arguments for a particular theory or point of view about the topic under discussion in a reasoned manner. The style of writing is generally cogent and the linking of statements and arguments by the use of words such as 'however' and 'therefore' gives an impression of a logical sequence. Professional and academic terms are commonplace, from which it can be deduced that these texts are aimed at midwives and other health professionals who are engaging in professional agendas. By employing these various strategies, the authors present themselves as reasonable, literate professionals.<sup>9</sup>

Some papers lent themselves more easily than others to the application of CDA. In particular, the reports of some of the quantitative studies, for example, those by Cheyne et al (1995) and Haertsch et al (1998), proved less amenable to this method than most of the qualitative papers in the sample. Nevertheless, it was possible to identify a variety of social practices and relationships from all the papers selected for analysis, in all of which the focus on midwives' interprofessional working involved their relationships with doctors. In one exception to this rule, the paper by Lumsden (2005) also concerned their relationships with neonatal nurses. In 11 papers, it was possible to identify the authors' orientation to childbirth. Authors of 13 papers referred, implicitly or explicitly, to the dominance of the medicalised hierarchy. Other practices included the professionalisation of midwifery (14 papers), and midwives' relationships with childbearing women (11 papers) (see Appendix 3).

### ***Orientation to childbirth***

In six of the papers considered here, the authors' orientation to childbirth was not identified. In another five, acceptance of a medicalised approach to childbirth was evident, in particular, the acceptance of medical definitions of risk and 'normality'

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<sup>9</sup> Of course, very similar conclusions can be drawn from the application of CDA to this entire thesis.

(Hundley et al 1995, Brownlee et al 2006, Haertsch et al 1998, Bailes and Jackson 2000, Lumsden 2005). For example, when Brownlee et al (1996) wrote about the issue of women being referred during labour from midwifery to obstetric care, no mention was made of the appropriateness of these referrals from a midwifery perspective. Similarly, Hundley et al (1995) did not comment on the 'strict protocols for 'booking', admission and transfer.' (p.164) which determined the allocation of women either to a low-risk or obstetric unit. Contradictions were noted in the paper by Bailes and Jackson (2000): despite presenting themselves as supporters of women's choice, there was evidence of these authors' acceptance, and even expectation, that support for women's choices depended on medical approval:

The midwife reminded Laurie and Tom that . . . the consultant physician they had chosen usually wanted labor to start within 12 hours of ruptured membranes and the baby to be born within 24 hours . . . . The midwife placed a call to the consulting obstetrician to negotiate a plan for initiation of labor . . . The consultant agreed . . .

(Bailes and Jackson 2000, p.541)

Adherence to the holistic midwifery ethos, which supports women's choice and minimal intervention in physiological processes, was identifiable in only six papers, four of which were written by UK authors (Davies 1997, Harman et al 1998, Hosein 1998, Brodie 2002, Pollard 2003, Lane 2005):

Of the 21 midwives who felt that the decision regarding the place of birth should be theirs as the responsible professional, common remarks included: . . . . 'women are not aware of the dangers.' This attitude could be described as a paternalistic one.

(Hosein 1998, pp.372-373)

### ***Dominance of the medicalised hierarchy***

Only four (sets of) authors intimated that the relationships between midwives and other professionals were usually egalitarian (Miller 1997, Harman et al 1998, Bailes and Jackson 2000, Lumsden 2005). It was noticeable that all the USA midwife-authors were in this group: this may have been due to the fact that the papers found focused on small-scale group practices, or on educational issues, rather than on midwives working in large medically-oriented systems, as was the case with the UK and Australian authors. In all the other papers considered here, midwives' interprofessional relationships were presented as being generally hierarchically-

based to their disadvantage, although Brownlee et al (1996) and Pollard (2003) also suggested that UK midwives occasionally interacted with medical staff as equals.

Seven authors depicted midwives as being restricted or oppressed by their working conditions (Meah et al 1996, Davies 1997, Haertsch et al 1998, Hosein 1998, Levy 1999, Brodie 2002, Pollard 2003). For example, when reporting her findings concerning midwives' relationships with obstetricians, Levy (1999) made the midwives the subject of sentences, a grammatical strategy which usually confers agency. However, verbs were often used in a negative context, and she used intransitive verbs almost exclusively: 'midwives did not feel sufficiently powerful' (p.108). Passive forms were also often used: 'midwife A was accorded the power' (p.108). The overall impression created by these linguistic structures was therefore one of constriction and passivity, coupled with a lack of influence; even though the midwives were the subjects of the sentences, they had no effect on anything or anyone else. This impression was reinforced by the use of emphatic language: 'it was strikingly apparent that . . . midwives were highly aware of . . . power over them' (p.108). In this way, the author presented and reinforced the image of midwives as members of an oppressed group.

Similarly, Brodie (2002) portrayed Australian midwives wishing to practise 'woman-centred' midwifery as victims of the medically-dominated system. The first sentence of the abstract began 'This research gives a voice to midwives . . . ' (p.5), the implication being that midwives had hitherto been voiceless. Brodie frequently applied the phrase 'lack of (recognition/status/visibility)' to midwifery, thereby reinforcing the impression of an occupation with little power or social influence. Factors affecting midwifery were frequently presented in sentences whose subjects were either abstract or non-human: 'A perceived resistance to change . . . was reported. . . . Opportunities to practise . . . varied . . . ' (p.7). This grammatical strategy resulted in there being only limited suggestions of human agency in the system as a whole. Interestingly, in an exception to this general usage, Brodie conferred agency on a group of midwives who were presented as being part of the problem: ' . . . some midwives and unit managers also supported a 'medical' approach to care.' (p.7). By contrast, the impression of 'woman-centred' midwives as people at the mercy of a non-human system was reinforced in the same paragraph: ' . . . medical dominance of midwifery practice that restricted midwives' desire to fulfill their role.' (p.7). The contrast between these midwives and the system was heightened by the use of the word 'desire', which conferred feeling

humanity on them; it was not, for example, their 'capacity' or 'ability' that was restricted, it was their (frustrated) 'desire'.

### ***Professionalisation of midwifery***

Eleven (sets of) authors from the UK and Australia supported midwifery's professionalisation, either through advocating reform of midwifery education, or highlighting the need for midwives to have more recognition and/or control over their own practice (Hundley et al 1995, Brownlee et al 1996, Meah et al 1996, Davies 1997, Hosein 1998, Haertsch et al 1998, Fraser 1999, Brodie 2002, Pollard 2003, Lane 2005, Lumsden 2005). For example, in their study concerning midwives' attitudes towards research, Meah et al (1996) drew on wider policy developments to support their professionalisation agenda:

The new style maternity service has enabled midwives to reassert their position as autonomous practitioners . . . Clearly, policymakers and users have faith in midwives' ability to provide efficient and effective maternity care.  
(Meah et al 1996, p.73)

The first sentence in the quote above insinuated that midwives had official support which provided them with the possibility of agency; furthermore, the use of the word 'reassert' suggested that they had hitherto been denied this agency, and thus their rightful place in the healthcare arena. The beneficence and reliability of midwifery practice was implied by the juxtaposition of the phrases 'have faith' and 'efficient and effective maternity care', particularly as the former was linked to 'policymakers and users'. These authors also presented data related to these wider developments to emphasise their position:

Participants also expressed the opinion that in the light of the government's recognition of the midwife's role, midwives have increasing professional responsibility to conduct their own research, . . .  
(Meah et al 1996, p.75)

When Lane (2005) described the 'new professionalism' with which midwifery is associated, she used syntax to present midwives as proactive, capable beings, in conjunction with a benign vocabulary which emphasised the humanity of both midwives and childbearing women:

. . . midwives marked out a separate terrain by embracing a holistic, non-interventionist, and politically inclusive paradigm.

The midwife looks at the social context for causal explanation. She has faith in the normality of the female body. . . . Some called it a 'partnership' model of care. It refers to a relationship characterised by 'communication exchange, trust, reciprocity and integrity'.

(Lane 2005, p.10)

Interestingly, this author went on to say that 'new professionalism' is not enough, in her opinion, and strongly advocated that midwives improve their relationships with the medical profession. This need for better collaboration with obstetricians and other medical staff was also a strong theme in the papers by the three USA authors (Miller 1997, Harman et al 1998, Bailes and Jackson 2000).

### ***Midwives' relationships with childbearing women***

In three of these 17 studies, midwives' relationships with women using the service were characterised as being hierarchically-based, with the midwife enjoying relatively superior status (Hosein 1998, Levy 1999, Lumsden 2005). While six (sets of) authors did not address this issue, in a further eight studies authors suggested that the woman-midwife relationship was usually, or often, egalitarian (Hundley et al 1995, Brownlee et al 1996, Davies 1997, Harman et al 1998, Fraser 1999, Bailes and Jackson 2000, Brodie 2002, Lane 2005). For example, Hundley et al (1995) made specific reference to midwives making decisions with labouring women.

However, the representation of these relationships in some of these papers was more complex than that. For example, Bailes and Jackson (2000) stated a number of times that the childbearing woman was the person who had ultimate control over her pregnancy and birth, a stance consistent with support for holistic woman-centred care. However, the use of language within the paper raised some questions about the authenticity of this stance. Throughout the paper, the woman and her partner were referred to by their first names, while the health professionals (midwives and obstetricians) were referred to by role: 'the midwife educated Laurie and Tom' (p.542). This was somewhat anomalous, given that in western English-speaking society, the combined use of first names and titles or roles for different actors usually confers an unequal relationship in terms of status, with the use of a first name signifying an inferior position (as is the case with children) (Tannen 1994). The grammatical structure also revealed discrepancies. Despite her stated position



of control and power, the woman was usually the object of a sentence, and was seldom the subject. By contrast, the midwife was usually the subject of a sentence, and seldom the object: 'the midwife was able to reestablish Laurie's confidence' (p.542). Moreover, the power that the midwife wielded was made abundantly clear, to the point of being able to influence the couple's personal relationship: 'the midwife observed family dynamics and served as a mediator' (p.542). These linguistic structures indicated that, whatever their stated intent, these authors presented a discourse about the centrality and power of the midwife, rather than that of the woman.

In another example, Davies (1997) did not comment on the fact that a midwife in her study characterised a woman who did not wish to abide by midwifery recommendations as 'manipulative'. This omission gave the impression that the author either agreed with this characterisation, or did not notice its implications, that is, that midwives expect women to do what they say. This author's use of language also conveyed an impression of midwives rather than women being powerful:

Most deliveries are carried out by midwives, both in hospital and at home  
... (Davies 1997, p.224)

In this depiction, it appears that birth is heavily dependent on midwives' activities, with no suggestion that it has anything to do with what childbearing women actually do. In this way, both Bailes and Jackson (2000) and Davies (1997), despite their stated position, appeared to be portraying midwives' relationships with women as being hierarchical, with the latter expected to occupy a less powerful position than the former.

### ***Authors' reinforcement of discourses***

Some authors appeared to be reinforcing specific discourses concerning midwives and interprofessional working. One such discourse could be termed 'Midwife good, doctor bad'. Bailes and Jackson (2000) dehumanised members of the medical profession through the use of phrases such as 'the midwife, the woman and her family, and the medical system' (pp.537, 540, 542, 543). Only the midwife and the woman / family in her care were accorded the privilege of being people. Similarly, midwives who complied with GPs' wishes and did not offer women homebirth were described as displaying 'submissiveness' by Hosein (1998, p.373). By using this term, a perception was fostered that these midwives could only be operating from a

powerless context: the possibility that the midwives actually agreed with the GPs was not considered (so they remained 'good'). In another example, Meah et al (1996) presented midwives as progressive professionals, attempting to implement research-based practice, 'only to be thwarted by senior medical staff, without sufficient justification' (p.80). Where authors appeared to be presenting a more balanced picture, midwives were still depicted as occupying the moral highground:

'The manager of a small rural public unit pointed out that obstetricians were not 'bad', but they were the logical product of medical and educational prejudices.'

(Lane 2005, p.11)

In Lane's paper, there was no such suggestion of 'prejudice' attached to the midwifery perspective on birth and organisation of practice.

By contrast, Miller (1997) appeared to espouse a discourse of 'we're all in this together'. Her report was written so that all the professionals appeared to be equally responsible for the quality of the interaction:

'Individual practitioners came to their practice environments with a variety of personal experiences . . .'

(Miller 1997, p.303)

When discussing dysfunctional group practices, she made no reference to any profession by name. In the whole report, other than once being used as an example of a general case, there was only one instance of the medical profession being singled out as the subject of a sentence, and it was immediately balanced by that position being taken by midwifery in the following sentence; consequently, neither profession was presented as having more influence on the situation than the other. The focus was on what structures work in collaborative practice. A beneficence was suggested in phrases such as 'guided participants to work together', 'allowed for collegial discussions', 'led to comfort', 'to learn from one another'. This benign vocabulary supported the idea of effective interprofessional working between midwives and doctors being essentially desirable and, importantly, achievable.

### ***Interprofessional relationships in maternity care***

Authors' perceptions of relationships within maternity care appeared to be based on differing combinations of the characterisations and depictions described above. For example, Hosein (1998) and Levy (1999) saw both midwives and women using

the service positioned disadvantageously, but differently, within the hierarchy (women subordinate to midwives, midwives subordinate to medical practitioners). Bailes and Jackson (2000), on the other hand, presented midwives as being on equal terms with medical practitioners, but exerting control over women; while Brodie (2002) presented women and midwives as partners in oppression within the traditional medicalised hierarchy:

Within this organisational culture, many midwives are unable to fulfill the role for which they were educated and are losing their skills and confidence.

. . .

In maternity services, women are usually healthy and their needs may be 'invisible' . . . ' (Brodie 2002, pp.10-11)

Two of the studies included in this analysis concerned midwives who worked independently or in small group practices (Miller 1997, Bailes and Jackson 2000). Findings from these papers cannot therefore be assumed to relate to midwives practising within large, medicalised and hierarchically structured organisations. The overall impression given by most of the authors of the remaining papers was that midwives could generally not structure either their practice or their interprofessional relationships in a way that was satisfactory for them, or which accorded with their (and the authors') conception of what the midwifery role should be. Through examining the way in which they were presented in these studies, it can be seen that midwives' interprofessional relationships were framed in four different ways.

#### *Healthcare professionals operating on an equal basis*

Four (sets of) authors (Brownlee et al 1996, Harman et al 1998, Pollard 2003, Lumsden 2005) presented midwives as 'professionals' embedded within the organisational structures, perceiving themselves to interact with other healthcare professionals from this standpoint:

Not only are midwives being consulted for their views by their midwifery colleagues, but this has extended to junior doctors who also seek out midwives . . . for support in their decision-making. .... Without exception,

all midwives cited the help and advice of the ANNP<sup>10</sup> as being invaluable  
. . the midwives were also supporting the ANNP in her role.

(Lumsden 2005, p.454)

#### *Professionals striving for recognition*

A second position, which was also the most common, was represented by 10 (sets of) authors (Hundley et al 1995, Meah et al 1996, Davies 1997, Haertsch et al 1998, Harman et al 1998, Fraser 1999, Symon 1999, Brodie 2002, Pollard 2003, Lane 2005). In this perspective, midwives were seen to be professionals who supported the dominant discourse to a considerable degree, but who were striving to assert their own status within a hierarchical medicalised system:

The involvement of medical staff . . . had a negative effect on satisfaction.

. . . The main problem identified by midwives was medical staff's lack of  
'trust' of midwives' judgement: (Hundley et al 1995, p.170)

#### *Practitioners defending the midwifery ethos*

Four authors (Hosein 1998, Brodie 2002, Pollard 2003, Lane 2005) depicted a third alternative in which midwives were presented as practitioners who supported the holistic midwifery ethos, and therefore often related to other healthcare professionals from a position where either subterfuge, compromise or reconciliation between conflicting approaches was required:

Respondents . . . said they did not follow policy when they considered it clinically inappropriate. There was a feeling that in some situations autonomy was only achievable through stealth.

(Pollard 2003, p.119)

In these last two schemas, medical professionals were often presented as adversaries.

#### *Practitioners accepting or preferring their current position in the hierarchy*

Suggestions of a fourth position were also found in eight papers. Cheyne et al (1995), Brownlee et al (1996), Hosein (1998) and Levy (1999) presented midwives as accepting their current position in the hierarchy. In another four studies,

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<sup>10</sup> Advanced Neonatal Nurse Practitioner

participants portrayed midwifery colleagues as actively preferring this position, and as being unwilling to assume professional autonomy (Symon 1999, Brodie 2002, Pollard 2003, Lane 2005). These midwives' relationships with medical professionals appeared to be based on a desire for the latter to take responsibility for clinical practice:

Midwives can be remarkably dull, and passive; and very quick to turn on their obstetric colleagues to make their decisions for them, when there's no need whatsoever. (Symon 1999, p.249)

### **Summary**

Analysis of these papers revealed that there was no unified or consistent representation of the position which midwives adopted in their interprofessional relationships, either internationally or within the UK. Representations of all four positions identified above were found among the UK authors. Many authors appeared to support midwifery's professionalisation project. However, medical control of childbirth and hierarchical relationships between midwives and medical practitioners appeared to be accepted as commonplace, if not desirable. Women using the service were frequently depicted as lacking power within the system of care delivery.

### **The rules governing UK midwives' practice**

UK midwives' legal obligations and sphere of practice, as specified by their regulatory body, are currently set out in the document *Midwives rules and standards* (NMC 2004b). Prior to that, they were detailed in *Midwives rules and code of practice* (UKCC 1998). The genre to which they belong can be characterised as 'official organisational communication prescribing members' behaviour'. These documents are formatted as A5 booklets, whose covers have similar lay-outs, with the title prominent in large font in the upper third of the page. In the earlier version, the UKCC badge is at the top of the page above the title, while in the later one, the NMC's name is spelled out in full in that position, also in large font. There is then a large blank space, and at the bottom of the page, on one line of text in a smaller font, stands the phrase: 'Protecting the public through professional standards'. In the earlier version, the UKCC's name is spelled out in full just above this phrase, which, however, stands out due to its being in a different colour from the other text on the cover. The wording of this phrase evokes two discourses in particular: midwives cannot be trusted to practise safely without a set of rules to follow; and

safety is achievable through applying 'professional' standards. The juxtaposition of these discourses invokes the full weight of the concept 'professionalism', with its connotations of authority and knowledge. The physical lay-out of the covers reinforces the message that these discourses underpin the rules and standards.

The text within these booklets is laid out in clearly numbered sections and subsections, in which paragraphs are separated by spaces. The overall impression is therefore very businesslike, an impression reinforced by the style of language:

2 The requirements of paragraph (1) of this rule need not be satisfied where a midwife has within a period of five calendar years immediately preceding the year of giving notice of intention to practise . . .  
(UKCC 1998, p.16)

The formality of the vocabulary combined with the stilted syntax marks these documents out immediately as 'official'. There are some differences between them. In the older booklet, each section heading is set within a coloured strip; in the newer booklet, this use of colour has been extended so that particular items of information are presented within coloured blocks. This has been used most extensively for 'Guidance' sections following each rule, which were not present in the older booklet. By contrast to the 'officialese' used in individual rules, the 'Guidance' sections are written more informally, often addressing the midwife reader directly:

Your records relating to the care of women and babies are an essential aspect of practice . . . They demonstrate whether you have provided an appropriate standard of care to a woman or baby.  
(NMC 2004b, p.22)

The newer version of the rules thus appears to be more 'user-friendly', and is in keeping with the style of many current documents, which are designed to be accessible to most readers (see, for example, Central Office for Research Ethics Committees 2006).

### ***Definition of a midwife***

At the heart of these rules is the WHO (1992) definition of a midwife (see Appendix 4). Implicit in the wording and formal style of this definition is reference to

a number of social practices: the situation of birth and midwifery within the dominant medical model<sup>11</sup>; state/governmental prescription and control of citizens' rights and responsibilities concerning health behaviours; and formal education/qualifications underpinning the authority of 'professionals'. Relations invoked include those between the state and its citizens, and between healthcare professionals and members of the public. In both these cases, the relation is one of authority of one entity/group over another. A third relation of representation is implied between the state and healthcare professionals. The use of phrases like 'necessary supervision' and 'preparation for parenthood' reinforces the idea that members of the public cannot manage the process of childbirth satisfactorily or safely without the intervention of healthcare professionals. The definition is lent authority and weight by the inclusion in the first paragraph of the words 'regularly', 'duly', 'successfully' and 'legally', none of which contribute substantively to its meaning.

A clear hierarchy of knowledge concerning childbirth is implicit in this definition: midwives know better than lay people, but the statutory bodies, entrenched in the dominant medical model, know best. Midwives are consequently expected to represent the statutory bodies and this model. This hierarchy justifies the position whereby midwives are obliged to 'educate' and 'supervise' women and their families, while themselves being subject to rules and standards prescribing their sphere and manner of practice. The ongoing influence of patriarchal attitudes concerning both midwives and the women they attend is clearly visible (Bates 2004).

### ***Midwifery, medicalisation of birth and the power of the state***

The tenor of the rules is directly prescriptive: there is little suggestion that midwives are autonomous professionals who can use their own judgement. The frequent use of 'should' and 'must' makes this clear, even where the prescribed course of action appears to depend to a large extent on the co-operation and responses of women and their families:

A midwife . . . Should work in partnership with the woman and her family  
(NMC 2004b, pp.16-17)

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<sup>11</sup> In this 'official' view, individuals from any society are not recognised as 'midwives' unless they have undergone some form of medicalised training. See footnote on p.12.

In this instance, there appears to be no allowance made for the fact that some women may not wish to work in partnership with midwives. The discourse of a one-way flow of information and authority from midwives to women is obvious throughout these documents, typified by the requirement that midwives should ‘ . . . enable the woman to make decisions about her care . . . ’ (p.17). There is no suggestion that women are able (and may prefer) to make decisions about their own health and wellbeing without ‘enablement’ from a healthcare professional.

In both versions of the rules, it is stated that, should a woman be pursuing a course of action which the midwife deems to be unsafe, the latter should outline ‘any potential risks, so that the mother/woman may make a fully informed decision about her care’ (UKCC 1998, p.28, NMC 2004b, p.18). Practice norms provide evidence that the assumption here is that such risks are only incurred where women do not wish to comply with the medicalisation of birth; there is no suggestion that compliance with the medical model carries its own risks, and there is no expectation that a midwife will enlighten women about them to facilitate their making ‘fully informed’ decisions (AIMS 2006b).

Women’s rights to make decisions about their own bodies are enshrined in law in the UK, where the foetus has no legal rights (Hewson 2004). Both versions of the rules refer obliquely to this situation, in that they specify processes for midwives to follow when a woman requests care that could cause ‘significant risk’ to her or her baby, and cannot be persuaded to change her mind. The language here is telling: in this instance, the woman ‘rejects’ the midwife’s advice (alternatively, she could decide to stay with her preferred course of action, or some such variation). The midwife ‘should’ cope with such non-compliance by a variety of strategies, including involving her supervisor of midwives, making detailed records of any pertinent discussions, and consulting other members of the healthcare team.

It is interesting to note that in the older rules, there is no mention of a woman’s being competent to make controversial decisions (which is the default position in law). However, in the newer rules, midwives are advised to consult ‘an appropriate health professional, such as a Consultant Psychiatrist’ (NMC 2004b, p.18), should they doubt the mother’s mental competence. So it is now being suggested explicitly that



'rejection' of advice may be due to a woman's defective state of mind; midwives are implicitly expected to subscribe to the discourse of the 'unreliable feminine'<sup>12</sup>.

Similarly, there is now an assumption that midwives necessarily agree with state control of individuals' health behaviours. In both versions, the documents state that midwives must:

. . . respect the right of individuals to self-administer substances of their choice. (UKCC 1998, p.31) (NMC 2004b, p.19)

However, in the newer version, this statement is followed by a proviso that, where women are using 'illegal substances', it becomes the midwife's duty to

. . . assist her by liaison with others in the multi-professional team to gain further support or access to detoxification programmes.  
(NMC 2004b, p.20)

Whatever the actual feasibility or wider effects of such a course of action, the midwife does not have any choice in such a situation. Her professional obligations, as set out in the current rules, require her to act on behalf of the state, which is considered to be acting in the woman's best interests.

An alternative interpretation of the effect of the current rules is found in the Royal College of Midwives (RCM) position paper *Refocusing the Role of the Midwife*:

The existing framework liberates rather than constrains midwifery practice. There is considerable scope for flexibility in the interpretation and focus of that role . . .  
(RCM 2006, p.1)

However, this paper is based on explicit acceptance of the medically located definition of a midwife (WHO 1992) and the concept of the midwife being the expert in 'normality' defined according to obstetric, rather than midwifery, parameters. Consequently, any 'flexibility' can only be found within a context which fits the obstetric perspective on childbirth.

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<sup>12</sup> See Chapter 4.

In summary, although a prime function of midwifery is assumed to be providing autonomous woman-centred care and acting as an advocate for women and their families (Bates 2004), statutory obligations require that midwives in the UK align themselves with the values and approaches inherent in the medical model of childbirth and in patriarchal discourses of professionalism and state control of individuals' health behaviours.

### ***Midwives' obligations with regard to interprofessional interaction***

A midwife in the UK is obliged to call other healthcare professionals to

. . . assist her in the provision of care' whenever 'a deviation from the norm . . . becomes apparent in a woman or baby.

(UKCC 1998, p.17-18, NMC 2004b, p.16).

There is no further explanation of what the 'norm' entails; however, since the rules and the definition of the midwife on which they are based are located within a medical perspective (see above), it is reasonable to interpret this term within the same frame of reference.

Interestingly, erosion of embodied medical dominance is evident in the changes made to this rule between 1993 and 2004. The professionals from whom midwives must request help have changed from 'a registered medical practitioner' (UKCC 1993, p.20), firstly to 'a registered medical practitioner or such other qualified professional who may reasonably be expected to have the requisite skills and experience' (UKCC 1998, p.18), and subsequently to the current 'other qualified professional who may be reasonably be expected to have the requisite skills and experience' (NMC 2004b, p.16). These changes signal a widening sphere of interprofessional relationships and working in midwifery. For example, since neonatal nurses have become more involved in neonatal resuscitation (Redshaw and Harvey 2000), their presence in an emergency where these skills are required is more appropriate than that of many medical practitioners.

As well as requesting help when situations are not 'normal', guidance accompanying the rules suggests that midwives should work constructively with other healthcare professionals to provide appropriate care to women and their families. Although such interprofessionality is mentioned only three times within both documents, midwives' routine collaboration with a range of other professional colleagues within

the established healthcare system appears to be assumed. Again, the centrality of medical practitioners has disappeared, with the earlier version specifying ‘. . . roles of midwives and registered medical practitioners and others . . .’ (UKCC 1998, p.28), while the later version says ‘. . . roles of midwives and others . . .’ (NMC 2004b, p.18).

This erasure of specific mention of doctors in this context could signal that the medical perspective is currently less privileged than in former times. However, the current rules explicitly suggest that midwives consider involving medical practitioners when women do not follow their advice, and they appear to expect midwives only to perceive risk where women do not wish to comply with the medicalisation of birth (see above): therefore there does not appear to be any evidence of a decrease in the dominance of the medical perspective, quite the contrary. It seems rather to be so entrenched that the possibility is not even considered that any healthcare professional may be operating according to other perspectives. Consequently, the actual presence of a medical practitioner may no longer be considered necessary to ensure that the dictates of the medical perspective are observed. Ironically, these changes in the rules may also indicate that individual medical practitioners now have less influence in some situations because the professionalisation strategies of some non-medical healthcare workers have been successful, at least to some extent.

Whatever the wider significance of these developments, it seems that the rules governing midwifery practice in the UK assume the interaction between midwives and other healthcare professionals to be located in a framework within which they are all representatives of a medicalised approach to birth.

### **Policies guiding midwives’ practice in the research site**

As is common in NHS maternity units, midwives’ practice in the research site was governed by policies which detailed specific actions, clinical and otherwise, which were to be taken in various circumstances. As detailed in Chapter 6, the policies chosen for analysis were *Augmentation of Labour* and *Vitamin K Policy* (see Appendix 5). In the obstetric perspective, labour is considered to be progressing ‘normally’ when a woman’s cervix dilates at a rate of 1cm per hour (Williams 1993). When the rate of progression is less than that, labour is considered to be ‘abnormal’, and in the NHS, midwives must take action to address the situation, either by

consulting an obstetrician, or by following an obstetrically drafted policy. Newborn babies have levels of Vitamin K, a substance involved in blood-clotting, which are much lower than that found in the rest of the population (Michie 1993). It is therefore assumed that all newborn babies should be given a dose of Vitamin K shortly after birth (DH 1998a). In the NHS, this drug is usually administered by midwives, who are obliged to follow paediatrically drafted policies in this regard. Both the selected policies therefore involved midwives' either liaising with medical staff, or operating in relation to medical perspectives concerning childbirth.

Both these documents were written in an authoritative genre, with little or no suggestion that practitioners should use their own professional judgement or make decisions that might differ from the policy contents. The language used in them was accordingly generally prescriptive. However, there were differences in the way that language was used to describe concepts, conditions and actions. In the labour policy, these were usually framed in clinical terms:

Causes include:

- Cephalo-pelvic disproportion (CPD)
- Incoordinate uterine action (uncommon in multiples)

Management in multiparous women should be discussed with registrar on-call.

If 7-10 cm interval longer than three hours and instrumental delivery required, strongly consider trial in theatre.

Secondary arrest in a multiparous woman is an indication for prompt referral to acute unit.

Excerpt from *Augmentation of Labour*

By contrast, the Vitamin K policy was written in a mixture of clinical and non-clinical language:

There is now an oral form of Vitamin K that can be given to babies as a liquid but it is less effective than the single injection . . .

. . .

Vitamin K (1 mg) intramuscularly should be offered to all newborn infants.

Excerpt from *Vitamin K Policy*

Whereas the labour policy appeared to be directed at professionals, the first part of the Vitamin K policy appeared to be written for service users. The opening statement read:

The paediatricians, midwives, health visitors and public health doctors  
are responding to the recommendations from the Department of Health . .  
Excerpt from *Vitamin K Policy*

This may reflect the controversy that has surrounded the route of administration of Vitamin K, with some suggestion that giving it by injection is linked with an increased risk of childhood cancer (Golding 1992). It appears that the writers of this policy may have drafted it so that it could be shown to parents when administration of Vitamin K was being discussed.

In both policies, information was presented as factual. According to the medical view, there is a universal need for administration of Vitamin K in the first few days of a baby's life (DH 1998a). However, this is a controversial issue, with this 'need' being contested and debated in some areas (Wickham 2003). The opening declarative statement in which midwives were grouped with other professionals as responding unquestioningly to the medically-based recommendation for its universal administration (DH 1998a), clearly represented them as being aligned with the values and priorities inherent in a medicalised approach to childbirth. Similarly, the definition of dysfunctional labour and the options for action suggested in the labour augmentation policy (which entail significant invasive interventions) were presented in a way that implied that no others exist, which is not the case (Davis 1992).

In both policies, following on from the giving of 'factual' information which established a need for action, detailed instructions were then given about what midwives should do. While prescriptive, the tone of the labour policy was softened by the use of words like 'may' and 'consider':

#### **Primary Dysfunctional Labour**

This may be described as progress of less than 1 cm/hour. The options to consider, with maternal consent are:

- Artificial Rupture of Membranes (ARM)
- If no progress after two hours consider Syntocinon augmentation.

Excerpt from *Augmentation of Labour*

In both policies there was explicit mention of the need for maternal consent, or in the case of the Vitamin K policy, parental consent. However, the tone of the latter policy was particularly dictatorial: verbs were usually preceded by either 'should' or 'must', the latter sometimes being emboldened and even put into capitals, further reinforcing an impression of the policy's prescriptive nature:

Vitamin K route, dose and administration **MUST** be recorded on the  
discharge letter. Excerpt from *Vitamin K Policy*

Both policies were written in an impersonal style, followed by a reference list. Academic credibility was thereby invoked, that is, the impression was given that these policies were based on authoritative 'neutral' knowledge. In reality, they were located within the medical model of childbirth, and as such, did not allow for differently-framed considerations or perspectives.

The assumption of the superiority of medical knowledge was highlighted in both policies. In the labour policy, it was stated that Syntocinon<sup>13</sup> should not be used with women who had given birth before, until a registrar could assess them 'in order to eliminate other causes for slow progress, ie malpresentation'. In most maternity units, there is a high probability that the senior midwives would have far more experience than a junior registrar, and would be accordingly more competent to make such an assessment in many cases (Green et al 1994, Brownlee et al 1996). In the Vitamin K policy, it was stated that parents who did not wish their babies to receive the drug were to be referred to a medical practitioner. In these cases, a midwife would already have discussed the administration of Vitamin K with parents.

In summary, both policies were written in an authoritative genre, using prescriptive language, although the labour policy was less dictatorial in tone than the Vitamin K policy. Both policies presented medically-based information as factual knowledge. Midwives were represented as being aligned with the state and with the dominant medical discourse concerning childbirth, and there was little suggestion that they should use their own professional judgement, and no indication that any other perspective concerning childbirth should be called upon to determine a course of action in these particular situations.

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<sup>13</sup> Syntocinon is a drug given to induce and/or increase and strengthen uterine contractions (Silverton 1993).

## **Unity versus division**

Analysis of all these various documents has highlighted both unifying and divisive discourses and practices operating in midwives' interprofessional working.

Consideration of all three types of source, that is, the research papers, the rules governing UK midwifery practice and the unit policies, reveals that UK midwives are firmly embedded in medicalised structures which maintain divisions between them and medical staff, and between them and women using the service. In particular, the privileging of the medical approach to childbirth reinforces these divisions, since it logically categorises doctors as knowing most, and childbearing women as knowing least, with midwives somewhere in the middle on the knowledge continuum. From the literature, it also appears that midwives' attempts to challenge this approach and these structures have at times resulted in further division between themselves and medical staff, as there has been a tendency to demonise doctors in order to promote the midwifery agenda. It is interesting to note, however, that there are deliberate moves both in the USA and Australia to address this situation. A consideration of the UK authors who have presented midwife-doctor relationships as egalitarian shows that, in some cases, midwives' increased levels of skill have helped to promote unity between different staff groupings, including doctors.

Midwives' challenge to the status quo has not always resulted in more unity between midwives and the women using the service, since sometimes midwives' adherence to their professionalisation agenda has also exacerbated this division. However, there are also signs that the attempt to implement a 'partnership' model of working is unifying in this regard, as it does show some signs of midwives and women operating within a more egalitarian framework.

Apart from one research paper, it was only in the rules governing midwifery practice that any mention of other non-medical healthcare professionals was found. The changes made to the rules between 1993 and 2004 indicate that collaboration between midwives and these professionals has been promoted at an 'official' level. This decentralisation of individual medical practitioners can be regarded as a practice which has promoted unity between midwives and non-medical professionals.

In the next three chapters, I shall present findings from the fieldwork I conducted in the research site.



## Chapter 8. The way the unit worked.

Findings from the fieldwork data are presented in Chapters 8-10. Abbreviations are used to denote different individuals in terms of their profession/role within the maternity unit (see Table 2 below). Where numbers follow these abbreviations, for example M1, a specific abbreviation-number combination always indicates the same individual.

AN	anaesthetist
CM	community midwife
CT	consultant (senior obstetrician)
HCA	healthcare assistant
JM	junior midwife
M	middle-ranking midwife
MM	midwifery manager
P	paediatric doctor (middle grade or junior)
PC	paediatric consultant
R	the researcher
RCP	receptionist
RG	registrar (middle grade obstetrician)
SHO	senior house officer (junior obstetrician)
SM	senior midwife
W	woman using the service

**Table 2. Glossary of abbreviations denoting participants by profession/role.**

Data sources used in these three chapters comprise the following:

- fieldnotes constructed over 21 observational sessions, lasting an average of five hours each;
- 31 interviews, conducted with 19 midwives, four obstetricians and seven women using the service (one midwife was interviewed twice);
- the research journal kept during the data collection period.

The data sources are differently represented throughout the three chapters. The findings presented in Chapter 8 concern the semiotic features of the physical environment and general atmosphere and interaction in the unit, and therefore draw mainly on observational data recorded in fieldnotes, with only occasional reference to interview data. By contrast, Chapter 9 draws heavily on the interview data, since

the findings focus on individuals' presentation of their perceptions of the midwives' professional standing and their orientation to the provision of midwifery care. A small amount of data drawn from the fieldnotes and the research journal are used to support the interview data. In Chapter 10, in which the findings concern the midwives' interprofessional relationships in the unit, material is drawn from both the interview and the observational data, with occasional reference to the research journal.

### **Physical environment**

The maternity unit was situated within a large general hospital on the outskirts of a small city in England. It comprised three distinct areas: the antenatal clinic, the delivery suite and the ward. Women who were in labour or experiencing a problem which required immediate attention, either antenatally or postnatally, attended the delivery suite. After they had given birth they were usually transferred to the ward, where women would also stay if they were hospitalised during the antenatal period. The two areas were on different floors within the same building, constructed during the 1960s. Women were transferred between the two areas using lifts located on a common lobby/landing area on each floor; these lifts also served other areas in the hospital, so that they were used by a wide variety of hospital staff and the general public, as well as staff and women from the maternity unit. There was also a flight of stairs between the two floors which staff used regularly. The antenatal clinic was situated in a separate area in the same building, but as no data were collected there, no description of it will be provided.

