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Beyond Qualification: Learning to be Midwives

by

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**A thesis submitted in partial fulfilment of the requirements for the
degree of Doctor of Philosophy in Health and Social Studies**

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Declaration

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

Abstract

“I know that every day I am gaining experience ... learning more” (Int. 6(a))

This thesis examines the social practices and associated learning that shape the meaning of midwifery for new members of the profession. In doing so it explores the extent to which the implications of practice either liberate or circumscribe midwives’ identity formation. The thesis further suggests how this identity formation may impact upon commitment to a long term career in midwifery. The theoretical framework for this thesis acknowledges that continuing professional development and evidence of recognised learning activity is, for all midwives, a professional requirement. However, less attention has historically been paid to the unstructured, unintended and relatively informal learning that occurs within and throughout midwives’ involvement in everyday practice. It is through these forms of learning, and drawing upon data elicited through surveys, interviews and diaries, that this thesis seeks to make a contribution.

Using a social model of learning, particularly through Wenger’s (1998) work on communities of practice, the development of identity is presented as a negotiated process mediated to a greater or lesser degree by workplace relationships. Whilst relationships with pregnant women form an important element of this process, the thesis argues that collegial relationships generally assume greater importance and impact on the development of identity and meaning for newly qualified midwives. By situating the everyday experiences of newly qualified midwives within a broader theoretical debate about social learning, identity and the making of meaning, this thesis suggests that the contemporary ‘doing’ of hospital based midwifery remains within what are fairly narrowly prescribed, contested, yet firm boundaries.

The development, existence and negotiation of these boundaries is central to the space which pregnant women, midwifery and midwives can occupy. These boundaries are simultaneously hierarchical, intra professional and personal. Furthermore, in practice, these boundaries are frequently unclear and rapidly changing. Whilst this contributes to a potentially dynamic opportunity for identity formation, the thesis demonstrates how this also transpires to contribute to an unstable, frustrating and frequently challenging context particularly for newly qualified members of the profession.

Overall, this thesis contributes to an understanding of the development, or lack of development, of midwifery practice at theoretical, conceptual and practical levels. Viewing practice as social learning offers a new perspective on the opportunities and challenges inherent in the current model of care. Simultaneously it suggests a new perspective on the recruitment crisis faced by the profession and accordingly the opportunity for new potential solutions.

Introduction

Introduction

This thesis is concerned with the social dynamics of workplace learning within midwifery and the implications this may have for the current retention crisis. Whilst both issues surrounding childbirth and midwifery have been explored from a number of sociological and educational perspectives (Jordan 1978, Oakley 1980, Katz Rothman 1982, Hunt & Symonds 1995, Murphy-Lawless 1998, Benoit et al 2001) the explicit application of this for workplace learning has received less attention. Furthermore, whilst much attention has been focused on the retention problems within the profession (Stafford 2001, Ball et al 2002, Curtis et al 2006) little of this has made any explicit links to the potential for how and what the practice of midwifery itself teaches participants and what the implications of this, if any, may be. Nevertheless, it is undeniable that the profession is indeed facing a crisis. Despite a sufficient number of qualified midwives residing within the UK, 74.4% of maternity units are experiencing some level of staff shortage (RCM 2005). Furthermore of the 43,064 midwives registered with the Nursing and Midwifery Council almost 25% are currently choosing not to practice (NMC 2005). Based on survey data, interviews and diaries this thesis seeks to offer some insights into the everyday realities of practicing midwifery in the West Midlands and how these experiences may impact on commitment to a long-term career as a midwife.

Rationale

Whilst continuing professional development (CPD) within midwifery has been the focus of much attention and development (NMC 2004) the specific impact of the more informal

notion of workplace learning has received less attention. However, the current context of practice seriously curtails even stipulated CPD requirements.

“Against a backdrop of obligatory cost-cutting, significant recruitment and retention difficulties, and associated challenges with maintaining 24-hour service delivery, many midwives are struggling to meet their continuing professional development [requirements]... Where limited study time is available ... it is often entirely taken up by attendance at in-house mandatory training sessions” (Carne 2006)

In consequence much of the formal learning opportunities available to qualified midwives are becoming increasingly restricted and circumscribed. In distinct contrast, as practising midwives they are daily exposed to the social relations of practice and the “lessons” (Lave and Wenger 1991:15) that this imparts. Furthermore, if we take into account the initial findings of the ongoing LiNEA project (Eraut 2003) - which explores learning during the first three years of Post registration/Postgraduate employment in accountancy, engineering and nursing - which has directly identified workplace social relationships as a significant factor in learning, the significance for midwifery of learning through participation begins to become apparent. This perspective however, is not new.

Begley’s work (1999, 2001, 2002) looks at a population of Irish student midwives and explores a similar notion of informally received wisdom. She refers to the “hidden messages” (1999:267) of practice and examines the context and pressures of work as they reflect on how and what is learnt. However it is Eraut (2003), once again that specifically links this learning to retention suggesting that in nursing specifically the pressure of work

and the resultant experiences affects retention of staff (p10). It is this crucial interconnection, between workplace learning and staff retention, which underpins this thesis.

Retention of qualified members is vital to sustain any profession. However 'retention' has become such a familiar issue, particularly within the healthcare arena, that its definition often remains unspecified. It has custodial overtones (Oxford dictionary 2003) but in its simplest form it is addressing the issue of 'remaining within'. For the professions this one generic term refers to the hugely complex and multifaceted challenge of encouraging qualified and recognized members of a particular community to 'remain within' and continue to practice in that sphere.

By accepting individuals into NHS funded educational places the Government initiates a committal of resources to that individual. One of the most recent reports from the Audit Commission (2002) recognized that recruiting staff 'is, of course, only the first step.' (p19). At a very basic level retention, therefore, is about realizing a return on that investment, once the individual is qualified to practice in their chosen capacity. However, it is also about issues specific to each different profession. One such issue for midwifery, is that consistently over 99% of the workforce is female (NMC 2005). Indeed midwifery remains a 'rare example of a women's career where both practitioners and command hierarchy are overwhelmingly female' (Allison and Pascall 1994:203). This may give rise to specifically different issues within the workforce, and therefore maybe call for specifically different solutions. Nonetheless, the issue of retention has always been a priority for the NHS, maternity services here being no exception.

Retention has been an issue for midwifery since the formal structuring of the profession (Radford and Thompson 1988). Initially the difficulty with retaining midwives was thought to be predominantly that the short supplementary midwifery course offered was simply a tempting and quick route to dual qualification. This qualification, rather than an end in itself, served to enhance an already established nursing career. However, despite the continued existence of the short course, the increasing intake of singly qualified midwives has failed to attenuate the retention issue, which remains of major concern.

At the start of the new millennium with 60,000 midwives out of practice (Macfarlane and Mugford 2000) the situation for midwifery seemed to be ever worsening. The government response was to pledge its commitment to exponential growth in student intake and funding, including support for Higher Education institutions preparing for larger student populations. However, recruitment is only one part of the picture; retention remains equally important. Such thinking was clearly displayed in the Royal College of Midwives collaboration with the Department of Trade and Industry to explore why so many midwives choose to leave practice (Ball et al 2002).

Following that research, Ball et al (op cit) suggested that in order to understand the complexities of retention further there was a particular urgency to explore “the work experiences ... of singly qualified, direct entrant midwives” (Ball et al 2002:101). This was, in part, due to the fact that younger and/or newly and singly qualified participants in this study were statistically more likely to struggle with numerous factors which, compounded, may increase the likelihood for dissatisfaction with midwifery and ultimate departure. However, this still begged the question about just what it was that they are

'learning' about a career as a midwife very early on. The nature of the initial study by Ball et al (op cit) prevented any in-depth exploration of these factors, for which, in any case, there was evidence of some regional variation.

The West Midlands in particular fared poorly in this report. When the authors combined leavers under the age of 50 with those dissatisfied with midwifery the West Midlands was one of the "significantly higher" regions (p40) and it was additionally singled out as a region having "more reports than most" of bullying (p71). This study sets out to address these neglected issues pertaining to the learning experiences of newly qualified direct entry midwives in the West Midlands.

By focusing especially on the newest members to the profession it is hoped firstly to give voice to what Ball et al (op cit) termed the most 'vulnerable' members of the profession. Firstly, by considering their experiences in terms of legitimate peripheral participation, a concept which seeks to theorize the transition from novice to master, I hope to attend to some of the borders of practice. As Merriam et al (2003) suggest;

"attending to the borders thus makes visible not only the learning that takes place, but also some of the ethical-normative issues implicit ... in practice" (p173).

Secondly, I hoped to capture a population just embarking on their chosen profession and one imagines furthest away from thoughts of leaving. In exploring these stories I hoped to uncover not only reasons why midwives may consider leaving but perhaps more importantly reasons why they may choose to stay. I have framed the exploration in terms of, legitimate peripheral participation (LPP), communities of practice (COP) and

transitional workplace learning of newly qualified graduate midwives. Furthermore I locate the work within a feminist postmodern framework recognizing firstly, the inherently feminist nature of midwifery work and secondly, the often complex and contradictory multiplicity of experience. Combining both quantitative and qualitative data, their experiences are theorized within the framework of a social theory of learning. By overlaying components of this theory upon the data generated areas of ‘fit’ and ‘misfit’ become apparent. This thesis thereby helps illuminate how social theories of learning can be usefully applied to consideration of the midwifery profession and, in part, the difficulties of retention. Also other areas, such as workplace cultures and relationships reveal their pertinence. As such, this thesis extends current understandings in this area both theoretically and empirically.

It is hoped that this thesis will ‘speak’ to at least three different audiences: those who will assess its original contribution to an already established body of knowledge; those who are involved or interested in the profession of midwifery and those who either strive daily in the work described or those who simply aspire to do so. For each I hope to offer a critical discussion bounded by history and an academic format, framed within a sociological imagination but ultimately liberated by hope for the future.

The research questions

Whilst the design and process of the research for this project is addressed in detail in chapter three, it addresses three research questions. These are;

1. How does the inter- and intra-professional structure of the workplace affect experiences in the work setting?
2. What is the curriculum of the workplace in terms of organizational and professional mores and expectations and how are these institutionalized as transitional learning for newly qualified midwives?
3. What learning, formal and informal, occurs in the everyday of the workplace and how does this affect commitment to a long-term career as a midwife?

Whilst these questions form the foundation for the exploration and discussion that follows, my hope is that in making more visible the discrete and social nature of learning in professional practice and midwifery in particular, this research may prompt greater recognition of two important issues. Firstly the innocuous and persistent nature of contemporary midwifery practice which many suggest, and this thesis supports, still retains an 'industrial' stance (Kirkham 1999, Eatherton 2002, Walsh 2005). Secondly, it is hoped to illuminate how this circumscribes a self-perpetuating 'learnt' state of affairs. Most importantly it addresses the learning that this imparts to all currently practicing members of the profession and the larger community which we serve. The focus of the study is on the newest members of this community with a research design formulated to

try and 'hear' their perceptions and stories of beginning to live in the world of qualified midwifery. My final aim therefore has been to develop an appreciation of the lived experience of becoming a midwife. Appreciating the complex nature of this task I have tried to weave through how both organizational and personal factors influence this process. Also I explore in depth the numerous boundaries these midwives experience and ultimately how all these factors contribute to the overall curriculum of the workplace.

Synopsis of the thesis

This thesis surveys all the direct entry midwives in the West Midlands qualifying in the summer of 2003 and then follows fifteen of these midwives across their first year of practice. Five of these midwives also kept brief diaries. The survey was then repeated after one full year as a qualified midwife, in the summer of 2004.

This thesis is organized into eight chapters, divided into two parts. Part one, containing the first three chapters comprises the literature reviews and the research methods and methodology. Chapter one reviews the educational literature. It charts the development of a discipline from an area focused on continuing education to the development of a field much more aligned with lifelong learning, embracing the complex and dynamic concepts associated with theories of social learning. Furthermore associated concepts of tacit learning, experiential learning and learning within the professions are considered. This creates the backdrop against which to contextualize the discussion whilst helping to locate the two main concepts upon which the educational analysis rests. The proposed framework for this discussion is outlined, focusing on two main and inter-related

concepts; legitimate peripheral participation (Lave and Wenger 1991) and communities of practice (Wenger 1998) which are key to my analysis.

Chapter two then establishes the landscape of contemporary midwifery through detailing the context within which this research took place. Two main threads within this chapter explore the historic development of the profession of midwifery from firstly a perspective based on the professional and political developments and secondly from an educational perspective to suggest how these equally contribute to the current structure and provision of maternity services. Finally the literature related to retention, specifically retention within midwifery is explored before reviewing how closely associated literature such as literature on emotion work may feed into complex understandings of workplace learning.