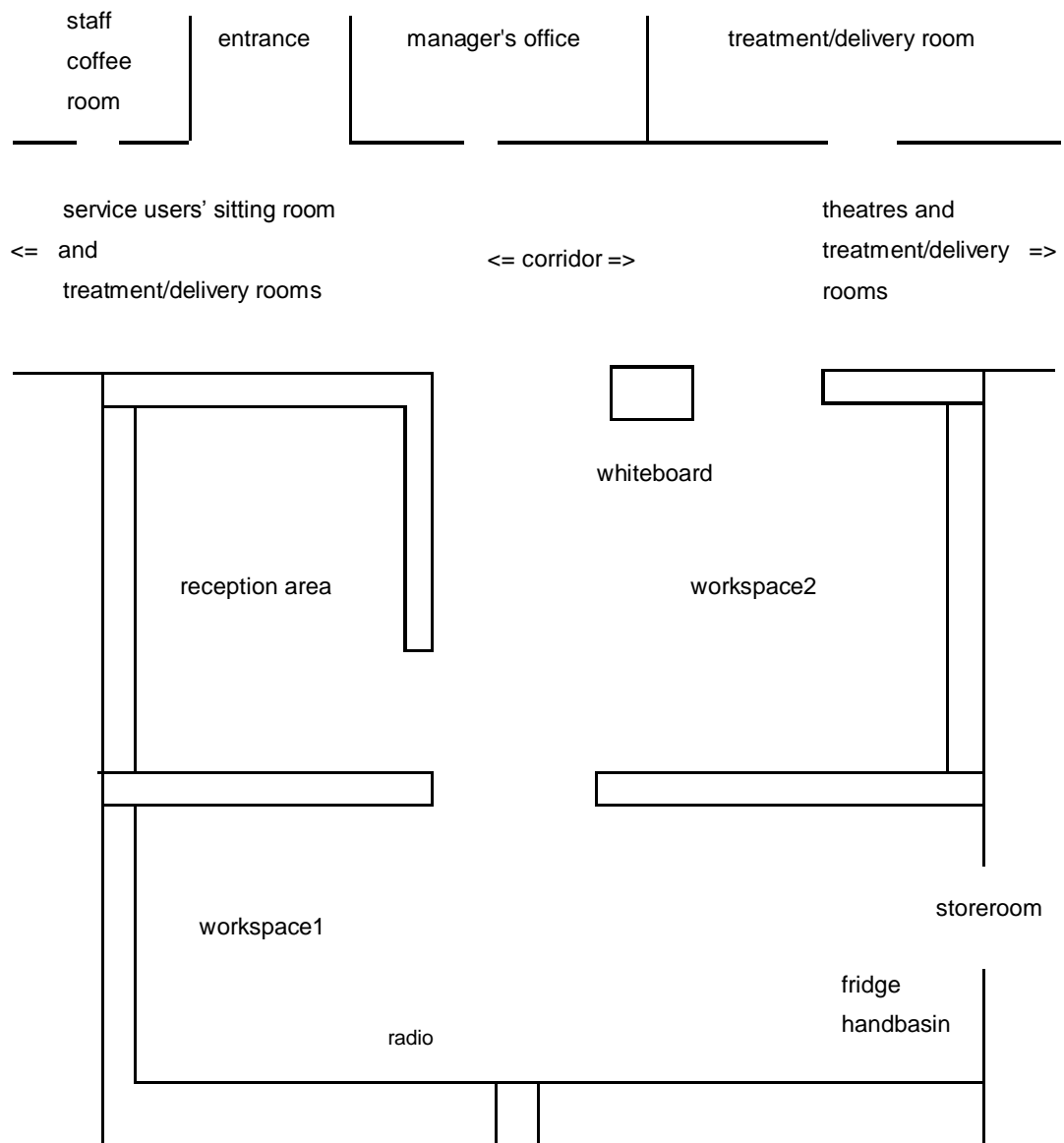
The entrances to both the delivery suite and the ward were electronically controlled. This is a common feature of maternity units in the UK, implemented following the abduction of babies from some units in the 1990s (Dimond 1994, Midwives Chronicle 1994). Staff had security passes which allowed them to move freely in and out of these areas; anyone else had to be let in and out. Those wishing to enter an area had to press a door-bell; this alerted a member of staff inside, who would question the individual about the nature of their visit by means of an intercom, and then admit them (if appropriate). The entrances were also equipped with closed-circuit television cameras, so that staff inside the area could see who was waiting to be admitted.

### ***The delivery suite***

After having passed through the security doors, entrance to the delivery suite was effected through a corridor lined with windows, on either side of which was a well-tended courtyard with plants. Another set of doors led to the reception area within a large central open space, an administrative area which was effectively divided into four distinct areas (see Figure 1, p.116). The reception area was directly opposite the doors, so that anyone coming through them would immediately come into contact with staff there. The reception area was situated against a side wall; a counter at a height of approximately 1.2 metres curved from this wall around the front and part of the side of the reception area. Another counter at the same height, but further back, projected from the wall into the room for the same distance as the front counter. The effect of this arrangement was to create a fairly large cubicle-like space, in which two or three people could move around comfortably, bounded by the wall on one side, and by the counters on the other three sides. The gap between the two counters allowed access into the cubicle from the side. The cubicle contained another counter at normal desk height which ran inside the back counter, along the wall, and inside the front counter, two swivel chairs, a computer, a telephone and a filing cabinet, as well as assorted folders and other stationery items.

The counter at the back of the reception area divided the room on this side into approximately two equal halves, front to back. Another counter at normal desk height ran along behind this division, along the side wall and the wall at the back of the room. Midway along the back wall there was a vertical division, which extended upwards from the counter surface for approximately 0.5 metres. Next to this division stood a portable radio, plugged in to an electric socket in the wall, which had windows above the counter looking out into the hospital car parks. There were also three computers and a telephone situated on the counter, and the space also contained a number of swivel chairs. Beneath the counter, next to the gap which allowed access to the reception space, was a shelf on which were a number of large ring-binder folders.

Further on from the vertical division, the counter continued along the back wall, stopping when it reached the adjacent wall. On this side of the division, there were cupboards underneath the counter. Against the adjacent wall was a handbasin and a fridge, and a cupboard for controlled drugs. A doorway led into a storeroom, which opened off the central space. On the other side of the doorway, another



**Figure 1. Layout of central administrative area in the delivery suite.**

counter, also at a height of about 1.2 metres, projected into the middle of the room. This counter was at the same level as the one behind the reception desk, so that the room was divided on both sides into two roughly equal halves, front to back.

The divisions also bisected the room from side to side. The area opposite the reception space was also equipped with a counter at normal desk height, which ran along the division near the storeroom door, along the adjacent wall and along another counter, also at a height of approximately 1.2 metres, which projected for a short way into the room. The effect of this arrangement was to create another space near the front of the room, on the opposite side of the reception area, although there were only structures marking it off on two and a half sides. A pillar between the two areas, at the level of the front counters, added to this effect. Access to the space was possible either between the pillar and the front counter, or from the middle of the room (where there was no barrier). There were two computers and a telephone on the lower counter inside the space, which also contained a number of swivel chairs. A large whiteboard stood inside the pillar, facing into the space.

The four distinct areas together making up the whole central space thus comprised the reception area, the space behind it (workspace1), the area which contained the fridge and provided access to the storeroom, and the space opposite the reception area (workspace2) (see Figure 1). There was a gap of approximately 1.5 metres between the two divisions in the centre of the room, so that individuals could move easily between the areas at the front and the back of the space. All the counters were made of the same material, a light-coloured hard surface which appeared to be waterproof. The walls were white, and the floor was covered with a plasticised wood-effect vinyl.

The space beyond the two front counters and the pillar formed a corridor, bounded by a fourth wall. This corridor extended further into the delivery suite on both sides. The delivery suite manager's office and an adjacent treatment/delivery room opened off the corridor directly into the central space. As the corridor continued into the unit on either side of the central space, other rooms opening off it included more treatment/delivery rooms, a sitting room for service users, store cupboards, toilets, bathrooms, a sluice and a kitchen, as well as an operating theatre.

Treatment/delivery rooms had notices on their doors: 'Please knock and wait.'

There were also spaces on the doors for the names of the women, their partners

and the midwife assigned to their care. Only the first names of women and their partners were given, while the full name of the midwife was written down.

A door close to the main entrance to the delivery suite opened off this corridor into the staff coffee room (see Figure 1), which looked out on to the courtyard. This doorway was thus obliquely opposite the reception area, and very close to it. The coffee room was equipped with half a dozen easy chairs, a low round coffee table and a television set. There was a sink and a cupboard containing crockery on the wall next to the windows. Various jars of tea and coffee, as well as a toaster, a microwave oven and a hot water urn stood on a counter on the adjacent wall. Below the counter were more cupboards and a drawer containing cutlery. There was also a fridge located against this wall. The room also held lockers, as well as hooks for hanging up coats and a noticeboard.

All observational data collection took place in the central space and the coffee room.

#### *Frontstage and backstage*

During the period over which data were collected, it was observed that a wide variety of individuals moved into and through the central space, which served as the main administrative and co-ordinating centre for the delivery suite: these included midwives, health care assistants, medical practitioners (mostly obstetricians and anaesthetists) and other health professionals, theatre staff, hospital porters and administrative staff, laboratory technicians, pharmacists and, of course, women who were using the service, their children (both newly-born and older), and their relatives and friends. Members of staff might or might not be actually working on the delivery suite. The main activities conducted in the central space, other than holding discussions, appeared to be completing paperwork, using the computer and talking on the telephone.

By contrast, the coffee room was usually only used by midwives, health care assistants, administrative staff and medical practitioners actually working on the delivery suite. However, all obstetricians working in the maternity unit would meet in the coffee room each morning for the day's briefing. The midwives and administrative staff tended to eat their meals and take breaks in the coffee room. During these times, as well as eating or drinking, they would commonly read magazines or newspapers, watch television and chat. Both midwives and medical staff sometimes also used the coffee room for attending to paperwork.

Due to this variation in use, the central space and the coffee room could be regarded as respectively representing *frontstage* and *backstage* areas (Goffman 1959). However, blurring of the boundaries between these areas was observed, most notably in terms of food and drink. It was common to find staff members bringing cups of tea and coffee through to the central area. These cups would often be put down and left on the various counters, as staff needed to go elsewhere. A member of the administrative staff was observed once standing in the reception area eating yoghurt while she talked to the delivery suite manager, and midwives and medical staff were also seen eating toast and/or sandwiches in the central area on a number of occasions, while attending to paperwork or having clinical discussions. On one occasion, a bowl of pistachio nuts was placed on the counter behind the reception division, so that staff could help themselves as they came and went. On another occasion, a senior midwife was observed taking a bag of nuts out of her pocket and offering them to the individuals with whom she was having a clinical discussion; on another day, this same midwife brought a bag of hot chips into the area and offered them to everyone there.

The blurring of frontstage/backstage boundaries was also observed through other mediums. Details of each service user were written on the whiteboard, including her name and clinical details regarding her current situation and/or the progress of her labour, as well as the name of the consultant obstetrician to whom she was assigned, and that of the midwife attending her. Paper messages for individual members of staff were sometimes pinned to the board, and it was also used for general information for staff, who regularly consulted it and often gathered there to hold discussions. Keeping the whiteboard updated was an ongoing task, performed usually by the midwives. However, in addition to the usual clinical information, on one occasion it bore the following message: '*Full name(M)* has got engaged!!'. The radio on the back counter was permanently switched on at a low volume, usually tuned to a station playing popular music. Staff members often engaged in personal conversations while in the central area:

SM3 comes through, talks to CT2, have a chat about cars. Friendly, laughing. SM3 asks about CT2's wife, he tells her about a skiing trip, they compare cars' performance. They carry on chatting, RG8 still on the phone. SM4 and CM talk by the reception desk, CM leaves. SM4 joins in conversation about cars, still leaning on reception desk. SM3 leaning on workspace2 counter.

*Excerpt from fieldnotes*

### *The delivery suite as 'text'*

If one considers the semiotic elements of the physical environment of the central area of the delivery suite, the most notable permanent features were the counters and the separate areas they created, the computers, the assorted files and paperwork, the telephones and the whiteboard; more ephemeral features were food items, drinks containers and the music emanating from the radio. The separate areas demarcated by the counters appeared to be used differently by different staff groups:

2 Ms sitting at back counter (workspace1), M and HCA at workspace1 division, SHO sitting at workspace2 division writing notes.

3 Ms at workspace1 division, SHO and AN at workspace2 desk.

RCP and 2 Ms still talking at reception desk, 3 doctors still talking at workspace2 counter. 1 M still on computer at back counter (workspace1).

SHO comes through, asks for a woman's notes, M tells her they're in the delivery room, SHO goes off down the corridor. 'Islands' continue – doctors at workspace2 desk, Ms at reception desk back counter (workspace1).

### *Excerpts from fieldnotes*

This differing usage will be discussed further in Chapter 10. The counters themselves, the computers, the files, paperwork and the telephones represented social practices concerning 'work' and 'paid employment'. In this context, the concepts of 'work' and 'paid employment' are instantly recognisable to any individual who operates in the industrialised western world in the early years of the twenty-first century. The predominance of hard, flat surfaces and functional seats reinforced this impression. These features offered no personal touches, and this was clearly a public, rather than a private, space (Ribbens McCarthy and Edwards 2001). To anyone with any experience of working in the NHS, the whiteboard clearly identified the central space as being within a hospital; in the same way, the information written on it identified the central space as being within a delivery suite. Familiarity with the whiteboard distinguished between those who were initiated into the ways of NHS maternity units and those who were not. This included medical staff who came from other areas:



Two female ANs, one in theatre gear, one in street clothes, come and stand by the board. AN (street clothes) explains the system to AN (theatre gear). M1 is by the counter.

AN (theatre gear): 'I'm being stupid, but – MI doesn't mean MI?' (querying what's written on the board).

M1: 'No, 'membranes intact'.<sup>14</sup>

*Excerpt from fieldnotes*

So there was a definite discourse of 'community', to which individuals either did or did not belong, which was evoked by the simple fact that newcomers, even experts in their field, required initiation into the commonplace meanings of communications displayed on the most prominent source of information in the area.

The fridge and the handbasin within this most undomestic environment, the controlled drugs cupboard and the nature of the floor-covering reinforced the message that this was a hospital setting. This impression was further supported by the fact that many of the staff wore scrubs, that is, short-sleeved v-necked tunic tops over loose trousers, both items being made of the same material (the issue of individuals' appearance will be discussed at greater length below). These garments are instantly recognisable to any television viewer with access to western television programmes set in hospital areas. So the combination of these features signalled to all those entering the area that this was a place of work within a hospital, which in turn evoked other discourses prevalent in our society, including those of the 'employee/worker', the 'employer/boss', the 'patient', the 'healthcare professional/worker', and 'institutional responsibility for illness'.

However, these messages were overlaid with others concerning what I have called 'physical comfort'. There was a notable degree of informality about the way that the staff took care of their own needs in terms of food and drink when they were working in the delivery suite. The fact that drinks and food items were brought into the area, consumed there, and sometimes left there represents very different social practices from those of 'work', and 'paid employment'; additionally, this did not conform to traditional notions of the need to keep the hospital environment tidy and uncontaminated<sup>15</sup>. On the contrary, practices represented by this behaviour include 'feeling at home' and 'relaxation'. The constant stream of music added to this representation, as did the occurrence of personal conversations. The inclusion of

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<sup>14</sup> In general medical areas, MI means 'myocardial infarction' (heart attack).

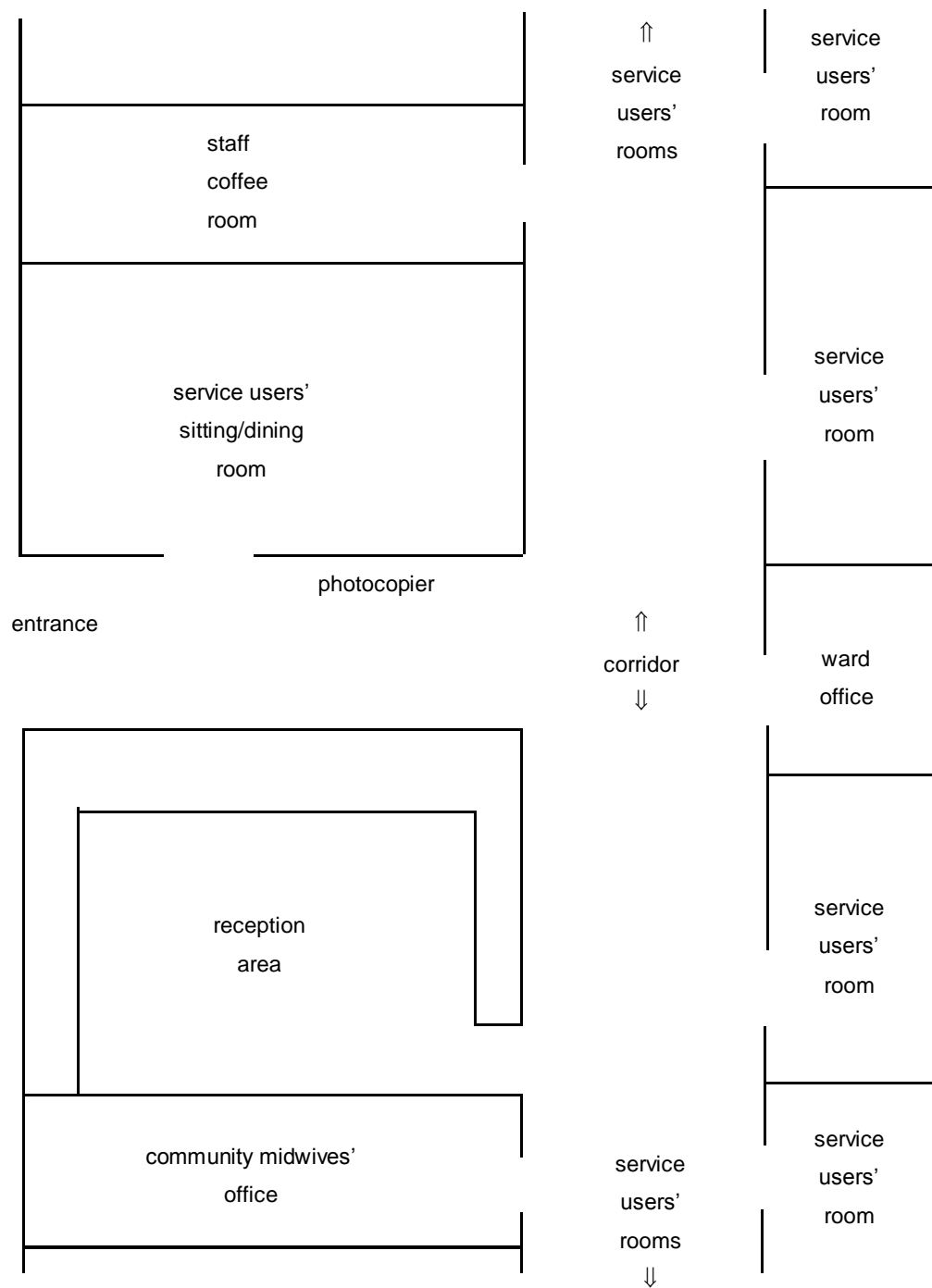
<sup>15</sup> See 'CDA, power and interprofessional relationships in midwifery' in Chapter 3.

social messages on the whiteboard also contributed to the idea of the space being inhabited by individuals with their own personal lives, rather than merely by 'workers'. So the discourses of the 'individual' and the 'insider who belongs' must be added to the list of those evoked by the physical environment of the delivery suite.

### ***The ward***

Once passing through the security doors at the entrance to the ward, individuals found themselves in a short passage with a wall on one side, with a doorway opening into a sitting-cum-dining room for women and their visitors, and a photocopier; and on the other, a counter at normal desk height (see Figure 2, p.123). This counter formed a side barrier to the reception area; on it were various books and folders, but also a small white bucket into which specimen bottles and tubes were placed for collection and transfer to the hospital laboratories, and a bottle of disinfectant hand gel, which everyone entering the ward was asked to use. The passage ended in a much longer corridor, running at right angles to and across it. Similarly to the delivery suite, the reception area took the form of a cubicle, demarcated by counters on two sides and by walls on another two sides. The front of the reception area faced into the long corridor, with a counter approximately 1.2 metres high running across it; the lower counter continued underneath the higher one and also ran along the back wall. On the low desk at the front were two computers, two telephones and various files and assorted stationery items, while the back counter held a number of books and folders, a fax machine and an electric fan. The cubicle contained two swivel chairs, and there was room for three or four people to move around inside it. The entrance to the reception area was between the front counter and the side wall. The counters were made of the same materials as those on the delivery suite, and the floor was covered with a light-coloured patterned vinyl.

The long corridor ran away from the reception area in both directions. Doors opened off it at regular intervals: these mostly led into rooms in which women who were staying on the ward were housed. Most had four beds in them, although there were a few small rooms with only one bed apiece. The four-bedded rooms were divided into bays, demarcated by curtains with a floral print, each of which contained a hospital bed, a small cot on wheels and a locker. Each bed had an overhead



**Figure 2. Layout of the ward areas.**

light and a call bell, both of which could be operated from the bed. Each room also had a handbasin in it. The doors to all the four-bedded rooms and to some of the single rooms were usually kept open. There were also a meeting room, store cupboards, toilets and bathrooms situated along the corridor, which was decorated with posters and paintings depicting women and babies in soft focus. There were vases of flowers, both silk and fresh, at various points, as well as the occasional soft toy. Posters on the walls conveyed information about breastfeeding, car seats for babies and postnatal exercise. A wall-rack carried information leaflets about a variety of subjects, including welfare benefits available to pregnant women, particular medical conditions in pregnancy and general information about the NHS Trust in which the maternity unit was situated. In addition to all these objects, there were also fire extinguishers and items of clinical equipment – trolleys, packs of instruments, oxygen cylinders and masks, yellow and red buckets for used needles marked ‘Sharps’, and a tupperware box labelled ‘Emergency PPH Kit’<sup>16</sup>.

The ward office was a small room opening off the corridor. This contained a desk-height counter running most of the length of one side wall, an ordinary office desk on which stood a telephone, a few swivel chairs, a cupboard for drugs, and a whiteboard with the names and clinical details of the women currently on the ward. As in the delivery suite, the names of the relevant consultant and the midwife assigned to an individual’s care were also recorded on it. An exercise book resting on a counter by the door was marked ‘Ward Communication Book. Please read. For everyone to use! Midwives, Nas, Drs . . .’<sup>17</sup>. The floor coverings and surface materials were similar to those in the reception area.

The staff coffee room also opened off the corridor. This was a long rectangular room, with a window opposite the door on one of the short sides. It was furnished in a similar style to the delivery suite coffee room, with cupboards, a kettle, microwave, toaster and fridge, as well as a selection of easy chairs, two low coffee tables and a television. Two noticeboards were situated by a corner of the room, on adjacent walls. One of these appeared to be for work-related information, while the other contained notices of a more social nature, for example, notification that a night out was planned because a member of staff was retiring.

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<sup>16</sup> PPH stands for post-partum haemorrhage (which can occur shortly after giving birth).

<sup>17</sup> Nas stands for nursing auxiliaries, otherwise known as healthcare assistants.

The ward served as a base for community midwives employed by the Trust. They had a separate office which also opened off the corridor. This room was the same shape as the coffee room, and had two desk-height counters running along the long side walls. These both bore files and paperwork; one of them also had a computer, a telephone and a tray with cups, coffee and tea on it. There were two noticeboards above this counter, carrying a mixture of work-related and social notices, as well as a display of 'thank-you' cards from families. There was also a filing cabinet with a potted plant on top of it next to the door, and a number of swivel chairs in the room.

Observational data collection took place in the reception area, the corridor, the ward office, the community midwifery office, the coffee room and one bay within a four-bedded room.

#### *Frontstage and backstage*

All the ward areas described above, apart from the coffee room and the offices, were open to public access (once individuals had been admitted through the ward security doors). Individuals coming regularly to the ward included women using the service and their families or friends, administrative staff, porters, medical staff (mostly obstetricians, paediatricians and anaesthetists), midwives, neonatal nurses, nursery nurses, healthcare assistants, physiotherapists and phlebotomists, as well as community-based health or social care professionals. Staff actually based on the ward included midwives, healthcare assistants, nursery nurses and administrative staff.

The coffee room was only used by staff based on the ward, and almost only for taking meal breaks. The ward office was used by both hospital staff and community-based professionals, notably for attending to paperwork and for conducting confidential discussions or telephone calls. Staff from other areas would consult the whiteboard to gather information about particular women, including the room in which they could be located. The ward midwives kept the whiteboard updated. Only community midwives used the community midwifery office.

The division between frontstage and backstage behaviour was far more marked than on the delivery suite. No drinks containers or food items were taken out of the coffee room, with the exception of those consumed by the receptionists, who did not leave the reception area for coffee breaks. Within the public spaces and the rooms

used by the women staying on the ward, it was relatively unusual to find members of staff holding personal conversations, or being engaged with anything other than work-related issues. The coffee room, by contrast, was where most personal conversations were held; work-related conversations were often held using language and expressing opinions that were unlikely to be employed in the more public areas of the ward. The community midwifery office served as a similar space for the community midwives:

CM10: 'The health visitor at *place* . . .'

CM2: 'Pink jumper?'

CM10: 'Yeah – pink jumper. She's one of those health visitors who does everything. She wants to do postnatal depression, and wonders if the midwives want to get involved.'

CM5: 'She is so enthusiastic, you want to do your clinic and she's saying 'What about this, what about that?' '

CM10: 'She's in the room. That is the problem, she's in the room, she's on the computer.'

*Excerpt from fieldnotes*

This division, however, was not absolute, and there were frequent examples of members of staff momentarily dropping their professional personae in the public spaces:

M11 comes and leans over the reception desk.

M11: 'I want to go home today. I don't like it.'

RCP2 laughs. M11: 'You're just pulled all ways, aren't you?'

*Excerpt from fieldnotes*

The ward office was a place where the boundary between different modes of behaviour was more blurred, depending on who was present: when only ward-based staff were in it, or other professionals who were well known to them, then some backstage behaviour was observed:

M20 (to physiotherapist): 'I tell you who does need your help.' Gives details about a woman. 'She had a big bleed.'

Physiotherapist: 'So that's a priority really.'

M20 tells an anecdote about another woman, with similar problems to the woman she's concerned about.

M20: 'These big girls don't do themselves any favours, really.'

*Excerpt from fieldnotes*

### *The ward as 'text'*

The semiotic elements of the public environment in the ward signalled clearly that this was a hospital setting. Although there were features that evoked 'work' and 'employment', such as the computers and the telephones, they were far less obvious than objects such as the clinical equipment in the corridors, the health-focused information leaflets, and the arrangements of the beds and curtains within the women's rooms. Again, staff were mostly dressed in theatre scrubs, adding to this message, and many women wore nightwear and dressing gowns, evoking the discourse of the 'patient'. The lack of activity or objects related to 'physical comfort' for the staff meant that, unlike the delivery suite, the discourses of the 'individual' and the 'insider who belongs' were not obviously elicited, while those of the 'healthcare professional/worker' and the 'worker/employee' were.

Social practices concerning parenthood were represented by the leaflets, paintings and posters, both decorative and informative. In all of these, women and babies were presented looking healthy and relaxed, as did the few men who also appeared in these displays. Expectations concerning parental responsibility were signified by the emphasis on safety and infant feeding in the posters. The paintings were particularly soft and subtle in their representation of motherhood, bearing little resemblance to the painful, messy and possibly traumatic experiences that many of the women staying on the ward would have recently undergone. By contrast, the clinical equipment in the corridor signified a discourse of the 'ever-present risks associated with childbirth', which requires medical intervention to be made safe. The plethora of information leaflets reinforced the message that individuals had now entered a phase in life where they were likely to be significantly involved with 'official' societal and institutional systems, particularly the healthcare system. So the discourse of 'responsible, happy parents producing contented, healthy babies' under the benign guidance and protection of an external, knowledgeable and legitimate authority was strongly evoked.

### ***The presence of the public***

A major difference between the ward and the delivery suite was the extent to which members of the public were present in the common areas. On the ward, the corridor, the women's rooms and the sitting-cum-dining room were frequently occupied by the women who were staying on the ward and their assorted friends and relations. This latter group adopted the role of the 'hospital visitor', bringing gifts and cards, admiring the new babies, and controlling the activities of small children who had not yet grasped the rules of the game. By contrast, on the delivery suite, while members of the public were at times in the central area, their presence was much less common. When women arrived at the delivery suite reception area, they were almost immediately taken to a treatment/delivery room, whose door to the corridor was kept shut. Women in the delivery suite were usually only accompanied by one or two other individuals, and only rarely by children, so that the flow of the public was both far smaller and more controlled than on the ward.

It thus may be that the reason for the greater blurring of frontstage and backstage behaviour of the staff on the delivery suite compared to that of the staff on the ward arose from an awareness of both an organisational and wider societal imperative to maintain an illusion of professionalism, incorporating the representation of 'expertise' and 'control', when under the gaze of the public. This argument is supported by the fact that when the same individuals were observed in both areas, their behaviour was seen to conform to (and therefore to reinforce) the norms of the area in this regard; that is, they modified their behaviour, depending on the area in which they were working. This modification of behaviour is entirely compatible with the tradition of regulation of individuals' embodied behaviour (both staff and service users) through which our hospital system has developed (Foucault 1973, 1977). The fact that the doors to most of the women's rooms on the ward were kept open reinforced this discourse of 'regulation of behaviour' through affording all members of staff opportunities for surveillance. On the delivery suite, women would spend very little time without a member of staff present.

The difference in the representation of the women's and the midwives' names on the delivery room doors was consistent with the representation of 'control'. The lack of the women's surnames on the doors may have arisen through a concern with confidentiality, as many individuals, including members of the general public, could be present in the delivery suite at any one time. However, as mentioned previously, in English society the combined use of different forms of names usually confers an



unequal relationship in terms of status, with the use of only a first name signifying an inferior position (Tannen 1994). The semiotic effect of the naming system on the doors, therefore, was to confer superior status on the midwives relative to the women and their partners.

### **General atmosphere**

In both areas staff appeared to be generally at ease with one another, and to operate in a relatively relaxed manner (remembering the differences between the two areas noted above). Features that contributed to this impression concerned appearance, conversational topics and communication styles, including non-verbal behaviour.

### ***Appearance***

As mentioned above, many of the non-administrative staff wore scrubs in both areas; in the delivery suite they invariably also wore clogs, either their own or those which the hospital supplied in the operating theatres. These clothes sent an unmistakable message concerning the nature of the activities within the unit. However, there were distinctions in staff members' appearance, although these were obvious only to those who were part of the system, and not necessarily to the women using the service. The scrubs were available in different colours: medical staff wore light blue, midwives wore dark blue, healthcare assistants who had achieved a particular level of national vocational qualification (NVQ) wore dark green, while those without an NVQ wore light green. So the colours of the scrubs worn represented formal distinctions between the professional/ occupational groupings in the unit which were consistent with the established NHS hierarchy. This was particularly notable in the fact that there was a difference in the colours worn by the healthcare assistants, based on whether or not they had achieved a qualification: the discourse of 'status defined by professional/occupational qualification' was clear to see. Interestingly, this neat system of identification was vulnerable to upset: individuals who were in the unit on a temporary basis, such as midwifery or medical students, also wore light blue scrubs, as did anyone else who, for some reason or another, was unable to find scrubs of the appropriate colour (there were far more pairs of light blue scrubs available than those of any other colour). This meant that, even to those who were familiar with the colour-identity system, it was sometimes impossible to tell who was who:

Talk to young woman in scrubs, thought she was an SHO – she's not,  
she's a student midwife. *Excerpt from fieldnotes*

Each member of staff wore an identity badge, either on a strap around the neck or clipped to an item of clothing.

The trend noted above for personalisation of the physical environment in the delivery suite could also be seen in the way that different individuals sometimes teamed their scrubs with other items of clothing:

Everybody wearing clogs except anaesthetic assistant (male), wearing trainers.

JM comes in . . . wearing a pale blue hoody over her dark blue scrubs.

CT3 comes back in, suit jacket over his scrubs, goes into same  
(treatment/delivery) room as previously.

*Excerpts from fieldnotes*

Consistent with the lack of personalisation of the public areas on the ward, this trend was not generally seen there, although there were exceptions noted. One midwife, who had worked in the unit for a number of years, was seen wearing a purple and white striped t-shirt with her scrubs trousers on one occasion, instead of the matching tunic top. A junior midwife (early 20s) regularly sported a nose stud and a thumb-ring.

As mentioned above, obstetric staff congregated in the delivery suite coffee room at the beginning of the day. They usually arrived wearing their street clothes, and if working on the delivery suite or in the theatres, the middle and junior grades would change into scrubs at some point during the morning. The obstetric and anaesthetic consultants covered the delivery suite on a rota basis; they divided their time between the delivery suite, their offices and other parts of the hospital. Together with the senior midwife in charge of the delivery suite, the obstetric consultant would review the situation with regard to the service users there a few times during the day, and the anaesthetic consultant would review the needs of women scheduled for caesarean section. Most operative and instrumental procedures were carried out by registrars, or by SHOs under their supervision. The consultants were available for

more complicated cases and emergency situations. They usually only changed out of their street clothes if they needed to be directly involved in a medical procedure.

### **Gender**

Fewer than 0.4% of registered midwives in the UK are male (NMC 2005). As is the case in most English maternity units, all the midwives working in the research site were female, as were the healthcare assistants and the administrative staff. During the first two periods of data collection, almost all the obstetric registrars and senior house officers were female. There were also female consultants, both obstetricians and anaesthetists. On a number of occasions when I was collecting data on the delivery suite, the consultants who were covering it were also female. This all-female workforce produced a distinctive overlay to the environment, which appeared to reinforce gender stereotypes, often with regard to individuals' appearance (particularly among the medical staff):

AN in theatre gear (scrubs and gown) is wandering around carrying her handbag.

RG5 comes through, sits down to write at workspace2 counter, hair down (long, usually tied back).

*Excerpts from fieldnotes*

The average age of the midwives and junior/middle grade obstetricians appeared to be about 30 years old. There were only a few older midwives; even among those in a senior position, the majority were relatively young. Of the two female obstetric consultants, one appeared to be in her late 30s, while the other seemed to be in her early 40s. The younger doctors, in particular, often dressed in a way that signalled their youth and gender, rather than their profession:

RG6 is young, female, shortish skirt, bare legs, high heels, yellow hoody.

Big yellow hibiscus hair ornament.

*Excerpt from fieldnotes*

Interestingly, this type of gender-signalling was much less obvious among the community midwives (independent of age), whose street clothes were generally more muted in both style and colour, with little additional ornamentation.

Some conversations also helped to strengthen the impression of a 'feminine' overlay to the environment:

Three young female doctors in street clothes come over to a computer on the back desk, then go away again. They're talking about clothes.

By the board. Female consultant AN and RCP chatting about RCP's grandchildren.

RCP, HCA, M, domestic, SM5 – all standing around reception desk, have a discussion about SM5's lip gloss.

*Excerpts from fieldnotes*

It was also noted that all staff, including the administrative staff and the healthcare assistants, addressed and referred to the female consultants by their first names. They, in their turn, appeared to know the first names of most of the midwives and administrative staff working on the delivery suite.

Gender stereotyping was further reinforced by the fact that the male consultant obstetricians invariably wore dark suits when coming to the area, and were usually addressed as Mr *surname*, and referred to in their absence either as Mr *surname*, or by their full name (*first name, surname*). There were three male consultants, two of whom appeared to be in their 40s, while one was approximately 60 years old. In the third data collection period, there were more male registrars in the unit. Conversations in which they were involved heightened the impression of gender stereotyping among the workforce:

Medical student (male): 'I was wondering what time the caesarean is?'

RG7 (male): 'Kicks off at 1.30'.

*Excerpt from fieldnotes*

There were, however, a few occasions when the composition of conversational groups did not reinforce gender-stereotyping in this way:

3 Ms and RCP at desk, still talking about jewellery. RG (male) has joined them, standing with them.

*Excerpt from fieldnotes*

Even though the staff based on the ward were also all female, there was no such obvious gender overlay. This seemed to be due to the fact that the staff did not tend to personalise their scrubs, nor did they generally engage in purely social conversations in the public areas. The medical staff who came to the ward were also often dressed in scrubs; those who wore their street clothes did not stand out

in the same way as they did on the delivery suite, partly because there were members of the public also dressed in street clothes moving around the ward, and also because during the three data collection rounds there was a balance between the numbers of male and female paediatricians who were also working there, and who usually wore street clothes.

In the ward coffee room and office, on the other hand, the conversation frequently took a typically 'feminine' turn:

In ward office. MM2 is sitting with 3 Ms, chatting and joking about men.

P (male) comes in and they all go quiet, some giggling.

*Excerpt from fieldnotes*

### ***Conversations and communications***

The conversations observed fell into three categories: personal/social (as those mentioned above); clinical discussions; and non-clinical work-related discussions/interchanges. In both the ward and the delivery suite, the informal style of communication adopted by the staff during their social conversations was also used for most other interaction:

Doctors and medical student in the delivery suite coffee room; RG2 can be seen from the reception desk, she's in the coffee room discussing a case with one of the SHOs.

SM6: 'RG2's name?'

RG2: 'Yeah?'

SM6 (holding out phone): 'Midwife at *place*.'

RG2 comes to the desk and talks on the phone, then puts it down.

RG2: 'This lady's coming in from *place* with a dodgy perineum ten days post-delivery.'

M14 (coming past): 'Oh, who's that?'

RG2 gives the details.

At ward reception desk. Two RCPs talking, JM4 leaning on the desk writing. HCA1 (from delivery suite) leaning on the desk.

HCA1: 'I'll just steal some pillows. I bet you haven't got any.'

HCA1 and JM4 walk away.

*Excerpts from fieldnotes*

This informal conversational style was reinforced by other behaviours, for example, leaning on the higher counters and physical contact between staff when talking to each other:

HCA comes out of delivery suite coffee room with doll and pelvis. RG9 (female), M and HCA – ‘Oh *HCA name*, you’ve delivered.’ All laugh, RG9 has an arm round HCA’s shoulder.

M11 is standing by the ward reception desk with a form in her hand. SHO3 comes down the corridor, M11 stops her, leans against her and looks at the medical notes in her hand.

M11: ‘If I just get the number off there, I can ring.’ She reads the number from the notes, SHO3 waits for her to finish.

M11: ‘Thank you’.

*Excerpts from fieldnotes*

It was also common to hear staff joking and laughing, something that was commented on by one of the women:

Everyone gets on with everyone else, which makes it feel a bit better being here for so long. You have the door open and you hear them laughing.

*W2, interview*

SM4 comes back pushing a trolley. She’s getting on with sorting out the monitors on her own. CT4 (male) comes through and comes over to see what SM4 is doing. MM1 comes out of her office, joins them, she and CT4 talk about the monitors. She explains that delivery suite has been allocated some money for some new monitors, they talk about which type they are.

MM1: ‘Don’t stand there too long, SM4 will plug you in.’ All three laugh.

SM8 is standing near the ward reception desk, waiting for the photocopier to warm up, getting frustrated.

RCP2: ‘You should warn me when you want to photocopy, I could warm it up for you.’ They talk a bit more.

SM8: ‘I could ring down, but I think that’s taking slavery too far.’

They both laugh, SM8 goes back down the corridor.

*Excerpts from fieldnotes*

As is demonstrated in these excerpts, seniority or occupational group *per se* did not appear to determine conversational style on most occasions. The more relaxed staff behavioural style in the delivery suite was emphasised even further by the fact that individuals often sat on the lower counters when holding discussions:

Three obstetricians joined by another one – also young female. CT1 and AN1 sitting on the counter. All look very at home.

. . . Female consultant AN comes in, joins the doctors, four now sitting on the counter, all chatting; a medical student has also joined them.

SHO2 and M sit on the counter together and chat.

*Excerpts from fieldnotes*

### ***Verbal and non-verbal behaviours as ‘text’***

In both areas, the semiotic elements of the staff's behaviour were congruent with those of the physical environment (see above). As far as appearance went, staff on the delivery suite signalled their individuality as strongly as they did their professional standing, which was not the case on the ward. The physical use of the environment, such as leaning and sitting on counters, emphasised the discourse of 'being at home', particularly on the delivery suite. The discourse of 'community' was obvious in both areas, reinforced through the medium of informal communications, physical contact and jokes.

However, the semiotic elements also revealed complex and somewhat contradictory discourses in operation. The different colours of the scrubs were interesting, as the message they sent could only be decoded by those 'in the know'. Women and other members of the public would not necessarily be able to tell the difference between the occupational groups on this basis, unless initiated into the system:

W4: Every day we saw a different woman . . .

R: Did you know who they were . . . ?

W4: No, no, I remember that finally we actually saw what we established was a midwife, because I actually made a point of looking at her name badge . . . the first actual contact we had was this woman who turned up in green, a green uniform . . .

*W4, interview*

R: Could you always tell who was who?

W5: Yeah, because they'd got different colours on. It took me a bit of time to work out what they were, I worked out that they must have been what used to be SENs or something, I guess, like I could see they were one rank down from the midwives, but I did have to ask who was who; but by the time I'd been there a couple of days I started working that out.

*W5, interview*

So while the general communication style was undoubtedly informal and egalitarian, the scrubs signalled adherence to a different agenda within the organisation, that of hierarchy of occupation and qualification. Another discourse of division observed was that relating to gendered practices. It was notable that there was fluctuation in the dominance displayed by these two discourses: at times, and particularly during social conversations, staff appeared to be signalling gender more strongly than occupation, while at other times the opposite was true.

### **The delivery suite-ward divide**

The delivery suite and the ward each had a senior midwifery manager who was answerable to the manager of the maternity services. Senior midwives on the delivery suite were based there permanently; more junior midwives were based in either one area or the other for varying lengths of time. So care for service users flowed between both areas, and service users and staff members moved between them both. However, the geographical separation between them, and the difference in the focus of care provided, resulted in the impression of two disparate places, commonly referred to as 'upstairs' and 'downstairs'. Staff appeared to feel allegiance to one or the other area, rather than the unit as a whole, and sometimes dissatisfaction was expressed about having to move from one area to the other:

Midwives will have ballot about rotation from the ward to delivery suite (3 months or 6 months) – 'up and down' doesn't suit everybody.

*Excerpt from fieldnotes*

. . . the wards think that cds (*delivery suite*) swan about and don't care about them; cds think the wards sit down and have a break every half an hour and don't care about cds; when actually both groups work extremely hard and have their own stresses that day.

*SM1, interview*



This impression of a division was reinforced by the language used by some staff, for example, the delivery suite HCA who came to 'steal' pillows from the ward (see above). There was also a perception that the medical staff were less interested in their work on the ward than their work on the delivery suite:

I think they see downstairs as being the centre of maternity care, and so when they come up here it's just part of the job, and they just get on and do what they've got to do and then go down . . .

*M6, interview*

One of the women who had been hospitalised for a number of weeks appeared to have assimilated this division as a normal feature of the environment:

. . . there's not a lot of point of them (*the obstetricians*) coming up because it just wastes their time when they can see other people that they need to see . . .

*W1, interview*

### **Unity versus division**

The physical environment and the general atmosphere of the maternity unit signalled the operation of a variety of competing and shifting discourses, which could be categorised according to whether they promoted unity or division between different individuals/groupings; and according to whether they challenged or reinforced wider societal discourses concerning medicalisation and professionalism (both of which incorporate a gender bias) (see Tables 3 and 4, pp.139-140). Discourses of division and separation, which reinforced these wider discourses, were evoked through the physical environment in terms of the demarcated spaces within the delivery suite, and the 'frontstage' and 'backstage' areas in the ward. These features signalled divisions both between staff themselves and between staff and the general public. These divisions were reinforced by the clothes worn by different individuals, in particular scrubs or nightwear (as opposed to streetclothes), respectively signalling 'healthcare professional/worker' or 'patient'; streetclothes that strongly signalled gender; and different coloured scrubs signalling different professional/occupational groups. Divisions between the staff were also noted due to the difference in geographical situation and clinical focus between the two areas, particularly with respect to variation in behavioural style. However, in both areas, informal behavioural and communication styles which challenged the wider societal discourses promoted a unifying discourse of 'community', with respect to those who

'belonged' to it - that is, staff who were comfortable and habitually worked within the respective areas. This discourse was, however, both unifying and divisive: cohesion between those 'inside' was enhanced, but it served to separate them from those 'outside'. There was however, a process whereby those 'outside' could be initiated into the 'community' and brought 'inside'. Within the 'community', gender-signalling created sub-groups which were also both unifying and divisive. Interestingly, even between these sub-groups there appeared to be individuals who were able to interact in such a way that the boundaries, while never disappearing completely, appeared to 'soften': in particular, there were some male obstetricians on the delivery suite who were included and who joined in some of the typically 'feminine' conversations.

Different discourses appeared to be managed by different individuals with a considerable degree of skill, which appeared to entail behaving in such a way as to reinforce a particular discourse at a particular time. The next two chapters will focus more closely on how the semiotic aspects of the midwives' professional behaviour related to both unifying and divisive discourses.

**Table 3. Social practices which promoted unity between different social and occupational groups within the unit, in relation to wider societal discourses concerning professionalism and the medicalisation of birth.**

	<b>Social practice promoting unity in the unit</b>	<b>Social/occupational groups affected by the practice</b>
<b>Practices which challenged the wider societal discourses</b>	Informal behavioural and communication styles	All staff
	Cross-boundary clinical practice	Midwives and senior obstetricians Midwives and healthcare assistants
	Support for women's choices concerning their care	Women and midwives Midwives who prioritised women's choices
	Support for the midwifery ethos	Women and midwives who prioritised this ethos Midwives who adhered to this ethos
<b>Practices which reinforced the wider societal discourses</b>	Gender-signalling	Women across different occupational groups
	Gendered tasks	Midwives and healthcare assistants
	Distinction between value of different skill sets and/or knowledge	Midwives and medical staff
	Medical control of birth	All those members of staff who adhered to this approach to birth
	Shared expertise	Midwives and obstetricians Midwives and healthcare assistants

**Table 4. Social practices which promoted division between different social and occupational groups within the unit, in relation to wider societal discourses concerning professionalism and the medicalisation of birth.**

	<b>Social practice promoting division in the unit</b>	<b>Social/occupational groups affected by the practice</b>
<b>Practices which challenged the wider societal discourses</b>	Cross-boundary clinical practice	Midwives and more junior obstetricians Midwives and GPs
	Support for women's choices concerning care	Midwives who did and did not support the principle of women's choice
	Supporting the midwifery ethos	Midwives who did and did not support this ethos
<b>Practices which reinforced the wider societal discourses</b>	Use of different spaces	Midwives and medical staff
	Separate working areas	Midwives on the delivery suite and those on the ward
	Different clothes	All occupational groups Men and women Women using the service and professionals/employees in the Trust
	Gender-signalling	Women and men Midwives and medical staff
	Gendered tasks	Medical staff and other groups
	Distinction between value of different skill sets and/or knowledge	Midwives with different skill sets Healthcare assistants with different skill sets
	Distinction between different types of midwifery	Midwives with differing orientation to the 'normal'
	Hierarchical structures	Staff with and without particular skills Senior and junior staff Midwives and paediatricians
	Medical control of birth	Women and healthcare professionals Midwives with differing orientation to birth
	Gendered language	Medical and non-medical staff Women and professionals
	Uniprofessional ownership of practice	All occupational groups
	Separate conversations	All occupational groups

## **Chapter 9. The midwives as professionals in the unit.**

In this chapter, I present findings concerning the way that the midwives operated within the organisation in terms of their professional role. In particular, I shall focus on midwives' standing within the unit, and their orientation to the provision of midwifery care.

### **Midwives' standing within the institution**

In order to understand how midwives interacted with other professional groupings, I felt it was necessary first to contextualise their position within the institution. I considered key concepts to include the effects of both institutional and wider hierarchies; and the fit between their role as professionals and their attitudes towards professionalism within the institutional context. For the sake of clarity I will present findings concerning these concepts separately, although this is an artificial distinction, as they are of course related to and interlinked with each other.

#### ***Hierarchies***

Awareness of the reality of the wider social hierarchy in which they operated was apparent in many of the midwives' interviews. Many of them seemed to consider a fairly strict hierarchy, in which they were in an inferior position, to be the occupational norm in many (if not most) maternity units. This issue was sometimes raised through an expression of satisfaction that the hierarchy within the research site was not experienced as being particularly oppressive. One of the community midwives stated her views very directly:

I would really find it difficult now to go back to being subservient to the medical staff. I would find that quite difficult, after being here for so long and being trusted, and being encouraged to go out and make my own decisions and be what I trained to be, you know, I would find that difficult. When I speak to people (*in other Trusts*) that . . . have the same experience as me, and they tell me what they have to do each day, you know telling the consultants about a normal multip<sup>18</sup> in labour or something . . . I couldn't do that.

*CM3, interview*

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<sup>18</sup> A woman who has given birth at least once before.

Other midwives also expressed their preference for the more informal situation in their current posts:

I was quite surprised . . . here it's very kind of mutually respectful . . .  
and it's a real pleasure and it's very balanced I think.

*CM5, interview*

. . . nobody seems to be afraid to talk to anyone else . . .

*JM4, interview*

As mentioned in the previous chapter, communication between staff of differing status was usually conducted in a non-hierarchical style:

MM2 and SM4 discuss shifts – otherwise quiet. HCA comes and looks at the board. MM2 calls over: 'morning *name*'. HCA smiles and turns round: 'morning.' MM2 and HCA sit and chat together.

*Excerpt from fieldnotes*

However, this did not mean that the institution was based on egalitarian principles, and there was a distinct institutional hierarchy operating (signalled to some extent by the different coloured scrubs – see Chapter 8). Appreciation of the lack of hierarchical oppressiveness within the institution did not mean that midwives were unaware of the operation of the existing hierarchy:

. . . it's pretty good compared to other places . . . though, you know . . .  
the hierarchy is still in place firmly, so if it is any better it's only marginally better . . .

*CM6, interview*

. . . they don't tend to know us indians that well . . .

*M6, interview*

It became apparent that, despite the egalitarian communication style and the informal nature of much observed interaction, there was a clear hierarchy operating between senior and lower-ranking midwives within the unit (the effects of hierarchy on relationships between midwives and other professionals will be discussed in Chapter 10).

Unsurprisingly, differing views concerning this situation were expressed by midwives from the different groups, with less senior midwives more likely to feel restricted in their role:

M8: . . . normally you go through the senior midwives, and that's just the way that, it's the way things are here . . .

R: Ok, so who has the power here?

M8: The G grades. (laughter)

R: Can you say more about that?

M8: Not on tape! (laughter) I think, without mentioning any names or anything like that, I think there are certain people who are probably a bit more . . . more like the boss than others, but only a small minority.

*M8, interview*

The use of the phrase 'that's just the way that, it's the way things are here' signalled M8's resignation to and acceptance of the status quo in this regard. Her perception of her position in the hierarchy was graphically indicated by the exclamation 'Not on tape!'. However, an alternate position which allowed for the effects of personal agency, while still acknowledging these restrictions, was expressed by another midwife:

JM19 comes into coffee room – chat about culture. She feels that if you stand up for yourself, and aren't 'bolshy, trying to buck the system all the time', you're ok.

*Excerpt from research journal*

By contrast, some senior midwives appeared to be unaware of the effects of the hierarchy on more junior midwives:

You know when you first come to somewhere and you're junior in a health organisation, you do feel that you're at the bottom of the pile and that you can't say what you think, but here you can and you're encouraged to.

*MM2, interview*

Other senior midwives considered the operating hierarchy to be both appropriate and supportive of junior midwives, even if the latter did not appreciate this:

R: Where does the power lie?

SM3: I don't think it's, it's any power, particular power if you like, there is line of responsibility. We know as a senior midwife you've got to communicate with our H (*MM1*), we don't go over her head, so hierarchy is kept quite nicely, she takes it to *MM3*, you know, where it's necessary.

*SM3, interview*

I think that the senior midwives get very much more supported by management than people realise. Until I became one, I never realised just how much sort of secret support was going on . . . I think that's why the structure does work well, because they (*senior midwives*) feel supported and they can therefore support the junior midwives . . . I think that the junior midwives are a lot more supported than they think they are.

*SM1, interview*

Status and seniority were often expressed in terms of midwives' relative experience:

. . . on our team you need at least a year's experience before coming out . . . they tried bringing newly qualified girls out, and you could perhaps carry one as a development role but you just can't do it, you know.

*CM7, interview*

There was, however, an explicit statement from one senior midwife that the operation of the hierarchy did not entail senior midwives' interfering with other midwives' practice:

. . . the senior midwives, we don't go into a (*delivery*) room unless we're invited, so we assume that the midwife is happy with her care.

*SM2, interview*

The last two quotes illustrate the inherent tension between the observance of hierarchical difference among midwives, and the concept of the midwife as an autonomous professional.

There was also evidence in data collected from women using the service that midwives in the unit did not always behave like 'professionals':

I asked her if I'd be staying . . . and I'm like 'I just want to know so I can get my daughter sorted out with babysitters if I'm staying in' . . . she (*the midwife*) said 'You know the score, you're not silly, you know what's



happening deep down', she said ' You know I can't say any more than that, 'cos it's more than my job's worth'. *W1, interview*

Generally speaking, there appeared to be an acceptance among the midwives that midwifery is an occupation which is (appropriately) situated within hierarchical structures. However, some of the midwives appeared to be aware that such acceptance might not be compatible with the current rhetoric surrounding midwifery in terms of professionalism and autonomy. Most presented themselves in interview as aware and competent professionals. It seemed to me that some also took care to intimate that they were working in an organisation that afforded them their full professional status, and consequently downplayed institutional aspects that contradicted this stance. This was demonstrated by modulation within their speech, by which the effects of the hierarchy could be discounted:

I suppose there is a bit of a hierarchy between midwives here, . . .  
*CM3, interview*

An underlying discourse, particularly among the senior midwives, was that their institutional hierarchy was based on differing levels of clinical competence and knowledge, which is congruent with the wider hierarchy represented in the rules and standards governing midwifery practice in the UK (NMC 2004b)<sup>19</sup>. There was no explicit mention or awareness of gendered practices within the organisation, but reflections of the gendered nature/origin of the operating hierarchy were visible in the way that older or more senior midwives often referred both to more junior midwives and to healthcare assistants as 'girls', no matter how old they were:

Anyway I got her through, and then two of the other girls (*HCAs*) who had different assessors . . . said could I help them. *M5, interview*

SM5 (*speaking to RG*): 'I'll just let the girls (*midwives*) know – where are you going?'

M11 comes down the corridor pushing an incubator, talking to RCP2.  
M11: 'What's the new girl's (*HCA*) name?'

*Excerpts from fieldnotes*

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<sup>19</sup> See Chapter 7.

An alternative interpretation of this usage, with its possible connotations of camaraderie, could consider that it was employed to reinforce the sense of community between the midwives and the healthcare assistants. However, if this was the case, it would be logical to find it extended to the female obstetricians, given the degree of informality and the 'feminine' modalities of communication noted between the female members of staff across different occupational groups (see Chapter 8); but no obstetrician was ever referred to as a 'girl' by a midwife. So I can only infer that the use of this word was a reminder of the gendered hierarchy, based partially on the system of domestic service, in which nursing and midwifery have been located since their establishment as organised occupations (Dingwall et al 1988).

This assignment of non-adult status to women working in the service was applied even more strongly to women using the service. Language use revealed an underlying discourse of infantilisation, a phenomenon previously noted by Oakley (1993), signified particularly both by possessive and diminutising adjectives:

CM2: 'I must speak to the health visitor about one of my girls.'

SM2 (at front desk): 'MM1, I can't find your girl to listen in.'

SM5 on the phone to an anaesthetist, requesting an epidural for a woman. SM5: 'She's a lovely little girl, but she's struggling.'

*Excerpts from fieldnotes*

### ***Professionalism within the institutional context***

When asked directly whether or not they considered themselves to be professionals, all bar one of the midwives answered that they did. The dissenting individual justified her reply by explaining her concept of 'a professional':

I probably see a professional as you know managerial in a suit . . . I'm  
very hands on and clinical . . .

*M8, interview*

Underlying this reply is a discourse of professionalism incorporating authority and non-engagement in manual work. Interestingly, M8 went on to say that she 'probably should' consider herself to be a professional:

R: Why?

M8: I don't know, I just think we have an important job with the public and that should mean that we're a professional . . . *M8, interview*

I interpreted this as an explicit reflection of the current professionalisation agenda within midwifery. Another midwife, while accepting that she did consider herself a professional, was clear that this was a strategy she employed in order to avoid becoming overly emotionally involved with the women she attended:

I suppose I do, but only because I've had to . . . protect myself in a way . . . as time's worn on and I've got . . . a bit worn out and soaked up too much information, too many emotions, I've had to think, well if being a professional means just separating myself a little bit then that's what I am. *CM6, interview*

This midwife contrasted her interpretation of professionalism with that of other midwives in the unit:

But that's my definition of professional, it's about keeping a distance really, whereas I'm not sure that everybody has that view of the profession. I think some people's interpretations are 'I know better than you' . . . and I don't think that's necessarily true. *CM6, interview*

Indeed, most other midwives evoked discourses of responsibility, knowledge and targeted education when discussing their status as 'professionals':

. . . you have to work within professional standards . . . *CM7, interview*

. . . we're all professionals, we're all sensible, we all know what we're supposed to be doing . . . *JM4, interview*

They have said to us . . . that we need to do counselling skills on antenatal clinic. But my opinion of that is you can't do counselling unless you're a trained counsellor. You can talk to women, and you can offer support, but you can't truly counsel somebody unless you've qualified as a counsellor. *M6, interview*

Similarly, some of the medical practitioners viewed the midwives as ‘professionals’, inasmuch as they (the doctors) considered them (the midwives) to be competent clinicians with their own field of expertise:

. . . midwives are there to be the professional looking after normal pregnancy, normal labour . . . *CT1, interview*

This view applied particularly to senior midwives in the delivery suite and to community midwives:

Their clinical knowledge is excellent. They’re very experienced midwives. *RG1, interview*

. . . ours (GPs) I think say ‘well we’ve got perfectly good midwives, leave it to the professionals’ . . . *W6, interview*

One incident observed demonstrated that there was an expectation that midwives would conform to accepted professional conventions governing the way that clinical information was conveyed in written form:

RG2: ‘This lady’s coming in from *place* with a dodgy perineum 10 days post-delivery.’  
M14 (coming past): ‘Oh, who’s that?’  
RG2 gives the details.  
RG2: ‘I’ll just finish the conversation I’m having in here, then I’ll come.’  
She goes back into the coffee room.  
M14: ‘Ok.’ She goes and writes on the whiteboard – ‘dodgy perineum’.  
The ANs and an SHO are all still talking by the right hand counter (workspace2), they stop and look at what she’s written.  
M14: ‘That’s according to RG2.’ *Excerpt from fieldnotes*

So while it was quite acceptable for RG2 to use an informal expression when communicating vocally, even when the topic was work-related (as discussed in Chapter 8), the doctors’ reaction and M14’s response indicated that this was not normal acceptable practice concerning written communication in the unit.

Some of the women using the service implied that they expected midwives to be ‘professionals’:

I didn't have a particularly good relationship with my local midwife, I felt she didn't come across as really caring and that's what I would be looking for in a healthcare professional . . . there were two particularly good midwives . . . who I felt were very caring, very professional, good communicators, very supportive. *W5, interview*

However, the issue of professional status was not necessarily particularly important to all the midwives. One midwife considered herself a professional, and was not entirely content with the operation of the hierarchy in the unit, but nevertheless enjoyed working there. However, she was considering looking for a midwifery post in another trust, because she was due to rotate to the antenatal clinic against her wishes. When questioned further, she framed her orientation to her occupation purely in terms of factors influencing her personal life:

M6: The reason I do shifts is to accommodate my children, because they go to their father's on a week-end, so I work week-ends. There'd be no point me being home on a week-end with no kids there, so I'd have to go somewhere where they could accommodate what I need, really.

. . .

R: So what will you do, leave and look for something somewhere else?

M6: I'll look for something somewhere else. I know that *other unit* and *other unit* tend to be more flexible with people with children, and I know that *other unit* don't object to midwives deciding if they want to work in a particular area . . .

. . .

R: What are the good things about working here?

M6: Being near my house (*laughs*). I'm not far from home, not far from the kids' school. They're a good bunch, they get on, we all get on well . . . it's a nice unit to work in. *M6, interview*

There were other discrepancies and contradictions noted concerning the midwives' professional status. In response to a query concerning her expressed satisfaction with her working environment, a junior midwife answered:

I like the unit, I'd like to think that I'm . . . a midwife at heart, I'm not an obstetric nurse . . . *JM4, interview*

I found this distinction intriguing, and went on to question other midwives about their perceptions of midwives and obstetric nurses, and also asked them which they

considered themselves and their colleagues to be. They all saw a difference between these two occupations:

. . . we're more autonomous in our role than an obstetric nurse.

*M8, interview*

. . . I think a true midwife is working out stuff for herself and when she gets into an area that she knows is abnormal she'll refer on; I think obstetric nurses are working alongside (*obstetricians*) and referring all the time if they need to or not . . . they're not making their own decisions;

*CM6, interview*

. . . they (*obstetric nurses*) are basically, they're skill based, they're trained to do a job . . . they're not trained to think and act beyond, past that . . .

*CM7, interview*

However, one newly-qualified midwife, when asked what she thought this difference was, replied caustically:

Here, not a lot.

*JM9, interview notes*

In fact, the midwives expressed a variety of opinions about whether they and their colleagues were midwives or obstetric nurses. One community midwife felt that she and her community colleagues were midwives, but viewed the midwives practising in the hospital as obstetric nurses:

I think most of them must be obstetric nursing, because I don't see how you can't when you're working alongside so many doctors.

*CM6, interview*

She contrasted her current position with her experience in another unit:

I thought I was a midwife and now I look back and . . . I was really obstetric nursing; occasionally I'd have a shift where I wasn't . . . even within that I was still having to refer to the senior midwives who were then referring to the doctors anyway . . . I was obstetric nursing even when I liked to think of myself being a midwife;

*CM6, interview*

However, JM4 and M8, both working in the hospital, were quite clear that they were midwives, and not obstetric nurses (unlike JM9). By contrast, SM1, a senior midwife, stated that she did a 'massive amount' of obstetric nursing:

. . . because we have a high risk case load, so a lot of women that come through the door are high risk and need referring to the doctor; anyone who considers that not to be the case would be an idiot really, because it's clearly obvious that women who need to see a doctor regularly are not under the realm of the midwife entirely . . . I would say my present work is probably more than half and half, but it's probably more, less than half is midwifery really. *SM1, interview*

In an earlier interview, SM1 spoke about senior midwives' overseeing junior midwives, but also stated that midwives were 'given their full autonomy' in the unit. However, it was clear that the midwives did not enjoy full autonomy with regard to their practice, which in many cases was governed by unit policies, although some midwives stated that they were meant for guidance, rather than being prescriptive. Analysis of two of these documents revealed a differing level of prescription between the policy governing care for the women using the service, and that governing care for babies within the unit, in relation to two specific areas of care (see Chapter 7). Policies were made by a policy review group, of which the membership included, among other individuals, senior midwifery managers and medical consultants. Observation of one meeting of this group, at which there was both midwifery and obstetric representation, revealed that most decisions were taken jointly by the obstetric consultant and the midwifery manager in overall charge of the unit.

When asked about their observation of the policy governing the need for augmentation in labour, some midwives used language that did not fit with the concept of their being responsible, autonomous professionals:

Personally I find it, with normality which is what we're experts in, I find it quite strict. *JM4, interview*

I know that a lot of midwives feel that once they're in hospital, we've got this policy of a centimetre an hour - it's quite ludicrous really. *M6, interview*

There are still some that would force someone to augment them on the  
centimetre an hour . . . *CM3, interview*

The idea of being 'forced' to practise according to a policy that is considered to be 'strict' or 'ludicrous' does not fit well with the notion of professional autonomy. Most of the midwives went on to say that it was unusual for them to follow this policy rigidly. However, they also spoke about being 'allowed' to deviate from it and having to 'negotiate' their position. This discourse of 'permission' was also evident in the way that one midwife spoke about the tension between being a professional and being an employee:

CM5: . . . they really let midwives be midwives here, as much as you  
could be on the NHS . . . we're not independent midwives so we do have  
to abide by Trust protocols and procedures . . .

R: Who's 'they'?

CM5: Well I suppose I mean the management . . . the whole system . . .  
I suppose I was thinking of myself as an employee.

*CM5, interview*

The use of 'they' and 'them' to indicate those representing the hierarchical authority structures, as opposed to 'we' and 'us', that is, those who were subject to them, was a commonplace feature of the midwives' speech.

CM5 actually intimated earlier in the interview that she did not always follow policy if, in her clinical judgement, it was not warranted. However, some midwives felt that midwives should always follow unit policy, irrespective of their own views:

Had a conversation with SM5 and SM7 and student about informed  
choice. Clear that both midwives are very obstetrically orientated – don't  
like physiological third stage, think some community midwives influence  
women against Vitamin K – don't approve of midwives giving women their  
personal opinions if they're different from Trust policies and guidelines.

*Excerpt from research journal*

Interestingly, in this context, midwives were portrayed as having 'personal opinions', rather than using their own professional judgement. Once again, the discourse of midwives being expected to be representatives of the medically-oriented establishment was clearly discernible.



Another example of the tension between being a 'professional' and operating within the institutional context was found in M5's account of her involvement in the educational programme established to help healthcare assistants gain an NVQ. Throughout her interview, she referred to other authorities (her manager, the NVQ organisation, the government) whose decisions had impacted on her role:

. . . and then *MM3* said that everybody we employ as a nursing auxiliary now has got to do NVQ Level 2; *M5, interview*

As the midwives were to be responsible for training the healthcare assistants, this signified a lack of autonomy and engagement in decision-making. At the same time, M5 clearly considered herself to enjoy superior status to that of the healthcare assistants: she referred to them consistently as 'girls', even though most appeared to be in their forties and fifties; and she referred to them only in the passive voice as being 'taught' by her, rather than as being active learners. She intimated that task competence and recognised qualifications were desirable for anyone working in that environment:

. . . it's basically making their job more interesting, and making them part of the team, and giving them a qualification. *M5, interview*

The mention that they became 'part of the team' suggested three things: that there was a perceived entity called 'the team' to which selected members of staff belonged (including M5 herself and other midwives); that a worker in that environment was not considered to be 'part of the team' unless seen to have some professional competence, as opposed to providing only basic care; and that the provision of basic care was not highly valued. This was also suggested by the statement that 'it's basically making their job more interesting'. The fact that the healthcare assistants would gain a qualification was presented as something automatically good in itself; so M5 presented herself as someone supporting the drive for the professionalisation of the NHS workforce.

This stance was shared by other midwives, who made clear distinctions between qualified and non-qualified healthcare assistants, and were of the opinion that they would all be better off being 'trained' to do 'more interesting' work:

. . . it's good for them . . . it gives them something more to aim for as opposed to just coming in and you know, making the beds and serving the meals . . . that'll be quite interesting to see how that sort of pans out when they're all qualified.

*CM4, interview*

We're trying to encourage all our healthcare assistants to become NVQ2 trained . . . to actually increase their job satisfaction. You know to come to work in a place like this and to just make beds, or just give out teas and coffees and stuff like that . . .

*MM2, interview*

Again, the provision of basic care was presented as being less valuable than the performance of tasks that required the acquisition of clinical skills. However, there was no doubt that the provision of basic care was important for the women using the service:

. . . you were aware lunch was about 'cos you could smell it, and that was a bit haphazard about what happened . . . depending on who was serving the lunches . . . one of them, they were very good, came round and made sure everyone had had a lunch, 'Right, have you eaten today mum? . . . I'll go and get it for you' you know, and it was brilliant - and half the time you had to rely on the partners to go and get it for you . . .

*W4, interview*

I tell you who was good as well, the healthcare assistants, they were fantastic, they were always full of information if you wanted to know anything . . . and the lady that brought the tea as well was part of the team, the cleaners, and of course they served the meals as well, the healthcare assistants . . .

*W5, interview*

Interestingly, W5's view of the 'team' included all the Trust employees who worked on the ward, as opposed to the midwives' distinction between those with and without particular skills.

Despite their perception of themselves as 'professionals', it became apparent during observation that the midwives often engaged in activities which were not directly related to their professional role or their sphere of clinical practice. This included those which could be categorised as 'domestic' tasks, such as cleaning, or organising the physical environment:

SM7 comes through pushing a monitor, which she starts to clean. SHO3 looks at her in enquiry, she responds: 'Water and j cloth. I've put my cleaning hat on. Reminds me of my nursing time, actually.' – pulls a face.

SM2 and HCA are pushing beds and cabinets down the corridor, going backwards and forward, chatting all the time.

*Excerpts from fieldnotes*

Again, the midwives' engagement in these tasks reflected the gendered division of labour, in which domestic responsibilities are assigned only to women. No doctors were ever observed involving themselves in similar tasks, a situation in which the female doctors could be seen to enjoy the status of 'honorary men'. Both male and female doctors did occasionally make hot drinks for the midwives, but this could be construed as a social, rather than a domestic, task. A factor influencing this division of labour could also have been that, while the midwives and healthcare assistants tended to be based in an area, the doctors were not. There was, therefore, an element of 'ownership' of the space, which carried with it a perceived responsibility for its physical care.

The sharing of domestic tasks could also be seen as serving to reinforce the discourse of 'community', through affording an opportunity for members of staff to work together in a relatively informal manner. Interestingly, one of the women using the service viewed the sharing of tasks from this perspective:

R: so you see the midwives and the auxiliaries working well together . .

.

W1: yes, yes, they do work well together, and even like the receptionists and the whole lot, the domestics . . . they all help out each other with things they can do, 'cos it sort of relieves the pressure a bit so . . . it is quite nice, so that's a bit more relaxed as an atmosphere.

*W1, interview*

Overall, in terms of their standing in the organisation, the picture concerning the midwives was somewhat contradictory. Most of the midwives viewed themselves, and were seen by both medical colleagues and the women using the service, as professionals, and presented themselves as adherents of professionalisation. However, there were differences of opinion as to whether they were practising mainly as obstetric nurses or as midwives; they appeared to associate greater

levels of skill and higher professional status with the latter. They occupied set positions within the institutional hierarchy, their autonomy in practice was undoubtedly restricted, and they were not party to decision-making which substantially affected their role within the institution; they also engaged in tasks which were not directly related to their professional role. A recognition of the current imperative for midwives to be seen as professionals was demonstrated by the modulation within some interviewees' speech, which served to downplay effects of the operating hierarchy which could be viewed as incompatible with this agenda.

### **Midwives' orientation to the provision of midwifery care**

The maternity unit, like most other NHS units in the UK, was established and run according to the predominant medical model of childbirth. It would have been very unusual for it to be run according to any other ethos, given that only medical practitioners and registered midwives are permitted in law to attend a birthing woman in the UK (Bent 1993). From my own midwifery experience and my previous research (Pollard 2005), I was aware that midwives who subscribed to the medical model were often more comfortable practising in the NHS than those who wished to adhere more closely to the holistic non-interventionist midwifery ethos. For this reason, I wished to explore individual midwives' orientation and attitudes both to midwifery (in particular their conception of 'normality') and to the women whom they attended.

#### ***Orientation to midwifery***

A number of the midwives made it clear that they considered there to be at least two different types of midwifery, that is, holistic midwifery that dealt only with 'normal' women, and midwifery that involved extended skills and the care of women with 'complications'.

. . . the division between normal women in the community and midwifery-led care, and so-called high-risk care - or consultant-led obstetric care - is different;

*CM5, interview*

Individuals' orientation was to a large extent reflected in their (aspirations concerning their) place of work, that is, either in the community or in the hospital.

JM9 thinks that the midwife's role equates to obstetric nursing in obstetric units, and that midwives need to be in a midwife-led unit to have a

midwifery role. She would rather do that, and is hoping to move into that situation, or be in a community team, in about 6 months' time.

*JM9, interview notes*

One community midwife (an exception to the rule) explained this succinctly:

I always thought that I was going to be a hospital midwife and that's sort of always what I wanted to do, and coming out to the (*community*) teams is really for experience, as opposed to what I want to do; whereas the other people in the teams, that's what they see as midwifery.

*CM4, interview*

Whichever type of midwifery individuals preferred to practise, it was evident that a significant component of the midwifery role involved surveillance of the woman and her situation:

. . . you'd just be monitoring it (*labour*), and just sort of checking regularly to make sure that there is progress . . .

*JM7, interview*

This was unsurprising, as all UK midwives learn their clinical skills in environments which operate in accordance with the wider discourse of childbirth involving inherently dangerous physiological processes that require constant monitoring by professionals in order to be kept safe.

A corollary of the distinction between different types of midwifery appeared to be that in some instances, the provision of midwifery care for women experiencing 'normal' pregnancy and childbirth was not seen to be as valuable as the provision of obstetrically-led care for women experiencing problematic pregnancies:

. . . midwifery in my heart is really just about home deliveries and doing that whole fantastic normal thing with women . . . but it's not that interesting all the time; so in order to make your brain work you do actually need to do something a little bit more complicated.

*SM1, interview*

This juxtaposition of 'fantastic' and 'not that interesting' led me to wonder whether SM1, a senior midwife often in charge of the delivery suite, really did think that the

'normal thing' was so 'fantastic'. Certainly, it seemed that the community midwives' skills, which mostly involved providing care to women without complications, were not necessarily valued by the hospital midwives:

I've worked in both places . . . and just recently come out (*into the community*). It's quite interesting . . . the sort of views that people have working in the unit (*hospital*) of what the community people do are very negative . . . in the main unit, they seem to think that they (*the community midwives*) don't do very much, and they don't know what they're doing when they come in here (*to the hospital*), because they only know about normal things, so they're useless with anything goes wrong, as soon as anything happens that's sort of not normal; and I think they don't have a very high opinion of them.

CM4, interview

Another community midwife expressed resentment that the hospital midwives considered their work to be more important than that of the community teams:

. . . in the hospital they actually are coming from a very different place . . . they have a perception of us as of being community midwives dealing with home births, and some of the team births in the unit, but also if things get too hectic . . . they're the priority so they have to call on us . . . that leads to some conflict sometimes. I think that sometimes we see ourselves very differently from that, we see ourselves as . . . a separate resource who should be physically somewhere else. They will be asking us to do something that they see as completely reasonable . . . come and help out on delivery suite, we see it as taking a member of staff away from all the other things that need to be sorted.

CM6, interview

These sentiments and opinions reflected the wider discourse which appeared to be operating when the midwives talked about the healthcare assistants' gaining the required skills for the NVQ. In the same way that the midwives differentiated between the healthcare assistants on the basis of those skills, so some of them seemed to differentiate between midwives who mainly practised 'normal' midwifery and those who frequently needed to exercise skills involving medicalised treatments and procedures, the latter being considered to be more capable, clinically speaking. This in turn was a reflection of the wider gendered hierarchy which values medical

(‘masculine technological’) knowledge and skills above midwifery (‘feminine natural’) knowledge and skills.

Ironically, some of the community midwives appeared to possess extremely high level midwifery skills, inasmuch as they regularly (if not frequently) cared for women who gave birth at home who were classed as ‘high-risk’. For example, CM6 recounted an experience concerning her community colleagues’ attending a planned homebirth of twins, one of whom was presenting by the breech. Multiple pregnancies and breech presentations are considered to be ‘abnormal’ (not merely uncommon), and thus it is very unusual in the UK both for women in that position to give birth at home, and for midwives to be responsible for their care without the direct supervision or involvement of an obstetrician.

Central to this distinction concerning types of midwifery was the concept of ‘normality’. In much of the midwifery literature, ‘normal’ pregnancy and birth are considered to entail the natural physiological process taking its course without requiring any intervention (Anderson 2003); the concept of the midwife as the ‘guardian of the normal’ is enshrined in midwifery philosophy. Congruent with this stance, when midwives were questioned about the definition of dysfunctional labour on which the *Augmentation of Labour* policy was based, they evaluated it in terms of what they considered to be the natural progress of labour, drawing on their own midwifery knowledge:

I don’t think it’s a very accurate definition, because the majority of labours, especially of primigravidas<sup>20</sup>, labour at a slower speed than that. I think the research shows that it tends to be a centimetre perhaps every two hours. JM7, interview

However, midwives still referred to the concept of ‘normality’ based on medical definitions of risk:

. . . if it’s been a normal, low-risk pregnancy . . . M6, interview

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<sup>20</sup> Women giving birth for the first time.