Chapter three provides a reflexive account of the research methodology and the methods employed together with a description of the setting. The rationale behind the choice of a multi-method approach utilizing surveys, interviews and diaries is discussed and justified. The negotiation of research access and dealing with six ethics committees is also discussed. I explore the influence of my own personal background on the research and offer a reflexive account. In relation to this the inherently feminist nature of the project is addressed and justified and some germinal thoughts on reciprocity are offered.

The chosen research methods are outlined and detailed consideration is given to the choice of tools for analysis and the attendant advantages and disadvantages of these choices. Given that, in the field of health particularly, qualitative research is often criticized for lacking scientific rigour (Mays and Pope 1995) attention is then given to the 'gold standard' assessment criteria for research and its applicability or otherwise, for this

project. The chapter concludes by presenting some detail about the fifteen newly qualified midwives whose stories form the basis of the main qualitative dimensions of the study.

The second part of the thesis presents the main findings chapters and a conclusion. Four chapters, numbered four to seven present the findings of the study through the combined forms of data which is used both quantitatively and qualitatively to support the main findings.

Chapter four focuses on relational and contextual issues of the workplace. In doing so it explicitly addresses the second research question; what is the curriculum of the workplace in terms of organizational and professional mores and expectations and how are these institutionalized as transitional learning for newly qualified midwives? In order to address the transitional learning aspect, the notion of identity is employed to clarify how the identities these new midwives are able to adopt, whilst in one sense dynamic and ever changing are dependent on the reciprocal effects of workplace context and personal engagement. In order to do this, the framework suggested by Griffiths (2005) is employed and attention is given to the impact particularly of socio-political structures of power and diversity. This chapter extends the concept of community of practice (Wenger 1998) to include the context and impact of socio-political structures of power. Whilst much of the foundation of the theory I offer is supported by copious amounts of midwifery research (Kitzinger 1991, Wagner 1994, Tew 1995, Kirkham 1999, Walsh 2005), an original perspective is offered through the vehicle of communities of practice overlaying what is already known. Hence the original concept of 'midwifery' is theorized and discussed. In

turn, the implications this may have for identity formation are considered. Nevertheless, recognizing the importance of this discussion of workplace context, the chapter develops to combine this with consideration of the opportunities and challenges for personal engagement to some extent defined through diversity. The combination of these then serves as a platform from which to consider the social learning experiences that this may impart. This discussion is then extended in the next chapter addressing the inherently emotional nature of midwifery work.

Chapter five directly addresses the keystone concept of ‘emotion’ which, to some extent, is relevant to all the other findings. It gives consideration to the sources of both emotional reward and emotion work in the lives of these participants. As these experiences predominantly form the ‘meaning’ of midwifery the discussion enlists the dual concepts suggested by Wenger (1998) as essential to formations of meaning; participation and reification. These are then transposed back into the stories from the data to extrapolate the potentialities for learning. Consideration of how management of this emotion work serves to potentially ensure, to some degree, persistent peripherality for these midwives then ensues. Finally the possible consequences of this position are discussed as well as counter strategies of resistance. For the remaining two chapters, I continue to dissect the interplay of inter- and intra- professional relationships in the workplace and how these affect everyday learning.

Chapter six directly addresses the first part of research question one; How does the inter- and intra-professional structure of the workplace affect experiences in the work setting? It explores doctor – midwife hierarchies and leads to a discussion on not only the everyday

workplace relationships of medics and midwives but the more fundamental framing relationship between medicine and midwifery. Building upon the conceptualization of 'medwifery' in chapter four, this leads to a consideration of the concepts of jurisdictional boundaries and occupational demarcation and what these may contribute to understandings about workplace learning when combined with a social learning perspective.

Chapter seven continues the address to research question one by exploring intraprofessional relationships and the effects these have on workplace experiences. It focuses particularly on hierarchical relationships in midwifery and, for reasons which emerge later on, the discussion comes to centre on these relationships in the context of working within a busy central delivery suite. Furthermore in relating the experiences of participants, the frequently implied and sometimes articulated concepts of professional bullying, oppression and horizontal violence are explored as are their implications for workplace learning. Subsequently, the chapter then explores the potential in this work setting for both positive learning encounters and for strategies of resistance to an oppressive culture, such as the strategy of non-participation. These two final chapters combine to suggest a workplace setting and everyday pedagogy which is circumscribed to a great extent by the relations extant within the service and amongst those providing it.

The final chapter, chapter eight, reviews the theoretical and empirical findings of the study particularly in relation to the original research questions and as an original contribution to knowledge. The midwives' experiences are drawn together to inform the

profession, policy makers and the wider health community of the benefits of viewing practice through the lens of social learning in action and recognizing the power and impact of everyday lives as they are experienced and lived in the workplace.

PART ONE

Chapter 1

Communities of Practice: Exploring a Theoretical Framework

Literature Review: Communities of Practice: Exploring a Theoretical Framework

Introduction

This chapter sets out to establish the theoretical framework of learning within which this work is situated. Initially it reviews the historical development of general learning theories and maps the progression from predominantly cognitive theories of learning towards social theories of learning. Then the substantive areas of literature which relate directly to this thesis and the theoretical framework of social learning are reviewed. This leads to expanding upon the literature which connects theories of social learning to issues within health care and the working lives of health care professionals. The ensuing literature review then addresses issues of the power and oppression and their operations in the professional workplace as issues that consistently reappear. Finally, given that the preceding literature has suggested notions of centrality and peripherality these are taken up in the context of practice and considered alongside the accompanying and related notion of boundaries.

In doing this the chapter highlights the fact that many of the approaches adopted within the learning literature remain predominantly cognitive. According to Saunders, this cognitive bias is a major contributory for the underestimation of non-formal learning in the literature on workplace learning (Saunders 2006). This thesis seeks to address this imbalance by contributing an analysis of situated social learning in contemporary midwifery practice focusing specifically on issues of hierarchy and boundary negotiation.

The move from cognitive to social theories of learning

In the last couple of decades the whole area of ‘learning’ theory has developed, and research in adult learning has evolved substantially. A decade ago Jarvis (1996) described some of the complexities of this rapidly developing field and was himself caught in the developments as his text reemerged in 2004 with a suitably adapted title and substantive new content. The title loses ‘Continuing Education’ and instead adopts the concept of ‘Lifelong Learning’ (Jarvis 2004). The reasons for this are explored at length in an interim publication (Jarvis et al 1998). Despite the conceptual change of direction some of the fundamental tenets persist, notably that education, in its many guises, continues long after compulsory schooling and well into peoples working lives and careers. Furthermore, that much of this learning may be unplanned, unintentional and unconscious.

Learning theory, as one would expect, is a contested field in which different approaches vie for supremacy. According to Jarvis et al (1998 op cit.) four main approaches to learning theory can be identified: behaviourist, cognitivist, social and experiential.

Saunders (2006) offers an updated and extended taxonomy recognizing six differing “theory narratives” (p1); functionalist, marxist, liberal, progressive/emancipatory, social practice and boundary crossing. Whilst neither list is by any means exhaustive they provide a framework for considering educational theories and different approaches.

Whilst each approach could no doubt contribute a unique perspective to the subject, it is with the latter categories of each that this thesis is concerned. Whilst we will necessarily consider aspects of social and experiential learning it is with the more recent categories of

social practice and boundary crossing that the thesis really engages. These all fall within the extended notion of social learning.

Social learning is the term for a multifaceted, complex and dynamic range of theories applied to learning in specific contexts. There are numerous ways that the topic may be approached but the idea itself is far from new, as the work of Parsons (1951) testifies.

Social psychologists such as Mead (1863-1931) offered us a vision of learning beyond the individual, building on the work of Vygotski throughout the 1970s, Bandura (1977) is largely credited with developing this work into a solid social learning theory. However as Jarvis et al (1998:43) point out:

“His argument is conducted in a sociological vacuum”

Bandura offered a notion of learning that unfortunately seemed to neglect the structure and culture of the society within which that learning developed. There remained elements of individualism and behaviourism which to some extent limited it as a ‘social’ theory of learning.

Nevertheless, there has continued to be an increasing interest in the ‘social’ aspects of social learning. Eraut (2000) reinforces the fact that;

“Learning is always situated in a particular context which comprises not only a location and a set of activities in which knowledge either contributes or is embedded but also a set of social relations which give rise to those activities. This raises the important question of the extent to which any given piece of knowledge is individually or socially constructed within that context” (p130)

Much of the focus of Eraut's work stems from an interest in tacit knowledge and has been concerned with understanding the creation and application of professional knowledge (1994, 1998, 2000, 2001). Whilst tacit knowledge has historically been recognized as "that which we know but cannot tell" (Polanyi 1967) this definition has subsequently been problematised (Molander 1992, Spender 1996) such that the concept's scope and breadth, its meaning and applicability, have consequently become contested. For Molander (op cit), though, there is no learning without at least some tacit aspect. This continued concern with tacit knowledge, alongside the related concepts of informal learning and situated learning has contributed to the development of a wide literature on various aspects of non-formal learning. This is complemented by considering the experiential aspects of learning.

Experiential learning, as distinct from social learning, once again returns us predominantly to the individual. One of the most familiar models used to exemplify this theory is Kolb's learning cycle. Although much debated and improved (Boud et al 1985), it remains one of the most recognized, accepted and adopted models for understanding learning from experience. The initial work of Kolb (1984) has been much developed most notably by Honey and Mumford (1992) who have transposed it into a taxonomy of learning styles and arguably both have foregrounded the individual above all else. The limitations may be manifold (Beard & Wilson 2002, Miettinen 2000) yet as the foundation for experiential learning, it offered opportunities to explore contextualized experience and the associated learning. In particular this approach suggested that everyday experiences may be learning opportunities;

“Everyday life takes place in, and relates to, people’s social context. In the process of experiencing in all its modes, people learn - sometimes deliberately but often incidentally. Experiential learning in everyday life is almost synonymous with conscious living” (Jarvis et al 1998: 56)

Given then that many people spend the majority of their waking hours involved in work, paid or otherwise, the implications for workplace learning are evident with learning informing many aspects of practice and vice versa. Concepts of tacit learning, experiential learning, informal learning and social learning all hold valuable insights and to some extent each may be subsumed within another however, none alone seems sufficient to capture the complex interplay of the individual in the contemporary workplace. A connected but expanded theory which seeks to progress this is situated learning theory.

In 1991 Lave and Wenger published their landmark text on situated learning. Emerging as a “radical and important rethinking” (p1) of previous conceptualizations of learning, this text sought to reconsider and widen the debate on the “*situated* nature of learning” (p1). Suggesting that previous accounts of learning had overlooked or marginalized the fundamentally social nature of learning activity, they sought to espouse a theory that redressed this balance. They offered an analysis of situated learning in five different settings: Yucatec midwives, native tailors, naval quartermasters, meat cutters and nondrinking alcoholics. In doing so they demonstrated the slow acquisition of skills and knowledge as the novice moved from peripheral participant to a more centripetal role.

They based their analysis on the fundamental notion of legitimate peripheral participation. However they were particularly interested in moving;

“ beyond the context of pedagogical structuring, including the structure of the social world in the analysis, and taking into account in a central way the conflictual nature of social practice” (p49).

This expanded the opportunities for new ways of understanding practice as developed in the follow up text in this series (Chaiklin and Lave 1996). Two years later Wenger (1998) once again expanded the notion of situated social learning by developing his notion of ‘communities of practice’ as dynamic, integrated, complex social sites of learning. The two main concepts derived from this body of work, ‘legitimate peripheral participation’ (LPP) and ‘communities of practice’ (COP), form the basis for this thesis’ theoretical perspective. Whilst neither is adopted uncritically, both have value in the analysis of the everyday learning of newly qualified midwives. It is important at this point to consider each of the concepts further in order to assess their utility in the midwifery work setting. As the broader concept of the two I will deal with COP first.

Communities of practice

The concept of communities of practice has provided fertile ground for the investigation of many occupations such as teaching, or more recently call centre working (Taylor and Bain 1999, Brannan 2005, Colley and James 2005). It has also proved useful in exploring less formal and perhaps recognizable communities such as witchcraft, surf schools and dancing (Callahan 2005, Light and Nash 2006, Merriam et al 2003). Recently there have

also been attempts to make the link into health care (Eraut 2002, Blaka 2006). Initially this section will look at the concept in its broadest sense before focusing on its more specific application and finally its useful application in Blaka's (2006) analysis of midwifery learning.

Building on the kind of situated learning described within LPP (Lave and Wenger 1991) which is yet to be considered, Wenger developed the notion of communities of practice (1998). In essence, Wenger describes communities of practice as those in which;

“collective learning results in practices that reflect both the pursuit of our enterprises and the attendant social relations. These practices are thus the property of a kind of community created over time by the sustained pursuit of a shared enterprise” (1998:45)

The notion, just like the phenomena it seeks to describe, is somewhat amorphous and has been used in a variety of surprisingly different ways. Paetcher (2003) for instance applies the concept very broadly to learning particular forms of gender and describes how it is possible to conceptualise masculinities and femininities as “performative” (p69) and therefore theoretically constituted of elements of practice, meaning and identity.