When considering the *Vitamin K Policy*, two community midwives framed the recommendations concerning its administration within the concept of natural physiological processes:

I don't know if it's really necessary . . . I think that really there must be a reason why they've got low levels of Vitamin K; *CM5, interview*

We know that if a woman's fully breast feeding, their baby's had a really straightforward, natural (*birth*), then they're going to start producing their own Vitamin K quite quickly . . . *CM6, interview*

However, all the other midwives spoke about the policy in terms in which 'normality' was equated with 'common practice':

. . . when you normally explain that most babies have it, explain what it is, most people are quite happy to have it. *SM2, interview*

These midwives' replies were not only framed within the medical perspective, but also with reference to the wider underlying discourse of state control of individuals' health behaviours:

. . . there's a national recommendation and a local recommendation, very strongly, that all babies have it. *CM3, interview*

These discourses were reinforced by midwives who said that they agreed with the requirement set out in the *Vitamin K Policy* that parents who did not want their babies to receive Vitamin K should be referred to a medical practitioner (paediatrician or GP). Only one of these midwives recognised the irony of the situation which assumed that they were able to give parents sufficient information to enable them to consent to Vitamin K administration, but not enough for them to refuse consent. This was an interesting example of the phenomenon Robinson (1995) wrote about when discussing the concept of informed consent – that is, that many healthcare professionals assume this means that information-giving automatically results in consent:

The word 'consent' is so embedded in their minds that they do not understand that it cannot truly exist without 'refusal' existing not just in theory, but in fact. (Robinson 1995, p.616)



The fact that most midwives did not even recognise, much less question, this incongruity revealed their acceptance of the wider discourse concerning the hierarchy of knowledge which underlay the policy's requirement for referral to a medical practitioner: parents know less than midwives, so need to be told by them about Vitamin K so that they will consent to their child's receiving it; if they do not consent, it is because they have not been given sufficiently authoritative information, so they must then see a medical practitioner, who no doubt will be able to impress upon them the need for the drug's administration by giving them even 'better' information than that available to the midwives.

Midwives referred frequently to their being the 'experts in normality', so could be construed as seeing themselves as the 'guardians of the normal'. However, there was a question mark about what they were actually guarding, since their interpretation of 'normal' varied between the concepts of undisturbed natural physiological processes, medical definitions of risk and commonplace practice located within a prescriptive medical perspective. The following exchange was observed at a policy review meeting:

MM3 talks about needing lay representation on some of the committees, says lay representation is very important. Discussion about who might be approached.

CT1: 'I don't want somebody where it's been so straightforward that they can't imagine what it's like being normal, with no hidden agenda.'

*Excerpt from fieldnotes*

There were four midwifery managers and one consultant obstetrician present at this point; none of the midwives challenged the obstetrician's opposition of the terms 'straightforward' and 'normal'.

An interesting twist to the concept of 'normality' was revealed during an interview with one of the midwifery managers. The unit midwives had recently started to conduct examinations of newborn babies, an activity which had previously been the province only of the paediatricians; some of the midwives also conducted ventouse<sup>21</sup> deliveries (the boundaries of the midwife's role will be discussed in

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<sup>21</sup> Ventouse deliveries entail the extraction of the baby from the mother's vagina by means of a mechanised vacuum device (Silverton 1993).

Chapter 10). When explaining which babies fitted the criteria for midwifery examination, rather than paediatric examination, MM1 stated:

. . . the criteria is for normal delivery, I mean a midwife ventouse delivery would be classed as a normal delivery . . . *MM1, interview*

This revealed how the definition of 'normality' can change, in this instance dependent not on what was actually happening in terms of the physiological process of birth or on what was commonplace practice, but on which professional was involved: the midwife is the expert in 'normality', therefore, if she routinely conducts a procedure, it becomes 'normal'. There was evidence that midwives working in hospitals have become distanced from normal (natural) birth in some individuals' perceptions:

The NCT antenatal teacher actually kept emphasising that really and truly they're (*hospital midwives*) only there for acute cases, acute care, they're not there for everyday births, normal deliveries . . .

*W4, interview*

### ***Attitudes to women***

It should be remembered that in the UK, it is illegal for women to give birth without intentionally involving either a medical practitioner or a registered midwife (Bent 1993). Most women accordingly use NHS maternity services, and midwives are professionally obliged to offer 'woman-centred care':

. . . it is vital that midwifery care be centred on each woman's unique and individual needs. *(RCM 2006:1)*

As stated previously, the principle of women's right to make choices concerning their care is enshrined in law in the UK (Hewson 2004). However, this right is often only reluctantly respected when women's choices conflict with recommendations located within the medical model of childbirth with its associated definitions of risk (Pollard 2005). One of the community midwives referred explicitly to the wider societal discourse underlying this situation:

. . . the biggest problem I think in our culture is that everybody trusts the hospital and the doctors, everybody thinks it's safer and in fact, you

know, it isn't, the more people fiddle around with you the more likely there is to be problems . . .

*CM6, interview*

The concept of women's choice appeared in many of the midwives' interviews, particularly when observation of unit policies was being discussed. Some midwives accepted in a matter-of-fact way that women had the right to make choices:

I could discuss it (*Vitamin K*) with them . . . it's really up to them, I don't see the point of being heavy-handed about it, it's really up to them.

*CM5, interview*

Others appeared to support women's choice when there was no conflict with their own professional judgement, even if this meant not abiding by the unit policies:

. . . she had a homebirth, and she refused Vitamin K . . . I let the GP know and I let the health visitors know, and that was sort of the end of it really, I mean obviously she had a nice non-traumatic delivery at home, so . . . she didn't really need it.

*CM4, interview*

Some midwives expressly stated that women's choices should be respected, no matter what the circumstances. There were shades of difference in the way that this opinion was expressed, sometimes as a point of professional obligation, and sometimes as a matter of principle:

. . . we're the advocates really aren't we . . . we're open to listening to their side of the argument really, and basically everybody does have a free choice and I mean certainly the way the law stands at the moment, we've obviously got to work within the law . . . she has a right to endanger her own life - but then that happens so rarely that you know, you just have to work with it.

*CM7, interview*

Thinks women should be able to choose what they do, even if it's 'unsafe'. As long as they've had all the information, then they should be able to choose what they do, and midwives shouldn't be able to withdraw care, women should be entitled to care.

*JM9, interview notes*

However, some of the senior midwives in the hospital felt it was 'unreasonable' for women to insist on a course of action that did not fit with medical perceptions of risk and safety. One of these midwives expressed herself in quite extreme terms:

I think it's completely reasonable for anybody to want what ever they want, as long as they're prepared to take on board the fact that they or their baby might die as a result of it . . . the fact that it will destroy midwives' lives if it happens is somewhat irrelevant really, you can't make someone want what they don't want . . .

*SM1, interview*

In fact, many midwives' opinions about women's choice appeared to hinge on the discourse of safety only being achievable through applying 'professional' (that is, medical) standards (which I see as underpinning the *Midwives rules and standards* (NMC 2004b)). Unlike JM9, SM1 thought that midwives should be able to withdraw care from women if they disagreed with the choices they were making<sup>22</sup>.

Interestingly, this view was shared by CM6, who supported women's choice as a matter of principle, but felt that midwives should also be able to decide whether or not they wished to offer care in certain situations (not necessarily connected with perceptions of safety). Despite these sentiments, there was evidence that women's choices concerning their own care were respected within the unit. This was undoubtedly due in part to the strong support the midwifery managers gave the midwives in this regard.

In accordance with the wider discourse concerning authoritative knowledge, another factor that appeared to affect some midwives' views was their perception of the competence of the women (and their partners) to make appropriate choices. Parents were generally considered to be less competent than the midwives, unless they themselves were also healthcare professionals, and in particular, medical practitioners:

I feel the parents don't always have the full information and knowledge at their fingertips to make a decision.

*CM1, interview*

It depends on the individual circumstances, I mean, somebody who's - we've had recently a consultant paediatrician wanting his baby to have

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<sup>22</sup> This is not a legal option for midwives in the UK (UKCC 1998, NMC 2004b).

oral Vitamin K - it's recommended i.m. (*intramuscular injection*) is the better route. *JM4, interview*

There was evidence that at least some of the midwives equated 'scientific' (that is, medical) knowledge with 'neutrality', thereby demonstrating the privileging of the medical perspective:

We have to try and give information in a very unbiased way, and with as much medical knowledge, I suppose, behind what information we're giving as possible. *CM1, interview*

There were a few midwives who did not mention women's choice at all during discussions about the unit policies, seeing this issue only in terms of whether or not they themselves were free to make decisions.

Midwives also varied in the degree to which they spoke about women in active or passive contexts. A few indicated that they regarded women as active participants in the care-giving process. This was particularly noticeable through their use of syntax, where women were the subjects of sentences and clauses:

. . . they tend to be wanting active natural births, they're using other methods, they're not having early epidurals . . . *CM5, interview*

However, many indicated by their speech that they assumed a level of control over the women. This was clearly illustrated by phrases such as that used by SM1, who spoke about women being 'under the realm of the midwife' (see above). Midwives' use of syntax also revealed a discourse of control, in that women became objects of sentences and clauses. This was found even among midwives who explicitly supported the midwifery ethos:

From my perspective as a community midwife definitely, that's one of the key things, not bringing women in too soon, because that's what happens. *CM3, interview*

This assumption of authority concerning women's actions was also evident in the way that a midwife spoke to a woman about the way she was feeding her baby:

She didn't even say hello, she didn't even say her name . . . she sort of looked at me and said 'Oh, well I hope you're breastfeeding, are you breast feeding?'  
*W4, interview*

Intimations of control and authority were also evident in the construction of phrases, particularly those denoting 'ownership', that midwives and other staff used between themselves to refer to women:

M8 to RG5: 'Oh, can I speak to you? I've got a lady . . .

HCA talking to SM5: 'Is your lady going upstairs?'

*Excerpts from fieldnotes*

'Horses sweat, gentlemen perspire and ladies glow'. In my experience, very few women 'glow' during labour; copious sweating, together with involuntary excretion of other body fluids, is far more common. The use of the word 'lady' in this context can be interpreted as contributing to the gendered discourse surrounding the control of birth. This usage helps to maintain a discourse of sanitised birth, in which women are clean and genteel, submissive and restrained in their behaviour, and unlikely to upset established societal patterns. Feminist midwives have for a long time been urging their colleagues not to speak about women as 'ladies' (or 'girls'), but rather to refer to them as 'women' (Leap 2004).

Similarly, using the word 'patient' to refer to birthing women obviously evokes a discourse of illness and the need for medical intervention and control. It also can be seen to indicate that midwives consider themselves to be in a nursing role, rather than being 'with woman'. Some midwives in the unit did use this term when talking about women using the service:

. . . just quickly handing over a patient and sort of rushing off to the next patient.  
*SM2, interview*

However, a few midwives (noticeably CM3, CM5 and CM6) almost exclusively referred to women using the service as 'women'. It was also evident that other individuals attempted to alter their language when they were speaking to me, obviously aware of the controversy surrounding these terms:

We have had staff suggestions in there as well as patient suggestions as well, or women's suggestions . . .

*MM3, interview*

Midwives also commonly referred to women in terms of their physiological processes, medical procedures they were undergoing, and their physical location:

. . . anything normal goes to the (*community*) team . . .

*CM4, interview*

SM5 on the phone to an anaesthetist, requesting an epidural for a woman: 'She's 9cm, but she's a deflexed OT<sup>23</sup>.

Doctors sitting having coffee . . . M13 appears at the door.

M13: 'I don't know if you want to see the section lady, she was transverse, but I think she's breech now.'

HCA: '*JM4*, 9-2 (*room 9, bed 2*) wants you for her blood pressure, when you have a moment.

*Excerpts from fieldnotes*

The effect of these forms of reference was to consign women to the position of being objects in the system. There was direct evidence that they were sometimes regarded as objects, and even overtly treated as such:

HCA, student and M5 discuss when women can go after delivery – no mention of what woman wants to do.

A bed comes through the door (*on to the ward*) and stops by the desk, pushed by SM3 and HCA1. The woman is sitting up in it.

SM3: 'Where's she going?'

RCP2: 'Who's she?'

SM3: 'Mrs *name*.'

RCP3: 'Room 5, bed 4.' They go around the corner with the bed.

*Excerpts from fieldnotes*

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<sup>23</sup> Occipito transverse – the sagittal suture of the baby's skull is lying in the transverse diameter of the mother's pelvis. Deflexed OT – the baby's chin is not tucked into its chest, which makes birth more difficult (Silverton 1993).

Although the woman was sitting up and conscious, none of the three members of staff addressed her directly or acknowledged her presence as a human being. She was simply a 'thing' that needed to be transported from one place to another, a component of a task that needed completing. This was a demonstration that at times, it appeared to be more important for the staff that the system be kept running smoothly, rather than that individual women be appropriately served by it. SM2's presentation of the administration of Vitamin K reinforced this impression:

We give that when we do the check when they're first born, when we weigh them and do all that, that's when we tend to give it . . . when you normally explain that most babies have it, explain what it is, most people are quite happy to have it. *SM2, interview*

The phrase 'and do all that' meant the set of routine tasks that were conducted after a baby's birth in order to process the baby through the system. So the priority to keep the system moving appeared to supercede concerns about tailoring care to individual women's needs or wishes. Women who did not fit smoothly into the system could consequently be viewed as being difficult or manipulative:

SHO3: 'I discussed it last time, she can go home.'  
M10: 'I have already mentioned it to her.'  
SHO3: 'Some they want to go home, some they don't want to go home; and the ones who should stay want to go, and the ones who should go want to stay.'  
M10: 'I agree with you entirely.' . . . SHO3 reads from the woman's notes.  
SHO3: 'This is her second admission, isn't it?'  
M10: 'Yes, I think so.' (Her voice drops to a whisper) 'She likes it here.'  
*Excerpt from fieldnotes*

Some of the women interviewed confirmed these impressions when relating accounts of their experiences in the hospital. One spoke about the 'scary hospital midwives'; another related how she felt that it was simply assumed that she would fit in with the system:

. . . it was almost like 'You're ours now, we can do what we like and that's it, you're here' almost, rather than working with somebody who's clearly heavily pregnant, clearly quite upset . . . *W6, interview*



Yet another recounted how, when she'd wanted to shower the first night on the ward after a caesarean section, she had been made to feel that she would be disturbing routine:

It was so hot and I was sweating and I really wanted a shower, and she goes 'What, do you want a shower at this time of night!' . . . you know, like, 'You must be really stupid, you must know how things go in here' - well, no I don't. *W5, interview*

However, not every midwife prioritised the needs of the system over those of the women. W5 spoke about the midwifery care being 'very variable' on the ward: 'it depends who you get.' She and her husband characterised the midwife who was with her on the delivery suite as 'supportive and encouraging', 'excellent' and 'fantastic'. One woman who had developed complications in late pregnancy was told by a registrar that she needed to stay on the ward overnight:

I think that he probably just wanted us to stay in because it would be convenient to have us there straightaway in the morning for the next test. *W8, interview*

She was not keen to do so, and was supported in her choice to go home and return in the morning by the midwife involved in her care. W8 also commented that her community midwife was 'quite good about adapting to your personal preferences and desires.' Certainly, the community midwives were more likely than the hospital midwives to speak about the system as being flexible, and in terms of trying to reconcile its requirements with the wishes of the women:

It's much better to work with a woman . . . they know our system is very flexible, we will move heaven and earth to try and make it as pleasant as possible for them in as safe as possible an environment. So it's often better to go in at a booking and say 'Ok, we're listening to all what you're saying, let's see how we can achieve this.'

*CM7, interview*

Overall, there seemed to be a range of opinions among the midwives about the value of different types of midwifery care, the degree of choice women should have, and the degree of authority midwives should exercise in their relationships with

women. Generally speaking, community midwives appeared to be aligned with the holistic midwifery ethos, valuing 'normality' which was equated with natural physiological processes, and wishing to support women in exercising choice; while many hospital midwives prioritised the smooth running of the system and appeared to be concerned that women did not make choices that could be thought unsafe from a medical perspective. There were, of course, exceptions noted to these observations among both groups.

### **Unity versus division**

The semiotics of the midwives' speech and behaviour (with a few exceptions) confirmed that they helped to maintain the dominance within the unit of the wider societal discourses expressed in the *Midwives rules and standards* (NMC 2004b)<sup>24</sup> concerning the danger of birth, the desirability of professional (that is, medical) control, and the superiority of medical ('masculine technological') knowledge above that of non-medical ('feminine natural') knowledge. Discourses of division included the distinction between levels of care (basic / skilled) and types of midwifery (normal / medicalised); acceptance of midwives' restricted autonomy within the system; and gendered tasks and language use. These all served to reinforce distinctions between individuals in the same occupational groups on the basis of different competencies and/or areas of work; between different occupational groups; and between different operational levels within the organisation (see Table 4, p.140).

However, they also served to reinforce the discourse of 'community' on a smaller scale: for example, those midwives who valued 'normal' midwifery care highly, constituted a relatively cohesive small group within the larger group of midwives who considered medicalised skills to be more valuable. There were fewer instances of discourses reinforcing community on a larger scale. One exception to this was the discourse of the gendered division of labour, whereby the sharing of non-professional tasks served to reinforce collegial relationships between the midwives and the healthcare assistants. Similarly, the prioritisation of the needs of the system served to unite midwives and other staff in the service of a common goal (see Table 3, p.139).

Overall, it seemed that the wider societal discourses and the status quo (which affected the midwives' standing in the organisation and their orientation to the

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<sup>24</sup> See Chapter 7.

provision of midwifery care) were more likely to be maintained than to be challenged by practices within the unit. However, some challenges were observed, for example, the fact that midwives did not always follow the unit policies. On the other hand, in their orientation to the system and their use of language when referring to women using the service, midwives often helped to reinforce the dominant gendered hierarchical discourses concerning childbirth. Nevertheless, there was evidence of alternative discourses operating among some of the midwives, particularly those who supported women's choice as a matter of principle. The potential divisiveness of different discourses concerning women's choice was illustrated by the fact that some midwives disapproved of other midwives' offering women information which could lead to 'unacceptable' choices. In the next chapter, I will present findings concerning the way that midwives' behaviour and orientation towards their professional colleagues from other disciplines related to the provision of maternity care in the unit.

## **Chapter 10. Midwives' participation in interprofessional interaction in the unit.**

In this chapter, I present findings concerning midwives' participation in interprofessional relationships in the unit. In particular, I shall focus on the reference to, and signification of, different occupational groups; the maintenance and shifting of boundaries between midwives and other professional /occupational groups; and the impact of interprofessional issues on care provision.

### **Reference to different occupational groups**

It was noticeable that when asked about their interprofessional relationships, nearly all the midwives in this study responded initially by talking about the obstetricians. Typical responses to a question about the quality of interprofessional working in the unit were:

I do think that the consultants and the obstetric teams liaise very well with delivery staff.  
*JM7, interview*

I think we've got a very good system here . . . I think (*obstetric*) consultants respect midwives' thoughts and views on things and they listen to them . . .  
*MM2, interview*

Of the four midwives who did not respond in this manner, two referred first to other midwives. A senior hospital midwife distinguished between midwives based on the delivery suite and those based on the ward; and a community midwife spoke about relationships between community and hospital midwives. After their initial reference to obstetricians, two other community midwives also differentiated between hospital and community midwives.

Another two community midwives first mentioned health visitors, and then spoke about GPs, social workers and community psychiatric nurses. Other midwives went on to mention physiotherapists, social workers and theatre staff, although nearly half of them needed prompting to talk about anybody other than medical staff (including anaesthetists). Two midwives mentioned ultrasonographers. There were also only two unprompted references to healthcare assistants. I found this surprising, considering the closeness and frequency with which all the midwives worked with healthcare assistants. However, it may have been an indication that they

interpreted the word 'interprofessional' only to involve occupational groups whose members hold a recognised qualification and enjoy a degree of professional status.

Midwives almost uniformly described the interprofessional working between the midwives and the obstetricians favourably, using adjectives such as 'brilliant', 'fantastic' and 'supportive'. They often compared their experiences in the unit with previous experience elsewhere:

I have to say, one of the things that really does stand out from the time that I did in *place1*, *place2* and *place3* . . . I would really find it difficult now to go back to being subservient to the medical staff.

*CM3, interview*

As illustrated in this quote, the perception that they were on an equal footing with many of the medical staff was often key to this opinion. However, this was not always the impression given to the women using the service:

Some of the registrars, they seem to get on really, really well, and then other ones, the midwives seem a little bit subdued . . . it's sort of (*sharp intake of breath*) 'Doctor's here' . . .

*W1, interview*

The midwives tended to characterise their relationships with different occupational groups chiefly on the basis of ease of communication. So, where other professionals were seen to be both available and approachable, the relationship was considered to be 'good':

The obstetric teams liaise very well with delivery staff and . . . other staff like physios, that sort of thing, the communication does seem to be pretty good . . .

*JM7, interview*

I enjoy my working relationship with them (*the GPs*), it's very easy to talk informally or formally about women that we've got interest in or concerns in . . . I think the relationship between the health visitors and the midwives is good . . . because we do tend to keep seeing them, it's not hard to see them.

*CM5, interview*

The consultants have quite a presence . . . they're not just names on paper, they're actually people that you can go and talk to.

*CM3, interview*

The converse was also true:

The GPs really like to communicate by e-mail, and I personally would prefer to speak face-to-face, so I find that difficult. *CM1, interview*

Most of the community midwives reported good relationships and good communication with GPs (sometimes attributed to the fact that many of the GPs were not actively engaged in antenatal care, so the midwives felt they were able to work without interference).

Apart from the medical profession, the occupational group which drew most comment were social workers. Although two midwives intimated that their relationships with social workers were satisfactory, during interview five others explicitly stated that they had problems with them, mainly due to perceived unreliable methods of communication:

These women come in with at-risk plans and agreements and everything, and they deliver at three o'clock in the morning; and you're supposed to inform somebody (a social worker), or you want somebody to be there, and you can't get hold of anybody, and I think that is a problem . . .

*CM4, interview*

These sentiments were also noted in conversations involving other staff:

Delivery suite. Conversation between midwives at board before hand-over. Need to notify social worker about client – they did so in the middle of the night, but then were asked to ring again in the morning. 'Don't they communicate with one another?' A few minutes' conversation about lack of communication between social workers themselves, and their unavailability at crucial times. 'They always take a week's holiday then, don't they?'

Ward office. PC1: 'You can never get hold of a social worker who's taking responsibility.'

*Excerpts from fieldnotes*

Some community midwives also stated that they sometimes had problems contacting health visitors. Interestingly, during observation it became apparent that some community midwives did not necessarily know the health visitors attached to

GP surgeries, even though they were all responsible for the provision of care to the same women.

The issue of familiarity with colleagues from other disciplines appeared to be pertinent for midwives in the hospital:

It might be the fact that a lot of the medical staff, obstetric and paediatric, have been here a while, and so they're well-known, and there's a lot of trust built up between the teams.

*JM7, interview*

Of course they change every six months, you just get to know people, they've all changed round . . . Sometimes it provokes anxiety, if they have practised in places with different protocols. Then it takes a little while, sometimes for them to adapt, or for the midwives to get used to them.

*M1, interview*

M1's representation of the factors involved demonstrated a concern for maintaining the integrity of the system in which she was working. There was evidence that some midwives considered other occupational groups in terms of how they aligned with their own ethos of care. For example, two community midwives spoke very differently about health visitors:

I think I feel really with some professionals we integrate very easily, and with others we find it quite difficult. I think for instance health visitors, most midwives find very easy to sort of approach and talk to them.

*CM1, interview*

There's definitely a potential for antagonism between the midwife and the health visitor, because we hand over to the health visitor . . . there's that kind of rivalry there, like 'We're (*health visitors*) taking this role really seriously and you're (*midwives*) just messing about with it' . . . I don't know why that is, it's very strange, I suppose because they're coming from a more health policing role . . . it's all very much about social control . . . I think midwives are a little bit more of a law unto themselves . . . there's a little bit more - rebellion in midwives I think . . . whereas I think health visitors generally tend to be a bit more by the book.

*CM6, interview*

Unlike CM1, CM6 appeared to see herself and her community midwifery colleagues as somehow 'outside' the established system; phrases like 'health policing role', 'social control' and 'by the book' evoke the discourse of health professionals acting as agents of the state, monitoring individuals' health behaviours and status in accordance with established procedures. Tellingly, CM6 initially touched upon the issue of blurred occupational/professional boundaries. Health visiting is an integral component of primary care; once women are considered no longer to need midwifery care, the liaison between community midwives and health visitors constitutes the main interface between the maternity services and the primary care team. So a temporary overlap of responsibility for the provision of care may be the mechanism through which such differences in professional ethos are brought into focus.

Another characterisation of other occupational groups was expressed in terms of clinical skills. At a meeting to review unit policies, at which senior midwives, midwifery managers and a consultant obstetrician were present, the following exchange was noted:

General discussion, turns to physiotherapists' role on the unit.

CT1: 'I don't think it would make much difference if they weren't here.'

Discussion about need for physiotherapists – everybody seems to think that they're not that useful.

MM3: 'Where they do come in is the fitting of the fembrace.'

CM12: 'But it can't be very hard.' *Excerpt from fieldnotes*

This opinion was, however, at odds with that expressed by most of the midwives who were interviewed, and who regularly interacted with the obstetric physiotherapists:

We've got a really good team of physios here. *JM4, interview*

We deal a lot with them, antenatally and postnatally, they're excellent, really very, very good; and they just dovetail with things like parentcraft . . . and they do a lot of prophylactic antenatal and preventative work which is really good; and there's things like symphysis pubis dysfunction, stuff like that, we can send through to them. *CM7, interview*



On occasion, individuals from other occupational groups were singled out because of a particular skill:

SM4: 'And she's got one of *first name*'s epidurals in.'

M17: 'One of what?'

SM4: 'Dr *first name*'s epidurals. He does good ones.'

*Excerpt from fieldnotes*

### **Signification of different occupational groups**

Within the unit, there were a number of signifiers which served to indicate the existence of separate occupational groups. As mentioned in Chapter 8, these included the coloured scrubs and the counters in the delivery suite demarcating areas which appeared to be used differently by different groups. The obstetricians and other medical staff appeared to 'own' the right hand side of the delivery suite (workspace2), while the midwives and administrative staff 'owned' the left hand side (workspace1)<sup>25</sup>. Although this division was not absolute, it was comparatively unusual to find members from one of these groups congregating or working in the other group's space. The whiteboard appeared to constitute some sort of middle ground, where all the staff would meet and mix.

Different conversations and discussions, of both a social and a clinical nature, would frequently be conducted within the two separate groups:

Three obstetricians joined by another one – also young female. CT1 and AN1 sitting on the counter (workspace2), having a clinical discussion. All look very at home. Three senior midwives chatting at other counter behind receptionist (workspace1). Some midwives at back computer counters – discussion about cats, cat food and giving them mineral water.

*Excerpt from fieldnotes*

However, these exchanges were quite porous, in that they could extend from one group to the other, depending on the subject matter:

Three midwives go and join in the doctors' conversation. Discussion about domestic violence. The conversational group now extends from

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<sup>25</sup> See Figure 1 on p.116.

one counter to the other, taking in the area in front of the board. The midwives are over by the reception desk, the doctors are in workspace2 . . . conversation flows and breaks between the two groups.

*Excerpt from fieldnotes*

The phenomenon of different occupational groups engaging in separate conversations was also apparent in other areas:

Delivery suite coffee room. Two young female doctors in street clothes are sitting have a clinical discussion. SM4 and SM1 are standing by the kettle, having a separate clinical discussion.

*Excerpt from fieldnotes*

Lots of conversation, chat, etcetera, among the staff on the ward. My impression is that it's often profession-specific – separate conversations going on among midwives, healthcare assistants, receptionists, domestics.

*Excerpt from research journal*

Unlike the delivery suite, there was no obviously marked territory on the ward, with the exception of the reception desk, which was clearly the receptionists' domain. However, the midwives had no problem commandeering it when they felt it was necessary:

M11 comes to desk.

M11 to RCP2: 'Can I use your phone, I can't get on my phone.' RCP2 moves away.

M11: 'I'll have your seat as well.'

*Excerpt from fieldnotes*

The midwives, in fact, appeared to 'own' both the ward and the delivery suite:

Other professionals come on to the ward, for example, obstetricians, paediatricians, physiotherapists, do what they need to do, tell midwives if there's something they need to know, write in notes, etcetera, and then leave.

RCP1 at desk, busy arranging things, SM5 comes through pushing a monitor . . .

SM5: 'Are you our doctor today?' to young woman AN in scrubs.

*Excerpts from fieldnotes*

This situation was linked to the operating hierarchy within the unit, which, unusually for the NHS, was not demarcated strictly according to occupation (medical versus non-medical). In both areas, doctors below the rank of consultant appeared to defer to the senior midwives. There was acknowledgement that this was at odds with normal practice in the NHS:

Ward coffee room. MM2 and three other midwives having coffee. They have a conversation about doctors 'from the general side'.

M11: 'I hate it when they sweep in, six or seven of them, and they don't even look at you.'

M12: 'They come with an entourage.'

M11: 'Then I say 'Excuse me, I'm the midwife, and my name is *first name, surname* (stands up and mimes holding out her hand for shaking).

They all laugh.

*Excerpt from fieldnotes*

M11's strategy of active engagement in these situations was observed in use by a senior midwife on the delivery suite, although there was no indication that it was deliberately employed to establish equality of status. On an occasion when medical input from other specialities 'from the general side' was required, it was noticeable that communication involved only medical staff at consultant level until SM2 joined in:

A large group of doctors comes and stands in the corridor by one of the counters, SM2 is in the middle of them. Only the three consultants (medical, AN, CT1) are talking. SM2 listens to the consultants talking, then starts to contribute information. CT1 and SM2 look through the notes together, SM2 points something out.

*Excerpt from fieldnotes*

Issues concerning the superior status of the senior midwives within the unit hierarchy were commented on by one of the obstetric registrars, when talking about her own position in the unit:

RG1: I'll just listen to what they (*the senior midwives*) say and do as they say, really, which is having to go along their lines.

R: And what's that going to be like for you?

RG1: It's difficult, it's going to be difficult . . . They're very experienced midwives, especially some of them are very good ventouse practitioners

and they're very good teachers as well - but I still feel there's that rivalry between female doctors and senior midwives . . . It's their domain (*delivery suite*); and I think midwives in this unit are getting more responsibilities now, because they're doing ventouses . . . so in effect they do run the delivery suite, and you're at their beck and call - they're the powers that be, really, in delivery suite, which can be difficult for someone like me.

*RG1, interview*

This view was not universal among the registrars, most of whom appeared to interact in a positive manner with the senior midwives, and reported feeling supported by them. However, RG1 importantly touched on the fact that some midwives in the unit conducted ventouse deliveries, which in most obstetric units in the UK is the sole province of obstetric staff. This raised once again the relevance of disputed professional boundaries to the nature of the midwives' interprofessional relationships.

## **Professional boundaries**

### ***Midwives and obstetricians***

Over the last twenty years, all NHS midwives have extended their core clinical repertoire, which now includes skills that previously were considered to be only the province of obstetricians. Until recently, however, these skills comprised only those which could be considered appropriate for anyone attending women in labour, such as abdominal palpation<sup>26</sup> and perineal suturing<sup>27</sup>. Some midwives have also acquired more general skills such as cannulation<sup>28</sup>, which are needed for medicalised procedures that have become commonplace during labour. However, it is rare for NHS midwives to have acquired skills that relate centrally to the obstetric domain of 'abnormality' in labour and birth.

The unit was unusual in this regard, in that some of the senior midwives conducted ventouse deliveries; this could be construed as direct and significant encroachment on the obstetricians' sphere of practice. The quote from RG1 above indicates that she saw this situation as contributing to what she characterised as 'rivalry' between

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<sup>26</sup> A manual technique to assess the position of the baby, including whether head down or breech.

<sup>27</sup> Repair of damage to a woman's vagina or perineum.

<sup>28</sup> Insertion into a vein of a hollow needle, needed for intravenous administration of fluids and/or drugs.

the senior midwives and the female obstetricians. When questioned about this practice, another registrar made her feelings plain:

I don't personally agree they should be doing ventouses at all . . . a ventouse is a medical piece of equipment and it should stay that way, you know, where does it stop? I think if you say you can do a ventouse, you have to be able to put up with the consequences of a failed ventouse, and that's emergency caesarean section. Now we're not training midwives to be doing those yet, it's completely out of the realms of normal midwifery.

*RG2, interview*

However, the consultant obstetricians supported the midwives in this regard:

. . . if they are obeying the criteria, they won't have a failed ventouse, because they should only do it when the head is very low, when it's in the OA position<sup>29</sup>.

*CT1, interview*

The bottom line, of course, was that the midwives would not have been able to continue this practice without the support of the obstetric consultants in the unit. Nancarrow and Borthwick (2005) note that the extent of 'vertical substitution' is always controlled by the more powerful occupational group. A noticeable feature of the relationship between the consultants and the senior midwives was the respect in which each group held the other:

If we (*the midwives*) do a ventouse and it fails, a registrar or consultant won't come and reapply a ventouse, they will do a forceps or whatever, because they say if a midwife can't get it neither would they. So it's a very high level of mutual respect both ways.

*MM1, interview*

We've got a very good team of midwives here, a very professional group, and we link in with them on a regular basis on labour ward with the management of patients.

*CT2, interview*

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<sup>29</sup> Occipito-anterior. The most common position of the baby shortly before birth - the sagittal suture of the baby's skull lies in the anteroposterior diameter of the mother's pelvis, with the occiput against the mother's symphysis pubis (Silverton 1993).

It should be noted that the consultants had all achieved their career ambitions in environments where medical staff enjoyed superior status to midwives. Unlike the registrars in the unit, they had never had the experience, as juniors, of having to defer to midwives. There was acknowledgement that this cross-boundary working could be difficult for obstetricians new to the unit, accustomed to more traditional observance of hierarchy and more traditional division of labour:

When they (*new obstetricians*) start I always see them and have a chat with them . . . Registrars have done obstetrics before obviously so they're familiar with the midwifery role, what they're not always familiar with is our extended role . . . When SHOs come . . . I see them as well and I go through the difference between the role of a midwife and the role of a nurse, which is probably what they're used to with the nurses more doing the doctors' bidding if you like . . . it's quite a role reversal where the midwife will be actually telling the SHO, or guiding the SHO and they're only here for a learning experience. We do occasionally have a problem with an SHO . . . it gets knocked out of them quite quickly . . . if we had some concerns about a particular registrar or SHO, we would actually speak to the consultant about it.

*MM1, interview*

This account was corroborated by the consultants:

We occasionally get the odd problem with a newish junior doctor . . . who insists on treating the midwives as nurses to do exactly as he tells them . . . we do not tolerate that, and we say to our juniors 'The midwives know far more than you guys know, and you must respect them and defer to them, they're professionals in their own right'.

*CT1, interview*

Adherence to, and support of, the discourse of professionalisation was evident in comments made by both the obstetricians and the midwives; the greater the level of medicalised knowledge and skill, the more highly regarded the practitioner:

. . . they (*the ventouse practitioner midwives*) are highly skilled professionals . . .

*CT1, interview*

. . . they (*the obstetricians*) respect us more for being able to do it (*ventouse delivery*) . . .

*SM3, interview*

Even where obstetricians considered this practice to be inappropriate or problematic, there was evidence that they respected the midwives for their clinical abilities (see the quote by RG1 above). Senior midwives were frequently fully involved in clinical discussions with the obstetricians. Symmetry of communication observed in these instances revealed that the occupational hierarchy did not greatly affect how individuals from the different groups contributed to these discussions:

At the whiteboard. Conversation about an incident with a poor outcome earlier in the week. RG8: 'I feel like an idiot'. General conversation about clinical picture – open about findings, diagnoses, reassure each other about what happened – involves CT2, RG8, SM4 and SM3.

SM3, SM1, M and RG2 chatting at the reception desk. A very difficult caesarean section last night, wedged head, RG2 couldn't get the baby out, had to call the consultant in. RG2 talks about it: 'I was really scared.' Midwives all very supportive, very encouraging, discuss case with her, reassure her. SM1: 'It's good that you were scared.' Talks about the danger of becoming complacent when everything has gone well for a while, episodes like the previous evening's 'get you back to reality.'

*Excerpts from fieldnotes*

The midwives and the obstetricians did not always agree about what was happening clinically:

Report by the board. M: 'The docs' estimate (*of blood loss*) is 1000ml, we make it 1500.'

*Excerpt from fieldnotes*

One of the senior midwives spoke at some length about situations where there was a difference of opinion, and where a decision had to be made concerning appropriate action to take:

I think it does happen, and I think that's a good thing, anyway, because as a rule it keeps everybody thinking . . . it doesn't seem to be too much of a problem with dealing with it. In situations that I've personally been involved in, because obviously I can't talk for everybody else, a large majority of our registrars . . . if I've said to them 'I'm not totally convinced about this, what do you think?', they're very happy to discuss it; and certainly the consultants, you can say to them 'Well, this is what I think, what do you think?' There have been a couple of occasions where I've

had to call a consultant over the head of a registrar and say 'I'm not happy with your decision, if you're not prepared to discuss it with me I'm going to call the consultant'; and on those two occasions I've had excellent response from the consultant, who's been prepared to come in and talk to us both and sort it out . . . obviously, as a midwife your responsibility as you know is to go to the highest authority to deal with it, if you don't feel comfortable; but generally we've managed to resolve most things without having to get anybody else involved, but if you have to call a consultant, you have to call a consultant. *SM1, interview*

Decision-making is an activity which demonstrates power relationships within an organisation. Whatever the practical effects of SM1's strategy, the reminder of the traditional hierarchy was evident in her speech, in that she reported going 'over the head' of the registrar; and of course, the consultant had final say (which would often, of course, be appropriate, given that such situations usually involve caring for women who require obstetric input). However, the language that SM1 used did in part reveal a discourse of subordination rather than of egalitarian co-operation. This was also signified by the fact that she felt it pertinent to mention that she was able to enter into discussion with her medical colleagues – so there was clearly a possibility that this might not generally be the case in maternity units. This impression was reinforced by her subsequent comments:

SM1: You can't be forced into a situation where you're doing something you're clinically unhappy with, just because you don't want to upset anybody. But I think most of the senior midwives are pretty - formidable characters, they're certainly strong enough characters that they would stand up for themselves without having to think too much about it.

R: What about the junior midwives?

SM1: I think the junior midwives find it much harder; but I don't think that they should have to be in that position anyway. *SM1, interview*

These and other data made it clear that, on the delivery suite, the senior midwives' position in the institutional hierarchy differed from that of the junior midwives, who were not expected to engage with the obstetric staff without involving the senior midwives. While the senior midwives considered this to be appropriate, this was not always the case as far as the junior midwives were concerned:



When she needs a doctor, she goes directly to them, not through the senior midwives. She'll go to a senior midwife with a problem before a doctor if she thinks it's something the senior midwife can help with. I observed that most of the contact with the doctors seems to be with the senior midwives – she responded, yes, the doctors come on to cds (*the delivery suite*) and only talk to senior midwives, 'Who's in charge?'. Thinks all midwives in different areas have the same responsibility, but seniority plays a part. 'I wouldn't be expected to take charge in some situations, only having been here a few months.'

*JM9, interview notes*

JM9 clearly distinguished between her professional obligations in terms of her practice, in which she expected to be in a working relationship with the obstetricians; and her obligations as an employee in the system, who could be expected to 'take charge'. The division between the senior and the junior midwives in relation to liaising with the obstetricians was less noticeable on the ward:

JM15 comes into the office and goes on the phone. MM1 and CT3 come into office to discuss a woman. They all sit down to discuss her, CT3 looking at notes.

MM1: 'So all Mr. CT3's going to do is tell us what he thinks we should do.'

They talk further about the woman.

CT3: 'Do you want me to look at the (*caesarean section*) wound?'

MM1: 'I don't know - (to JM15) How do you think she'll react? She's seen all lady doctors -'

JM15: 'I don't mind, I'll look at it and let you know if I'm not happy with it.'

They agree a plan of care.

*Excerpt from fieldnotes*

It was interesting that the decision regarding the extent of direct obstetric involvement was made in this instance by the most junior person present, namely, JM15. Notwithstanding the possibility of disagreements, decision-making appeared to be normally a co-operative process between the midwives and the obstetricians (as above). However, it should be noted that on all observed occasions, decisions were being made concerning practice within the framework of the unit's medicalised policies. There were no observed incidents of decision-making processes where midwives were attempting to go against accepted practice. However, when CM6 was recounting the episode of the planned homebirth for the woman expecting twins, she stated that two senior midwifery managers had been actively involved in

preparation for this event, and one actually attended the birth. It is very unlikely that this would have been the case if no obstetric consultant had been willing to accept that the community midwives were supporting the woman in her choice of a homebirth. In terms of their statutory obligations, the midwives would have had to inform an obstetrician of this plan, due to the 'abnormality' of the situation (NMC 2004b).

The fact of the consultants' overall control over birth in the unit was illustrated in the following account from a woman using the service:

They (*the community midwives*) presumably know everybody there (*at the hospital*), if they need to speak to a certain consultant. One of the midwives mentioned . . . when she rang up for my appointment she had the choice of two, and she said no, it couldn't be him, because the other one is less tolerant of home birthing for first time mothers . . . the other one was much more amenable.

*W6, interview*

So it appeared that even though homebirth and women's choice were strongly supported by the community midwives and the managers, medical control over 'normal' women was still operating.

Despite the co-operative norm described above, an element of competition regarding the two professions' involvement in certain situations was apparent. For example, when a woman was about to give birth to twins in the unit, the following exchange was observed:

At the reception desk. SM3 comes to the phone, tells the person on the other end that the twin woman's cervix is fully dilated, SM3 is now waiting for the registrar. Puts the phone down. SHO asks her a question.  
SM3: 'He (*the registrar*) might not get his hands on them (*the twins*). Both of them are cephalic (*head down*), so we're hoping that the midwife will deliver them. But the registrar should be there.'

*Excerpt from fieldnotes*

This situation provided an example of the tensions that can arise due to the prevailing concepts surrounding 'normality': as stated above, multiple pregnancies are considered to be 'abnormal', and therefore to need the involvement of an

obstetrician, while births involving cephalic presentation are assumed to be 'normal', and therefore the province of midwives.

In addition to decision-making, an area where power relationships within an organisation can be revealed is in the delegation of tasks. It was noticeable that the senior midwives routinely assigned tasks to the SHOs and sometimes also to the registrars, though in the latter case, this was usually framed as a request for review and consultation concerning a particular woman using the service. However, this was by no means a one-way process, and both junior and senior midwives were often asked by medical staff to carry out particular tasks or procedures.

During the period of data collection, midwives assumed another obstetric role, that of assisting the surgeon during caesarean section. Both midwives and more junior obstetricians expressed reservations about this development, mainly due to the perception that when difficulties arose, the surgeon would require a level of support which the midwives, with their limited training in this respect, would be unable to provide.

### ***Midwives and paediatricians***

The relationship between the midwives and the paediatricians appeared to be less consistent than that between the midwives and the obstetricians. This was probably due to the pattern of care delivery, which resulted in the midwives and the paediatricians being less well known to one another:

We probably don't see the paediatricians as much as we see the obstetricians, so I think that there's a difference there.

*MM2, interview*

The two professions seldom worked closely together. The paediatricians were only present on the delivery suite when asked to attend a birth, and in such cases would only be present for a short time, during and immediately after the actual birth itself. Their main interaction with the midwives occurred on the ward, where they would come to examine all the babies within a day or two of birth, and where they would be involved in the care of unwell babies. According to a midwife based on the delivery suite during the data collection period:

We probably don't know them as well, obviously, they're not here as much. You get to know them better on the wards, they come round every day to check babies.

*M1, interview*

The exception to this was the relationship between the consultant most involved in neonatal care and some of the senior midwives, or those who had been in the unit for a long time. Observed interaction between these individuals demonstrated the ease of an effective, long-term relationship:

PC1 and M11 coming down the corridor talking. They stop by the front desk, and M11 turns to him and puts her hand on his shoulder.

M11: 'Now what? I've just said she can't. (Turns to RCP2). What's he like?' Discussion about baby.

*Excerpt from fieldnotes*

Direct communication between more junior paediatricians and midwives on the ward appeared to be sporadic. The main form of communication used was written: paediatricians would come to the ward office, and read instructions and medical notes to determine which babies they needed to go and examine or review; any information or instructions they wished to convey to the midwives would usually also be in written form. It was not uncommon to see paediatricians working their way around the ward without ever engaging with, or being engaged by, any of the other staff working there (this was also true of other medical staff).

When direct interaction between the paediatricians and the midwives was observed, it appeared to be conducted in the informal style common to most interaction in the unit (see Chapter 8). When new to the unit, the paediatricians appeared to have to rely on the midwives to tell them about the ward routines:

P comes into office. M11: 'Mrs *name* in 2-1 is back.'

P: 'Right'. He asks M11 about an abbreviation written in the book (all communications for the paediatricians are written in this book, which stays in the ward office). P introduces himself to M11, he's only been here a few days. She gets up, goes over to him, tells him about some of the systems and protocols.

*Excerpt from fieldnotes*

The midwives' practice concerning neonatal care appeared to be quite circumscribed by unit policies. This seemed to be a source of frustration for some of them, and was also seen to impact negatively on their clinical skills:

CM4: I trained in a different unit, the way things happen with babies here is quite different, the paediatricians are very hot on doing lots of observations and things on babies, and weighing babies . . . actually doing temperatures and doing things like that, as opposed to leaving us to look at a baby and say 'this is a well baby', 'this isn't a well baby'.

R: What do you think about that difference, that way of working?

CM4: I hate it. I think it's horrible. Yeah.

R: Here?

CM4: Yeah. Only because of what I was used to elsewhere. . And I was talking to someone else who I trained with a while ago, and I said I think my observation skills of babies are not the same, not as good, because I'm relying on taking temperatures and doing things like that, as opposed to stripping off a baby, maybe, and just looking at it, and feeling it.

*CM4, interview*

CM4 went on to detail how she would have to negotiate with the paediatricians in order to give care which she considered to be appropriate. Noticeable in her account was the effect of the hierarchy and the medical perspective on the ease with which these negotiations could be conducted:

Some of the babies that they class as small for dates, as well, the paediatricians can be quite funny about them and they say 'Oh they've got to have two weight gains before they go home'; and you say 'Well actually, they're feeding really well, they're weeing, they're pooing, they're pink and warm . . . it's their second baby, or something like that, and the weight was only this'; and you have to sort of be a bit forceful with them sometimes and say 'Well look, that's just silly and the mum wants to go home, and if you don't let her she's going to self-discharge, so' – sometimes they're a bit funny about things; and it tends to be at the SHO level, rather than above, and if you get past the SHOs, the registrars will be thoroughly sensible about things and listen to what you say. I don't know whether it's because they're sort of fairly inexperienced and they're going by the letter of the guidelines, whereas with the registrars you can sort of say 'Well look, it's doing all these things it should be doing, yes, it hasn't had a weight gain, but it's not unwell in any way.'

*CM4, interview*

CM4 clearly positioned herself and the paediatric registrars similarly as competent practitioners, contrasting their 'thoroughly sensible' approach to care with that of the

SHOs' being 'a bit funny about things'. This was also a relatively uncommon occurrence of a midwife invoking a discourse of 'normality' in relation to neonatal care which was at odds with medical definitions of risk. However, it was apparent from one woman's account of her experience in the unit that some of the midwives did not question the medicalised care given to the babies:

We weren't really keen on the blood glucose tests . . . I'm not sure if we really objected to them doing them over and over again how difficult it would have been to get that through to them (*the midwives*) at all, because they didn't really seem willing to sort of bend on that issue, they were very firm that they needed to do this and had to do it every so often.

*W8, interview*

The efficacy of testing newborn babies for blood glucose levels has been questioned, so although widespread, this procedure is not uncontroversial (see, for example, Johnson 2003). One of the midwifery managers offered a possible reason for the apparent rigidity of the paediatricians' implementation of the neonatal policies:

I think the difference is, is that they (*the paediatricians*) come at it purely from a medical point of view, because of working on special care<sup>30</sup>, it's very medicalised, and rightly so, because the babies are sick that go there. I think sometimes they find the transition very difficult up here because we're often talking about full term healthy infants.

*MM2, interview*

The unit policies were ostensibly made with input from both midwives and paediatricians. However, during the interview with MM2, it became apparent that the final say in neonatal matters rested with the paediatric consultants:

What happens is that somebody brings in observations and they've been in for years for as long as I can remember, and then you question 'Actually, why are we doing all these things?'; and sometimes it takes a very forward thinking consultant to say 'Well actually, let's change them'; and that's what's happened with PC1, is that we have cut some of the

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<sup>30</sup> Neonatal intensive care unit (NICU) - a specialised unit for babies requiring high-dependency or intensive care due to illness or significant prematurity.

It seemed that the midwives sometimes had to exercise considerable skills in order to gain the paediatricians' co-operation. In observed instances of interaction concerning neonatal care, midwives and paediatricians usually appeared to reach mutually acceptable decisions in an amicable manner:

Ward office. P1: 'Ok. . . . So it's actually below the line. What's it on, the biliblanket<sup>31</sup>?'

JM15: 'Yes.'

Discussion about baby's jaundice level and neonatal guidelines.

P1: 'Yes, that's a bit of a tricky one.'

JM15: 'She's desperate to transfer back to *place*, where they also have a biliblanket.'

P1: 'It's a tricky one, you could call it either way.'

They debate the pros and cons of treatment.

P1: 'Potentially they could go tomorrow at the earliest.'

They negotiate a plan with which they're both happy.

P1: 'Shall I go and have a word with mum?'

JM15: 'Yes, that's lovely, thank you.'

*Excerpt from fieldnotes*

As a midwife, JM15 was not allowed to discharge the baby. So in order to support the woman's choice to leave, she had to negotiate a compromise which would be acceptable to the medical perspective prioritised within the unit. Her strategies included using the word 'desperate', which injected a feeling of urgency into the situation, as well as providing reassurance that medical recommendations could still be followed, that is, that the situation would still be under control from the paediatric point of view.

W8 described how she had stayed overnight in hospital after the birth of her baby because the midwife could not persuade the paediatrician to discharge her baby:

I don't think that she (*the midwife*) ever was able to sort of sway them (*the paediatricians*), if her opinion differed from theirs, I don't think that

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<sup>31</sup> A lightweight fiberoptic pad which can be placed inside a baby's blankets in order to provide phototherapy for the treatment of neonatal jaundice.

she ever sort of won that battle, basically they just demanded that they get their way. *W8, interview*

W8's use of language indicates a clear perception of the midwives' relationships with the paediatricians being adversarial in this instance.

Some of the midwives in the unit were learning to conduct the standard neonatal examination (the 'first-day check') which all babies in the UK are expected to receive within the first few days of life. This was a situation comparable to the midwives' conducting ventouse deliveries, in that it constituted a significant and direct encroachment on the paediatricians' sphere of practice. The move to equip midwives to conduct this examination has not been universally popular, with some paediatricians in other units expressing doubts that midwives are capable of learning how to do this (Pollard, unpublished data)<sup>32</sup>. However, in the unit under study, this extension of their role had been championed by one of the paediatric consultants:

Ward corridor. PC1 has a chat with me about midwives doing first-day checks. He talks about how the paediatricians in *place* were very resistant to the idea, and wanted him to follow their line. They claimed that there was trouble with the validation of the course – he said he didn't agree with that, as it was an ENB <sup>33</sup>course, so if there was a problem with it, then there was a problem with all ENB courses; feels it was a pretext. He refused to go along with it, supported midwives' training. Now the training is happening in *place* as well.

*Excerpt from research journal*

The consultant's support for this development of their role was attributed by one of the community midwives in part to the quality of the interprofessional relationships in the unit:

I think probably we benefit, or it's a symptom of the fact that we do have very good working, interprofessional working relationships between

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<sup>32</sup> From my previous study exploring midwives' perceptions of their professional autonomy (Pollard 2003).

<sup>33</sup> The English Nursing Board, which was one of the regulatory bodies for nurses and midwives in England before the creation of the NMC.



midwives and doctors here, that it's got off the ground and we are one of the flagship ones, or one of the earlier ones to adopt this.

*CM5, interview*

However, another community midwife made it clear that not all medical practitioners associated with them welcomed their adoption of this new role:

Regarding examination of the newborn, there's a lot of resistance from one particular surgery in this area, the GPs don't feel that it's an appropriate role for midwives; but the midwives have been trained regardless, because of all the other GPs that have ok'd it. So we still do it, I mean they will let us do it, but they're very passionately, they're quite vocal about their feelings; so that's a bit of a shame in that respect.

*CM3, interview*

This quote again makes it clear how doctors controlled 'vertical substitution' (Nancarrow and Borthwick 2005), and consequently, how dependent the midwives were on their approval when exercising new skills or extending their clinical repertoire: 'all the other GPs that have ok'd it' and 'they will let us do it'.

### ***Midwives and non-medical practitioners***

The blurring of boundaries between midwives and other groups also occurred in relation to non-medical professions/occupations, particularly health visitors and healthcare assistants. As the quote by CM6 above showed, there was a perception that the overlapping nature of their care could contribute to a perception of professional rivalry between health visitors and community midwives. However, CM6 was the only interviewee who voiced this idea; most other community midwives intimated that they enjoyed good working relationships with the health visitors. CM1 spoke about 'integrating easily' with them, and CM5 used phrases such as 'we'll share anything that we've got'. There was symmetry in their use of syntax when discussing this relationship, so that neither profession was presented as being more or less in control than the other. Nevertheless, the situation on the ground may have been more complex than the overall picture suggested by the midwife interviews. During observation, the wish to keep their practice separate from that of the health visitors was apparent in the way some community midwives spoke among themselves:

CM10: The health visitor at *place* . . .

CM2: Pink jumper?

CM10: Yeah – pink jumper. She's one of those health visitors who does everything. She wants to do postnatal depression, and wonders if the midwives want to get involved.

CM5: She is so enthusiastic, you want to do your clinic and she's saying 'What about this, what about that?'

CM10: She's in the room. That is the problem, she's in the room, she's on the computer.

*Excerpt from fieldnotes*

In this instance, the 'enthusiasm' of the health visitor did not appear to be regarded as helpful by the midwives, so the notion of 'sharing' put forward in interview by CM5 was offset by this exchange. The reference to 'one of those health visitors' signalled identification not only of a separate occupational group, but of a personality type which was recognisable within it. The relationship between the midwives and this subset of health visitors was characterised as problematic, because of the latter's non-observance of appropriate occupational distance. This characterisation appeared to be due at least in part to the perceived impact on the midwives' management of their caseload: 'you want to do your clinic'.

The other workers with whom there was potential for overlapping roles were the healthcare assistants. As mentioned in Chapter 9, they were being encouraged to obtain an NVQ, which entailed acquiring some clinical skills. These included nursing skills, such as providing bladder care for women after caesarean section, as well as core midwifery skills, such as monitoring women's blood pressure<sup>34</sup> and helping them to breastfeed. While there was acknowledgement that this extension of the healthcare assistant's role could be interpreted as encroachment on the midwife's role, in interview all the midwives stated that they supported this development. During observation, it appeared that some of the midwives were proud of the fact that the healthcare assistants in the unit were exercising these new skills:

HCA2 comes in, tells M1 that 'her lady' has had a bath, and that she's feeling faint.

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<sup>34</sup> Due to physiological changes in women's circulatory systems, and the significance of blood pressure levels in certain complications of pregnancy, its monitoring during pregnancy and in the period immediately following birth is considered to be a specialist skill (Silverton 1993).

M1: Did you do her blood pressure?

HCA2: No, I have that dirty bed to do.

M1 (to me): 'HCA2's our NVQ, she can do blood pressures . . .'

M1 is showing HCA2 off to me.

*Excerpt from fieldnotes*

As mentioned previously, many of the midwives saw this situation as beneficial for the healthcare assistants in terms of their career and status within the organisation. During interview, the midwife who was responsible for the NVQ programme in the unit made it clear that this was not actually a new development for the healthcare assistants, but rather a return to a role they had previously enjoyed, and which had been taken away from them:

We have gone full circle, because when I started here, oh I don't know, twenty plus years ago, the NAs (*HCA*s) used to take catheters out, take venflons out, help with breastfeeding, they used to do quite a lot of the things that the midwives did. We had a new manager who came along and said 'No, they make the beds and they do the meals.' . . . Anyway it's gone full circle, they want them to do all these things again now.

*M5, interview*

It was noticeable that, where there was no blurring of boundaries with regard to professional practice, relationships with non-medical practitioners were quite straightforward, as could be seen with most midwives' comments about their physiotherapy colleagues. This was even the case with the social workers when issues of communication and organisation of care were taken out of the equation:

I think the social workers know where we're coming from, know what we've got to do . . . it's like the roles are much more defined in a sense because there hasn't been that connection historically.

*CM6, interview*

### **Drivers for cross-boundary working**

When talking to the midwives about overlapping roles, it became clear that the chief reason for these various cross-boundary initiatives was to facilitate the smooth running of the system:

We often run into problems of getting the registrar to do them (*ventouse deliveries*); because it could be that they were very busy in with a section

and they couldn't come, yet this patient just needed a lift out . . . they started with the night staff, you know, they are on permanent nights; and they thought perhaps they are more useful than the day (*staff*), because in the day there are also admin jobs and so many other things; and they thought at night . . . they could save raising the registrar.

*SM3, interview*

R: Where has the impetus for that come from, for you to be doing the (*first-day*) checks?

CM5: . . . we're talking about expanding the midwife's role, we're . . . reducing junior doctors' hours, GPs are withdrawing from some maternity care, and I think all of those factors, plus midwives are cheaper, I think there's a whole combination of things, really.

*CM5, interview*

R: And since I was here last, the midwives are now assisting in theatre...

MM1: Yes.

R: So how did that come about?

MM1: That's only at night. It was because of the junior doctors' hours . . .

*MM1, interview*

R: The NVQ training for the HCAs, doing blood pressures and things like that – what do you think about that?

SM1: I think it's really good . . . anything that can be done to relieve the clinical burden, or the burden of midwives so they can be allowed to do their clinical midwifery can only be a good thing.

*SM1, interview*

Increased job satisfaction and status because of enhanced skills were seen as beneficial side-effects, rather than the main justification for these developments. It was noticeable that the midwives spoke about the healthcare assistants' acquisition of clinical skills in terms of whether or not it would bring advantage to them (the midwives):

Taking blood . . . it's a practical help certainly for the phlebotomist, because we don't take that many bloods, anyway, really, so I think it's helping the phlebotomist more than it's hindering or helping us.

*M6, interview*

A similar view of cross-boundary working was echoed by the obstetric consultants, when talking about the midwives' acquisition of obstetric skills:

They're (*the registrars*) very much on their own in the evening, and so having midwives who can do episiotomy repairs, who can do simple ventouses . . . means that the registrar does have some assistance from a different direction. *CT2, interview*

We don't have enough junior doctors to provide adequate cover in the middle of the night . . . the midwife is standing in theatre doing nothing until the baby comes out, so it was felt that they could usefully assist at that stage . . . *CT1, interview*

It appeared that, where the difference in status in the hierarchy was such that individuals were secure in their position relative to other professionals, cross-boundary working was seen as support, rather than encroachment. Certainly, the obstetric consultants did not seem to be threatened by the midwives, and nor did the midwives appear to be threatened by the healthcare assistants. This contrasted with the views of some of the obstetric registrars, whose position in the hierarchy was much closer to that of the midwives who, from their perspective, were encroaching upon their practice domain (see quotes above).

Although the obvious purpose of keeping the system running smoothly was to provide appropriate care for the women using it, it appeared from some of the quotes that this was not the staff's absolute priority in terms of individual women. For example, SM3's presentation of the rationale for training the night staff to undertake ventouse deliveries rather than the day staff was framed in terms of the other tasks that needed to be done during the day, and the desire to protect the obstetric registrars from being woken unnecessarily during the night.

This theme of 'protection' for the medical staff was also apparent in other midwives' accounts. CM4 recounted how she had attended a woman who gave birth in the middle of the night to a baby with Down's Syndrome. This was unexpected, and the parents wanted, understandably, to speak to someone who could give them in-depth information about their situation. CM4 stated that she had to be very assertive to prevail upon the paediatric SHO to wake up the registrar:

It's not very easy with paediatricians, they're quite protective of the registrars . . . the SHO was a bit 'Oh well I don't know whether to get her up at two o'clock in the morning' and I said 'Well you know, this lady's just had a Down's Syndrome baby, that's what she's there for - ' . . . I think they are quite protective of them.

*CM4, interview*

These accounts suggest a link to the more traditional working patterns within the NHS, in which a significant focus of nursing staff's role was to support junior doctors, many of whom worked very long hours. The requirements of the European Union working time directive should mean that this is no longer the case in most NHS settings (European Foundation for the Improvement of Living and Working Conditions 2004).

It was apparent that the senior midwifery managers strongly supported the development of effective interprofessional relationships in the unit, and had taken steps to establish appropriate structures to facilitate them:

MM1 said that when she instituted the mixed coffee room on delivery suite, some of the older midwives didn't like it, but she made a point of saying that it was better for all the staff to share the coffee room, better for interprofessional relationships.

*Excerpt from research journal*

Given the prevailing hierarchy in the NHS, it would not have been possible for any of the cross-boundary initiatives involving the midwives and the medical staff to have been implemented without the support of the majority of the medical consultants and the senior midwifery managers. In fact, in keeping with the perception that the main justification for these initiatives was to benefit the system, it appeared that they had actually been instigated by individuals in senior positions, rather than merely supported. There seemed to be some ambiguity, however, about the provenance of the NVQ programme for the healthcare assistants:

They (*the healthcare assistants*) said they wanted more hands-on . . . so we said, 'Well what do you want?' . . . so we put together some modules.

*MM3, interview*

I think it came from the Trust . . . any of the auxiliaries (*healthcare assistants*) being employed now have to do, they have to have, or be

prepared to do, level 2 (NVQ) . . . I think it's come from the government.  
They want everybody computer-friendly and everybody with a  
qualification. *M5, interview*

Whatever the facts of the case, it appeared that the perception on the ground was that this too was a 'top-down' initiative. The use of the word 'they' in this context signalled M5's view that the status and conditions of NHS employees were dictated by wider societal currents than those with which she and her colleagues were directly in contact.

### **The midwives' interprofessional relationships in the unit**

Overall, it appeared that the interprofessional relationships with which the midwives were most concerned were those involving medical staff, particularly obstetricians. As far as this occupational group was concerned, the unit appeared to operate a relatively flexible interpretation of the midwives' statutory obligations, as set out in the *Midwives rules and standards*, that they should request help from another practitioner when 'deviation from the norm' was identified (NMC 2004b). This was evidenced by the midwives' attending 'high-risk' women giving birth at home, and their practice of conducting ventouse deliveries. In this context, it is worth remembering the shift in the concept of 'normality' that was evident in the unit with regard to babies born with the aid of a midwife-wielded ventouse<sup>35</sup>.

With a number of professional groups, there appeared to be some tension resulting from role overlap and blurring of professional boundaries. There was also evidence that, if there was a perception of role overlap, it was in horizontal relationships where midwives and the other professionals concerned had similar status within the organisational hierarchy, that practitioners were protective of their own professional sphere. Midwives supported cross-boundary initiatives involving vertical relationships, where they and other groups occupied different niches in the traditional hierarchy. These initiatives involved those whereby they acquired skills which previously had been the domain of the medical staff; and also those which they thought would impact beneficially on their own workload, namely, those involving the healthcare assistants.

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<sup>35</sup> See Chapter 9.

## **The impact of interprofessional issues on care provision**

The collegial atmosphere and the good working relationships which appeared to be the norm in the unit promoted the impression that care was decided and provided in an integrated manner. However, members of staff from different occupational groups usually worked alone, particularly on the ward. The impression given to the women using the service was consequently one of being cared for by a large number of different people, between whom there was little interaction:

There was lots of different people, different people coming from all different directions, I didn't know where they were coming from.

*W4, interview*

However, W4 also stated that she thought the communication between the ward midwives and the staff on NICU was very good (her baby was in NICU for 24 hours).

In observed instances when midwives and medical staff interacted jointly in providing care, they did not appear to include the women as 'partners':

We all go to W9's bed. CM1 asks her about her clinical history, starts talking about smoking (W9 smokes).

PC1 joins in to give more advice about stopping smoking.

I think that CM1 and PC1 look like they're doing a double act – both standing, W9 sitting on the bed.

*Excerpt from fieldnotes*

This impression of a 'double act', in which the staff provided information or told women what decisions had been made, was also apparent in other observed interactions. The professionals appeared to dominate these exchanges. One of the women using the service interpreted the staff's body language and manner of joint communication in a similar way. She had been planning a homebirth, and was referred to the hospital in late pregnancy for monitoring, due to concern about the baby's size. While she was there as a day patient, a decision was taken that she should be induced. In interview, she reported this decision as being presented to her as a *fait accompli*:

R: And then the SHO came?

W6: Yes, with another midwife . . . they then explained to me why it would be a great thing - in fact they weren't really explaining to me why it



would be a great thing if I got induced, they were explaining to me why they were going to induce me essentially.

R: Did you get that sense coming from both of them?

W6: Yes, oh absolutely, they were stood very close, stood up as well, I was sitting down. *W6, interview*

An important outcome of effective interprofessional working is thought to be consistency of information and advice (Warde and Bunker 2001, Davis and Greenwood 2005). However, despite the good relationships between the staff in the unit, this appeared to be variable, with two women reporting being given contradictory information by the medical staff and the midwives, and a further two saying they had received conflicting advice about breastfeeding. However, two women also stated that the staff had presented a consistent front to them, one saying that there had been 'no confusion' in what she had been told by different professionals.

The impression given by some of the midwives that there was a divide between the hospital and the community was reinforced by some of the women interviewed, with reports of poor communication between staff in the two areas:

R: What about between say the hospital and . . . what about the communication backwards and forwards?

W5: No. I don't think there is any, my midwife didn't know that Mr *name* is not a consultant anymore. He works I think in the assisted conception clinic, but he used to do antenatal care but he doesn't do that anymore, and she wasn't aware of that, she put me down for Mr *name* and Mr *name* was not there. *W5, interview*

One woman reported that there had been problems between the community midwives and the hospital in arranging for her to receive anti-D during her pregnancy. There was also confusion over whether she should have it after giving birth<sup>36</sup>:

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<sup>36</sup> Women whose blood type is Rhesus negative are offered an anti-D injection prophylactically in pregnancy to prevent iso-immunisation, should the baby's blood type be Rhesus positive. In the latter case, it is common practice also to offer women anti-D after they have given birth (Silverton 1993).

When I got upstairs I mentioned anti-D, and the grumpy midwife sort of looked at me and 'Oh I don't think that's necessary' . . . and of course it turned out the second day she give it me . . . it just, (*sighs*) you know, the community midwives are saying 'Oh yes, this is a standard procedure, doink, doink, doink-doink, doink'; as soon as you go upstairs 'Well, it might not be necessary, we don't know' and in the end they gave it to me anyway.

*W4, interview*

However, other women had had more positive experiences:

She thinks that the way everything worked together was good, and was particularly impressed by how the hospital and community midwives worked together.

*W7, interview notes*

The women also considered the quality of interprofessional working in the community to be variable, with differing reports concerning the efficiency of communication between the midwives and the health visitors, and between the midwives and the GPs. Only two of the women interviewed saw their GPs throughout their pregnancy; most were cared for primarily by the community midwives, with additional obstetric input in a few cases.

### **Unity versus division**

The support for, and implementation of, the cross-boundary initiatives described in this chapter evoked a discourse of shared expertise and joint achievement of goals within the unit; this also incorporated a discourse of prioritising system maintenance, particularly among the hospital staff. These discourses were generally cohesive in their effects, reinforcing the sense of community among those working within the unit, but served at times to exclude the women using the service, whose priorities were undoubtedly different (see Tables 3 and 4, pp.139-140). A contradictory discourse centred on uniprofessional ownership of areas of practice; however, this discourse appeared to have become marginalised in the unit. Nevertheless, discourses of professional control were still apparent in that there was overall obstetric control over pregnancy and birth, and paediatric control over neonatal care; these discourses served to separate the occupational groups. The discourse of belonging to a distinct occupational grouping was maintained by group members' behaviour and use of physical spaces. Practices and perceptions concerning problematic communication, as well as area of work (community or hospital) also served to reinforce this discourse.

The discourse of professionalism was evoked strongly through the cross-boundary initiatives, all of which were seen to equip individuals with skills which would bring them greater job satisfaction, greater scope of practice/influence, and greater status within the organisation. Once again, however, this discourse served to emphasise the divide between the women using the service and the healthcare workers providing it. The unifying discourses reinforced by the interprofessional relationships and practices within the unit appeared therefore to be operating within greater discourses of division (support for professionalisation and medical control of birth).

## **Conclusion**

In Chapters 8-10 I have presented my findings concerning the midwives' interprofessional working in the unit, and have located them within wider societal discourses, as discussed in Chapters 2-5 and illustrated in the documentary analysis (Chapter 7). A number of social practices have been identified which appeared to affect or be part of the interprofessional working involving midwives in the unit. These included communication methods and language use, the use of the physical environment, including behaviour and presentation through physical appearance, the control of birth and the sharing or restricting of expertise.

### ***Communication methods and language use***

The informal methods of communication served to reinforce a sense of community between the staff working in the unit. The relationships suggested were therefore those of workers sharing a common aim, and in this sense they challenged the wider societal discourses, as they suggested equality of status between professionals and non-professionals, medical and non-medical workers, and between men and women. However, the gendered use of language was at odds with this practice, and helped to reinforce the wider discourses. Midwives accordingly presented themselves variously as co-workers, members of a hierarchy, women or professionals, depending on the situation they found themselves in.

### ***The use of the physical environment and behaviour***

Physical behaviour and appearance generally reinforced the impression of informality in the unit, and in so doing, challenged the status quo. The highly gendered appearance of some of the young female obstetricians also served this purpose, in that representation and self-identification of these staff members as women (albeit located within wider societal discourses concerning gender) were

often more evident than their representation and self-identification as doctors. However, the use of different coloured scrubs to signify different occupational groups and the way that the physical spaces within the unit were used, reinforced the status quo. This clear system of signalling was nevertheless vulnerable to upset, since the doctors' light blue scrubs were used by other occupational groups as the need arose. On the delivery suite, the demarcation of the two work spaces maintained a division between the midwives and the doctors; similarly, the separation of the 'front-' and 'backstage' areas on the ward reinforced the differences between the workers and the public, including the women using the service. Separate conversations between members of the same occupational groups, even in a shared space such as the delivery suite coffee room, also served to strengthen the impression of individuals' self-identification in terms of their profession/occupation.

### ***The control of birth***

The support at senior management levels for women's choice concerning their own care served to unify both women using the service and all those members of staff with the same attitudes. Similarly, orientation to the holistic midwifery ethos brought together those midwives and women who considered that childbirth should not be medically controlled. The relationship invoked by these practices was one in which midwives and women were regarded as acting in partnership, which is fairly congruent with comparatively recently established discourses concerning the public's ideal relationships with health or social care professionals (DH 1998b, 2001). However, these issues divided the midwives themselves, according to their individual orientation.

The distinction between the value of different skill sets and knowledge, as well as the different areas of practice, also served to divide the midwives. This was broadly (but not absolutely) based along the hospital-community divide, and signified varying levels of support for the acquisition of medically-oriented clinical skills. Midwives who subscribed to the superior value of these skills and of medical knowledge in general, evoked hierarchical relationships with other midwives and professions/occupational groups, as well as with the women in their care. Superiority in this hierarchy was conferred on the basis of these skills and knowledge, so that the medical consultants enjoyed highest status, while the women using the service were at the bottom of the pile. This at times resulted in the relegation of these women to the position of objects in the system, reinforced by and

reinforcing the prioritisation of its needs above theirs. These practices, of course, reflected the traditional structure of the NHS and maintained the wider societal discourses in which it is grounded.

### ***Expertise***

The acquisition of specific skills by members of occupational groups to whom they did not traditionally apply served, in the main, as a unifying force within the organisation. It mitigated against hierarchical divisions purely on the basis of occupation, although of course it established the pre-eminence of a hierarchy of skill. Relationships invoked then included those of a collegial nature between individuals with shared expertise, and those of a hierarchical nature between those with and without specific skills. This could be construed as supporting the wider discourse of professionalism, although perhaps not in its traditional form. Midwives generally identified themselves as skilled in one respect or another (including midwifery versus medical skills).

### ***Discursive practices***

It is of interest that out of 17 social practices specifically identified in connection with the midwives' interprofessional working, 13 involved discursive practices which reinforced wider societal discourses concerning traditional notions of professionalism and the medicalisation of birth, both of which incorporate a gender bias in which the 'feminine' is unfavourably compared to the 'masculine' (see Tables 3 and 4, pp.139-140). Despite this, the midwives presented their interprofessional relationships in a generally positive light. I shall discuss these issues further in Chapter 11. In particular, I shall consider implications for the midwifery profession, for women using the maternity services, and for the maintenance of the status quo regarding the medicalisation of birth in the UK.

## **Chapter 11. Discussion.**

### **Introduction**

In an attempt to identify and explain the mechanisms maintaining poor inter-professional working in midwifery, I set out to explore how NHS midwives' discursive practices either reinforce or challenge wider social discourses concerning power, gender, professionalism and different approaches to birth. I also aimed to examine midwives' relationships with all relevant occupational groupings, not only medicine. My findings raise questions related to these discourses about midwives' interaction with colleagues from other occupational groupings, as well as about the effect of their discursive practices on their interprofessional relationships. In this chapter, I will discuss the findings in relation to these discourses and to other social phenomena, and will also consider implications for midwifery and for women using the service.

Significantly, unlike many reports of interprofessional working in midwifery in the UK (see, for example, Meah et al 1996, Davies 1997, Hosein 1998, Levy 1999, Meerabeau et al 1999, Farmer et al 2003, Pollard 2003), most midwife participants in this study did not experience their relationships with other professional/occupational groupings as problematic. On the contrary, they were usually presented as being extremely good, particularly where obstetricians were concerned. As this is the group that midwives have most struggled with in the past, this is a particularly interesting finding. So the perceived status quo concerning these relationships in the wider context was not in fact maintained in the unit. Another salient feature of the unit was that, if women insisted on being active partners in making decisions about their care in pregnancy and labour, there was strong managerial support for respecting their choices, even within a considerably medicalised framework of care and a system whose needs sometimes appeared to be privileged above those of the human beings within it. So, for example, the senior managers and community midwives ensured that appropriate support and care were given to the woman who chose to give birth to her twins at home. By contrast, neonatal care was medically orientated: for example, the midwives had to monitor even healthy babies' temperatures. There were also question marks about the degree of respect accorded to parents' wishes concerning care offered/provided to their children. This was shown by the unquestioning acceptance among most of the midwives that individuals who did not wish their babies to have Vitamin K should be

referred to doctors for further discussion. These findings cannot be viewed in isolation, but must all be linked into a consideration of wider social influences and practices.

My study revealed that most discursive practices within the unit supported the maintenance of wider discourses within society which privilege a medicalised approach to life (including birth) and the traditional gendered hierarchical structures and power relationships associated with the concept of professionalism (see Tables 3 and 4, pp.139-140). However, these are the very discourses that have been identified as contributing to difficulties between midwives and other professional groups (Witz 1992, Oakley 1993, Lane 2005). Why then did the unit midwives feel that their interprofessional relationships were so good? Two factors in particular appeared to contribute to this situation: one involves the nature of those few practices within the unit which challenged the traditional hierarchy, at least in part; and the other revolves around the midwives' perceptions of their own professional identity and of 'normality' within midwifery practice.