Paetcher (op cit) explores masculinities and femininities as a learned consequence of various communities of practice. She explicitly avoids the term gender arguing that it has become a somewhat static notion “increasingly being used as a way of classifying phenomena that are effectively treated as sexual differences” (p70). Her analysis constructs masculinities and femininities more as performative identities learned through

processes of participation and non participation in communities of practice. Hence she argues that learning what it means to be male or female, within a given social configuration, results in shared practices which sustain those identities. In reference to identity she states;

“it is defined not just internally by the individual but externally by the group’s inclusive or exclusive attitude to that individual” (p74)

Her argument, whilst considering COP in a very broad sense, has resonance both with other studies (Merriam et al 2003, Light and Nash 2006) and with the findings within this thesis. This is particularly so both for her emphasis on practice and her construction of “otherness” (p74). Here, practice is conceived as an ongoing learning process. This notion is one thread connecting the four substantive findings chapters of this thesis. Furthermore, her definition of “otherness” takes full account of the importance of both participation and nonparticipation in the formation of identity;

“Identity can in this way be seen as being related to competent and convincing performance of a particular role; it is defined not just by the individual but externally by the group’s inclusive or exclusive attitude to that individual” (p74)

This point is examined in more detail with regard to midwifery practice in chapters five, six and seven. This serves to frame an exploration of the boundaries at which participants in this study had to discover and locate their forming identities through a process of negotiation that encompassed the omnipresent tension between individual and community. Each chapter explores what the boundaries are, the tensions experienced

there and what the implications for learning are. However, whilst Paetcher (op cit) used masculinities and femininities to focus her argument, it is also important to consider other useful conceptualizations of COP.

Duguid (2005) uses the very different strategy of questioning accounts of knowledge in mainstream economics. In doing so he challenges both notions that try to reduce knowledge to information held by individuals and notions which explore tacit knowledge as merely “uncodified explicit knowledge” (p109). He makes a strong argument that too many studies foreground community to the neglect of practice and both are vital in order to maximize the analytic potential of COP. Furthermore the impact of both on identity is repeated as; “learning in the sense of becoming a practitioner ... can usefully be thought of as learning to *be*” (p113) once again this is identified as inextricably tied up with identity location within the community of practice. He stresses, “Within the COP the knowing *how* of the community, not merely of an individual, is on display” (p113). This has implications throughout this study as it traces novice midwives negotiating both *how* the community is and how they are to *be* within it. Nevertheless, the thrust of Duguid’s argument is for a narrowing of the application of COP theory in order to accommodate and allow for the beneficial input of alternative approaches that offer similar analyses (Cohan and Prusak 2001). These approaches include, for instance, theories of tacit knowledge, social capital theories and theories of professional socialization. Whilst each of these undoubtedly could contribute an alternative lens for analysis of this data, I believe that the theoretical framework of LLP and COP gives scope for consideration of the broad understanding of a larger community, such as the two papers described above, and is also useful in consideration of ‘community’ in a smaller sense. In fact Wenger’s

original text (1998) took this approach focusing on the world of work in claims processing. This more detailed scrutiny of communities helps to reveal how, in many complex and overlapping ways, ‘everydayness’ forms learning. Its useful application is evident in a number of studies which have looked at the more micro application of the concept. It is to these studies that we now turn.

Whilst there are numerous studies that would support this contention (Lagache 1993, Merriam et al 2003, Callahan 2005, Colley and James 2005, Light and Nash 2006), I choose to focus on three in particular. These are Merriam et al (2003), Light and Nash (2006) and Colley and James (2005). The first gives insight into learning in a marginalized community (which I will argue midwifery has become). The second explores issues of overlap which are particularly relevant when exploring boundaries and the third offers provocative accounts on non-participation or “unbecoming”. Firstly I want to consider Merriam et al’s (2003) study which focuses on the practices of Wiccans and on the processes of becoming a witch. The data for the project came from semi-structured interviews with twenty practicing Wiccans, from which a team of researchers drew their subsequent conclusions. Whilst Wicca is a legally recognized and rapidly growing religion it remains “underpinned by stigmatization” (p174). The parallels between midwifery and witchcraft notwithstanding (Ehrenreich & English 1973) it explores the dynamic process of finding Wicca, being introduced and moving towards the centre of practice. Whilst this piece, as many others, is open to the criticism that it assumes a uni-directional process, it nevertheless demonstrates how in this community there is a “heavy component of informal learning ... [where] practices and beliefs are more experiential, intuitive and earth based rather than intellectualized” (p186). This has

direct parallels with the informal learning associated with midwifery and part of this project sought to explore if the experiential and situated elements of learning were acknowledged to the same degree as the intellectual. However, the authors suggest that in order for this type of learning to occur participants need to be situated in an “emotionally safe environment” (p186), as such, throughout this project, the emotional climate of practice is foregrounded. The study also hints at issues of boundary as participants frequently seek to keep their Wiccan identities hidden and distinctly remote from their everyday identities. This is in stark contrast to that of professionals who are often proud of their ‘other’ identity. Here Light & Nash’s (2006) study is of use as they consider the issue of ‘overlap’.

Light and Nash (2006) explored the everyday experiences of four young cadets in Australia involved in three overlapping communities of practice. They were Surf club, School and Sports clubs. They followed and analysed the experiences of these four cadets as they participated in each community. Their findings echoed Becker’s (1972) study by suggesting that the circumscribing nature of school and sport club activities failed to provide sufficient opportunities for participants to engage in legitimate peripheral participation “at every organizational level” (p89) and thereby restricted opportunities for learning. Conversely surf club encouraged engagement at all levels and a trajectory of participation. The authors further suggest that failing to offer such participation may render a practice as not necessarily a “‘true’ community of practice”. This point however is contestable, as Myers (2005) points out in his study of risk and Sellafeld. Whilst the workers he studied could never hope to have access at every organizational level, a COP approach, despite its shortcomings in being able to recognize and account for the full

dynamics of power, “clearly has something to tell [us] about the role of ... communities in the work of enterprises ... about the importance of practices ...the ways processes involve people ... and about the importance of social learning” (p211). Nevertheless, the surf club emerged, predominantly because of its inclusivity, as the most powerful exemplar of learning and identity formation. Whilst boundaries are not addressed specifically the study suggests that when communities do overlap participants potentially identify most readily, if not strongly, with the community which offers a “sense of security, belonging, place and purpose” (p92). This notion forms a second thread connecting the four substantive findings chapters of this thesis. However, as a final consideration, particularly given that retention is one concern of this study, I now turn to a paper which explores the potential for individual agency when any or all of the above elements are absent. This explores the possibility that, rather than choosing to participate in a trajectory of becoming, people choose non-participation or a trajectory of “unbecoming”.

As most of the focus of this study is on learning to be or, becoming a midwife, it is essential to consider the converse option. It may be that participants, for a variety of reasons choose to delay, suspend or resist the trajectory of becoming altogether. This is explored in depth in chapter five. Colley and James (2005) provide a clear challenge to the unidirectional assumption of LLP and describe two case studies of tutors in higher education who through a combination of political, personal and professional factors make the protracted decision to exit from the mainstream of their profession and in fact in both of these cases, exit completely. Whilst this study has strong echoes of the ‘Why Do Midwives leave?’ report (Ball et al 2002), it also has resonance for this study in that it

highlights the potential for individual and personalized trajectories of practice. In doing so there is a plea to;

“consider professionals also as human beings living wider lives, and to explore the possibility that their knowledge and practices are produced and reproduced with reference to a wider set of influences” (Colley and James 2005:6)

Chapter four takes this plea seriously in the section that explores the impact of the diversity of participants on the identities to which they are able to subscribe. It is revisited in chapter five when considering issues affecting the choice of persistent peripherality. The main thrust of this discussion supports the call for more dynamic concepts of participation and this is something that this thesis considers of inordinate worth and seeks to reinforce. Finally, however, it is relevant to review how the concept has already been usefully applied to midwifery.

Blaka (2006) presents the findings of her qualitative case study which sought to explore the learning processes of midwifery students in a Norwegian maternity ward. Seven new midwifery students were observed with their preceptors over a period of twelve months and from this data Blaka builds a socio-cultural analysis of learning. The study in many ways has similarities with the work of Begley (1999) conducted with Irish student midwives. Whilst Begley did not specifically employ a COP approach the underlying philosophy is similar, furthermore these two studies have similarities which are in contrast with this project. In the first instance all participants, in the Norwegian and Irish studies, are midwifery students rather than qualified midwives and all are registered nurses prior to their midwifery education. Furthermore, in Blaka’s study the author is

concerned specifically with the interactions between student and preceptor which gives rise to the concern that all the preceptors were “preselected by the ward manager” (p37). This may have provided the opportunity for the ward manager to only select their best preceptors. Blaka (op cit) found that three key themes emerged which were; being welcomed and accepted; a supportive learning dialogue; and being in the right place at the right time (p38). These all strike a chord with this thesis’ finding. The first two aspects depend on the intercollegiality of practice, whose importance for the learning experience is confirmed in the present study. Furthermore they suggested an environment of “balanced exchanges” (Hunter 2006) which is a concept of reciprocity that recurs throughout the analyses of data within this study. Therefore it becomes evident that applied both in its widest sense and employed with a more narrow focus the notion of COP usefully illuminates the complexities of learning through participation. Whilst, so far, the usefulness and applicability of the notion of COP has been demonstrated it is now equally important to consider the useful application of the second theoretical component that this thesis employs, legitimate peripheral participation, LLP.

Legitimate peripheral participation

The concept of legitimate peripheral participation (LPP) was introduced by Lave and Wenger in 1991 to describe a new perspective on the developmental and social learning inherent in different forms of apprenticeship. They presented a predominantly uni-directional notion of progression from apprentice to master which “encompasses a broad range of activities including sponsorship and planned, sequenced activities” (Spouse 1998: 347). This approach emphasised the importance of community and relational

aspects of learning. Whilst the uni-directional dynamic has been criticised (Colley and James 2005) it nevertheless formed a useful heuristic for considering the acquisition of learning outside of a formal curriculum. Lave and Wenger (op cit) argue that LPP encompasses a broad range of activities in which learning is integrated with practice and where through engagement with a community of practitioners and their involvement in everyday practice, newcomers become increasingly competent in their identity as practitioners. Such an understanding essentially ties learning to practice and in this respect fundamentally differs from the earlier, primarily cognitive, notions of learning. This social perspective on learning has numerous implications for learning within the professions.

Numerous authors have adopted the concept of situated learning, although not always consciously, in consideration of learning within the professions. Four decades ago Becker et al (1961) looked at what the “medical school did to medical students other than giving them a technical education” (p17). This work in many ways appears as a precursor to what Luke many years later (1996) termed the ‘pedagogies of everyday life’. Luke coined this phrase in an attempt to expand the sense of the term pedagogy and capture something of the learning inherent in various “dimensions of everyday life” (p4).

Although theoretically these two works are very different both address aspects of situated social learning. Interestingly, one of the most scathing critiques of LPP by Kupferberg (2004) maintained that Lave & Wenger’s work was overdependent on the ideas originally framed by Becker, particularly his paper ‘school is a lousy place to learn anything’ (Becker 1972). Kupferberg suggests that Lave and Wenger added little to Becker’s ideas and that their work “lacks sociological imagination” (p9). He prefers to use Becker’s own

concept of commitment (Becker 1960) and Bordieu's theory of Habitus (Bordieu 1993) to elucidate learning through practice. Whilst Kupferberg does provide an interesting and at times pertinent critique, I believe, he dismisses the concepts too easily whilst himself constructing a contradictory critique. For instance his representation of commitment is presented as static and such that "commitments are constructed very early in life" (p8). He seems to allow little room for the dynamics of changing commitment across the life course, particularly for women (Graham 1993). Furthermore, after making the valid point that the concept of communities of practice "doesn't fundamentally take into account that different occupations and professions have different social status" (p9), he immediately contradicts the implications of this statement by asserting that "individuals rather than any given community are ultimately responsible for the choice of a given professional identity" (p9). Thus, he fundamentally misreads the powerful nature of professional status stratification and the attendant circumscribing effects on other professionals acting in the same domain. These points are explored in much more depth in the findings chapters. Whilst Kupferberg is keen to dismiss this approach other authors have sought to investigate the possible explanatory power of LLP and COP still further. This is the position I adopt within this thesis therefore, to continue the focus on LLP it is enlightening to consider one project that specifically focused on the similar but different profession of nursing.

Spouse's (1998) longitudinal study explored the experiences of seven pre-registration nursing students as they 'learnt to nurse'. Whilst its focus is on "legitimate learners" (p349), it nevertheless places great emphasis on the degree of support, or what Spouse terms "sponsorship" (p347), which the learners receive. The conclusion is that it is a high

level of sponsorship that facilitates the best learning. However, Spouse is keen to emphasise that “sponsorship ... concerns the whole community” (p349) and it is here that the vital link between LPP and COP is most evident.