### **Practices challenging the traditional hierarchy**

#### ***Midwives and obstetricians***

There was little doubt that the extension of the midwives' role into areas traditionally considered part of the obstetric domain had affected the quality of the inter-professional relationships in the unit, particularly the midwife ventouse deliveries. This practice had been occurring in the unit for a number of years, so it was established and accepted as generally unremarkable when data collection started. Although only a few senior midwives actually conducted ventouse deliveries, this cross-boundary role appeared to have had a major impact on the power relationships within the unit. Imminent birth is undoubtedly one of the most stressful and demanding points of midwifery/obstetric practice, particularly when it appears that active intervention is required in order for the baby to be born safely. Furthermore, many obstetricians and GPs complain that midwives are unable to make decisions and/or are unwilling to cope with problems that arise in clinical situations (see, for example, Meerabeau et al 1999, Symon 1999). The fact that the midwives in the unit were able to make decisions concerning the need for intervention at a critical point in the birth process, and then to carry it out themselves, in cases where they would previously have had to involve the obstetricians, meant that their relationship no longer consisted almost exclusively of having to call doctors to deal with situations that they could not manage themselves.

It seems that when midwives acquire 'medical' competencies, medical practitioners may display more trust in their skills and abilities (Lumsden 2005). Both obstetricians and midwives in this study expressed sentiments to this effect. It should be remembered in this context that a common finding in the literature is that many medical and other practitioners mistrust midwifery practice (see, for example, Hundley et al 1995, Meerabeau et al 1999, Kornelson et al 2003). The expansion of the midwives' practice in the unit appeared to have had repercussions for the relationships between the obstetricians and those senior and more experienced midwives who were not ventouse practitioners, who were nevertheless also perceived as colleagues possessing the requisite clinical knowledge and expertise to make accurate assessments and to call for assistance appropriately.

These effects were reinforced through formal reflection of the midwives' clinical expertise in the unit structures, through the process whereby all new obstetric registrars and senior house officers were told what the midwives' role in the unit was, and were explicitly instructed by both the obstetric consultants and the midwifery managers that they were expected to defer to the senior midwives. These findings agree with those of Green et al (1994), who found that where senior midwives were not expected to defer to junior obstetricians, the relationships between senior midwives and senior obstetricians were both positive and constructive. In addition, this practice removed the problem identified in the literature concerning other practitioners' lack of awareness of the scope and extent of the midwife's role (Meerabeau et al 1999, Katz and Katz 2001, Brodie 2002).

The re-ordering of the traditional NHS hierarchy was further effected by the fact that the junior obstetricians were often taught a crucial obstetric skill associated solely with 'abnormality' (that is, how to conduct ventouse deliveries) by the senior midwives. An analogous situation was reflected in the study conducted by Lumsden (2005), where junior paediatricians started to consult midwives who had been trained to conduct the initial examination of the newborn. Although instruction of junior doctors by experienced nurses and midwives is commonplace, the underlying differences in skills and expertise are not usually explicitly reflected within the hierarchical structures of the organisation (Brownlee et al 1996, Wicks 1998). This can result in the operation of covert power, which is often a feature of systems in which there is a mismatch of skill and status. In a hierarchical organisation, overt status brings overt power: it appeared that the exercise of power within the unit was associated with seniority, length of experience and possession of clinical expertise,



rather than with membership of a particular occupational group. The overt status accorded to the midwives removed some of the conditions which would have supported the need for the operation of covert power.

This status was underpinned and made possible through the strength of the midwifery management in the unit. In particular, the stance of the senior midwifery managers and the obstetric consultants was crucial in maintaining the power relationships between the midwives and the obstetricians, since they sanctioned and supported this 'vertical substitution' as a specific 'add-on' to established midwifery practice (Nancarrow and Borthwick 2005). Conducting ventouse deliveries was not an ordinary component of the midwifery role in the unit. (The operation of similar dynamics was observed in the case of the relationships between the midwives and the paediatricians. In this area, some midwives were just starting to encroach on the paediatricians' territory, and it was obvious that the support of the management and the paediatric consultants was essential for the success of this initiative.)

The senior midwifery managers were also strongly supportive of midwives' respecting women's wishes concerning care in childbirth. This increased the midwives' power relative to that of the obstetricians, in that midwives' advocacy concerning women's choices could be privileged above safety issues as viewed from an obstetric perspective, for example, in the case of the woman having her twins at home. Another indication of the comparatively flexible exercise of power operating between midwives and obstetricians was the fact that many of the former felt able to ignore the obstetrically-oriented policy concerning augmentation of labour when they considered it to be inappropriate or to conflict with labouring women's wishes for care.

However, it was apparent that the balance of power between the midwives and the obstetricians was highly dependent for its continuation on a number of key individuals, both among the senior midwifery managers and the consultants. This meant, of course, that the midwives' position was vulnerable to changes of senior personnel within the organisation. This finding reflects those of Brodie (2002), where the importance of support from senior personnel was stressed by midwives wishing to increase midwifery involvement in care.

The informal nature of communication within the unit appeared also to impact positively on the interprofessional relationships of midwives with their obstetric

colleagues. This may have been particularly so during the periods of data collection for this study, given the very high numbers of female medical staff and the ensuing 'feminine' overlay noted in much observed communication, particularly on the delivery suite. This finding agrees with that of Miller (1997), who found that non-hierarchical structures enhanced interprofessional collaboration. During periods when there were no immediate tasks needing attention, it was noticeable that many staff engaged in practices which could be categorised as 'relationship building': so, for example, the consultants and the delivery suite receptionist chatted about their children and grandchildren, and midwives and other colleagues discussed topics involving jewellery, clothes and entertainment, as well as more personal issues concerning their own family members. Members of all occupational groups observed, particularly on the delivery suite, were liable to offer each other food and drink at various times. These practices both promoted, and were reinforced by, the informal style of communication used when discussing clinical and other work issues. However, this in itself was unlikely to be sufficient to account for the midwives' perceptions of the quality of their interprofessional relationships with the obstetricians; where problematic relationships with other occupational groups were identified or implied (see below), the organisation of care appeared to have more influence than styles of communication or interaction. Nevertheless, this ease of communication between the midwives and the obstetricians appeared both to reinforce and be facilitated by their collegial relationships, grounded as they were in the shared exercise of power.

All these practices challenged the traditional professional NHS hierarchy within the unit. However, they cannot be interpreted as unambiguously challenging wider discourses concerning the relative social status of professionals. On the contrary, attitudes arising from the midwives' cross-boundary working, in particular, reinforced many concepts traditionally associated with professionalism *per se*. The high value placed by both midwives and other professionals on their acquisition of clinical skills which were essentially part of the obstetric panoply, indicated the extent to which those two hallmarks of professionalism, that is, specific esoteric knowledge and skill, conferred membership of an elite group within the unit.

### ***Midwives and other occupational groups***

Over the years, issues of gender dominance have affected the relationships between midwives and a range of medical practitioners (Witz 1992). Midwives also interact routinely with a wide range of professionals from other disciplines, with

some of whom they share overlapping, and even contested, areas of practice (for example, health visitors). However, despite these factors, midwives' relationships with medical groups such as paediatricians and with non-medical practitioners have not received the degree of attention given to the obstetrician-midwife relationship. I can only speculate that this is because other areas of care do not carry the dramatic emotional loading that labour and birth do.

There can be little doubt that the physiological act of giving birth is one of the most numinous processes in which human beings are ever involved. Little wonder, then, that, even though UK midwives provide care to women from early pregnancy through to the end of the postnatal period (NMC 2004b), the relatively short process of labour, culminating in birth, provides such a central focus for so many midwives. Furthermore, there is a long history of often acrimonious rivalry between obstetricians and midwives over who should control labour and birth (Donnison 1988). It is therefore not surprising that most midwives needed prompting to talk about their interaction with occupational groupings other than obstetricians.

When they did so, it was clear that some interprofessional relationships in the unit were not so harmonious as initially depicted. In particular, midwives' problems with the paediatricians appeared to be quite widespread. Since most of the observed interaction between these two groups followed the informal style common in the unit, these problems did not appear to involve individuals' interpersonal relationships, but rather control of practice. Although there are reports of midwife-paediatrician conflict (see, for example, Meah et al 1996), the control of neonatal care has never been contested in the way that control of birth has. Caring for babies is often characterised as a mundane task, which does not lend itself to being viewed as a dramatic event. At the same time, the physical vulnerability of very small babies is emotionally challenging for many parents, who may feel more secure if an 'expert' is perceived to be taking responsibility for their baby's wellbeing (Force 2000). Unsurprisingly, there has been no public movement to support a 'natural' (as opposed to medicalised) start to life, no widespread social debate about appropriate care for newborn babies, and very little challenge to paediatricians' control of this area. So it was logical that the approach to care for babies in the unit reflected the wider societal belief and trust in the medical regulation of life.

An indication of this regulation was the requirement that all babies' well-being should be assessed by measurement of physiological functions, having temperatures taken

and being weighed on a routine basis. This focus on measurement is consistent with an approach developed through adherence to rational scientific discourses (Smith 1998). It contrasts with the approach adopted by many midwives, described by one of the participants in this study, in which well-being is determined through individual practitioners' using clinical judgement and general observational skills. Specific measurement of function is then usually conducted only if pathology is suspected. Consequences of the medicalisation of the care of healthy babies in the unit were that some of the midwives reported feeling 'de-skilled', and their relationships with the paediatricians remained essentially that of inferiors within the medicalised hierarchy. This position was both illustrated and reinforced by the comparatively prescriptive language used in policies concerning neonatal care, as seen in the *Vitamin K Policy*.

It remained to be seen whether the midwives' encroachment on the sphere of paediatric practice, through starting to conduct the 'first-day checks', would result in similar changes observed in the midwife-obstetrician relationships in the unit which resulted from the midwives' conducting ventouse deliveries. An alteration in the balance of power in midwife-paediatrician relationships was certainly found in the study conducted by Lumsden (2005), as a result of the midwives taking on this task. The fact that this new midwifery role in relation to babies also appeared to be causing friction in the community between midwives and some GPs, indicated a struggle for control over practice.

Problematic relationships with health visitors and social workers seemed also to involve the organisation of care. However, neither of these groups appeared to impact on midwives' control of their own practice. On the other hand, where there were contested approaches to care delivery, or overlapping areas of practice, a degree of rivalry could emerge, agreeing with findings reported by Farquhar et al (1998). Conversely, where there were no overlapping areas of practice, no such rivalry emerged, as was seen in the case of the midwives' relationships with the physiotherapists, which were unfailingly cordial (despite reservations expressed by the senior midwifery managers about the value of their work). This finding agrees with those of Anderson (1999) into midwife-physiotherapist relationships. So it appeared that clear and uncontested demarcation between occupations seemed to preclude any conflict, or even the necessity for negotiation, concerning practice. On the other hand, the lack of such clear demarcation at times gave rise to rivalry and a degree of dissatisfaction. This reflects the situation which has been found in the

wider healthcare arena with regard to the blurring of occupational boundaries (Booth and Hewison 2002, Rushmer 2005).

The unit midwives and the members of some other occupational groups, most notably the social workers and the healthcare assistants, appeared to share the aim of processing the women using the service through the system as efficiently as possible. When different ways of organising care or arranging communication hampered that aim, relationships were perceived to suffer. This demonstrates the importance of 'commonality', which entails both the sharing of a common aim and the means by which it is to be achieved (Meads and Ashcroft 2005, p.22). The finding itself is ambiguous: it could be interpreted as professionals attempting to work together in the best interests of the women using the service; on the other hand, it could also reinforce the perception that the main aim of this process was to serve the needs of the system itself.

My data support the view that the main rationale for many initiatives and practices in the unit was simply to keep the system going, a trend which has been noted in other areas of healthcare (Annandale 1998). The way that the performance of tasks was privileged above recognition of individuals or their needs, and the way in which women using the service were expected to comply with established routines and processes, together with the expressed rationale for, and implementation of, instances of cross-boundary working, indicate that, at times, the needs of the system took priority over the needs of both the women using the service and the staff working within it. This impression was particularly strong when the midwives and the healthcare assistants were working together. This appeared to be due to the midwives' being responsible for the clinical areas in which they practised, and the fact that the healthcare assistants were also physically based in these areas. These two groups consequently worked very closely together, and jointly appeared to direct many of their efforts towards maintaining the integrity and smooth functioning of the areas in question.

Methods of communication also seemed sometimes to contribute to problematic relationships between midwives and other groups. The pattern of direct face-to-face communication between different professionals within the hospital appeared at times to be sporadic and dependent on chance, as has been found in other healthcare settings (Reeves and Lewin 2004). However, there was an awareness of the importance of consistent and reliable communication mechanisms, and systems

were in place to support interprofessional communication, for example, the book on the ward which detailed concerns and treatment regarding babies, which was read by both midwives and paediatricians. By contrast, communication between hospital midwives and practitioners based in the community appeared to be ineffective and difficult at times. Similarly, community midwives reported having communication problems with other community practitioners. So, for example, effective working with social workers, health visitors and GPs were all mentioned as being hampered by difficulties in the way that the various groups were actually able to contact each other. The inconsistent and unreliable nature of these communication mechanisms was further illustrated by the fact that the women using the service had different opinions and experiences about the effectiveness of the communication between the community practitioners and those in the hospital.

The picture concerning the midwives' interprofessional relationships was not, therefore, so straightforward as initially presented, in that there were difficulties noted with some of their colleagues from other disciplines, in terms of hierarchy, practice issues and methods of communication. However it appears that, because the obstetric profession's influence on midwifery practice has been far greater than that of other occupational groups, and because interaction between the midwives and the obstetricians was generally characterised by mutual respect and support, most of the midwives reported enjoying good interprofessional relationships in the unit.

### **Midwives' perceptions of their own professional identity**

Earlier in this thesis I argued that any attempt to theorise interprofessional working in midwifery should include a consideration of the constitution and influence of midwives' professional identity, as well as the influence of power and gender. Hall (2000) stated that a strong marker of identity is that it is most strongly delineated by contrast with the 'other', that is, with what it is not. In this regard, it is worth noting how some of the unit midwives made a point of distinguishing between themselves and obstetric nurses. This distinction appeared to hinge around issues of professional status, mainly the degree of autonomy with which the different groups were perceived to practise, and the extent to which they were seen to operate under medical supervision. This perception can be directly linked to midwifery's professionalisation project.

In Chapter 5, the idea was posited of identity comprising a relational complex of culturally constituted dimensions (such as belonging to a profession) which affects the way individuals are positioned within social practices. This positioning is associated with a range of conceptual repertoires which themselves represent specific discourses (Clegg 1989, Gherardi 1996, Annandale 1998, Wicks 1998). Questions concerning midwives were identified: how are they affected by such relational complexes in their occupational role? what repertoires do they use? what are the commonalities/differences in how they present themselves and are received in the organization? in the following section, I shall attempt to answer these questions, and relate them to the way midwives reported their interprofessional relationships in the unit.

The data show that the relational complexes on which the unit midwives drew comprised repertoires which were associated with both their occupational role and their personal lives. Repertoires associated with their occupational role could also be categorised either in terms of their role as a healthcare professional, or their role as an employee within the organisation. Different repertoires appeared to achieve prominence within the resulting relational complexes at different times, depending on the priorities attributed by the midwives to particular circumstances. So, for example, the repertoire 'worker' appeared to be dominant when the needs of the system were prioritised at times when no specific clinical concerns had to be addressed. This was evident in the way that the midwives engaged in administrative or domestic tasks such as cleaning or general housekeeping, or moving women from one area to another, often working alongside the receptionists and the healthcare assistants in these instances.

The performance of these tasks often involved gender-signalling which operated in conjunction with the 'worker'; repertoires associated with the personal sphere, for example, 'grandmother', also incorporated gender-signalling. In fact, gender-signalling constituted a sub-complex of its own, comprising the repertoires 'woman', 'domestic servant', 'female relation' and 'girl'. The midwives in the unit appeared to 'do' gender in a number of ways<sup>37</sup>. Their physical presentation of themselves as 'woman' was not excessively marked, with small items of jewellery, the use of discreet make-up and simple hairstyles being the extent to which they used markers denoting 'femininity' (this contrasted with many of the young obstetricians' self-

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<sup>37</sup> See Chapter 4 for a discussion of the concept of gender as embodied performance.

presentation, which signalled their 'femininity' far more strongly). The midwives' social conversations, however, often focused on stereotypically 'feminine' concerns, most notably their physical appearance/ adornment and their immediate family. They also frequently used physical contact when speaking to colleagues of both genders. The presentation of themselves as 'domestic servant' extended into the work sphere insofar as it involved the performance of the domestic tasks outlined above. In this way, the midwives used their gender to reinforce their relationships at a social level with all the other occupational groups with which they interacted, and as co-workers with the receptionists and the healthcare assistants. This merging of the personal and the work sphere through the use of gender-signalling underpinned, and was in turn supported by, the informal communication styles discussed above.

Many of these aspects of the communication and interaction styles noted in the unit are not peculiar to midwifery or to the maternity services, or even to the NHS. As mentioned in Chapter 4, many working environments in industrialised nations are considered to have undergone a feminisation process over the last twenty-five years (Tienari 1999, Adkins 2002). Implicit in this process is a shift in workplace semiotics that support more 'feminine' modes of communication and self-presentation, coupled with a recognition of the need for 'emotional intelligence' at work, that is, for individuals to be aware of their own and other people's emotions and sensitivities (Rutherford 2001, Adkins 2002). In common with female workers in other sectors, the midwives in the unit demonstrated a tendency to make sense of their occupational roles through interpersonal communication and relationships, and to take opportunities to 'be themselves' at work, rather than simply disembodied and depersonalised workers (Rutherford 2001, Erickson and Pierce 2005). This was particularly so among midwives working on the delivery suite, away from the gaze of the general public.

As stated earlier, feminisation does not, however, automatically imply a shift in power from traditionally 'masculine' to traditionally 'feminine' roles and occupations (Tienari 1999, Riska 2001, Erickson and Pierce 2005). This was evident in the way in which the midwives in the unit used gender-signalling when operating in the professional sphere. Despite the general informality of communication style, in these instances the midwives used gender-signalling, particularly with medical colleagues, only to reinforce their traditionally inferior position in the hierarchy – this was effected most frequently by drawing on the repertoire 'girl'. In this way, despite the ease noted above, many midwives signalled that they did not constitute a threat



to the medical profession (whose members were never referred to as 'girls'). It should be noted that this repertoire was also used to reinforce status distinctions between junior and senior midwives. In a similar manner, the midwives' application of the same repertoire to the healthcare assistants served to emphasise the latter's even lower status in the hierarchy. Other discursive practices that were in alignment with these nuances of language included the coloured scrubs and the different use made of the physical spaces, especially on the delivery suite, which provided an example of the 'hierarchical spaces' posited by Witz et al (1996), through which a 'politics of the body' was played out in the unit. In this way, semiotic aspects of the midwives' social practices shaped their interprofessional relationships in accordance with the traditional hierarchy.

In Chapter 5, I suggested that interprofessional working in midwifery could be viewed as an area where different 'communities of practice' intersect. Eckert and McConnell-Ginet (1992) defined 'communities of practice' as groups in which members adopt particular ways of behaving and communicating as part of a shared process which aims to achieve a common goal. I was particularly interested to note how midwives' gender roles might alter in the intersection of the midwifery 'community' with those involving other professionals. My data indicate that the midwives in the unit appeared to use the four repertoires outlined above ('woman', 'domestic servant', 'female relation' and 'girl') in order to cement the social and interpersonal relationships within this intersection. However, when interacting professionally with medical practitioners, the only gender repertoire employed by the midwives was that of 'girl', which was used to remove any suggestion that they might threaten their medical colleagues. The use of repertoires pertaining to their own gender did not feature in their professional interaction with colleagues from non-medical occupations. Strategies for acquiring greater status in this intersection were directly linked to repertoires related to the possession of clinical expertise. This was obvious in the way that some of the senior midwives made a point of explicitly instructing obstetric registrars in specific situations, on the basis of the assumption of their (the midwives') greater experience and skill. It was also evident in the way that the midwives behaved when interacting with colleagues from medical specialities unrelated to maternity care. In these cases, the midwives appeared to define themselves in relation to their professional role, rather than to their gender.

All the midwives interviewed and observed presented themselves as possessing clinical expertise. However, this did not consistently represent the same discourse.

For midwives who appeared to operate within a more medicalised framework, expertise involved skills required to conduct obstetric or other medical procedures; however, for midwives who valued the role of the midwife as the expert in 'normality', expertise involved skills required to support women to give birth as naturally as possible. It should be noted that these different skill sets can be characterised in gendered terms: the former mainly involves a typically 'masculine', 'old' professional approach, that is, 'scientific' knowledge is applied in a controlling environment, where the woman using the service is a passive recipient of care (Lane 2005); while the latter is mostly concerned with a typically 'feminine', 'new' professional approach, that is, knowledge from a variety of sources is used in a supportive context, in which the relationship between the midwife and the birthing woman is a significant component affecting the outcome (Davis-Floyd 2005). Consequently, possessing clinical expertise appeared also to constitute a sub-complex, which incorporated two mutually exclusive gendered repertoires, 'the health professional delivering care' and 'the expert working in partnership with the woman'.

Many of the midwives were not fixed in their use of these two repertoires, but drew on either one or the other depending on circumstances. A significant determinant of the chosen repertoire appeared to be the individual's orientation to the matter at hand. For example, when some midwives spoke about caring for women in labour, they presented themselves as 'the expert working in partnership'; however, the same midwives, when discussing care for babies, moved to become 'the health professional'. Some midwives moved between these positions within even tighter areas of focus: for example, respecting women's wishes in labour accompanied self-presentation as the 'expert working in partnership', while in dictating what procedures should occur during labour, on the basis of medical definitions of risk, they identified themselves as the 'health professional'. A few midwives consistently drew on only one of these repertoires: two of the senior hospital midwives presented themselves only as 'the health professional delivering care', while one of the community midwives and one of the hospital midwives drew only on 'the expert working in partnership with the woman'. In keeping with the notion of marking identity through contrast with the 'other' (Hall 2000), some of the community midwives also clearly differentiated themselves from the hospital midwives, and vice versa. In this instance, the basis for difference appeared to be the 'other's' perceived choice of repertoire concerning clinical expertise.

It appeared that, in any one situation, individuals' choice of repertoire associated with clinical expertise influenced, and was influenced by, the way that they interacted both with the system and with other colleagues. In particular, the acceptance of the dominance of the medical profession, noted above, varied among the midwives, depending on which repertoire they were presenting. When 'the health professional delivering care' was predominant, the dominance of the medical profession and its perspective appeared to be taken for granted and perceived as appropriate; this could be seen in some midwives' expressed concern that women using the service should only make choices considered safe from a medicalised viewpoint. However, 'the expert working in partnership with the woman' appeared rather to be resigned to using different strategies to counter this dominance, exemplified by community midwives' referring women choosing homebirth to sympathetic consultant obstetricians.

Individual midwives' support for the medicalisation of birth appeared also to be allied to the choice of conceptual repertoire, which often indicated to what extent, or in which area of practice, the medical perspective was or was not taken for granted or questioned. Midwives' perception of 'normality' in relation to childbirth and to midwifery practice appeared to be related to this issue. As mentioned previously, there is no consensus about what 'normality' in this context actually entails (Downe 2001, Robinson 2001-2002, Anderson 2003). Where midwives assumed that 'normality' included medically-defined concepts of risk, and unquestioning acceptance of medicalised care, they usually adopted the 'health professional' repertoire (which carried with it the assumption that 'midwife knows best'). Conversely, where their perception of 'normality' was framed in terms of natural, undisturbed physiological processes, they were more likely to draw on the repertoire 'expert working in partnership'.

### ***Midwives' positions in relation to other professional/occupational groups***

Midwives' professional identity was linked to the way in which they positioned themselves in relation to other professional/ occupational groupings. In Chapter 7, I stated that UK midwives' relationships with other colleagues, as presented in the literature, are framed in one of four ways. To recap, one position assumes that they are professionals embedded within the organisational structures of the NHS, who interact with other healthcare professionals from this standpoint. An alternative framing reveals them to be professionals who support the dominant discourse to a considerable degree, but who are striving to assert their own professional status

within the hierarchical system. In yet a third position, they appear as practitioners who first and foremost support the traditionally holistic midwifery ethos, and therefore relate to other healthcare professionals from a position where either subterfuge, compromise or reconciliation between conflicting approaches to childbirth is required. In these last two schemas, medical professionals are often presented as midwives' adversaries. The fourth position identified midwives who support the medicalised hierarchy and/or whose relationships with medical professionals appear to be based on their desire for doctors to take responsibility for midwifery practice.

My findings show that many unit midwives positioned themselves in one of the first two ways outlined above, depending on which other profession/occupation was involved. When speaking about obstetricians, social workers and health visitors, and in their behaviour with them, many midwives presented themselves as professionals enjoying egalitarian relationships within the framework of the recognised medicalised approach to birth (although the effects of hierarchy were often evident). In this position, the most dominant conceptual repertoire on which they drew appeared to be 'the health professional delivering care' (tempered by the 'girl' as and when necessary). Conversely, when speaking about paediatricians, most midwives, although still drawing on 'the health professional', presented themselves as professionals who were still striving to assert their own authority within the hierarchy. Observed behaviours revealed midwives' use of strategy in this regard, in order to get the paediatricians to do what they wanted them to do. The data also confirmed the existence of adversarial relationships at times, as evidenced by one of the women using the service speaking about a midwife 'not winning a battle' with the paediatricians.

Both these positions were identified among community midwives with regard to GPs, although the first was more common than the second. Another finding from the data concerning these two positions was that the midwives related to colleagues differently, depending on their status in the hierarchy. For example, when relating to healthcare assistants in their professional role (as opposed to their role as an employee), the midwives clearly saw themselves occupying a superior niche in the organisational hierarchy. A few midwives positioned themselves in relation to the paediatricians in the third way identified in the literature, that is, as practitioners who supported the holistic midwifery ethos, and who had therefore to negotiate either compromise or reconciliation between conflicting approaches to birth (I did not find

any evidence of subterfuge in the unit). In this instance, they drew on the repertoire 'the expert working in partnership with the woman'. The lack of evidence concerning this third position with regard to their relationships with the obstetricians was doubtless the result of there being a strong ethos among the midwifery managers of supporting women's choice regarding labour and birth.

There is a question as to whether the characterisation of these four positions in the literature is sufficient to describe all midwives' interprofessional relationships. Although, as stated above, the first three identified positions were clearly discernible in my data, the fourth position, in which midwives accept their position in the medicalised hierarchy, appeared to be more complex than its presentation in the literature suggested. Some of the unit midwives appeared to occupy this position, in that they presented themselves as competent and accountable healthcare workers, who supported the dominant medical perspective surrounding childbirth, and who had little interest in challenging either the authority of the medical (or any other) profession or the hierarchy of the organisation. However, there was no evidence that any of these midwives wanted medical practitioners to take responsibility for midwifery practice. Issues affecting these midwives' personal lives, such as flexible working patterns and feeling valued at work, appeared to be prioritised more highly than those affecting their professional status within the organisation. In a national study of midwifery attrition, concern with personal issues was identified as influencing midwives' decision to leave midwifery (Ball et al 2002). Unlike midwives positioning themselves interprofessionally in one of the first three positions identified in the literature, those adopting this position could be perceived as taking a passive and reactive role in their interprofessional relationships.

The data show that many unit midwives identified themselves in the interprofessional context as 'health professionals' and, with some exceptions involving the paediatricians, generally perceived themselves as occupying an appropriate niche in the hierarchy. This meant that they experienced many of their interprofessional relationships also as appropriate, and consequently as satisfactory. However, consideration of my findings and the points made above result in the conclusion that it is not possible to talk about interprofessional relationships in midwifery as a cohesive or consistent phenomenon. Before discussing further implications for the profession, I wish first to turn to the issue of how the women using the service are located in relation to the varied picture presented above.

## **Midwives' interprofessional relationships and the women using the service**

Midwives are obliged to be advocates for women in their care (NMC 2004b). However, the interpretation of what this means varies. Midwives are not a homogenous group, but can be divided into those who are actively committed to choice for women, and those who have a more paternalistic attitude, so that they are only committed to women's choice where it is congruent with their own professional ethos, be it medicalised or non-interventionist midwifery (Pollard 2005). A similar division was found among the midwives in this study, most clearly (but not only) when addressing the issue of care for babies. Respect for women's choices is inextricably linked with the many factors impacting on, and influenced by, midwives' interprofessional relationships.

The findings from this study indicate that, although the unit midwives' interprofessional relationships often appeared to be very good, this did not necessarily translate into better care or experiences for the women using the service. Some of the midwives' discursive practices appeared to mitigate actively against their acting as advocates for the women, for example, their infantilisation of themselves and the women in relation to medical practitioners. Similarly, their reduction of women to the status of objects, when prioritising the needs of the system, did little to enhance the women's experience of using the service. The continued existence of this situation is disheartening, given that it is twenty years since Kirkham (1987) pointed out this tendency to treat women as 'work objects'.

There were also examples in the data of good working relationships between midwives and other colleagues which excluded the women using the service from processes of decision-making, and reduced them to passive recipients of care. It was noticeable that, although the workplace and workforce in the unit showed evidence of 'feminisation' over a range of parameters, which contributed to the establishment and maintenance of effective interprofessional relationships, there was little sign that there had been any 'feminisation' of care. Women using the service were still generally expected to follow the rules of the organisation, and to comply with the suggestions and recommendations of the healthcare professionals. It is sobering to consider that women characterised some midwives in the unit as 'scary' and 'grumpy'.

In addition to ignoring the issue of respecting women's choices, all these practices go against ways of operating which are currently being promoted among practitioners and theorists concerned with the advancement of interprofessional working. It is now widely accepted that the service user voice should be heard in the process of service provision (Thomas 2005). It is ironic that, although the concept of working in partnership with women has been an essential component of the holistic midwifery ethos for a considerable period of time (Page and Hutton 2000), it is not a concept that has had much support within the maternity services. This is no doubt due to their incorporation into the wider healthcare system, which, because of the dominance of the professional ethos, has not usually focused on service users as partners in care delivery. However, there are sectors of health and social care, most notably social services and mental health services, where it has been regarded as both necessary and desirable for some time to include and involve service users in interprofessional working (DH 1994b, Social Care Institute for Excellence 2001). This change in status for service users reflects evolving attitudes towards a more egalitarian relationship between professionals and the public, supported by a range of government initiatives concerning choice for service users (DH 2003b, Lissauer 2003). This developing social trend may result in time in women being included as partners in interprofessional working in the maternity services.

## **Power**

The findings concerning the midwives' interprofessional relationships raise questions about the extent to which traditional power relationships were maintained or challenged within the unit. Foucauldian notions of power focus on how knowledge and the organisation of existence are normalised, fixed and represented through multifarious discursive forms and practices (Laclau and Mouffe 1985, Clegg 1989). It is interesting to note that the normalisation of the medical perspective was not challenged to any significant degree within the unit. There were undoubtedly signs that an alternative perspective concerning care for women in labour was also operating, but it was in a relatively subordinate position in relation to the over-arching medicalised framework within which the midwives practised.

Throughout the midwife interviews, the participants' use of language and their expressed views often reinforced the perception of their inferior niche in the NHS hierarchy. This occurred even among the more senior midwives, and generally

appeared to be indicative of an acceptance of the wider societal discourses concerning the dominance of the medical perspective. Even though they as individuals had higher status and more authority in the unit than some of the junior and middle-grade obstetricians, there was tacit acceptance that the medical profession *per se* was in a position to dictate or sanction midwifery practice.

However, there were undoubtedly challenges to the power of individual medical professionals, both among those working in the hospital and among community GPs. These challenges appeared to be based, not on an alternative conception of relevant knowledge, but rather on destabilising the traditional hierarchy concerning gendered roles. In this way, the normalisation of the organisation of existence predicated on that hierarchy was challenged, not without some signs of conflict. The 'feminine' occupation of midwifery was gaining equivalence in some areas with the 'masculine' occupation of medicine, mainly through the use of usurpation strategies (Witz 1992). It should be noted that, as far as the obstetricians were involved, this equivalence was not only the result of an increase in senior midwives' status, but also of a relative decrease in the status of junior obstetricians (compared with their historical position in the hierarchy). In addition, 'feminised' styles of communication had almost completely superseded the 'masculine' interaction characteristic of organisations dependent on maintaining a chain of command. The comparatively amicable and productive way in which the midwife-obstetric relationships were constituted reflect Miller's (1997) contention that effective interprofessional working requires individuals' willingness to address power issues. Despite their encroachment on paediatric practice, the midwives' relationships with the paediatricians still reinforced traditional gendered power relationships to a considerable extent, evidenced by their perceived inability to practise as they wished to, and by their use of strategy to influence paediatricians' decisions.

It was noticeable that the contested area of practice involving midwives and health visitors did not appear to involve gendered roles. There was a suggestion that the relationship between them could at times be aggravated by conflicting approaches to care. On the other hand, it seemed that this situation resulted mainly from territorial disputes over responsibility for care. The lack of clear demarcation of boundaries seemed to be crucial in this instance, as in other areas of healthcare provision (Rushmer 2005). In this instance, the power relationships in the unit appeared to reflect those commonly found among occupational groups whose



practices overlap, but who share a similar position within the traditional NHS hierarchy (see, for example, Booth and Hewison 2002).

The relationships between the women using the service and the midwives, to a large extent, also revealed maintenance of traditional power relationships between professionals and service users. However, there were signs that this situation could alter. A number of midwives spoke at some length about the way that some women using the service were able to access their preferred type of care. An alternative Foucauldian definition of power is the ability to achieve goals (Clegg 1989). In this respect, these women could certainly be considered to be powerful. It was notable that midwives were not always appreciative of this situation, perceiving themselves to be losing power in this equation. The concept of power shared between midwives and women, although evident in some midwives' discourse, was only sporadically evident in the data.

All these findings support the Foucauldian view in which power relationships in the unit are perceived as comprising a network of shifting and contended alliances and social practices. Although this network seemed to be stable to a considerable extent, some areas of stability appeared to reinforce traditional power relationships (service users-professionals), while others demonstrated the ascendance of 'new' power relationships (midwives-obstetricians). There were also discrete areas which could be characterised as unstable, in which competition between different discourses was being contested (midwives-paediatricians).

### **Implications for midwifery**

The ongoing development of UK midwifery is inextricably linked with the way in which midwives interact with their colleagues from other disciplines, and the way in which maternity care is organised. There are numerous accounts of tensions and conflicts between midwives (see, for example, Kirkham 1999, Hughes et al 2002, Pollard 2005). This study, while not focusing on midwives' intra-professional relationships, has revealed that midwives' professional identity is inconsistent and fragmented to such a degree that tension and conflict may be inevitable, as individuals attempt to practise professionally in a way that makes sense to them, but which may be anathema to colleagues with whom they have to work closely.

In particular, it could not be assumed that any two midwives in the unit would agree, or even share a common understanding, about their position in relation to the

women using the service, their position in relation to their colleagues within the organisational hierarchy, the overall control of birth (including care for newborn babies), the preferred skill set for midwifery practice, or the issue of professionalism. The last factor may be the most salient, in that it can be considered to impact significantly on all the others.

In keeping with the wider drive towards being regarded as 'professionals', it was apparent that many midwives supported the concept of professionalism and its social consequences in its traditional sense: that is, professionals being primarily defined by possession of esoteric knowledge and expertise, which results in their being granted privileges and status in the wider social community. Despite the ever-increasing challenges in wider society to the traditional notion of professionalism (Annandale 1998, Astley 2006), many medical practitioners appear still to expect these privileges as a matter of course. Professional 'purity' is associated with the degree to which a sector of a profession deals only with matters associated with that profession's core esoteric knowledge (Abbott 1981). In a study of medical practitioners in Estonia, Barr and Boyle (2001) found that doctors' social rewards and privileges depended on the 'purity' of their medical speciality. Similar findings have arisen elsewhere with regard to other professions (Hagan 1990, Bellas 1994). In the Estonian study, the highest degree of 'purity' was associated with medical specialities for which additional training was a prerequisite, and in which doctors did not deal with minor ailments, saw only patients referred to them by other medical practitioners, and conducted major surgical procedures (Barr and Boyle 2001). It is not difficult to see how this categorisation of 'purity' can apply, at least to some extent, to medicine in the UK; one has only to consider the relative social status and financial rewards of neurosurgery and general practice.

In this system, obstetricians rate comparatively highly for 'purity', and therefore command privileges commensurate with their speciality. Due to their long close association and rivalry with the obstetric profession, it is not surprising then that many midwives hold a concept of professionalism which in some quarters is regarded as outdated (Lissauer 2003, Astley 2006). Claims for the 'professionalism' of midwifery are often made on the basis of traditional factors, such as possession of a specific body of knowledge (see, for example, Etuk 2001). Over the last 15 years, midwifery's 'professionalisation project' has largely focused on issues of education, autonomy and control of practice (Witz 1992, Sandall 1995, Neglia 2003). While the reconceptualisation of professionalism in nursing and medicine has been

discussed over the same period, with writers such as Stacey (1992) and Davies (1995) positing a 'new professionalism', it is only fairly recently that in-depth consideration of the concept itself has started to take place in midwifery (Pairman 2000, Davis-Floyd 2005, Lane 2005). No awareness of this alternative way of thinking about professionalism was found in this study. The unit midwives' perception of 'professionalism' was framed only in terms of its traditional conceptualisation.

There are fundamental contradictions between operating as a 'professional' in the traditional sense and working in partnership with individuals who are using the services. The aspirations of midwives to be recognised as 'professionals' evoke all these contradictions (Wilkins 2000). In the established healthcare system, traditional professionals know best, define processes over which they have control, dictate care delivery and other courses of action, control the activities of inferiors in the hierarchy and those of individuals using the service, and value skills and expertise associated with their own knowledge base over any which might be available to non-professionals (Freidson 1994). By contrast, working in partnership entails respecting and valuing both one's own and others' knowledge, sharing control over processes, negotiating appropriate care delivery and other courses of action, respecting and supporting the autonomy of colleagues and of individuals using the service, and valuing a range of skills and expertise. This approach to their professional practice can be found among lay midwives in the USA<sup>38</sup> (see, for example, Hillman 2004).