Whilst my own study is concerned with newly qualified midwives who perhaps in the formal sense can no longer be considered legitimate learners, they are nevertheless legitimate peripheral participants. As such, the requirement for a high level of sponsorship that will ensure the best learning outcomes persists. However, there is always the potential for dissonance between what the newcomer feels is in her best interest and what the community feels it is most important to impart. Consequently, it becomes apparent how it is important to now consider aspects pertinent to the individual working in the larger context. Whilst the literature reviewed so far builds an important landscape for understanding situated social learning the rest of the chapter will now concern itself with narrowing the focus to consider learning in the ‘front line’ of professional practice and specifically relate this to the caring professions. I shall start with the landmark work of Kramer (1974).

Caring and Public Service: Power, oppression and their boundaries.

Kramer (1974) used the term ‘reality shock’ to cover the numerous aspects of role transition experienced by newly qualified nurses. Kramer depicts many of the negative aspects of role transition, claiming that ‘reality shock’ is a product of high levels of stress, role uncertainty and value conflict that consequently becomes manifest in frustration, hostility, burnout and resignation (Kramer 1974). Whilst some authors have adopted Kramer’s term and support much of these findings (Clarke et al 1997, Kapborg et al

1998), other authors (Amos 1999) have suggested that the learning that takes place in this transitional period, whilst possibly difficult, is both useful and highly valued by the professionals themselves. This highlights the fact that this transitional phase is potentially one of the most important times of learning in one's career. However, what has become increasingly complex is how this learning is theorized or conceptualized (Eraut 2000). Here, the contribution of the concept of 'street-level bureaucrats' suggested initially by Lipsky (1980) has much to add.

Lipsky (op cit) set out to explore the "dilemmas of the individual in public services" (pxi) and examined a variety of human service bureaucracies at the 'front-line' of practice where policy interfaces with practice. Exploring the everyday existence of these street-level bureaucrats such as teachers, health workers and policemen, he came to suggest that whilst they had "substantial discretion in the execution of their work" (p3) they also frequently faced "the problem of resources" (p29). Whilst Lipsky identifies these resources as predominantly concerned with time and information, in the context of women's working lives, it is equally important to factor additional resources of the practical and emotional kind, as evidenced in the study of South African Nurses reported by Walker & Gilson (2004), to which we shall return. Lipsky described a recurring conflict in public services between organizational pressures and professional roles and values, which is reflected in some of the midwifery literature mentioned in the next chapter, notably that of Rosser (1998) on 'breaking the rules' and Hunter (2004) on conflicting ideologies. Similarly to Rosser (op cit), Lipsky suggests that in order to cope with the dissonance experienced in living this conflict, street-level bureaucrats frequently, albeit subversively, challenge and resist the organizational imperative and establish their

own 'working rules'. For midwifery, Kirkham (1999) uncovered a similar phenomenon consisting of "surreptitious behaviour" (p736) engaged in by midwives seeking ways to achieve objectives they felt could not be voiced clearly and directly. This was termed, "doing good by stealth" (p736) and whilst worthy in its intent, represented a strategy unlikely to achieve any change in the wider sense of practice, specifically because "both the aims, and the activity itself are concealed" (p736). Nevertheless, it appears that similar instances occur elsewhere. Walker and Gilson (2004), for example, find support for these findings in their work on nursing in South Africa. The study adopted a multi method approach to exploring the nurses' experiences in a changing environment that included a survey and in-depth interviews. They collected survey data from nurses at seven Community Health Centres and ten in-depth interviews were conducted in three clinics. The findings were consistent with an increasingly pressured work environment, which "seriously compromised key elements of their professional practice" (p1254). Furthermore, "dissatisfaction" (p1257) and "frustration" (p1256) were cited as contributing factors to some nurses' decisions to leave altogether. This is startlingly similar to the finding of the 2002 'Why do Midwives leave report' (Ball et al), which suggested that there were similarities with the difficulties and discomforts experienced in the execution of street-level bureaucracy. However Walker and Gilson (2004) also found that;

"Many nurses suggested that they managed the stresses associated with their jobs through ... close working relationships, pointing to the potential role of collegial relationships as a resource" (p1258)

They suggest that these relationships served an important support function and they are presented here in a totally positive light. This potential, of collegial relationships was certainly borne out in this study and is discussed in detail in chapters six and seven; however my findings suggest that whilst these are extremely important they can operate in both positive and negative ways. Furthermore, interactions within any community of practice but perhaps more particularly a professional community of practice are cross cut by issues of hierarchy and power.

No analysis of power is complete without some reference to the overwhelmingly influential works of Foucault. These works (Foucault 1973, 1976, 1977) have been important for problematising notions such as illness, madness, sexuality and criminality. Foucault suggests the basis of these notions rests on subject construction (Foucault 1973) and further problematises the notion of ‘experts’, social institutions and social practices, which may well be ‘empowering’, but which are nonetheless the result of a socio-historical construction that reflects power and domination. As such, any understandings of the operation of power in modern society must move beyond linear, static notions and perceive power as a dynamic function of social relations and processes (Foucault 1977). Whilst Foucault does not specifically address pregnant women, he describes how subjects such as ‘the patient’ are constructed through “the medical gaze” (1973:29). Similar constructivist notions have been developed more specifically in regard to women and pregnancy by various authors (Oakley 1975, Martin 1993, Murphy- Lawless 1998). These authors all suggest that, in one form or another, women’s bodies, female experience and childbirth have increasingly become sites of oppression. This thesis extends this body of knowledge that suggests the female experience as a site of

oppression, by suggesting that the female experience of being a midwife is reflective of this oppression. However, in doing so, it also suggests that paradoxically, it may be simultaneously cause and effect. Assuming this stance requires that the concept of COP is expanded to include aspects of power which Wenger (op cit) originally overlooked. It will be argued throughout this thesis that one of the main ways power manifests in the experience of being a midwife is in the experience of oppression. However, in order for this to be established, it will be necessary to consider the concept of oppression more closely.

Oppression exists when “a powerful and prestigious group controls and exploits a less powerful group” (Dunn 2003). In some instances, such as apartheid, child abuse or domestic violence the oppression may be obvious. In others instances it may be less obvious and less clear cut. Accordingly, the oppressed persons (or person) have their ‘reality’ prescribed and defined by the oppressor who maintains fundamental control, ultimately then the oppressed group “internalize the oppressor’s values as righteous and desirable societal standards” (Dunn 2003).

Young (1990) develops a postmodern perspective on the manifestations and operations of difference. Inherent in the critique is an analysis of oppression. Despite trying to avoid reductionism, for the purposes of clarity she offers an analysis within which she offers the ‘five faces of oppression’. These she defines as; Exploitation, powerlessness, marginalization, cultural imperialism and violence. She asserts that;

“The presence of any of these five conditions is sufficient for calling a group oppressed” (p64)

Whilst it would be possible to argue that each of these impinges on contemporary midwifery practice (LeBoyer 1974, Wagner 1994, Beech 2000) it is the two aspects of powerlessness and marginalisation that are most relevant to the concerns of this thesis.

Powerlessness emerged as a key theme in the follow up study to the original Ball et al (2002) report. This subsequent report (Curtis et al 2003) gathered data by talking to managers and revealed their frustrating and disempowered experiences. Whilst this emerged from a growing recognition of midwives as an oppressed and increasingly powerless group, this thesis considers but extends that position. Adopting a more Foucauldian definition, this thesis analyses power in terms of a circulating notion, whereby power is held, used and experienced in many different directions. Furthermore, the thesis explores and supports the notion that wherever there is power there is resistance.

In health care and more specifically midwifery, oppression has been the focus of much discussion and debate over the last twenty years or more (Katz Rothman 1982, Savage 1986, Kitzinger 1991, Lupton 1994, DeVries et al 2001). The debate ranges across the existence of oppression and its many manifestations but one persistent factor is the general recognition of medicine as the powerful and prestigious group. Since the observations of Foucault in 1973 and despite some attacks on the powerbase of medicine most notably managerialism, legality and the rise in consumerism, it is still arguable that little has really occurred to shake the authoritative stance of medicine in contemporary western society. And whilst there have been small successes these are predominantly outside of the bastion of the hospital workplace. The hospital still stands as a feature of

the “disciplinary society” (O’Neill 1986) wherein a specialized form of (medical) knowledge prevails and permissibly defines and regulates that which is correct and that which is deviance and therefore;

“The hospital is [still] the central feature of professional influence for medical power” (Turner 1994: 158)

Given the notions of power discussed above, no analysis of a contemporary institutional professional practice would be complete without a consideration of the operations of power within that community of practice. This is the main consideration of chapter four. The crucial aspect of power relations circulating within any community of practice is one that is missing from the original text (Wenger1998) and is one that this thesis seeks to rectify thus representing one of the ways that this study makes a new contribution to knowledge. Furthermore, in adopting a framework in which peripherality is of concern, the interplay of marginality becomes of concern and ‘boundaries’ and ‘borders’ form a consistent theme throughout the thesis.

Both the foundational concepts of this thesis, LLP and COP imply some notion of periphery and centre. Whilst LLP is very specifically concerned with moving from the periphery or border to the centre, COP is a more dynamic concept which avoids the notion of a singular centre but nevertheless implies movement from newcomer to old-timer. Furthermore, chapter four adopts and develops Wenger’s notion of a boundary practice established to “sustain a connection between ... other practices” (p114). Thus borders, boundaries, peripherality and marginality all become pivotal to this analysis.

This is in keeping with the postmodern stance of this thesis, which values and recognizes the contribution of evidence from relatively peripheral members of a professional community. As Giroux (2005) asserts, this can both provide a challenge and create further challenges. For instance:

“Postmodernism challenges by ...bringing the margins to the centre in terms of their own voices and histories. Difference holds out the possibility of not only bringing the voices and politics of the Other to the centers of power, but also understanding how the center is implicated in the margins” (p50)

Yet in doing so, he recognizes that this can simply lead to more refined forms of oppression by increasingly defining and refining the identity of ‘Otherness’. Whilst Giroux (op cit) offers a complex and at times abstract analysis of the nature of pedagogy and politics he nevertheless makes the conclusion that;

“Most importantly, postmodernism conceives of the everyday ...as worthy of serious ... consideration” (p51)

Hence this thesis offers an extended analysis of the everyday experiences of a group of newly qualified direct entry midwives in the West Midlands in order to illuminate how these experiences are both impacted by their social and professional context and in turn how these experiences reciprocally impact on that very context.

Conclusion

Learning as a concept has altered radically over the past couple of decades. In particular, the shift from more individualistic, cognitive, towards more communal, social theories of learning has opened up new perspectives on workplace learning (Chaiklin and Lave 1996). However much of the strength of this may lay in the ability it provides to combine notions of context led, socially orchestrated learning with consideration of complex and dynamic workplace environments. Such comprehension must additionally take account of the culturally specific socio-political relations of the environment that includes the circulation of power and its effects. The theoretical framework chosen for this study of communities of practice and legitimate peripheral participation comprehensively provides the basis for just such an analysis. It establishes a framework which foregrounds the relationality and fluidity of practice whilst also recognizing the symbiotic nature of practice and meaning making. However, whilst Wenger (1998), in his initial analysis, paid little attention to issues of power, this thesis builds upon the framework to demonstrate the essential nature of including circulating notions of power. This in turn impacts, in a variety of ways, on the resultant workplace learning. Applying this lens to the complexities of contemporary midwifery practice may provide for novel understandings of just what new midwives do learn in practice. However, initially the context of that practice needs to be established.

Chapter 2

Midwifery: the context

Midwifery: the context

Introduction

This chapter sets out to describe the context of current provision of maternity services and begins to describe some of the dilemmas concerning engagement in practice and retention that the service currently has. It is sensitive to the notion that “understandings of individuals engaged in practice must include some analysis of the sociohistoric context in which the practice developed and proceeds” (Chaiklin 1996:378). Thus, there is an initial review of the historical and political constitution of the service and its provisions.

Secondly, and particularly important, in the context of this project, looking as it does at direct entry midwives, suggested by some to represent “a new breed” of midwife (Mulholland 2002), I examine how this direct entry route came into being as a consequence of the educational developments of recent years. Furthermore, some of the issues that have arisen from these developments are explored in terms of jurisdictional boundaries before then the issue of retention is addressed directly. This is specifically taken up with regard to retention within midwifery, before finally the essential role of emotion work and the surrounding literature is explored.

Policy & Historical background - professional

The history of British midwifery stems from the unpaid work of the traditional handywoman. Childbirth was historically women’s work (Donnison 1977, Ehrenreich and English 1973). This was generally low status work, undertaken by a local woman and often included other ‘women’s tasks’ such as washing or childcare. Yet these texts

demonstrate how increasingly throughout the seventeenth and eighteenth century this position came under challenge from men, particularly medical men. The increasing recognition and power of the sciences and medicine exposed childbirth to a new way of thinking. Pioneers in the field of 'man-midwifery' such as William Smellie and William Hunter began to establish childbirth as a new science and criticize the historical practices of midwives (Wilson 1995). Simultaneously they introduced new theories, literature and practices which began to reconfigure the childbirth arena.

The nineteenth century saw the continuation of medical involvement and the emergence of lying in hospitals which offered the first real alternative to childbirth at home. The rising middle classes came to prefer obstetric care (Kitzinger 1991) and doctors were willing to provide a service, for those who could afford it. Midwives continued to work predominantly amongst the working classes, charging about one quarter of a doctor's rate and often providing extensive live-in family support following the birth (Kitzinger 1991). Simultaneously, there were ongoing campaigns, predominantly led by influential, middle-class women to professionalize midwifery. One of the overwhelming concerns of the campaigners was the high infant and maternal mortality rates (Leap and Hunter 1993) and it was believed that regulation of the profession and obliteration of the 'handywoman' would reduce death rates. These factors all combined to lay the foundations for the dramatic change midwifery was to undergo during the next one hundred years.

It was predominantly the twentieth century, though, that saw the development of midwifery into the recognizable form in which we know it today. Despite an initial

resistance from some elements of the medical profession, who were concerned that professional midwives might remove some of their work and fees, the first Midwives Act became law in 1902. This hard fought for Act “guaranteed pay for midwives, independent registration, training and medical autonomy” (MacMillan 2001: 326). For the first time, formal training opportunities were introduced whilst restrictions were placed on those who could attend women in childbirth (though real enforcement of this took an interim eight years). Training still predominantly took place according to the apprenticeship model, although the London Obstetrical Society and some of the lying-in hospitals did offer formal courses. There were numerous tensions between midwives and both the medical profession and the nursing profession (Donnison 1977). Whilst there was still a significant debate over the overall responsibility for the control of training and registration, professionalism generally tended to be resisted.

Midwifery, then, has followed a tortuous route throughout the twentieth century. Key events beyond the 1902 Act have included the 1936 Midwives Act. There was a continuing governmental concern about both the safety of childbirth and the working conditions of most midwives. They still worked on an ad-hoc basis and with diverse and often inadequate systems of remuneration. Following the depression of the thirties it was deemed desirable to establish a nationwide salaried domiciliary service. It was hoped that this would bring threefold benefits: it was intended to improve maternal mortality rates, improve the working conditions of midwives and attract the ‘right’ kind of people to the profession. This effectively banned the untrained handywoman from attending women in childbirth at all (Robinson 1990).

Robinson (op cit) goes on to describe the following years as firstly, a period of readjustment and professional consolidation in which midwives retained much of their responsibility and autonomy. However, with the imminent advent of a National Health Service, the medical profession once more began showing an interest in attaining a primary responsibility, and hence payment for, maternity care. Under the new NHS tripartite funding arrangements, pregnant women no longer sought out a midwife but now went to their general practitioner to claim their free care. This introduction of the fragmentation of care continued apace, despite obvious concerns and the Cranbrook committee, elected to investigate these concerns, in fact, compounded the difficulties for midwives. The Cranbrook report of 1959 extolled the virtues of midwives, but nonetheless recommended a much bigger role for doctors in the provision of care to pregnant women. This situation was exacerbated by the Peel report of 1970 that advocated facilities for 100% hospital delivery. Midwives, it appeared, were now extraneous to requirements. Robinson (op cit) refers to this period as “the decades of constraint” (p75). Numerous other authors (Kitzinger 1991, Purkiss 1998, Wagner 1994) chart the increasing medicalisation of childbirth and the marginalization of midwives to its apparent height in the seventies. The eighties and nineties have subsequently been marked by efforts, both governmentally (DOH 1982, DOH 1993) and by midwives themselves (Flint 1987) to address the fragmented, depersonalized and dehumanizing care that has resulted. Simultaneously, midwifery education has undergone dramatic changes. These inevitably play a major part for the contemporary understanding of midwifery.

Policy & Historical background - educational

The formal education, training and registration of midwives only emerged in the last one hundred years. Prior to the 1902 Midwives Act, anyone who practiced as a midwife could do so with no formal instruction and no requirement to be registered. As we saw earlier, however, the first Midwives Act changed this landscape considerably. The Act dictated a legal requirement that in order to practice, midwives must hold a certificate issued by an approved institution and be entered on the Midwives Roll held by the Central Midwives Board. Initially, there was only one route of preparation (Radford and Thompson 1988) and no requirement to hold any prior formal qualifications. At the beginning of the century very few women entered midwifery via nursing. However, from the 1920s onwards this changed (Fraser et al 1997) and increasingly transfers from nursing became a common route into the profession. The progressive change, from a profession of originally non-nurse midwives to the development by the mid 1980s of a predominantly nurse-midwife profession is comprehensively documented by Radford and Thompson (1988). Indeed, by the mid – 1980s the latter was by far the most common route into midwifery with only one training school remaining that could provide a course suitable for non-nurses (Fraser et al 1997). However, around this time there were a number of issues which led to a re-consideration of the situation. Ongoing recruitment and retention difficulties within midwifery were a concern, as was the ability of qualified midwives to satisfactorily fulfill their role. Furthermore, midwifery was strongly and clearly resisting a ‘medical’ identity having successfully fought against being identified as an arm of nursing for the project 2000 nurse education initiative. Resistance was aided and reflected by what Radford and Thompson (1988) term a general ‘swing away from medicalisation’

in both consumer groups and from within the profession itself. This context led to the Department of Health and Social Security supporting a three year study to investigate and promote Direct Entry Training for Midwives (Radford and Thompson 1988).

Consequently all Health Regions in England were called upon to provide at least one direct entry diploma or degree level course. Subsequently, in 1989 money was made available by the Department of Health in order to establish the first fourteen sites for these programmes, with the first students being enrolled the following September.

However, this was also a time of monumental change for midwifery education itself as schools were called upon to merge into higher education. Now enveloped in the competitive market of education providers, many other institutions also took up the challenge of direct entry training and, even without the initial funding, numerous other sites began to evolve their own educational courses. By 1994, thirty-five such courses had been validated, and this was despite the fact that the project intended to evaluate the initial fourteen sites, was only just reporting (Kent et al 1994). In consequence, there has been a surge of singly qualified midwives entering the service. This occurred before any rigorous evaluation had taken place and it was thus with some urgency that the English National Board commissioned the 'Effectiveness of Midwifery Education Evaluation Project', led by Diane Fraser, which finally reported in 1997 (Fraser et al op cit).

This report reached predominantly positive and optimistic conclusions about the effectiveness of the pre-registration programmes. Information gathered from a variety of sources and subjected to a multi-method approach formed the basis for an attempt to ascertain if a broad selection of pre-registration courses effectively achieved their

intended outcomes. Although a variety of recommendations were made, the report positively encouraged the continuation of the three year pre-registration training. What is less clear from the report is whether any of the courses examined were graduate programmes. Despite an initial desire to include a three year degree programme, there was the recognition that at that time, ‘very few ... are offered’ (appendix one, p2).

However, currently many are offered. There has been a continual drive towards a graduate profession and direct entry pathways. Increasingly, ‘new’ midwives have all the knowledge, abilities and skills commensurate with a graduate status and frequently no ‘nursing or medical’ background. What is unclear is whether presently, for midwifery and for the individuals involved, this is a blessing, a curse or some combination of both.

Evidently then, the relationship between midwifery and medicine has been one marked by change, compliance, dispute and “turf wars” (‘O’ Regan 1999). This has given rise to a landscape marked by constantly negotiated and ever-changing boundaries. These boundaries can simultaneously be a source of security and a source of frustration (Wenger 1998). The existence of, and negotiations across, these boundaries forms an essential element of the analysis within this project. In addition to Wenger’s conceptualisation of boundaries and what constitutes a “boundary practice” (p114), this study also employs the notion of jurisdictional boundaries.

Jurisdictional Boundaries

Abbott (1988) uses the term ‘jurisdictional boundaries’ to describe the recognized boundaries of practice between one profession and another. At a micro level this may also imply the boundary of practice between one professional and another. This concept

allows us to consider how, by extending the jurisdictional boundaries of medicine, obstetrics has achieved its dominance in the childbirth arena.

The extension of the power and control exerted by obstetrics has obvious parallels within a progressively technologising society (Ritzer 2004). However, the superordinate status claimed by obstetrics is not derived:

“simply by access to complex technology, or an abstract will to hierarchy [but] it is a way of organizing power relations ... that makes them seem literally unthinkable in any other way” (Davis-Floyd and Sargent 1997: pxii).

It is in achieving this status quo, whereby the current situation is quite “literally unthinkable” in any other way, that obstetrics has claimed the vast majority of contemporary childbirth experience as its own valid jurisdictional territory. Abbott (op cit) is quick to recognize, however, that claims to jurisdiction are far from static and need to be both fought for and defended on a variety of fronts. Jurisdictional claims can be made in various possible arenas; the legal arena, the arena of public opinion and finally in the everyday of the workplace. It is interesting to consider each of these arenas before justifying the focus of the remainder of this chapter on the latter.

The legal arena confers formal control of work boundaries. Legally the sphere of responsibility for midwives has always been ‘normal’ childbirth. It has historically been enshrined in the Midwives’ Rules, issued by the relevant governing body and that stipulate that in the case of any deviations from normal the midwife must seek help. Interestingly, the instruction until fairly recently included, “call a registered medical

practitioner” (UKCC 1998) whereas in the most recent update of the rules the term “medical practitioner” has been dropped and the instruction is;

“ where a deviation from the norm ... becomes apparent ... a practicing midwife shall call such qualified health professional as may reasonably be expected to have the necessary skills and experience to assist her in the provision of care”

(Nursing and Midwifery Council 2004(a): 17)

This is evidence of a subtle shifting of jurisdictional boundaries as midwives increasingly extend their sphere of practice and the government seeks to reduce junior doctors’ working hours. One may imagine this as progress for midwifery, although, a more critical interpretation may well argue that there are various reasons behind why midwives are increasingly being ‘allowed’ to absorb medical tasks. An expansion of their role that involves more medical tasks, however, is quite likely to impinge on other, different midwifery skills. An important aspect of this jurisdictional shift is how such matters really manifest themselves in practice. This will both be considered later in this chapter and is the main focus of chapter six.

The second arena, that of public opinion, builds an image of the profession. Abbott (op cit) argues that “for whatever reason, public images of professions are fairly stable” (p61). If this is the case, then it poses yet another difficulty for contemporary midwifery practice. As Lavender (2003) pointed out;

“some women may not fully understand the range of competencies of a qualified midwife and the care which they can provide” (p8)

Indeed, as services and midwives have become increasingly hospital-based, the public perception of midwifery has increasingly been of a profession similar to nursing, so much so that in many aspects of life the two terms are becoming regularly interchangeable (Central News report 2006). Increasingly, midwives are perceived as obstetric handmaidens and less as autonomous professional practitioners (Oudshoorn 2005). This poses a problem, both for any service developments that are proposed, as well as impinging on the constructive possibilities of midwives personal identities (Lavender op cit). Again, the importance for this study of the public perception of midwifery lies in how this perception of 'jurisdiction' becomes manifest in practice. It is to this question that we now turn.

It is evident then, that both legal aspects and public perception impact on contemporary midwifery practice. However, Abbott (op cit) assures us that,

“equally important ... is the workplace. Claims made in the workplace blur and distort the official lines of legally and publicly established jurisdictions; an important problem for any profession is the reconciliation of its public and its workplace position” (p60)

The everyday negotiations that form part of this reconciliation are an important focus of this study. And, as should become apparent, this reconciliation impacts immensely on the transitional learning of midwives. However, prior to looking closely at the relevant data from this study, as we do in chapter six, there are other important sources, specifically related to health care that illuminate the concept and its application. The most notable of these are by Stevens at al (2000) and Daykin and Clarke (2000). The former, whilst a

study from the Netherlands exploring ophthalmic and optical care, has implications for and similarities to current British midwifery. The latter is an exploration in much closer proximity to this study, in that it occurred both in a British hospital setting and that it also looked at frontline provision of care by qualified nurses. We shall investigate each in turn to see what they offer to our understanding of jurisdictional boundaries.

The study by Stevens et al (op cit) examined the provision of visual care in the Netherlands and how five different potential providers of care such as ophthalmologists, optometrists and general practitioners viewed their professional domains. What emerged was profound areas of overlap and lack of clarity which manifested in frustration and dissatisfaction. In addition, their findings confirmed a difference in the position of the medical profession and allied health professions, which perpetuated a medical dominance and hence ensured that “care will continue along more-or-less fixed professional status hierarchies” (p447). Despite much negotiation over occupational domains and claims to jurisdiction, what transpired in practice was much less clear-cut. As we shall see, these findings are similar to those of the present study.