The midwives in this study, with very few exceptions, appeared to be unaware of the contradictions inherent in the positions they adopted. As described above, they often switched between the gendered conceptual repertoires 'the health professional delivering care' and 'the expert working in partnership with the woman', apparently without realising they were doing so, or appreciating the wider implications of this lack of stability in their professional role. At the same time, their use of gender-signalling often reinforced their status as 'non-professionals', both in the general work sphere and in the professional sphere, where it was at odds with their defining themselves in relation to their clinical expertise. It was notable that simultaneous positive identification of themselves both as 'women' and as 'professionals' in

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<sup>38</sup> These practitioners in the USA are certainly not traditional birth attendants, so 'lay midwife' seems to be the only term that accurately describes them. See footnote on p.12.

relation to other occupational groupings did not occur. While many of the midwives perceived themselves to be operating with a considerable degree of autonomy, their practice in many areas was directed by medical priorities and policies, and there was widespread assumption that medical knowledge was superior to that from other sources, and consequent acceptance of the dominance of the medical perspective concerning care for women using the service. This combination of circumstances appeared to result in many midwives practising from a perspective of wielding power 'over' the women using the service, rather than working 'with' them.

However, whatever they might have thought about it, all the midwives acknowledged the women's right also to exercise power, through exercising choice in relationship to their own care. By contrast, many of the midwives appeared to consider it good practice to abide by medicalised procedures for neonatal care, even where they then went against or undermined parents' wishes. This was most obvious with respect to the administration of Vitamin K, which was not considered to be medicalised care, but rather a 'normal' procedure supported by 'neutral scientific' knowledge (a clear illustration of the normalisation of a particular body of knowledge). Cronk (2000) has made the point that if we, as a society, refuse to invest parents with power, and constantly give them the message that someone else knows better than they do, then it is quite incongruous to expect them to take responsibility for their children's behaviour at later stages of their lives. However, given our society's widespread endorsement of the medical regulation of life, and the growing assumption that it is appropriate for the 'authorities' to define the 'correct' way for individuals to behave in most situations, it would be unrealistic to expect a majority of midwives to act otherwise.

Data from this study confirm the existence of increasing acceptance of a medicalised approach to life and of state regulation of individuals' behaviours. In a manner which echoes the widespread pathologisation of children's behaviour, incorporating diagnosis of illness followed by medication (Ragg 2006), examination of the current *Midwives rules and standards* (NMC 2004b) showed that they now overtly suggest that women who do not wish to follow health professionals' advice may be mentally ill: that is, their behaviour is framed in medical rather than social terms, so that medical diagnosis with subsequent treatment (and control) becomes an obvious and justifiable course of action. Further examination of the rules reveal that midwives are expected to cope with women's 'rejection' of advice by using a variety of strategies, including involving supervisors of midwives, making detailed

records of any pertinent discussions, and consulting other members of the healthcare team. Midwives' own perceptions or beliefs concerning appropriate professional-service user relationships are not considered, and they are expected to represent the established view in this regard (NMC 2004b). Similar expectations were demonstrated by the hospital midwives' voicing disapproval when the community midwives informed women using the service about the range of opinions concerning the administration of Vitamin K.

The tensions and contradictions evident in the midwives' perceptions of their own professional identity can be traced to the classic conflict between two irreconcilable approaches to childbirth. It may be time to question the value of a non-medicalised perspective in our industrialised, technological society (Pollard 2003, Evans 2005). After all, if medical regulation of life and the technological imperative are considered the appropriate norms, why should birth be approached differently? On the other hand, UK society has always protected the rights of minorities, and in (usually) giving legal power to the women using the maternity services to choose how and where they wish to receive care (Hewson 2004), it continues to support women who wish to retain control over the process of giving birth (although there appears to be a very real danger that, in keeping with wider discourses concerning authority and individual behaviour, these rights may be at risk).

However, the expectation that midwives can and should embrace both these approaches, no matter what their own personal beliefs or inclination, appears to place them often in an untenable position. Perhaps midwives should also be able to choose what sort of care they offer to women, instead of having to respond to their wishes while simultaneously juggling professional and/or employment obligations. I have argued previously that both midwives and childbearing women would be better served if the midwifery profession in the UK was to be divided along the lines of obstetrically-oriented nurse-midwifery and women-centred holistic midwifery (Pollard 2003, 2005). Such a division of the profession would allow midwives to practise in the way that made most sense to them. It should be noted in this context that many young, recently qualified UK midwives have reported leaving the profession because they were not able to practise in the way that they wished to (Ball et al 2002).

Childbearing women who wish to have medicalised care in the UK are amply catered for, but this is not the case for those who prefer an alternative approach to birth. Even among the small number of service users who participated in this study,

there was one who showed very clearly that she favoured a non-medicalised approach from her caregivers. There were also reports from the community midwives concerning other women with a similar outlook on birth. It appears that a significant number of women would consider homebirth if it was presented to them as a safe, viable option (NCT 2006). A discussion of the comparative benefits for women arising from different approaches to birth is beyond the scope of this thesis. However, it is worth noting that supportive non-interventionist midwifery care has been proved beneficial for many women (Beech 2003, Rosser 2003). The current emphasis on choice for users of the health services should enhance pregnant women's ability to choose non-medicalised care, if that is what they wish for (DH and DES 2004). Being able to differentiate between 'holistic midwifery' and 'nurse-midwifery' would enable women to choose carers who would be wholeheartedly able to support them in their choices for themselves and their babies.

This could also help to clarify exactly what 'normal' pregnancy, birth and infancy are. There is a perception that the gap between 'normal' and 'natural' birth has been widening for some time (Robinson 2001-2002). Certainly, there was little agreement between the midwives in this study about what 'normality' actually entails. The degree to which a concept like 'normality' can be affected by discursive practice was clearly illustrated by the fact that ventouse deliveries being conducted by midwives were being classed as 'normal' births in the unit for some purposes, purely because midwives are supposed to be 'experts in the normal'.

There is little sign, however, that a division of the profession along the lines suggested above is likely to happen. So it becomes increasingly important to identify how midwives' working environment can support them in a role which is so often beset with difficulties and contradictions. In this study, it was clear that where rivalries and problems existed with other occupations and professions, the issue at stake was not usually the approach to birth. The phenomena of control and overlapping areas of practice were far more salient. The unit was particularly illuminating in this regard, as it allowed exploration of midwives' relationships with other healthcare workers based on both the traditional division of labour and on more innovative ways of working.

It appears that as long as the midwives felt that they had a sufficient and acknowledged share of power in their immediate working environment, and that their interpersonal relationships were satisfactory, they considered their interprofessional

relationships in a positive light. This finding confirms the importance of 'parity' in interprofessional working, as defined by Meads and Ashcroft (2005, p.21). It also agrees with those from other studies that showed that many midwives and other women workers tend to invest in their interpersonal relationships and conditions at work, to the extent that issues such as wider organisational power and financial incentives are relatively unimportant to them (Ball et al 2002, Erickson and Pierce 2005). The overt recognition of midwives' expertise, its reflection in the unit's hierarchical structures, and the egalitarian and informal communication methods employed in the unit appeared to be key features impacting positively on the midwives' interprofessional working.

### **Who benefits from the maintenance of poor interprofessional working in maternity care?**

As mentioned elsewhere in this thesis, a key aspect of the CDA approach incorporates consideration of how, and to whom, benefits are conferred through the maintenance of an identified social problem (Fairclough 2001b). From the literature, it appears that neither midwives nor women using the service benefit from poor interprofessional working in midwifery (CEMACH 2004, Kirkham and Stapleton 2004). Logic then dictates that, if such a benefit actually exists (and the conceptualisation of such a benefit is obviously crucial to its identification), it must accrue to some other social or occupational grouping. There is, of course, an argument that the medical profession has most to lose in terms of power and status, should effective collaborative working become the norm in healthcare systems (Barrett and Keeping 2005). Consequently, the maintenance of poor inter-professional relationships may be deemed preferable to the loss of professional and social privileges. From my data, it could be argued that this was the case as far as some of the midwife-paediatrician/GP relationships were involved.

It is more difficult to identify benefits where no such power differentials exist, for example between the midwives, health visitors and social workers. However, one can consider this matter in the light of 'horizontal violence', in which members of oppressed groups behave aggressively towards one another in reaction to their systematic exclusion from power (Robertson 2004). It can be argued that all of these occupations are concerned with promoting their own professional profiles, and therefore are mindful of issues of status and control within the wider system. So it would appear that, contrary to the statement above, midwives themselves may

benefit from maintaining poor interprofessional relationships in these situations, in that they are preferable to losing control over their sphere of practice. Obviously these benefits also accrue to the other non-medical professionals involved.

However, these apparent benefits should not be considered in isolation. It was notable that, where poor interprofessional working was identified in this study, everyone involved appeared to find such circumstances frustrating and counter-productive. By contrast, it was apparent that the general positive tenor of the midwife-obstetrician relationships promoted effective communication and collaboration between the two groups. While conflict concerning control over practice had not been completely eradicated, it appeared only to be occasionally problematic. So it appears that any benefit that accrues to midwives and other groups from poor interprofessional relationships is significantly limited, when compared with the advantages associated with effective interprofessional working.

### **A summary of the interprofessional working in the unit**

I have demonstrated how the unit midwives' discursive practices served either to reinforce or challenge wider societal discourses concerning the control of childbirth, professionalism and gendered roles in healthcare. CDA methods applied to these data have shown clearly how semiotic aspects of midwives' interaction with other professional/occupational groupings referred to a variety of social practices, invoked various social relationships and issues of identity, and revealed midwives' values concerning a number of social and professional issues (Fairclough 2001b). By using these methods, I have supported my argument that midwives' inter-professional working both influences and is shaped by the relationship between their ways of communicating and the exercise of power within their working environment, and that this interaction can only be properly understood through a consideration of how it relates to wider social discourses.

Given the influence of these discourses on all those concerned, and notwithstanding the tensions and contradictions in the midwives' role noted above, this unit appeared to have found a middle ground with the potential to work well for most of the midwives practising within it. It provided fairly medicalised care to women, which nevertheless was perceived largely to be appropriate and not too constricting in terms of midwifery practice. The midwives' involvement in conducting ventouse deliveries and in assisting at caesarean sections promoted good relationships and a perception that power was shared between them and the obstetricians, as well as a



sense of mutual support. The midwives also had a sense of being supported through the healthcare assistants taking on some of their designated tasks. Attempts were being made to improve relationships and power-sharing between the midwives and the paediatricians, partly through the midwives' starting to conduct the initial comprehensive examination of newborn babies. The implementation of all these cross-boundary initiatives was consistent with the current trend in healthcare to characterise procedures and competencies as being technically, rather than professionally, based (Cameron and Masterson 2003). The relative feminisation of the unit, which entailed reinforcement of informal communication styles and the support for relatively relaxed modes of behaviour, helped the midwives to 'be themselves' at work to a considerable extent (Rutherford 2001, Adkins 2002). In addition to all this, there was genuine support for women using the service who wished to retain control of the birthing process and/or to adopt a non-medicalised approach to childbirth. It was also possible for midwives who were most interested in this type of midwifery to practise in areas which facilitated their ambitions in this respect. As could be expected in our current social climate, these were few in number, but the principle of women's right to make choices, at least in relation to their own care, was well observed.

As mentioned above, a particularly pertinent factor enabling the unit and its staff to function in the way described here was the strength of the midwifery management and the positive relationships between the senior midwife managers and the consultant medical practitioners. The management and staff were working towards a common aim, in that they had optimised the relationships between midwives and some occupational groups, and were attempting to do so in relation to others. In an organisation like the NHS, there is little doubt that support of clinicians and managers at a senior level is needed for cross-boundary initiatives and restructuring of the traditional professionally-based hierarchy, which can only occur as a top-down process. In many NHS practice areas, there are good interprofessional relationships at a relatively senior level. However, this is not always accompanied by a concern to ensure that relationships involving those at lower levels of the hierarchy are equally congenial and constructive (Pollard et al 2006). It cannot be stressed too strongly that support at senior levels is essential, if interprofessional relationships among all the occupational groups are to flourish.

The final word must be about the people for whose benefit interprofessional working is undertaken. This study showed that good interprofessional working and functional interpersonal relationships among staff do not necessarily provide the

women using the service with good experiences, but can actually contribute to their disempowerment. It appeared that the need to treat women as active partners in care had been only partially and erratically realised in the unit. A vital step must surely be to involve the women using the service far more closely in decisions concerning the organisation and provision of care. Such involvement could hopefully mitigate the tendency of staff to prioritise the needs of the system above those of the individuals within it. Although these developments may seem to be some way off at the moment, some wider social trends support such a change. One can take heart from considering how far the culture of one NHS maternity unit has already moved from the stereotypical hospital environment of old, where doctors commanded, midwives listened, and women always did as they were told.

### **Limitations of the study**

This study shares limitations with many other qualitative research projects, in that it represents one individual's interpretation of a complex situation. Nevertheless, throughout the conduct of my study, I have aimed to establish its trustworthiness<sup>39</sup>. It must also be remembered that my data came from only one maternity unit, whose culture and organisational structures were not necessarily typical of other NHS maternity units. However, the unit in question certainly shared with other NHS maternity units common ground concerning both intraprofessional and inter-professional issues, and the control and scope of midwifery practice. So although the findings from this study cannot be generalised to the wider population of midwives, they may be applicable to other maternity care settings. Further research would be required to confirm this. I am, however, confident that my findings will contribute to a wider understanding of the complex operation of the many factors which affect the way that midwives work with, and relate to, their colleagues from other professional and occupational groupings.

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<sup>39</sup> See Chapter 6

## Chapter 12. Conclusion

The basic premise giving rise to this study was that poor interprofessional working in maternity care constitutes a social problem in the UK, in that it contributes to poor outcomes for women and their families, as well as causing difficulties for midwives in their professional lives (CESDI 2001, De Vries et al 2001, CEMACH 2004, Kirkham and Stapleton 2004). Reports of problematic relationships between midwives and other professional groups are sufficiently widespread for poor interprofessional working in maternity care to be considered the status quo (see, for example, Meah et al 1996, Davies 1997, Hosein 1998, Levy 1999, Meerabeau et al 1999, Farmer et al 2003, Pollard 2003).

Modern midwifery has developed within the dominant medical scientific discourse in which the female body and childbirth have been pathologised. Conflict exists between paradigms of wellness and illness among competing discourses about birth. Traditionally, midwifery adopts a holistic perspective, viewing birth as a natural physiological process (Leap 2004). By contrast, birth needs to be associated with illness to validate the predominance of the medical curative discourse in western maternity care (Oakley 1984). Over the last 150 years, both birth and midwifery practice have been increasingly institutionalised and governed by medical priorities and frameworks, largely as a result of perceptions concerning gender roles coupled with the rise of professionalism and the widespread medicalisation of life in western society (Stacey 1988, Witz 1992, De Vries et al 2001). Current changes within the UK healthcare system, in alignment with the discourses of the market and of service users' rights, are contributing to the complexity of the system within which maternity care is delivered (Annandale 1998).

The theoretical principle proposed in this thesis was that midwives' interprofessional working both influences and is shaped by the relationship between their ways of communicating with other colleagues and the exercise of power within their working environment. In an attempt to identify and explain the micro-level mechanisms maintaining the status quo regarding interprofessional working in midwifery, the aim of this study was to explore how NHS midwives' discursive practices either reinforce or challenge wider social discourses concerning power, gender, professionalism and different approaches to birth. This focus necessitated using methods that would enable both macro- and micro-analysis (Fairclough 1995), and a consideration of a

range of data from a variety of sources. I therefore adopted a hybrid research approach, incorporating methods drawn from both CDA and case study research.

Findings from analysis of both international and national midwife-authored literature, the rules governing midwifery practice in the UK, two local policies from the research site and the fieldwork data revealed that midwives' discursive practices, as evident in a number of social practices, could be characterised as promoting either unity or division between themselves and other occupational groups, as well as between themselves and women using the maternity services. In particular, gender-signalling appeared to promote unity between midwives and other members of staff in the social sphere, but division in the professional sphere. The performance of gendered tasks served to reinforce divisions between the midwives and the medical staff, while these same practices appeared to unify relationships between the midwives and their non-medical colleagues.

Midwives' professionalisation agenda was apparent in some practices, particularly those associated with cross-boundary working. These reinforced traditional notions of 'professionalism', and served to unify midwives adhering to these notions with members of other professional and occupational groups. However, they also created divisions between these midwives and others who were not involved in these initiatives, as well as those who explicitly supported the holistic midwifery ethos and the promotion of 'normal' birth. The midwives' presentation of their own professional identity also made it clear that they differentiated between themselves, according to whether they supported the medicalised system or the holistic approach to birth. Broadly speaking, the hospital-based midwives adhered to the former position, while the community midwives supported the latter, although exceptions were found among both groups. However, individuals' self-presentation in this regard was not always consistent, seeming to depend on different contexts and clinical conditions.

Midwives' support for medicalised approaches to care, particularly where babies were concerned, and the way in which they prioritised the needs of the system at times, served to create divisions between themselves and the women using the service. This effect also resulted from some practices which unified the midwives with other colleagues, as in these instances, the women using the service were at times treated as objects or excluded from decision-making processes. However, the strong management support for respecting women's choices, and the adherence to

the holistic midwifery ethos on the part of a number of midwives, promoted unity and partnership working between them and the women they attended in a minority of cases.

All these findings supported the Foucauldian view of power relationships in the unit as comprising a network of shifting and contended alliances and social practices. Although this network seemed to be generally stable, some areas of stability appeared to reinforce traditional power relationships, while others demonstrated the ascendance of 'new' power relationships. There were also discrete areas which appeared to be unstable, in which competition between different discourses had still to be decided.

Midwives' interprofessional relationships reflected their own professional identities, and the manner in which they positioned themselves with regard to the power relationships in the unit. They adopted one of four positions, identified from the wider literature: the health professional interacting as an equal with other colleagues; the health professional striving for professional status within the hierarchical system; the holistic midwife in conflict with the medicalised system; the practitioner who accepts or prefers her position in the hierarchy. Individual midwives' adoption of these positions was not necessarily fixed, but varied according to circumstances. This was consistent with the variability noted in the midwives' presentation of their own professional identity.

Given these variations, it appears that it is not possible to conceptualise UK midwives' interprofessional working as a phenomenon possessing either coherence or consistency. This may be partly a result of the UK system, which demands that midwives simultaneously adhere to a medicalised approach to childbirth, act as advocates for women, practise according to the holistic midwifery ethos, promote the professionalisation of midwifery and prioritise the needs of the organisations in which they work. It may be time to consider the division of UK midwifery into nurse-midwifery and holistic midwifery, in order to allow individual practitioners to choose between these conflicting conceptualisations, instead of trying, and inevitably failing, to embody all of them.

However, such a division of the profession seems unlikely in the UK. It therefore becomes important to identify how midwives' working environments can support them. My findings illustrated that where rivalries and problems existed with other

occupations and professions, the issue at stake was not usually the approach to birth. The phenomena of control and overlapping areas of practice were far more salient. Even where 'commonality' was not achievable, the concept of 'parity' (Meads and Ashcroft 2005, pp.21-22) appeared to be crucial to midwives' perceptions that their interprofessional relationships were satisfactory. As found in other areas of healthcare, it seems that midwives' involvement in decision-making concerning their conditions and sphere of practice is essential for effective interprofessional working in midwifery.

Finally, the participation in these processes of the women using the service needs also to be considered and promoted. Although good working relationships between midwives and their colleagues are undoubtedly valuable in themselves, my findings indicate that they do not inevitably lead to improvements in service delivery or enhanced service user experience. A key factor in this equation appears to be the extent to which childbearing women are actively involved in decisions concerning both the planning and delivery of care. A major priority for all maternity care professionals should therefore be to recognise that the women using the service possess unique and valuable knowledge about their own birth processes, and to include them as full partners in decision-making. In this way, interprofessional working in midwifery can become a positive experience for all concerned.

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## **Appendix 1 - Semi-structured guide for midwife interview**

Please tell me what you think about the interprofessional working in the unit.

What happens when there's a difference of clinical opinion between the midwifery staff and the obstetric staff?

What is the liaison like between junior midwives and the medical staff?

What other professionals or agencies do you work with?

Please tell me what you think about working with them.

The augmentation policy here has a definition in it that says that a labour that's progressing at less than a centimetre an hour is primarily dysfunctional. What do you think about that definition?

At the end of the Vitamin K policy, it says that if a woman refuses Vitamin K, she needs to be referred to a paediatrician/medical practitioner. Please tell me what you think about that.

What do you think about the HCAs doing their NVQs, and being trained in skills like taking blood pressure?

Can you tell me what you think woman centred care is?

What do you think about women who want care that doesn't comply with unit policies?

Do you consider yourself to be a professional? (Why/Why not?)

What is the difference between a midwife and an obstetric nurse?

Do you consider yourself to be a midwife or an obstetric nurse? Explore further.

Do you consider your colleagues to be midwives or obstetric nurses? Explore further.

(If the midwife has an extended role): How did it come about? What do you think about your involvement in it? Has it had any effect on the relationships between midwives and the medical staff? Explore further.

Is there anything else you want to say about the way interprofessional working happens in this unit?

## **Appendix 2**

### **Information and consent forms**

- Information sheet for staff
- Information sheet for women in the hospital
- Information sheet for women at home
- Consent form for staff
- Consent form for women in the hospital for observation
- Consent form for women in the hospital for interview
- Consent form for women at home for interview

## **Research Project to Explore Interprofessional Working in Midwifery**

### **Centre for Research in Applied Social Care and Health**

Health Training and Research Centre  
Building 650, Frenchay Campus  
Coldharbour Lane, Bristol BS16 1QY

## **Information sheet for staff**

You are being invited to take part in a research project which is being conducted as the basis of a PhD thesis.

### **Background**

It has been recognised that poor interprofessional collaboration can contribute significantly to sub-optimal care, and the last decade has seen a continuing emphasis on developing interprofessional working in UK health and social care services. However, staff anxiety concerning loss of status, erosion of professional role, and increasing workloads tied to decreasing resources can impede this development, although there is evidence that effective interprofessional collaboration can enhance professional role. The quality of interprofessional relationships can also affect job satisfaction.

UK midwives routinely interact with a wide range of other professionals. Available evidence, related to job satisfaction in some cases, highlights problematical relationships between midwives and medical staff. There has been very little in-depth exploration of these issues, and there is virtually no literature concerning midwives' relationships with non-medical colleagues.

### ***Purpose of the study***

This study aims to explore midwives' perceptions and experiences of interprofessional working, with a particular focus on the impact of interprofessional working on job satisfaction. The study will explore midwives' interaction with all other health and social care professionals.

### ***Study design***

This is a case study of midwifery within the maternity services in settings in *city*. The focus is to observe and record the nature of interprofessional working within the maternity services. Practice areas for inclusion in the study have been decided in conjunction with the midwifery manager and the midwifery team leaders.

The researcher will be present in each selected practice area for a number of days, on three separate occasions, over the twelve month period from November 2003 to November 2004. During that time, she will observe interaction between midwives and other staff. She may at times approach staff for more information/clarification about what she has observed. In addition, a number of midwives will be invited to individual interview; these interviews should not take longer than 10 minutes.

Some observations may involve service users. Where this might happen, all service users in the area will be supplied with written information sheets, and asked for their consent before being included in the study.

Another aim of the study is to find out what service users think of the interprofessional working in the unit. Together with midwives, the researcher will identify service users who can be asked to consent to individual interview. They may be at any stage of pregnancy, or in the postnatal period. Care will be taken to ensure that they have sufficient time to consider their decision about participating in the study, as well as the opportunity to ask questions about the study.

The following service users will be excluded from the study:

- women who are experiencing complications of pregnancy which may lead to premature delivery;
- women who have experienced perinatal or neonatal loss;
- women whose babies are receiving intensive care.

No observations, interviews or recruitment to the study will involve women in labour, or women who do not have the capacity to consent to participation.

### **Taking part in the study**

If you consent to take part in this study, the researcher may record details of interactions in which you are involved.

You may also be asked to take part in individual interview. The purpose of the interview will be to get a better understanding of your views about interprofessional working in the unit. Interviews will be audio taped and transcribed, if you agree to this method of recording.

### **Decision to take part**

It is up to you whether you take part in the study or not. If you do decide to participate, you are still free to withdraw at any time without giving a reason. Participants will be anonymous; there will be no way of identifying anyone who takes part in the study, or of relating information collected during the study to them.

Consent to observation does **not** imply consent to interview. Specific consent to interview will be gained.

If you decide not to participate in the study, no recording of any observations that include you will be made. However, the researcher may be present in your practice area when you are working.

### **Ethics**

This project has been approved by the *name* Local Regional Ethics Committee, the *name* NHS Trust, and the Ethics Committee of the University of the West of England, Bristol.

### **Results of the study**

All participants will receive a summary of the results of the study. The results will also be published in professional journals and presented at professional conferences.

### **Researcher contact details**

Katherine Pollard      Faculty of Health and Social Care, University of the West of  
England, Health Training and Research Centre, Building 650,  
Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY

Tel: 0117 328 1125

e-mail: [Katherine.Pollard@uwe.ac.uk](mailto:Katherine.Pollard@uwe.ac.uk)

## Taking Part in Research

**Centre for Research in  
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Facsimile 0117 328 1189

## Information for Service Users

You are being invited to take part in a research project. Here is some information to help you decide whether or not to do so. Please read the following information carefully and discuss it with friends, relatives and staff if you wish. Ask us if there is anything you do not understand or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

1. This study is about the way staff work together here, so you will not receive any direct benefit from taking part. However, information obtained during the course of the study may help us to improve service delivery in the future.
2. It is up to you to decide whether to take part or not. If you do decide to take part you will be asked to sign a consent form. If you do decide to take part, you are free to withdraw at any time and without giving a reason. This will not affect the standard of care you will receive. Staff will not be upset if you decide not to take part.
3. Any information collected about you during the course of the research will be kept strictly confidential. Any published report of the research will not identify you.
4. This study is not about medical treatment, so if you do take part, it will not affect your treatment and care in any way.
5. Consumers for Ethics in Research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London N16 0BW.

## Research Project to Explore Interprofessional Working in Midwifery

You are being invited to take part in this research project.

### What is the purpose of this study?

This study will look at the way that midwives and other staff work together in the maternity services.

### Why have I been chosen?

We want to observe how staff work together. This will sometimes involve observing them when they are involved in your care.

### Do I have to take part?

No, it is entirely up to you to decide whether to take part or not. You will be given this information sheet to keep, and if you do decide to take part you will be given a consent form. **You are still free to withdraw at any time** and you do not have to give a reason. This will not affect the standard of care you will receive. Staff will not be upset if you decide not to take part.



**Who is the researcher?**

The researcher is a midwife who works in another NHS Trust, and at the University of the West of England, Bristol.

**What will happen to me if I take part?**

This study is not about medical treatment, so if you do decide to take part, your care and treatment will not be affected in any way.

The researcher will be present on some occasions when you (or your baby) are receiving care, or when you are in discussion with different members of staff. **She will not be present if you need any intimate physical examination, if you are breastfeeding, or if the discussion is likely to be either embarrassing or upsetting for you.** Even if you agree to take part in the study, if at any time you prefer her not to be present, your wishes will be respected.

The researcher will make notes about how all the people present interact. After the observation, she may ask you if you are willing to be interviewed. You do not have to do this, and nobody will be upset if you decide you would rather not. If you do agree to be interviewed, you will be given another consent form. **You will still be free to change your mind**, and withdraw from the study at any time, without giving a reason.

If you do agree to be interviewed, the researcher will ask you some questions about what you think about the way that different members of staff communicate with you and each other. With your permission, the interview will be audio taped.

**Taking part in the research will not involve any physical examination.**

**Will my taking part in the study be kept confidential?**

All the information collected about you during the observations and/or the interview will be kept strictly confidential. It will not be possible to relate this information to you.

**What will happen to the results of the research study?**

Everyone taking part in the research will receive a summary of the results. The results will also be published in professional journals and presented at professional conferences.

**Who is organising the research?**

The research is being conducted as the basis of a PhD thesis, overseen by the University of the West of England, Bristol.

**Who has reviewed the study?**

This study has been approved by the *Name* Local Research Ethics Committee, *Name* NHS Primary Care Trust, and the Ethics Committee of the University of the West of England, Bristol.

**Researcher contact details**

Katherine Pollard      Faculty of Health and Social Care, University of the West of England, Health Training and Research Centre, Building 650, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY

Tel: 0117 328 1125

e-mail: Katherine.Pollard@uwe.ac.uk

## **Research Project to Explore Interprofessional Working in Midwifery**

### **Centre for Research in Applied Social Care and Health**

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Building 650, Frenchay Campus  
Coldharbour Lane, Bristol BS16 1QY

### **Information sheet**

You are being invited to take part in a research project. Here is some information to help you decide whether or not to do so. Please read the following information carefully, and take time to decide whether or not you wish to take part. Thank you for reading this.

1. This study is about the way health and social care professionals in the maternity services work together, so you will not receive any direct benefit from taking part. However, information obtained during the course of the study may help us to improve service delivery in the future.
2. It is up to you to decide whether to take part or not. If you do decide to take part you will be asked to sign a consent form. You will be free to withdraw from the study at any time and without giving a reason.
3. Any information collected about you during the course of the research will be kept strictly confidential. Any published report of the research will not identify you.

### **What is the purpose of this study?**

This study will look at the way that midwives and other health and social care professionals work together in the maternity services.

### **Who is the researcher?**

The researcher is a PhD student at the University of the West of England, Bristol. She is also a registered midwife.

### **What will taking part mean?**

The researcher will want to interview you. You can choose to be interviewed where the researcher works, or in your own home, or in another place of your choosing. The researcher will ask you questions about what you think about the way that different health and social care professionals communicated with you and one another during and after your pregnancy. The interview will take about half an hour and, with your permission, it will be audio taped.

### **Will my taking part in the study be kept confidential?**

All the information collected about you during the interview will be kept strictly confidential. It will not be possible to relate this information to you.

### **What will happen to the results of the research study?**

Everyone taking part in the research will receive a summary of the results. The results will also be published in professional journals and presented at professional conferences.

### **Who is organising the research?**

The research is being conducted as the basis of a PhD thesis, overseen by the University of the West of England, Bristol.

**Who has reviewed the study?**

This study has been approved by the *Name* Local Research Ethics Committee, *Name* NHS Primary Care Trust, and the Ethics Committee of the University of the West of England, Bristol.

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**Research Project to Explore  
Interprofessional Working in Midwifery**



**Centre for Research in Applied  
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Health Training and Research Centre  
Building 650, Frenchay Campus  
Coldharbour Lane, Bristol BS16 1QY

**Consent form for staff**

I have received written information concerning the above study, which aims to explore interprofessional working between midwives and other staff.

I understand that this study aims to gather information regarding the nature of interprofessional working within the maternity unit. Should I agree to participate in the study, I understand that my identity will be protected at all times and that all information provided will be confidential and will be destroyed at the end of the study.

I further understand that participation in this study is purely voluntary, and that my decision concerning participation will not affect my current or future employment prospects. Should I decide to participate, I understand that I may choose to withdraw at any time.

-----

Please indicate whether you agree or not to participate in the observational stage of this study.

**I agree to participate in the observational stage of this study** **YES/NO**  
**(please circle)**

Please indicate whether you agree or not to being interviewed for the study:

**I agree to be interviewed for the study** **YES/NO**  
**(please circle)**

**I agree to the use of audio taping during the interview** **YES/NO**  
**(please circle)**

Signature .....

Please Print Name .....

Post held .....

Name of Practice Area .....

Date .....

## Research Project to Explore Interprofessional Working in Midwifery

### Centre for Research in Applied Social Care and Health

Health Training and Research Centre  
Building 650, Frenchay Campus  
Coldharbour Lane, Bristol BS16 1QY  
Telephone 0117 344 8861  
Facsimile 0117 344 8848

## Consent Form for Service Users

Name of Researcher: Katherine Pollard

### Please initial box

1. I confirm that I have read and understand the information sheet dated ..... (version ..... ) and have had the opportunity to ask questions about the research. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that this research does not affect any aspect of my medical care, and that researchers will have no access to my medical records. ☐
4. I agree to take part in the above study ☐

.....

Name of Service User	Date	Signature
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Katherine Pollard

Researcher	Date	Signature
------------	------	-----------

## Research Project to Explore Interprofessional Working in Midwifery

**Centre for Research in Applied  
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Coldharbour Lane, Bristol BS16 1QY  
Telephone 0117 344 8861  
Facsimile 0117 344 8848

### Service Users – Consent Form for Interview

Name of Researcher: Katherine Pollard **Please initial box**

1. I confirm that I have read and understand the information sheet dated ..... (version ..... ) and have had the opportunity to ask questions about the research. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that this research does not affect any aspect of my medical care, and that researchers will have no access to my medical records. ☐
4. I agree to be interviewed for the study. ☐
5. I agree/do not agree to the use of audio tape.  
(Please delete as applicable) ☐

.....	.....	.....
Name of Service User	Date	Signature

Katherine Pollard	.....	.....
Researcher	Date	Signature

**Research Project to Explore  
Interprofessional Working  
in Midwifery**

**Centre for Research in Applied  
Social Care and Health**  
Health Training and Research Centre  
Building 650, Frenchay Campus  
Coldharbour Lane, Bristol BS16 1QY

**Consent sheet**

I confirm that I have read and understood the information sheet about the above study, which aims to explore interprofessional working between midwives and other health and social care professionals.

Should I agree to participate in the study, I understand that my identity will be protected at all times and that all information provided will be confidential and will be destroyed at the end of the study.

I further understand that my participation in this study is purely voluntary. Should I decide to participate, I understand that I may choose to withdraw at any time.

-----

Please indicate whether you agree or not to being interviewed for the study:

**I agree to be interviewed for the study** **YES/NO**  
(please circle)

**I agree to the use of audio taping during the interview** **YES/NO**  
(please circle)

Signature ..... Please Print Name .....

Address

.....

.....

Date .....

**Appendix 3. Midwife authors of peer-reviewed research papers concerning interprofessional working in midwifery: their orientation to childbirth; and their presentation of midwives' position in relation to the medicalised hierarchy, professionalisation of midwifery, their relationships with childbearing women, and their interprofessional relationships in large institutions.**

<b>Author(s)</b>	<b>Orientation to childbirth</b>	<b>Medicalised hierarchy</b>	<b>Professionalisation of midwifery</b>	<b>Relationships with childbearing women</b>	<b>Inter-professional relationships</b>
Cheyne et al 1995 (UK)	Not identified.	Midwives inferior to doctors.	No mention.	No mention.	Accept current position in the hierarchy.
Hundley et al 1995 (UK)	Accept medical definitions of normality.	Midwives inferior to doctors.	More control for midwives desirable.	Midwives and women equal.	Professionals striving for recognition.
Brownlee et al 1996 (UK)	Accept medical definitions of normality.	Midwives generally inferior to doctors; occasionally on an equal basis.	More control for midwives desirable.	Midwives and women equal.	Professionals on equal basis. Accept current position in the hierarchy.
Meah et al 1996 (UK)	Not identified.	Midwives oppressed/ restricted by system.	More control and improved education for midwives desirable.	No mention.	Professionals striving for recognition.
Davies 1997 (UK)	Supports holistic midwifery ethos.	Midwives oppressed/ restricted by system.	More control for midwives desirable.	Midwives control women (implicit).	Professionals striving for recognition.
Miller 1997 (USA)	Not identified.	Midwives and doctors equal.	Better collaboration with doctors required.	No mention.	Small group practice – no position identified.
Haertsch et al 1998 (Australia)	Accept medical definitions of normality.	Midwives oppressed/ restricted by system.	More control and improved education for midwives desirable.	No mention.	Professionals striving for recognition.
Harman et al 1998 (USA)	Supports holistic midwifery ethos.	Midwives and doctors equal.	Better collaboration with doctors required.	Midwives and women equal.	Professionals on equal basis. Professionals striving for recognition.
Hosein 1998 (UK)	Supports holistic midwifery ethos.	Midwives oppressed/ restricted by system.	More control for midwives desirable.	Midwives control women.	Defenders of the midwifery ethos. Accept current position in the hierarchy.
Fraser 1999 (UK)	Not identified.	Midwives inferior to doctors.	Improved education for midwives desirable.	Midwives and women equal.	Professionals striving for recognition.
Levy 1999 (UK)	Not identified.	Midwives oppressed/ restricted by system.	No mention.	Midwives control women.	Accept current position in the hierarchy.



<b>Author(s)</b>	<b>Orientation to childbirth</b>	<b>Medicalised hierarchy</b>	<b>Professionalisation of midwifery</b>	<b>Relationships with childbearing women</b>	<b>Inter-professional relationships</b>
Symon 1999 (UK)	Not identified.	Midwives inferior to doctors.	No mention	No mention.	Professionals striving for recognition. Prefer current position in the hierarchy.
Bailes & Jackson 2000 (USA)	Accept medical definitions of normality.	Midwives and doctors equal.	Better collaboration with doctors required.	Midwives control women (implicit).	Independent midwives – no position identified.
Brodie 2002 (Australia)	Supports holistic midwifery ethos.	Midwives oppressed/ restricted by system.	More control and improved education for midwives desirable.	Midwives and women equal.	Professionals striving for recognition. Defenders of the midwifery ethos. Prefer current position in the hierarchy.
Pollard 2003 (UK)	Supports holistic midwifery ethos.	Midwives oppressed/ restricted by system.	More control and improved education for midwives desirable.	No mention.	Professionals on equal basis. Professionals striving for recognition. Defenders of the midwifery ethos. Prefer current position in the hierarchy.
Lane 2005 (Australia)	Supports holistic midwifery ethos.	Midwives inferior to doctors.	Improved education for midwives desirable. Better collaboration with doctors required.	Midwives and women equal.	Professionals striving for recognition. Defenders of the midwifery ethos. Prefer current position in the hierarchy.
Lumsden 2005 (UK)	Accepts medical definitions of normality.	Midwives and doctors equal.	More control for midwives desirable.	Midwives control women.	Professionals on equal basis.

## **Appendix 4 - Definition of a midwife (WHO 1992)**

‘A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and healthcare. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.’