The second study conducted by Daykin and Clarke (2000) looked at the occupational demarcation between trained nurses and the health care assistants with whom they worked. Using semi-structured interviews and non-participant observation, they explored perceptions of working conditions. They found that nurses often utilized “exclusionary strategies” (p361) for demarcating clear occupational boundaries and thus ensured a subordinate position for the occupational group of health care workers, whilst ensuring a

superordinate position for themselves. This strategy of exclusion is essential to the formation of jurisdictional boundaries.

Historically in midwifery this can be seen from the times when the first male obstetricians hid their forceps beneath their clothes in order to conceal this superior knowledge from midwives (Ehrenreich and English 1973). In the present time, seriously contested research on breech births has all but removed them from midwives' sphere of practice and placed them firmly within the jurisdiction of obstetrics (Glezerman 2006). This shifting of boundaries serves both to exclude midwives from a particular sphere of practice, in this case vaginal breech births, whilst also ensuring that future knowledge associated with this practice will strictly be the preserve of those who operate within the realm of obstetrics. Nevertheless, in everyday practice, the reality is that these boundaries are and will remain essentially blurred. This resulting lack of clarity and confusion affects the experiences of midwives and hence impacts upon their learning. This was evident from the data collected for this study. Research question three concerns the impact of formal and informal learning and further asks; how does this affect commitment to a long-term career as a midwife? Therefore, having begun to consider some of the learning aspects it is now equally important that we explore the issue of retention itself. During the extensive political and educational developments set out here, more general consideration has been given to the increasing difficulties that the profession faces with retention. There is a growing unrest that the increase in midwifery training places and the additional direct entry route is not being translated into an effective increase in the midwifery workforce and that there is a growing retention crisis.

As was noted in the introduction, retention is both a familiar and contentious issue. An increasing concern at both the local and the political level renders retention, as a concept in itself, as well as in its specificity for midwifery, an important question. As we saw The Audit Commission (2002) recognized that recruiting staff “is, of course, only the first step.” (p19). Yet they are unclear as to exactly what is meant by the term retention. It is vital for this work that the concept of retention be understood and considered within the context, not merely of contemporary working lives, but within the arguably vastly more complex working lives of women (Tilly and Scott 1989).

Retention within midwifery

Many people who are qualified to assume the role of midwife choose not to. Accordingly, despite current Government policies geared towards increasing recruitment into midwifery, the issue of retention post-qualification remains a key concern. It is estimated that 60,000 registered midwives are out of practice (O'Dowd 2000). Moreover recent studies funded by the Department of Trade suggest that the mean length of service is decreasing (Ball et al 2002). Ball et al's study, for instance, highlights how midwives who leave are 'surprisingly young' and certainly not those approaching retirement age as may be expected. This study suggests that the general dissatisfactions expressed throughout midwifery are often felt most acutely by the more vulnerable members of the profession, particularly those newly qualified. Consequently, they suggest that turbulent and demanding organisational and professional cultures within health care are a primary reason why new recruits appear to quickly lose commitment and ultimately leave. Such a view is confirmed by Morton-Cooper and Palmer (2000:6) who comment that important

factors contributing to problems of retention are; “poor staff morale, a sense of being under-valued by society, the proliferation of less personally demanding/more rewarding career opportunities and less flexible working practices for health care workers.”

Certainly organisational and professional cultures have been recognised as important explanatory variables in respect of employee retention, yet the results from Ball et al (op cit) indicate that a considerable exodus may be occurring at an early point in some individual midwifery careers. This would suggest that midwives’ experiences of organisational and professional issues arising at the transition stages into midwifery careers are significant. It is of note that the youngest entrants to midwifery are overwhelmingly recruited from the direct entry programme, which is relatively new and little evaluated. Additionally, these recruits frequently have had no previous exposure at all to health care environments.

In the move towards ‘professionalisation’ and an all graduate profession, the education of midwives has evolved rapidly in a comparatively short period of time. From the first legal requirement for registration of Midwives in 1902 (MacMillan 2001) and the availability of formal training opportunities, the last one hundred years has seen the development to the current situation where most newly qualified midwives in the United Kingdom emerge from their courses as graduates. They simultaneously obtain both the requisite professional status of Registered Midwife (RM) and also a graduate degree.

Consequently the basic RM qualification may have been achieved by different individuals at certificate, diploma or degree level, all within the last ten years. This ‘raising’ of the academic status of the qualification has not gone unquestioned (Maggs

1994, Halliday 1994, Robotham 1997). However, certificate level courses have now become extinct and diploma level courses are rare. In fact, the diploma level is now the required 'minimum academic standard' for midwives (NMC 2004(b)). Degree programmes are becoming the accepted norm. Increasingly, entrants are no longer formerly nurses, but 'direct entrants', needing to meet set academic and professional standards. It is important, when considering the experiences of these non-nurse midwives, to understand how they represent a previously marginalized and undervalued section of the profession (Radford and Thompson 1994). Yet it is also important to appreciate how the number of direct entry midwives is set to continue increasing rapidly. In order to do so, it is necessary, as described earlier, to appreciate the historical, social and political construction of both current midwifery services and education. Also it is important to consider some of the relatively unique and defining features of the midwifery profession.

As evidenced previously midwifery remains a "rare example of a women's career where both practitioners and command hierarchy are overwhelmingly female" (Allison and Pascall 1994:203). However, we have an example, perhaps, of a similar career in the case of teaching. Indeed, a report published over fifteen years ago (Association of Metropolitan Authorities 1990) offered a framework for 'making teaching more attractive' (p4) to qualified female staff. The five main suggestions for structural modifications are startlingly similar to those issues only now being addressed within midwifery as evidenced in the strategy document, 'Improving Working Lives' (DOH, 2000). This document sets out to establish more flexible and family friendly working environments within the NHS, such that, all NHS employers are expected to be accredited as putting the Improving Working Lives standard into practice. Yet, whilst

offering a policy framework for improving the working conditions of midwives, this document reflects the response to continuing concerns over retention and working conditions. It does not actually specify what, in particular, generates these concerns.

Other authors, though, in other areas, have attempted to do this.

Gowler and Legge (1975) although predominantly offering an economic assessment of the retention of labour, describe four elements of the occupational role, which, taken in context, effectively impact upon the propensity to stay in one's role. They identify the job's requirements, expectations, performance and experience. With an alignment of the four factors, the authors believe there is a propensity to stay. They call this role integration. However, where there is a marked differential amongst the four factors, then the individual experiences role differentiation, which may manifest itself in various ways, one of which is by leaving. Ideally then, it seems that any working environment should seek to establish a fusion of job expectations and experiences. This study specifically seeks to establish whether midwives expectations throughout their first year of practice actually matches their experiences one year later. To this extent, I hope to explore not only the perceived fusion or dissonance of their roles as qualified midwives, but also, through the collection of qualitative data, to investigate more thoroughly how these experiences are perceived and what meanings these convey to individuals. Gowler and Legge (op cit) remind us that it is; "Difficult to maintain dissonant perceptions over relatively long periods of time' (p109). If this is indeed correct then it is important to consider how individuals seek and are able to reconcile this.

This same text suggests that; “employees may stay in firms not because they are satisfied with their jobs but simply because they are institutionalized’ (p114). This concept of ‘institutionalization’ is important to this study because the picture of contemporary midwifery practice that this study uncovers is still one that is inextricably bound to hospital experience and obstetric rule. Goffman (1961) described the disempowering experiences of inmates in an asylum. Whilst this may seem radically removed from midwifery, Bosanquet (2002) makes a powerful argument for considering the “status passages” (p302) experienced by women arriving at a hospital maternity unit and seeing them as directly parallel to the depersonalizing, dismantling and oppressive routines experienced by asylum inmates. Furthermore, in line with Foucault (1973, 1977) much of the work associated with the ‘care’ of pregnant women is increasingly based on surveillance and control and reflects the disciplinary power of modern maternity services. Nevertheless, what these systems seem to offer, both to those ‘offering’ them and perhaps those receiving them, is some degree of predictability, familiarity and a façade of safety.

Whilst the illogical nature of trying to enforce predictability on ‘people work’ has been criticized by numerous authors (Murphy-Lawless 1998, Toombs 2002, Ritzer 2004) so too, the façade of safety, particularly in regard to midwifery hospital care, has been exposed (Wagner 1994, Oliver 2005). Recently Stephens (2005) even went so far as to suggest that the safety argument could be turned on its head given the current state of affairs in modern maternity units. Nevertheless, the aspect of familiarity remains and the current system of care both successfully inducts newly qualified midwives and ensures they become familiar with a particular community of practice in action. Whilst any, or all

of the aspects thus far considered may impact upon an individual's decision to remain within or else leave midwifery they are, for the most part, practical or cognitive concerns. What is becoming of increasing concern, and this thesis will argue of increasing relevance, is attention to the inherently emotional aspect of the work within which all these women are engaged.

Emotion Work

There has been a major increase in interest for the status of emotion in the workplace. Hunter (2004) suggests this was triggered by the work of Hochschild (1979, 1983) who “drew attention not only to the significance of emotion in the workplace, but also to the work expended in managing emotion” (Hunter 2004: 262). Hochschild describes two forms of ‘acting’ that workers may employ in order to negotiate the requirements of emotion work; surface acting and deep acting. The former involves adopting an outward countenance appropriate to the expected emotion, whereas the latter involves the suppression of inner feelings. Both can be potentially harmful to individuals leading to a potential “loss of self” (Hunter and Deery 2005). This in turn must contribute to the identity (or identities) that workers are able to adopt, a concept which is explored further in findings chapters four and five.

However, studies of emotional work in health care have, by nature of the subject perhaps, predominantly occurred in settings associated with ill health (Smith and Kleinman 1989, Smith 1992, James 1992). Each reflects a rising concern that many current ‘caring’ contexts lie in uncomfortable apposition with the institutional and organizational pressures of the workplace. For instance, James (1992) reports on a study of hospice care,

considering how the basic premise of a model of 'family' care outside of mainstream medicine has fared. Whilst applauding the intent, she concedes that the organizational pressures they face means that what really evolves is an "ideal-type of workplace health care" (p491) rather than the "family care" (p491) to which they aspired. Everyday work involved routines and tasks which, as demands increased, left less time for more invisible caring. However, "failure to stick to routines was a disruption to the social order of the hospice" (p498) and this had a dual outcome. In one sense whilst the routines were oppressive they also provided a sense of job satisfaction, in that they had a defined end and could be seen to be done well. Caring, on the other hand, whilst revered by some staff also represented an ongoing 'demand' which often felt incomplete when families remained unhappy, as was frequently the case in a hospice environment. The dissonant experiences that this entailed for the staff demanded high levels of emotion work as they tried hard to deliver care, often "at personal cost to the carer" (p502). This undoubtedly has parallels with midwifery work.

In fact all the studies identified above have general relevance to emotion work in midwifery, as they each to some extent explore the management of feelings and the emotional aspects of 'caring' work in different settings; medical students, student nurses and hospice nurses. However, the most recent work of Hunter (2002, 2004) is the first to focus explicitly on the emotion work of midwives. It builds upon the platform established by the work of Sandall (1997, 1998) who explored the related subject of stress and burn-out in midwifery with the implications of both becoming apparent in the findings of the Ball et al report (2002). The aim of that research was to speak with those who had already made the often "protracted and complex" (pi) decision to leave midwifery. The

findings emphasized areas of experiencing and managing (or failing to manage) negative emotions and workplace relationships. Further research led by Kirkham (2005) examined why midwives stay in practice and why they may return to practice. It begins to map the current situation and address the more positive aspects of practice, identifying the crucial roles of individual ability to make a difference, and the necessity of practice conducive to the formation of meaningful relationships with women. Both of these are issues which to some extent are taken up within this study. Both also imply the necessity for an emotional, as well as a practical engagement in practice. Indeed emotion, of some description, forms a continuous link throughout often seemingly disparate studies in midwifery. This in many ways is not surprising, as it is widely acknowledged that pregnancy and birth represent emotionally intense experiences for women and their families (England and Horowitz 1998, Anderson 2000). Perhaps what is more surprising is that it is only recently that focus has fallen upon this emotional experience and the emotion work involved from the perspective of the caregiver (Hunter 2002, Deery 2003).

Hunter (2006) in her most recent work suggests this as an area of research in great need of attention and begins to suggest 'reciprocity' as a potentially useful concept in exploring how midwives experience balanced and emotionally rewarding relationships with women, or out of balance relationships requiring emotion work that are often experienced as emotionally difficult. Hunter's qualitative study involved a purposive sample of 19 NHS community-based midwives and sought to explore their emotion work experiences focusing on their relationships with clients. The study found four different types of relationships; balanced exchanges, rejected exchanges, reversed exchanges and

unsustainable exchanges. The balanced exchange describes a reciprocal relationship based on “give and take” (p1) from which the midwives derived a sense of emotional reward. The other three types of exchange were all “out of balance” (p1) and required emotion work. Despite the fact that the focus of this piece of Hunter’s work (2006) specifically addresses midwives relationships with women, reciprocity was an issue which had already arisen for consideration within this thesis and is addressed more thoroughly from both an epistemological and methodological point of view in chapter three. Nevertheless, beyond reciprocity, emotion of various kinds pervaded much of the findings within this thesis. Both intra- and inter-professional relationships were bounded by and gave rise to some kind of ‘feelings’. Often these were powerfully felt emotions. Chapter five explores this aspect much more thoroughly and explains the implications for the findings of this research study.

Conclusion

This chapter has introduced the historical background and current context within which newly qualified midwives are working and learning about midwifery. Politically and educationally, the service has developed, so that increasing student numbers are essential to provide enough qualified staff to supply the service. Meanwhile this service proliferates in an environment of medical dominance that it is increasingly difficult to resist (Walsh 2005). Childbirth has become essentially hospital based and despite much ongoing criticism of this approach (Kirkham 2004(a), Downe 2005(a)) and increasing

political support for change (DOH 2004) this reality still, for many, provides the context of their everyday lived experiences of being a midwife.

I have chosen to frame my study in terms of communities of practice and legitimate peripheral participation in the context of workplace learning and am including concepts such as oppression and horizontal violence in order to deal with power relations and social structure. There are, of course, other ways in which these data could have been interpreted and there is always the opportunity for secondary analyses.

Nevertheless, the empirical data presented here, within a feminist post-modern framework privileging a situated social learning perspective, has much to add to both the literature on communities of practice and also to a wider perspective on the complexities of retention. The next chapter presents a detailed account of the research design and methodology of this research study.

Chapter 3

Methodology and methods

Methodology and methods

Introduction

“I could imply, even subtly, that I have gained, risen, improved, grown theoretically and personally. I could suggest that I have made sharp, carefully worded, clear arguments, never violating their logical trajectories. However, none of these are suitable. Instead, I have wavered and mis-stepped; I have gone backwards after I have gone forward; I have drifted sideways along a new imaginary, forgetting from where I had once thought I had started. I have fabricated personae and unities; and I have sometimes thought I knew something of which I have written” (Scheurich, 1997; 1)

These honest words, offered by way of an introduction, signal something of the postmodern concern with the Truth, which is an epistemological concern of this thesis. However, they also reflect the disorientating process experienced by the novice researcher who must necessarily learn and adapt as the project develops. One may argue that this is of particular relevance to qualitative research (Darlington and Scott 2002). Despite the linear assumptions associated with research design, much of the process is iterative, interactive, reactive and essentially fluid. This chapter represents my personal account of conducting research into the informal processes of transitional social learning associated with qualifying as a registered midwife in the early 21st century in the West Midlands, UK. The data collection period extended over roughly one year, from the spring/summer of 2003, to summer/autumn 2004, as separate cohorts of midwifery students successfully gained their qualifications and embarked on midwifery practice as

registered practitioners. Data for the study was gathered using both quantitative and qualitative methods; survey data, interviews and diaries. Participants completed a questionnaire at the point of qualification and revisited this questionnaire one year later. Fifteen midwives were then interviewed, at three stages throughout their first year, providing forty-five interview transcripts. Five of these midwives also kept a diary for one week.

This chapter follows the research journey from inception of the initial 'tools', through the subsequent collection and analysis of the data. Particular attention is paid to the ethical considerations, issues of gaining access and social relations in the field. Whilst much of this is woven through the text to highlight the contextual nature of the decision making processes, the section on analysis is offered separately. This is specifically to enable a detailed focus on what ultimately is the vehicle for interpretation.

Whilst it is important to understand the reflexive nature of qualitative research, it is equally important to remember that any effects, negative or positive, can only ever be recognized and moderated never, I believe, obliterated. Shipman (1988) makes a similar point when saying; "'preconceptions... will still guide observation and interpretation... no academic detachment can now cushion the contact with those investigated' (p37). And whilst the richness and complexity of the data compound the difficulty of interpretation, every attempt is made to make the process, and influencing factors, visible to the reader. The section on analysis aims to address this. Ultimately, I aim to make a contribution to the literature concerning both midwifery practice and situated social learning. I do this, ever mindful of Morse's reminder, that theory can be nothing more than a "best guess"

(Morse 1994), even as it provides the best broad and recognizable but simplest model, for linking diverse facts and experiences, in a useful and pragmatic way (Morse 1994(a)).

The research process

Identifying the beginning of any research process is problematic (Silverman 2000).

Nevertheless, for the purposes of documenting my research journey I must elect a suitable, albeit somewhat artificial point of departure. As such I begin this section at the time of formal approaches to potential participants. Initially, I devoted much consideration to the optimum time and manner in which to approach the potential participants. They were a host of varied individuals, geographically, demographically and no doubt individually, disparate. All would be at an important, possibly stressful and pivotal point in their lives and careers. As the thesis sought to explore issues related to forthcoming careers, it seemed most appropriate to approach them through their education provider. As I had chosen a geographically bounded population, based on the local supervising authority (LSA) at the time, I needed to include all the providers of midwifery education within that area. They were; University of Central England, Coventry University, Keele University, University College Worcester, University of Wolverhampton and Staffordshire University School of Health. At that time, they cumulatively provided education and training for midwives across twelve different Health Authorities. Student midwife populations due to qualify in the summer of 2003 varied from groups of seven to thirty seven. The data collection began in May 2003 and ended in December 2004. However, before any data collection could be considered I needed to secure ethical approval.

Seeking ethical approval

Ethical approval has become an increasingly important aspect of social research. Whilst the processes and operations involved in obtaining ethical approval can vary widely across institutions, the core principles, such as beneficence and duty of care should be fairly clear (Darlington and Scott 2002). Within this project I had to approach six different education providers. My initial enthusiasm was somewhat dampened when a familiar, but fortunately distant, academic at the university where I was employed looked in horror on hearing about my task and referred to it as “a design fault”. Fortunately, this was not the impression of either of my supervisors, who both supported it as a necessary, appropriate and positive step in accessing the right people to address the chosen research questions.

Recognizing the time constraints of my planned project, there was an awareness of the need to access all the ‘direct entry’ midwives due to qualify in September 2003.

Therefore the quest to secure access began early that year. Firstly I approached the Professor within the largest school of Women’s Health Studies for advice about where to seek ethical approval for access to that cohort. The appropriate ethics committee was due to meet shortly and the documents were sent immediately. This ease of initial contact encouraged approaches to the remaining five. Although most school and faculty details are available from internet web sites, ethics committee information is far less overt. Three of the six schools were confident about who should be approached and provided details straight away. Two needed a little more time to establish the best person to contact and furnished the details after a slight delay and, in one case, a couple of polite reminders.

The remaining school felt that actually, ethical clearance was the responsibility of the researcher and their university of origin thus providing me with the quandary as to who, in this case, could approve the final approach. There followed much discussion with both sides about how best to proceed.

In the meantime, the largest provider returned comments asking for some minor changes in the participant information sheet. The ethics committee asked that I reveal some more personal information to participants and, in agreement with Polit et al (2001), also that I emphasize the right to withdraw at any time. These changes were duly made, returned and ethical approval subsequently granted. Having this approval seemed to add leverage to all the other approaches. Two schools asked for faxed copies of the first approval before making their own decision. Subsequently, five out of six schools sent verification of ethical approval and the logistical process of arranging to meet with all the participants could go ahead. At this point, the final school was still undecided about how we could proceed, but asked to see verification from the other sites, which then seemed sufficient for their needs, so that quite by surprise email notification of approval to proceed was received. Consequently, I needed my data collection 'tools' to be in order.

The survey tool

Surveys can play a fundamental role in qualitative research in a variety of ways. The application of the survey depends entirely on its design and in this case it was designed to provide additional quantitative supporting data to the qualitative component. Naturally, a main concern was that the survey tool had appropriate and valid content. To address this issue Fink (1995) suggests that the relevant associated literature is consulted for a

working model (p36). Hence, after much thought and an email discussion with two of the research team on the Ball et al report (2002), permission was granted me to adapt the original survey tool, utilized in their 'Why do midwives leave report' (op cit). for use in my study.

The original survey used by Ball and her research team was in five sections; A, B, C, D and E. Four sections were entirely appropriate for this project, but section C, covering 'Would you ever consider returning to midwifery?' was evidently inappropriate and therefore completely removed. Sections A, D and E formed the three basic components of the adapted survey tool and became, for the purposes of this research A, B and C. Section B was adapted.

Section B of the original survey, was in the form of a table of 'statements concerning midwifery'. These issues had emerged from phase one of the platform research as important factors in the decision made by some to leave the profession. For my initial survey, these were written in a future tense to try and gauge expectations about the role of a qualified midwife. One year later, the same statements were proffered although now phrased in the past tense to allow for comment on the experiences of the last twelve months. Both the survey tool and the accompanying statements are shown in appendix 1.

All survey information was entered into SPSS (statistical package for the social sciences) and a quantitative analysis completed. However, having made the necessary adaptations it was essential that this, as yet untested survey tool was assessed by a credible audience.

My first step was to pilot it.

Piloting and access

Piloting has been termed, “Reassessment without tears” (Blaxter et al 1996: 121). It was a vital step in ensuring that, in particular, the survey tool was clear and accessible but also to ‘test’ initial thoughts. It also provided an opportunity for me to meet with a group of direct entry midwives who had been qualified for just one year. This allowed me the privilege of listening to them outside of the confines of a hospital environment. It is important to recognize, however, that this was indeed a continuation of listening, on my part, as it was their ‘voices’, to a great extent, which led to the development of the research idea. This resonates with the position of ‘insider’ to the research topic, which I elaborate on later in this chapter, and recognizes that;

“as teachers, as students, as social researchers – we are positioned ‘inside’ the social and educational phenomena which are the object of our enquiries”
(Middleton, 1993: 129).

Using my clinical contacts, two midwives agreed to help arrange the group in one of their own homes. Bearing in mind that the chosen location needed to be easy for all to reach and that there would be limitations of space, I asked if we could convene about ten participants, as suggested by Fink (1995), for a time that would not be in excess of two hours. In the meantime the initial survey tool was completed and ten printed for piloting.

Early in May 2003 our small group gathered in Sheldon, Birmingham. Only eight midwives actually made it on the night and a consent form was distributed and signed confirming that any data emerging at that time was for piloting purposes only and

reaffirming that attendance was purely voluntary, furthermore that individuals should feel free to stop or withdraw at any time if they wished to do so. I also asked permission to take notes as conversation, flowing throughout the evening, might prove invaluable material, this was unanimously approved. The survey tool was distributed and individuals began to complete them. This gave me the opportunity to gauge approximately how long it took to fill in the survey. It quickly became apparent that question eight, the first of section B was causing some confusion. This question asked participants to place a tick along a scale of agreement or disagreement between two opposing statements. Some participants felt that they agreed with both statements. Even after discussion and clarification of their opposing nature, some remained torn. This is a paradox to which the research will return. However, the discussion that ensued led to a clarification of the wording and I added to the questionnaire; “Although this is a tough decision – **please use only one tick.**” Furthermore, the group as a whole was uncomfortable with one of the phrases used in question nine. Looking at aspects of midwifery that are important to them, one phrase offered, “Feeling appreciated and needed by the women I care for”. Generally the group disliked the word “needed” and suggested this was given more thought.

The only other comment regarding the survey tool, was that it did not seem to pay attention to the emotional demands of training, which indeed it does not. Taking this on board, it was explained that whilst there was no doubt an emotional burden during training that had impact (Begley 2001), this was beyond the remit of this tool which was intended basically to secure some rudimentary demographic data.

Equally useful to the explicit evaluation of the survey tool were the overt suggestions from the group, of things that had felt important to them, in their first year of practice. I also gathered ideas from the notes I made of conversations throughout the evening. These all aided further thought about the initial topics that might guide the subsequent conversations with participants. At this point I was ready to begin data collection.

However, despite having overcome the first gate-keeping hurdle, there was still the necessity of approaching and negotiating with each school individually. A formal letter was sent to all the Heads of School introducing myself and welcoming further enquires. It explained that, although ethical approval was already secured, it was clearly understood that without their approval the project would not progress. This was an important stage in negotiating relationships 'in the field'. Despite the fact that in this instance Hammersley and Atkinson's (1983) comments are specifically addressing ethnography, their comment still holds true that;

“Whether or not people have knowledge of social research, they are often more interested with what kind of *person* the researcher is than with the research itself. They will try to gauge how far he or she can be trusted, what he or she might be able to offer as an acquaintance or a friend, and perhaps how easily he or she could be manipulated or exploited.” (p78)

It was important that these gate keepers were given the opportunity to ask questions and a chance to understand both the research and the researcher. In reality, no further questions were asked and response was generally by email providing details of specific academic staff with whom to liaise in arranging the details of when and how to meet each group.