WHO (1992) Definition of a midwife Copenhagen, WHO

## **Appendix 5**

### **Unit policies**

- Augmentation of Labour
- Vitamin K Policy

# **Name Trust**

## **Maternity Services**

### **Augmentation of Labour**

The three main dysfunctional labours are prolonged phase, primary dysfunctional labour and secondary arrest. They frequently coexist. Early recognition of dysfunctional labour helps to plan management logically.

#### **Prolonged Latent Phase**

Define the active phase of labour. A definition of regular painful contractions with cervical dilation of at least 2-3 cm helps to differentiate the latent phase (less than 3 cm) from the active phase and 'prolonged' is more than 6 hours. Reassurance and appropriate analgesia are required.

#### **Primary Dysfunctional Labour**

This may be described as progress of less than 1 cm/hour. The options to consider, with maternal consent are:

- Artificial Rupture of Membranes (ARM)
- If no progress after two hours consider Syntocinon augmentation.

#### **Secondary Arrest**

This is arrest after initially satisfactory progress in active phase, and it is important to recognise this position and act on it, particularly in multiparous women.

Causes include:

- Cephalo-pelvic disproportion (CPD)
- Incoordinate uterine action (uncommon in multiples)

Management in multiparous women should be discussed with registrar on-call.

If 7-10 cm interval longer than three hours and instrumental delivery required, strongly consider trial in theatre.

Secondary arrest in a multiparous woman is an indication for prompt referral to acute unit.

#### **Previous LSCS**

Due to increased risk of scar dehiscence in this group of women augmentation of labour with syntocinon should not be commenced without prior discussion with a consultant obstetrician.

## Administration of syntocinon in the intrapartum period for nulliparous and multiparous women

### Indication

- To facilitate induction of labour following amniotomy or SRM
- To augment labour where slow progress is diagnosed (and membranes are ruptured)

### Aim

To achieve regular effective contractions without hyperstimulation of the uterus. Maximum contraction rate should not exceed 4:10 with a duration of 45-60 seconds.

### Dose

5 IU Syntocinon in 50ml normal saline.

Administered via a syringe pump commencing at:

1.2 ml/hr	=	(2) mu. Units Syntocinon increasing to:
2.4 ml/hr	=	(4) mu. Units Syntocinon
4.8 ml/hr	=	(8) mu. Units Syntocinon
9.6 ml/hr	=	(16) mu. Units Syntocinon
14.4 ml/hr	=	(24) mu. Units Syntocinon
19.2 ml/hr	=	(32) mu. Units Syntocinon

At 15 minute intervals for both nulliparous **AND** multiparous women.

If contractions are still inadequate at this stage the registrar should be contacted before the dose is increased.

The amount of Syntocinon required is titrated against length, strength and frequency of contractions. In the presence of abnormality of the fetal heart rate, call Senior House Office (SHO) and Registrar. The Syntocinon infusion should **NOT** be stopped **EXCEPT** in the presence of prolonged bradycardia.

For **NULLIPAROUS** women Syntocinon for augmentation can be prescribed by a senior midwife in *place*.

For **MULTIPAROUS** women, Syntocinon for augmentation should not be commenced without assessment by the registrar on call to eliminate other causes for slow progress, i.e. malpresentation.

Continuous monitoring is necessary – a good quality external trace is acceptable.

## **Syntocinon in 2<sup>nd</sup> Stage**

### **Nulliparous women**

If, following 30-40 minutes of effective pushing, no progress is made, Syntocinon augmentation should be considered and may be prescribed by a senior midwife before consultation with medical staff. The regimen would be as before but increased at **FIVE MINUTE** intervals in order to achieve efficient contractions.

### **Multiparous women**

Physical examination and assessment by the Registrar is essential before Syntocinon is commenced.

## **Reference**

Gee H (2003) *Poor Progress in Labour* Evidence-Based Obstetrics Ch. **47.5** p354-359

Kean L (2003) *Previous Caesarean Section* Evidence-Based Obstetrics Ch. **47.9** p371-374

*Name Trust*  
**Maternity Services**

## **VITAMIN K POLICY RECOMMENDATIONS**

The paediatricians, midwives, health visitors and public health doctors are responding to the recommendations from the Department of Health<sup>1</sup> that all babies should receive a vitamin K injection on the first day of life.

### **RESEARCH ON VITAMIN K AND BABIES**

In 1992 one study<sup>2</sup> suggested that vitamin K given by injection was associated with a higher risk of childhood cancer than giving vitamin K by mouth. This report caused concern and, for some time, hospitals have given vitamin K by mouth to newborn babies. Since 1992, a number of careful investigations have been carried out in several different countries and none of them has been able to confirm the link between vitamin K injection and cancer. Thus it has been concluded that the results in the 1992 report were due to a chance and no link can be shown between vitamin K and cancer.

### **ORAL VITAMIN K**

There is now an oral form of vitamin K that can be given to babies as a liquid but it is less effective than the single injection and has to be given as three doses over the first 4-6 weeks of life. This is much more complicated to arrange and there is a danger that some babies will miss out on the second or third dose.

#### **POLICY**

##### **Antenatally**

The information leaflet and discussions about vitamin K must take place during the antenatal period and documented in the maternity notes.

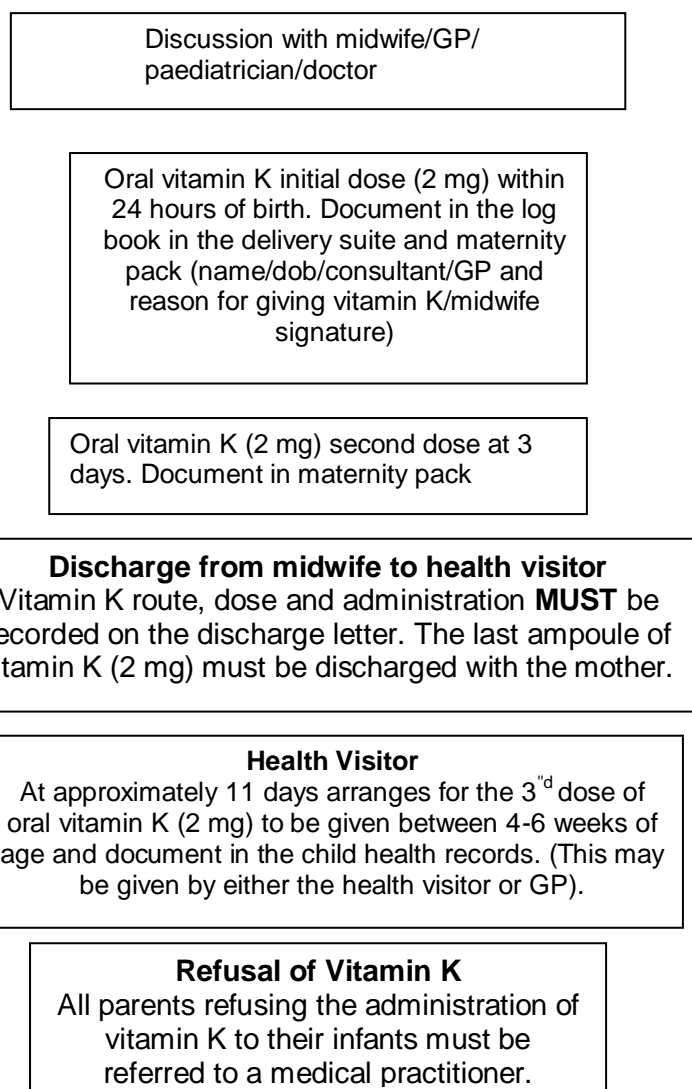
##### **Postnatally**

Vitamin K (1 mg) intramuscularly (IM) should be offered to all newborn infants. Parental consent **must** always be sought. The consent, route of administration, time and date must be recorded in the maternity records and child health records.

##### **Oral vitamin K**

If parents request oral vitamin K, discussion **must** take place about the preferred route of administration. Discussion **must** include the effectiveness of the oral route and the difficulty of administration. This **must** be undertaken by a midwife, general practitioner (GP) or paediatrician.

## FLOW CHART FOR THE ADMINISTRATION OF VITAMIN K BY THE ORAL ROUTE ONLY WHEN THE IM ROUTE HAS BEEN REFUSED



For the purposes of this protocol and in line with the Patient Group Direction agreement Konakion MM Paediatric will be referred to as oral vitamin K or phytomenadione.

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1 PUCMO/98/3 PUCNO/98/4. *Vitamin K for newborn babies*. London: Department of Health, 1998

2 Golding J, et al. Childhood cancer, intramuscular vitamin K and pethidine given during labour. *BMJ* 1992; 305 341-346.



## **Appendix 6 – Advertisement to recruit women to the study**

Did you have a baby in *city* during 2004?

I am a researcher from the University of the West of England, Bristol, who wants to talk to a few women about the different health professionals they saw during and after their pregnancy. I want to discover what women think about how all these professionals work together, and whether it affects the care that women get.

If you think you might be interested in talking about this, please contact me on 0117 328 1125, or e-mail me at Katherine.Pollard@uwe.ac.uk. I will then send you more details about my research, so that you can decide whether you want to be involved or not.

## **Appendix 7 - CDA of selected documents**

### **Example of interactional analysis – research paper**

Davies J (1997) The midwife in the Northern region's 1993 homebirth study *British Journal of Midwifery* 5(4): 219-224

#### **1) Identification of genre**

This study belongs to the genre 'peer-reviewed professional journal paper'. The author has adhered to the conventions ruling this genre:

writes in the third person;

develops an authoritative voice through declarative sentences, stating a position on a subject for which evidence is cited;

on the basis of these position statements, an argument is developed in a reasoned manner about the topic under discussion;

writing is generally cogent;

statements and arguments linked by words such as 'however' and 'therefore', which gives an impression of a logical sequence.

#### **2) Textual analysis**

The following extract demonstrates the representation of social practices, the construction of social relations and identities, and the expression of social values:

'Lack of consultation was mentioned by several midwives who felt undermined when, having given care during the pregnancy, they were not consulted when the booking was changed to hospital. When a woman's booking was changed, the midwives were not always consulted, and six midwives wrote of their disappointment with the changed booking, and how they felt that it was not always in the woman's best interest. The decision to change bookings was made by the obstetricians and GPs and the midwives believed them to have been unnecessary in a number of cases. One woman changed to a hospital booking because she felt that all the community care was unsupportive, from both the midwives and the GP; they in turn felt that they had been manipulated.'

(p.222)

*Social practices:*

communication practices (lack of consultation);

conflict between different approaches to birth (medically-defined risk / midwifery ethos);

emotional reactions ('undermined', 'disappointed', 'manipulated');

members of the public deferring to medical/health professionals (bookings changed, women acquiescent);

hierarchical structures (medical practitioners more powerful than midwives);  
restriction of midwives' practice (practice curtailed by doctors' decisions);  
professional control (control over birth exercised by health professionals);  
professional sphere/scope (extent of health professionals' sphere/scope of practice);  
sharing of information (way in which information is shared between midwives and doctors).

*Social relations:*

midwives – more knowledgeable than either the medical practitioners or the women using the service ('unnecessary', 'not in the woman's best interest');  
not in control in relation either to the medical practitioners or to women using the service;  
subservient to the medical practitioners ('were not consulted' – use of passive tense).

women – adversarial (the woman changing her own booking seen as 'manipulative');  
subservient to the system ('when a woman's booking was changed' – use of passive tense, no indication of the woman exercising any choice).

*Social identities:*

midwives – inferior status, not autonomous, thwarted champions of women.

doctors – autonomous, oppressors of midwives and of women, superior status.

women – hostile entity with insufficient cause for actions and a hidden agenda (viewed as 'manipulative', interesting given the agency conferred on this individual – use of active tense);  
objects within the system ('the booking was changed', rather than phrasing which referred to women as people or individuals).

*Social values*

emotional and professional adherence to midwifery ethos ('disappointed' and 'not in the woman's best interest');  
lack of midwifery control deplored (lack of consultation caused the midwives to feel 'undermined');  
non-compliance with medical recommendations acceptable;  
non-compliance with midwifery recommendations not acceptable;  
women's criticism of health professionals undesirable.

### 3)Interdiscursivity

This extract is taken from a report of findings, so it is not clear to what extent it reflects social constructions produced jointly by the author and the participants. However, it certainly reflects constructions produced by midwives. In the extract, discourses concerning midwives' position in the NHS hierarchy, medical control of birth, and the position of women giving birth in our society are combined. The use of the phrase 'lack of consultation' suggests an active omission within the system. The fact that the midwives were reported to be 'disappointed' when the women decided to go into hospital, and that they deemed some of the changes in booking to be 'unnecessary', and not 'in the woman's best interest' indicates a belief that the midwifery perspective on birth is superior to the medical one. At the same time, women using the service are portrayed as being subject either to the doctors' or the midwives' control – the one individual mentioned who opts to take control herself is portrayed as 'manipulative'. So the text suggests that the 'correct' stance to adopt is one in which midwives are viewed as and operate as equals with the medical profession, while at the same time the midwifery perspective on birth is privileged, and women comply with midwifery recommendations.

## **Appendix 8 - Thematic analysis.**

### **List of themes and associated categories.**

#### **1. Physical dimension**

beverage	making or drinking a beverage
clinequip	clinical equipment
diffdom	different groups using different physical spaces
distinct dress	distinctive feature of dress/appearance
envenhance	physical feature that adds to comfort
info	information posters/leaflets
mufti	wearing street clothes
music	music playing
othplace	distinction made between different areas
physcomf	activity adding to physical comfort
scrubs	wearing theatre gear
smart	smartly dressed
socint	items relating to staff members' social life
tidy	tidy appearance

#### **2. Activities / non-verbal behaviour**

admintask	performing an administrative task
clintask	performing a clinical task
domestic task	performing a domestic task
general	general activity
groupmerge	separate groups merge
help	help one another
ignored	individual ignored or not acknowledged
infbodlang	informal body language
own task	individual concentrating on his/her own task
sepgroup	separate groups
traffic	a lot of people coming and going
wander	individual moving around with no obvious purpose
workalone	individual working alone

#### **3. Communication**

agree	agrees with someone else
chat	talk about general issues
clinchat	have a clinical discussion
communication	regarding issues of communication
egal	exchange conducted in an egalitarian manner
getinfo	asks for information
givinfo	supplies information
greet	greet someone
infexp	uses informal expression
instruct	tells someone what to do
joke	makes a joke
laugh	laughter
negot	negotiate a course of action
nocomm	no communication
noresp	no response
repeat	repeats what's been said
request	makes a request
smile	smiles
share	shares information
socchat	have a chat about social life
sorry	apologises
symmetry	symmetry of communication noted
teach	teaches or explains
thanks	thanks someone
workchat	discuss non-clinical work issues

#### **4. People present**

person	specifies individual in terms of profession, rank and gender
service user	woman using the service, or those visiting/accompanying her

#### **5. Gender**

femenv	typically 'feminine' conversation, expression or appearance
mascenv	typically 'masculine' conversation, expression or appearance

#### **6. Professionalism**

agendaprof	concerning profession's issues/agenda
autonomy	concerning professional autonomy
boundary	concerning professional boundaries
care	concerning provision of basic care
clincontrol	demonstrates control of clinical decision-making
competence	concerning issues of clinical/task competence
confid	concerning issues of confidentiality
confident	concerning issues of confidence
decide	makes a decision/concerning issues of decision-making
diffprac	different approaches to practice
evbase	concerning evidence base for practice
fullinv	fully engaged in process
identity	concerning issues of professional identity
medprior	prioritises the medical perspective
physcontrol	demonstrates control of the physical environment
practice	concerning issues of professional practice
respect	demonstrates/concerning respect for self/other professional
role	concerning professional role

#### **7. Organisational culture**

comparison	compares current situation with previous experience
culture	concerning culture within the unit
downplay	minimises concerns/disadvantages already mentioned
govtpolicy	refers to effect of government policies on unit/practice
junior	concerning individuals with junior status in the unit
othauth	refers to other/wider authority
ownership	demonstrates sense of belonging to unit
senior	concerning individuals with senior status in the unit
support	demonstrates/concerning issues of support
sysprior	prioritises the needs of the organisation

#### **8. Other staff/professions**

active	is proactive or plays an equal part
familiarity	degree to which individuals are known to one another
goodip	reports/demonstrates good interprofessional working
ipoutside	concerning interprofessional issues with other agencies
proximity	degree of physical closeness, either socially or when working
relip	concerning interprofessional relationships

#### **9. Women using the service**

active	is proactive or plays an equal part
agendasu	concerning woman's preferences/agenda
consistinfo	concerning consistency of advice/information received
object	treated/referred to as object within the system
relclient	concerning relationships with women using the service
symptom	referred to in terms of symptoms/condition

**10. Midwifery practice**

care	concerning provision of basic care
diffprac	different approaches to practice
evbase	concerning evidence base for practice
identity	concerning issues of professional identity
mwethos	demonstrates/concerning traditional midwifery ethos
normal	concerning 'normality' of pregnancy and birth
practice	concerning issues of midwifery practice
role	concerning the midwife's role

**11. Area of practice/observation**

cds	delivery suite
coffroom	delivery suite coffee room
commoffice	community midwives' office
community	community
ward	ward

**12. Codes for CDA**

address	manner in which individual addresses someone else
downplay	minimises concerns/disadvantages already mentioned
infbodlang	informal body language
infexp	uses informal expression
laugh	laughter
metaphor	uses a metaphor to describe someone/situation/practice
passive	uses passive tense when talking about someone
relclient	how woman using the service is mentioned
relip	how member of another occupational group is mentioned
smile	smiles
symmetry	symmetry of communication
vocab	particular vocabulary noted

**13. Researcher reflexivity**

me	researcher involvement in conversation/process
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## Example of fieldnotes coded for thematic analysis

### Excerpt from fieldnotes made on delivery suite

### Codes

<p>08.35 Arrived on cds, made myself coffee, now at station. Feels busy. Lots of bustling around. Chat with a couple of mw's about the research, and about my history as a midwife. MM1 walking backwards and forwards between her office and the station. RG6 moving briskly between docs' board and station. Stops at board, speaks to SM5, who tells her there's nothing that needs her immediate attention. RG6: 'That's lovely, I'll go and have some more toast.' Goes to the coffee room.</p>	<p><b>cds</b> <b>traffic</b> <b>me</b></p> <p><b>person (female, mixed professions)</b> <b>givinfo</b> <b>workchat</b> <b>physcomf infexp</b> <b>coffroom</b></p>
<p>SHO has come to the station, in mufti, greets me: 'Morning'. I ask her how she slept, she was very tired yesterday after having worked overnight. We exchange a few pleasantries, she sits to read notes at the rt.hand division.</p>	<p><b>cds</b> <b>mufti</b> <b>me</b></p>
<p>RCP at desk, busy arranging, things, SM5 comes through pushing a monitor. She and RCP have a discussion about some equipment. SM5: 'I thought you said we could keep one.' They discuss requirements. SM5 has been bringing monitors through for a few minutes, there are now 5 of them in the station. SM5: 'Are you our doctor today?' to young woman AN in scrubs. They have an amicable discussion about a service user from a few days before, who needed a dural tap after an epidural (see notes from 30.6.04).</p>	<p><b>cds</b> <b>domestic task</b> <b>workchat</b> <b>workalone</b> <b>person (female, mixed professions)</b> <b>scrubs</b> <b>getinfo</b> <b>clinchat</b></p>
<p>08.55 3 M's by monitors, SM5 cleaning a lead which was left blood-stained. Discussion between M's and AN about levels of cleanliness in different parts of the hospital. I give her an info sheet and consent form. We talk about the research. AN: 'We don't have interprofessional relationships, we just stand around and gossip. This lot just tell me what to do and I do it.'</p>	<p><b>cds</b> <b>domestic task</b> <b>workchat</b> <b>me</b> <b>person (female, mixed professions)</b> <b>relip</b></p>
<p>She moves away, then comes back with MM1, they go to the back counter, looking at the anaesth. rota. 2 M's sitting at back counter, M and HCA at lt.hand division, SHO sitting at rt.hand division writing notes. 2 M's (CM and SM5) checking synto at rt.hand desk, RCP moving around station.</p>	<p><b>cds</b> <b>workchat</b> <b>person (female, mixed professions)</b> <b>diffdom</b> <b>clintask</b> <b>general</b></p>



## Example of interview coded for thematic analysis

### Excerpt from interview with SM1 (senior midwife)

### Codes

<p>R:.. Could you tell me what you think about the interprofessional working in the unit?</p> <p>SM1: <i>I think it's pretty good, to be honest. I think, um, I think we've got excellent relationships as midwives with the obstetric staff, really excellent. I think, um, I think we've got, in, in all honesty I think the interprofessional working is pretty good with everybody.</i></p>	<p><b>cds</b> <b>person (obstetricians)</b> <b>goodip</b> <b>relip</b></p>
<p>We've got a good relationship with the obstetric physios, we've got a good relationship with the obstetric staff, theatre, pretty good, I think we have our niggles, just like anybody else, you know, any other sort of groups of different professionals would have.</p>	<p><b>cds</b> <b>person (physios)</b> <b>relip</b> <b>goodip</b> <b>downplay</b></p>
<p>I would generally, generally say that we've got pretty good relationships, and with nicu as well. I think, you know, everybody has their differences of opinions, and certainly you'll meet personalities that don't like personalities, but as groups of professionals, I think it's probably about as good as it's been anywhere I've ever worked.</p>	<p><b>cds</b> <b>othplace</b> <b>goodip</b> <b>relip</b> <b>downplay</b></p>
<p>R: Mmm,what, what is it that makes it good?</p> <p>SM1: I think – god, that's a good question – I think it's good because there's good communication between everybody. I think that the obstetric staff have a certain amount of respect for the midwives and vice versa; I think, um, I enjoy, I think that most midwives enjoy working as midwives here because it's a pretty laid-back set-up, and midwives certainly are given their full autonomy, I believe; um, it's not got a hugely medical model, especially on the labour ward, so we don't have a situation which other units have, where the registrars try to do ward rounds three times a day, and were actually going into labour rooms. It tends to be a case of the, the senior midwife will co-ordinate with the reg and they'll go into rooms if they're invited. So they know what's happening, and they'll go in when invited. I think that engenders a lot of, engenders a lot of respect by the midwives, because they don't feel that someone's coming in and chasing them; but they also know because no-one's coming in, they have to think for themselves.</p>	<p><b>cds</b> <b>goodip</b> <b>communication</b> <b>respect</b> <b>symmetry</b> <b>culture</b> <b>autonomy</b> <b>passive</b> <b>clincontrol</b> <b>person (midwives, obstetricians)</b> <b>senior</b> <b>boundary</b> <b>goodip</b> <b>relip</b> <b>role</b></p>
<p>I think the midwives work well together, and there's good liaison between senior midwives and the registrars, and so I think, because people are allowed to work within their full scope it makes them happier in, in what they're doing professionally, and I think that helps. I think, I don't - it just seems to be very friendly, and I think we're very lucky like that.</p>	<p><b>cds</b> <b>goodip</b> <b>relip</b> <b>person (midwives, obstetricians)</b> <b>senior</b> <b>passive</b> <b>agendaprof</b> <b>communication</b> <b>culture</b> <b>ownership</b></p>

## **Appendix 9 – Textual analysis**

**List of themes and codes concerning associated representation of social practices, construction of social relations and social identities, and expression of social values.**

‘Self’ = speaker/interviewee;

‘Others’ = other staff members/ occupational groupings mentioned by speaker/interviewee

### **1. System/organisational operation**

#### *Social practices represented within the data*

Hierarchical structures  
Individuals trained to fit the system  
System inconsistency/quirks  
System maintenance/clinical routine  
System not rigid  
Wider health care agenda  
Wider social agenda driven by government policy

#### *Social relations constructed within the data*

Hierarchical differences between self and others  
Others responsible for care delivery/outcomes  
Self and others either in or out of the set of trained individuals within the system  
Self and others operate within boundaries  
Self and others positioned within system  
Self and others share tasks/commitment/understanding  
Women (not) subservient to the system

#### *Social identities constructed within the data*

Indeterminate external authority  
Others – defined by task  
Others – groomed to fit the system  
Self and others – adherents of the system  
Self and others – ownership/belong in system  
Women – objects in the system/defined by symptoms/patients  
Women – people, individuals  
Women – their choice paramount  
Women – their opinion of no account/of differing competence

#### *Social values expressed in the data*

Others having time/being available valued  
Security/support from the system valued  
System inconsistencies/quirks problematic  
Task performance valued

## **2. Standing/status within the organisation**

### *Social practices represented within the data*

Hierarchical structures  
Individuals needing to prove themselves  
Individuals trained to fit the system  
Misperceptions concerning status and standing  
Practice restricted by system organisation  
Separation between qualified and non-qualified staff  
Provision of basic care  
Working as employees

### *Social relations constructed within the data*

Hierarchical differences between self and others  
Others responsible for care delivery/outcomes  
Self controls/has no control over others  
Self and others either in or out of the set of trained individuals within the system  
Self and others operate within boundaries  
Self and others positioned within system  
Self subservient to external authority  
Women (not) subservient to the system

### *Social identities constructed within the data*

Others – defined by task  
Others – groomed to fit the system  
Others – non-qualified staff  
Self and others – adherent of the system  
Self and others – at mercy of women using the service  
Self and others – employees bound by the system/workers  
Self and others – feisty, in control, know what's what  
Self and others – neophyte  
Self and others – (not) autonomous  
Self and others – superior/inferior status  
Self and others – team members/not in team  
Women – objects in the system/defined by symptoms/patients  
Women – their actions affect staff  
Women – their choice paramount  
Women – their opinion of no account/of differing competence

### *Social values expressed in the data*

Autonomy valued  
Medical knowledge superior  
Professional competence valued  
Professional knowledge valued  
Qualifications/training valued  
Restriction based on other profession's estimation of risks problematic

### **3. Professional issues**

#### *Social practices represented within the data*

Advocacy/supporting women's choices  
Clinical practice/role  
Professional agenda/control and information  
Professional socialisation  
Professional sphere/scope of practice  
Professionalisation through qualifications/acquisition of knowledge  
Provision of basic care

#### *Social relations constructed within the data*

Health professionals inside the system  
Hierarchical differences between self and others  
Self and others share tasks/commitment/understanding  
Self has obligation to women using the service  
Self reassures/supports women using the service  
Women dependent on health professionals  
Women (not) subservient to the system  
Women outside the system  
Women separate from health professionals

#### *Social identities constructed within the data*

Basic care is a non-professional task  
Clinical/professional competence equals task performance  
Competence equals knowledge  
Others – defined by task  
Others – non-qualified staff  
Scientific knowledge is unbiased/neutral  
Self – adherent of professionalisation agenda  
Self – advocate for women using the service  
Self and others – follow professional agendas  
Self and others - intuitive  
Self and others – professional/highly skilled  
Self and others – (not) autonomous  
Self and others – superior/inferior status  
Women – (not) partners in care planning/delivery  
Women – objects in system/defined by symptoms/patients  
Women – people, individuals  
Women – their actions affect staff  
Women – their choice paramount  
Women – their opinion of no account/of differing competence

#### *Social values expressed in the data*

Autonomy valued  
Competence equated with task appropriate  
Non-qualified encroachment on professional role not appropriate  
Professional competence valued  
Professional knowledge valued  
Professionalisation valued  
Provision of basic care not valuable  
Qualifications/training valued  
Restriction based on other profession's estimation of risks problematic  
Women's choice valued  
Women (not) valued as partners in care planning/delivery

#### **4. Orientation to midwifery**

##### *Social practices represented within the data*

Advocacy/supporting women's choices  
Clinical practice/role  
Different types/areas of midwifery  
Medically-defined risk  
Midwives prioritise wellbeing of medical staff  
Normal midwifery  
Professional agenda/control and information  
Professional socialisation  
Professional sphere/scope of practice  
Professionalisation through qualifications/acquisition of knowledge  
Provision of basic care  
Surveillance

##### *Social relations constructed within the data*

Hierarchical differences between self and others  
Midwives inside the system  
Self has obligation to women using the service  
Self – progressive practitioner in comparison to others  
Self reassures/supports women using the service  
Women dependent on midwives  
Women (not) subservient to the system  
Women outside the system  
Women separate from midwives

##### *Social identities constructed within the data*

Basic care is a non-professional task  
Clinical/professional competence equals task performance  
Competence equals knowledge  
Medical knowledge is unbiased/neutral  
Others – non-progressive practitioners  
Self – adherent of professionalisation agenda  
Self – advocate for women using the service  
Self and others – at mercy of women using the service  
Self and others – follow professional agendas  
Self and others – intuitive  
Self and others – (not) autonomous  
Self and others – professional/highly skilled  
Self and others – superior/inferior status  
Self – progressive practitioner  
Self – reluctant supporter of women's choice  
Women – (not) partners in care planning/delivery  
Women – objects in system/defined by symptoms/patients  
Women – people, individuals  
Women – situation defined by physiology  
Women – their actions affect staff  
Women – their choice paramount  
Women – their opinion of no account/of differing competence

*Social values expressed in the data*

Autonomy valued

Competence equated with task appropriate

Interventionist care problematic

Medical agenda/intervention valued

Medical knowledge superior to midwifery knowledge

Midwife-led care/normality valued

Non-interventionist care valued

Non-qualified encroachment on midwifery role not appropriate

Normal midwifery not interesting

Professional competence valued

Professional knowledge valued

Professionalisation valued

Provision of basic care not valuable

Public's estimation of medical knowledge being superior to midwifery knowledge  
– problematic

Qualifications/training valued

Restriction based on medical estimation of risks problematic

Unlimited choice for women problematic

Women (not) valued as partners in care planning/delivery

Women's choice valued

## **5. Interprofessional issues**

### *Social practices represented within the data*

Communication practices (symmetrical/asymmetrical, formal/informal, functional)  
Crossing professional/occupational boundaries  
Midwives prioritise wellbeing of medical staff  
Normal human behaviour  
Occupation of/invitation to separate territories

### *Social relations constructed within the data*

Collegial atmosphere between self and others  
Others familiar/become known to self  
Others not a threat to self  
Others socially distant from self  
Others strange/unknown to self  
Respect between self and others  
Self and others constitute co-workers crossing boundaries  
Self and others operate within boundaries  
Self and others share tasks/commitment/understanding  
Self gives/gains support to/from others

### *Social identities constructed within the data*

Medical/scientific knowledge is unbiased/neutral  
Self and others belong to different/separate occupational groups  
Self and others – superior/inferior status  
Women – (not) partners in care planning/delivery

### *Social values expressed in the data*

Cross-boundary competence valued  
Egalitarian ethos supported  
Face to face communication valued  
Functional interpersonal space valued  
Medical agenda/intervention valued  
Medical knowledge superior to midwifery knowledge  
Non-qualified encroachment on professional role not appropriate  
Openness in communication valued  
Others being approachable/informal valued  
Others having time/being available valued  
Public's estimation of medical knowledge being superior to midwifery knowledge  
– problematic  
Reliance on electronic forms of communication problematic  
Restriction based on medical estimation of risks problematic  
Women (not) valued as partners in care planning/delivery

## **6. Social/personal issues**

### *Social practices represented within the data*

Communication practices (symmetrical/asymmetrical, formal/informal, functional)  
Emotional reactions  
Financial incentives  
Normal human behaviour  
Social situation

### *Social relations constructed within the data*

Collegial atmosphere between self and others  
Others familiar/become known to self  
Others not a threat to self  
Others socially distant from self  
Others strange/unknown to self  
Respect between self and others  
Self gives/gains support to/from others

### *Social identities constructed within the data*

Self and others – feisty, in control, know what's what  
Self – has a personal life  
Self – has career aspirations

### *Social values expressed in the data*

Egalitarian ethos supported  
Face to face communication valued  
Functional interpersonal space valued  
Openness in communication valued  
Others being approachable/informal valued  
Others having time/being available valued  
Personal life important  
Reliance on electronic forms of communication problematic



## Example of fieldnotes coded for textual analysis

### Excerpt from fieldnotes made on ward

### Code

<p>9.40 M5 (<i>midwife</i>) walks past the desk. M5: 'Is it me, or is it really cold today?' Receptionist: 'It's nippy.' Receptionist: 'M5, MM2 wants me to order 6 drip stands – is that the one?' (has an open catalogue, shows it to M5). They look at the catalogue together. M5: 'It's like that one . . . so . . .' They can't decide which one they're supposed to order. M5: 'That's got 5, we only need 4. 1, 2, 3, 4, 5, that's got 5 castors. . . . How much are they?'  Notes: M5 makes a social comment to Receptionist as she passes the desk. Receptionist then asks her for help, and engages her in an administrative task which a manager has asked her to perform. They address each other informally and by their first names, and approach the task together. There is clearly an egalitarian ethos operating, where midwives help other members of staff with tasks that do not fall within their remit as professionals.</p>	<p><b><i>Social practices</i></b> crossing occupational boundaries. informal communication. social situation. system maintenance.</p> <p><b><i>Social relations</i></b> co-workers crossing boundaries. hierarchy differences. sharing task. within system.</p> <p><b><i>Social identities</i></b> employees/workers.</p> <p><b><i>Social values</i></b> cross-boundary working valued. egalitarian ethos supported.</p>
<p>A bed comes through the door and stops by the desk, pushed by SM3 (<i>senior midwife</i>) and HCA1 (<i>health care assistant</i>). A woman is sitting up in it. SM3: 'Where's she going?' Receptionist: 'Who's she?' SM3: 'Mrs <i>name</i>.' Receptionist: '<i>room name</i>, bed 4.' They go around the corner with the bed. Receptionist and M5 continue their conversation about ordering the drip stands.  Notes: SM3 and HCA1 are performing a domestic task. There is an even more marked status differential between them than between M5 and Receptionist. There is a functional exchange between SM3 and Receptionist - it lacks the features of normal social interaction - no greetings, preambles, etc., limited to dealing with the task at hand. This appears to be acceptable/normal in this environment. The woman is reduced to the object of a task within the system – nobody addresses her, SM3 initially refers to her as 'she', and Receptionist doesn't ask her what her name is, even though she is sitting up in the bed, so clearly present and conscious.</p>	<p><b><i>Social practices</i></b> crossing occupational boundaries. system maintenance. functional communication.</p> <p><b><i>Social relations</i></b> co-workers crossing boundaries. sharing task. within system.</p> <p><b><i>Social identities</i></b> employees/workers. woman – object in system.</p> <p><b><i>Social values</i></b> task performance valued.</p>

<p>9.55  SM3 and HCA1 push the empty bed back around the corner on their way out of the ward.  SM3: 'She's not a happy bunny.'  HCA1: 'No.'  SM3: 'Neither is her husband.'  HCA1: 'It's because she has to stay in, I expect.'</p> <p>Notes: SM3 uses an informal expression 'not a happy bunny', which illustrates her attitude both to the woman (assigned inferior/reduced status within the system) and to her colleague (an equal in the task/exchange). The exchange is egalitarian and does not reflect the status difference between the pair (senior professional / non-professional). This is further signalled by the conversational symmetry, signifying social equality - HCA1 makes a suggestion about the possible cause for the woman's state.</p>	<p><b><i>Social practices</i></b>  crossing occupational boundaries.  informal communication.  system maintenance.  social situation.</p> <p><b><i>Social relations</i></b>  co-workers crossing boundaries.  sharing task.  woman subservient to the system.</p> <p><b><i>Social identities</i></b>  employees/workers.  woman – object in system.</p> <p><b><i>Social values</i></b>  egalitarian ethos supported.</p>
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## Example of interview coded for textual analysis

### Excerpt from interview with CM1 (community midwife)      Codes

<p>R: Within the unit, what about working in the unit with other professionals?</p> <p>CM1: I find on the whole it's, it's very easy. We, I have to communicate with, obstetricians, paediatricians, other midwives, ward clerks – I'm just trying to think sort of across the board – you know, NICU at times, who I have to communicate with, and amongst my other team members, and on the whole I don't find it difficult. Occasionally you get a - I've had a doctor who's been very busy, and then I didn't really feel she was being quite attentive to what I was saying, but you know, we still managed to get what I wanted, it was about referring a baby into hospital and she was still happy to see the baby, so – I just felt she didn't quite give me the time I needed to explain.</p>	<p><b><i>Social practices</i></b> asymmetrical communication. communication practices. hierarchical structures. occupation of separate territories.</p> <p><b><i>Social relations</i></b> hierarchical differences. others responsible for care delivery. operating within boundaries. no control over others. positioned within system.</p> <p><b><i>Social identities</i></b> belong to separate occupational groups. different status (superior/inferior).</p> <p><b><i>Social values</i></b> cross-boundary working valued. others having time valued. task performance valued.</p>
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<p>R: Right, ok. Can I just ask you very briefly about one of the policies, which is the Vitamin K policy? I mean, I'm assuming as a community midwife you're often the person who is actually giving women information about Vitamin K?</p> <p>CM1: Yeah.</p> <p>R: I notice the very last thing on the Vitamin K policy says that if a woman refuses Vitamin K she should be referred to a paediatrician; and I just wondered what you felt about that?</p> <p>CM1: Yeah I agree with that. We have to try and give information in a very unbiased way, and with as much medical knowledge, I suppose, behind what information we're giving as possible; and, you know, things are moving on all the time in terms of research, and although we try and keep up to date, I do feel sometimes the paediatricians could be more up to date than we are, and, I also know <i>paediatric consultant</i> in particular is very happy to speak to parents if they've decided they don't want to give Vitamin K, for whatever reasons; and I feel the parents don't always have the full information and knowledge at their fingertips to make a decision, and so I do feel somebody even more in the know than me can still give them unbiased information, if you like, so that - to help them make a decision, help them make a choice.</p>	<p><b><i>Social practices</i></b>  clinical practice.  communication practices.  medically-defined risk.  hierarchical structures.  professional control of information.  system/clinical routine.</p> <p><b><i>Social relations</i></b>  collegial relationships.  hierarchical differences.  obligation to women using the service.  operating within boundaries.  positioned within system.</p> <p><b><i>Social identities</i></b>  belongs in system.  belong to different occupational groups.  different status (superior, inferior).  medical knowledge unbiased.  not autonomous.  women – of differing competence.  women – partners in care planning.</p> <p><b><i>Social values</i></b>  medical agenda valued.  medical knowledge superior to midwifery knowledge.  others being approachable valued.  women valued as partners in care planning.</p>
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