Initial contact

Fieldwork is in constant conflict between what is “theoretically desirable on the one hand and what is practically possible on the other” (Buchanan et al 1988: 53). It was with an awareness of this that I set out to do as much as was practically possible to collect my data.

The first appointment was mid May in Staffordshire. Interestingly, whilst confident about the research project and about meeting potential participants, the greatest anxiety that day was what to wear. The researcher needs to project multiple ‘selves’, midwife, academic, student, lecturer; all of which had some bearing on the origins of the project and its trajectory. Somehow ‘the suit’ didn’t feel quite right although bearing in mind the previous quote on potential personal assessment, it also felt essential for projecting the trustworthy and responsible self. One entry, made in my research diary that day, notes how immediately I was alone with the potential participants, the jacket was removed. This was my attempt to seem less ‘official’ and create a potentially more equal relationship. I hoped to communicate my wish to engage in research *with* these people rather than *on* them (Reason and Marshall 1994).

Following an explanation of the project and the opportunity for questions, the survey was distributed. Aware that the group represented something of a captive audience I then left the room for a few minutes so that anyone wishing to leave could do so privately, although no one did. The response rate was around 98% as, of a potential ninety participants, eighty eight completed the initial survey. Two participants, from different sites, had to rush off on the day and both were given a copy of the survey and a stamped

addressed envelope in which to return it. Neither was returned. Nevertheless, by the end of September, after six relatively unproblematic site visits, the initial survey was complete.

The follow up survey, one year later was a postal survey and response rates were anticipated to be far less (Robson 1993). In fact 52 responses were forthcoming from the 88 documents posted. Only four of those required a reminder, and a three further envelopes were returned as the occupants had moved house. This represents a 59% response rate. This data was also analysed using SPSS.

The Research Sample: rudimentary demographics

The composition of the research sample was in many ways unsurprising and whilst with regard to gender, there are slightly more men within nursing overall, it reflects general trends within the nursing and midwifery active register in the United Kingdom (NMC 2005). Here there is an overwhelmingly female presence, an increasing representation of mature participants and a persistent, though changing, predominance of White membership.

The tables below portray a general profile of the research sample looking at some rudimentary descriptive variables including, gender, age and ethnicity.

Table 1: Gender breakdown of survey participants:

Gender	No.	%
Female	87	99
Male	1	1

Table 2: Age breakdown of survey participants:

Age	No.	%
25yrs or under	44	50
26 - 30	9	10
31 - 35	11	13
36 - 40	15	17
41 - 45	7	8
46 - 50	1	1
51 - 55	1	1
56yrs or over	0	0

If mature students are deemed to be over 25yrs of age, then it is evident that there is a 50:50 split in this sample.

Table 3: Ethnic breakdown of survey participants;

Ethnicity	No.	%
White	79	90
Black Carribean	3	10
Black African	0	0
Black – other Black groups	1	1
Indian	0	0
Pakistani	1	1
Bangladeshi	0	0
Chinese	0	0
None of these (please specify below)	4	5

Of the four participants that identified their ethnicity as ‘other’, these identified themselves as; Indonesian, Persian, mixed White & Hispanic and mixed White and

Mauritian. From within the sample, there was overwhelming enthusiasm to contribute further and participate in the qualitative data collection described below.

Participants for the qualitative phase

Participation in research is not something that midwives are regularly applauded for. Indeed Styles (2004) succinctly presents the difficulties of enlisting support from clinicians, whilst Albers (2004) offers reasons why this may be so. However, my experience was somewhat different. Perhaps this relates to the fact that at the first point of contact the potential participants were all effectively senior students, at the point of becoming midwives, rather than clinicians just yet. Arguably, they might be more familiar with and hopefully even, excited by, research and less likely to have yet experienced some of the limiting factors described by Albers (op. cit.). This was certainly borne out by the fact that all of the sample population, without exception, gave a forwarding address for a follow up survey to be sent to in one year's time. Furthermore, nearly eighty percent volunteered to be interviewed. However, in the section of the form asking if they might like to keep a diary for the project, responses were less clear. Whilst sixty one percent said 'yes', and thirty four percent 'no', four participants (roughly four and a half percent) answered 'maybe'. It is unclear whether this was to do with the explanation given about the diaries or whether it links to that fact that dairies are indeed a less familiar research methodology and may well be perceived as more 'private' or possibly 'intrusive'. This led, to the largely unexpected dilemma, of how to choose participants for the continuing qualitative work. Evidently, the decisions made at this

stage would impact on the potential of the resulting data to address the research questions it was intended to address.

The initial reaction, however inappropriate (Morse 1991), was to attempt some 'representative' sample. However, as a concept, any claim to a 'representative' sample not only seemed impossible, but indeed anathema to what this study sets out to achieve in exploring the unique and individual experiences of women. In keeping with the philosophy of Stanley & Wise (1993), the project from the outset accorded some degree of "researcher vulnerability" (p168). There was an awareness that;

"It [the project] relates research experiences to an audience as these are interpreted by the researcher. Nothing else is possible, so we must say this and make it central ... It might not be 'representative', but at least it has a chance of being honestly representative of the researcher herself" (p168-9)

This meant embracing the inevitable subjectivity of accounts and celebrating that richness. It also meant laying oneself open as the researcher, to the potentially painful criticism of peers and the research community which is an experience and fear, which feels to have changed little, since eloquently described by Richards (1986) two decades ago. Recognition of the philosophical underpinnings of the entire pursuit made it easier to resist the tendency to want to establish 'representativeness', rather than attempting to establish a selection of participants that in some rudimentary, demographic sense were 'reflective' of the entire sample population.

The selection of participants for the qualitative stage depended firstly, on consent to participate, and secondly, on a sample reflecting the age, gender, ethnicity and prior entrance qualifications of the target population. Location was also an appropriate consideration, so that in the broadest sense the experiences of the participants would reflect those of the larger midwifery population. The vast majority of newly qualified midwives in the target population trained in large obstetric units and began their working careers there. This was reflected in the sample population. Age was also an important consideration, particularly as Ball et al's (2002) study highlights how leavers are 'surprisingly young' and certainly not those approaching retirement age as may be expected. This report suggests that the general dissatisfactions expressed throughout midwifery are often felt most acutely by the more vulnerable members of the profession, particularly those newly qualified.

Gender is often an invisible category in research in midwifery. By virtue of the nature of enquiry research is usually concerned with women, either as consumers or providers.

Despite the fact that men and families have been increasingly included, they still remain notably marginal. This was indeed the case in the target population for this study. Of the ninety senior students set to qualify as midwives in September 2003, only one was male. Indeed this representation of one in ninety is actually 'excessive' when compared with the national statistics for registered midwives, which, in 2004, showed 148 men qualified and registered compared with 43,488 women (1:294). According to these figures 108 men are actually practicing and 33,578 women, again roughly 1: 311 (NMC 2005).

Therefore, one male in ninety was somewhat fortunate. Initially, it was planned to include him in the qualitative sample population, but despite the intention, circumstances

dictated that this was not possible and the subsequent qualitative work was completed with a purely female sample.

Ethnicity is another 'category' which may at times be subsumed and invisible. However, in order to maintain a study sample that was 'reflective' of the target population, it was important that this was taken into consideration. This presented the paradoxical situation of it feeling necessary as a consideration, but quite obviously, and justifiably perhaps, running the risk of accusations of tokenism. This seems an insurmountable dilemma in the context of this, and other, qualitative work with an appropriately small sample.

Therefore, the decision was made to proceed with selection, whilst actively seeking out diversity.

Finally, due consideration was given to prior qualifications, as increasingly recruits to the direct entry programme in particular are not coming from the 'traditional' educational route. There is a preponderance of mature entrants, who begin their midwifery education with college 'access' courses as their foundation. This is reflected in the age divide, with the younger students mostly entering via the traditional 'A' level route.

The initial plan was to enlist 'about' eighteen participants to allow the sample group to be small enough for the rich, in-depth data sought, but also to be large enough to accommodate diversity and allow for anticipated attrition across the year. Circumstances dictated that three participants were actually not in a position to proceed when the first interviews were due. Ultimately, a purposive sample of fifteen was established. This table is an outline of the fifteen midwives whose stories contribute to this study. I include the information on motherhood and age, as aspects of diversity that are considered in greater

detail in chapter four and working hours, which are particularly relevant in chapter five.

All participants were female.

Table 4. Profile of interview participants

Participant Number	Age	Children?	Full or part time
1	39	Yes	P/T
2	39	Yes	F/T
3	44	Yes	F/T
4	36	Yes	P/T
5	36	Yes	P/T
6	47	Yes	F/T
7	22	No	F/T
8	25	No	F/T
9	26	Yes	F/T
10	22	No	F/T
11	35	Yes	P/T
12	29	Yes	F/T
13	37	Yes	F/T
14	39	Yes	F/T
15	23	No	F/T

I have chosen to withhold information about their site of clinical practice or ethnicity here for purposes of maintaining confidentiality. Whilst the spread of ethnicity in the target population was considered earlier in this chapter, as regards clinical sites, suffice it to say that the representation of each of the six clinical sites, was roughly proportionate to the attendant populations.

The task of establishing relationships and recording their journeys then began.

The interviews

The interviews represented the point at which I began to form personal, albeit research relationships, with participants. Most participants were telephoned shortly after qualifying and interviews arranged. As the purpose was to discuss and record their experiences we needed a quiet setting. In keeping with my feminist epistemology, I asked each participant to decide where was most suitable for them. Thirteen out of fifteen asked me to visit them in their own homes. Two chose to meet me at their place of work, either at the end of a shift or on a day off.

One unexpected factor was the use of mobile telephones. Eight of the participants shared their mobile phone details with me and were happy to make arrangements by text. This had the advantages of not needing an immediate response, was cheaper than calling and details can be stored and re-checked if necessary. On the down side, there was also greater scope for doubt about whether the message had been received, whilst the greatest challenge occurred when one participant had her mobile phone stolen. It is interesting to note that, whatever the mode of contact, as the project continued, 'relationships' were forming (Finch 1984) and by the third and final interviews participants were just as likely to initiate contact, especially by text, as wait for the researcher to do so.

This aspect of relationship forming is a central consideration for qualitative research and has both positive and negative consequences. As identified long ago by Oakley (1981) and Finch (op cit), interviewing women often offers opportunities for establishing relatively informal and discursive relationships with participants. This may contribute to the truthfulness of disclosure, but also runs the risk, as Oakley (op cit) warns, of

introducing 'bias' if the researcher moves into the relationship of friend. In accessing the subjective experiences of these new midwives, this research hoped to hold the experiences of participants as fundamental within the research outcomes. This study thereby hoped to avoid the possibility of their 'reality' being 'separated-off' from the research, which, it is argued, is what happens when research attempts to be so 'clever' it transcends the personal and, "by doing so, downgrade[s] the personal and the everyday"(Stanley & Wise 1993:50). Furthermore, it is an attempt to do as Claxton (1999) advises, to describe and understand the "tangible manifestations of the workplace" (p314) in order to "get a clearer sense of what the learner's interior world looks like" (p332). This purpose required that:

"for a brief period researcher and subject meet on common turf, each 'truly being with the other'" (Belenky et al 1986:225)

The interviews increasingly provided this opportunity and resulted in the rich data acquired.

Armed with the best tape recorder I could borrow, tapes, note book and pencils, I travelled to interview fifteen women three times. A total of 45 interviews, over 4000 miles, 15 different locations, countless hours and numerous cups of tea later, the interviews were completed without a single withdrawal. This was a particular source of satisfaction to me and occasioned a certain pride in the participants, particularly because a serious conversation with a respected male academic and avowed positivist one year earlier, guaranteed me that this figure would be reduced by the end. Despite having factored in for possible attrition, I felt, perhaps in my naivety, that developing good,

respectful research relationships may attenuate this. It was thus with great pride that I completed my 45th interview in December 2004. I transcribed all the interviews personally. Participants were numbered 1-15 and the interviews were designated as (a), (b) and (c) to signify first interviews at three months qualified, second at six and final at twelve months respectively. During the interviews, I also asked six participants, if they would keep diaries for one week. Two of these were requested at each stage of the project, six in total.

Diaries

The diaries were intended to compliment the interview data and add further depth to the qualitative exploration. It has been suggested that diaries can link qualitative and quantitative approaches (Dex 1991, Ross et al 1994). However, in this context, their use was more about adding depth. Recognising that they could only provide a snapshot of working experiences, they were intended to be as ‘easy’ as possible. It was apparent very early on in the research just how busy all these women felt and it was necessary to avoid adding another arduous task to their burdens. Hence, similar to the approach used by Galloway and Winfield (1999), the diaries were intended to be kept for one week only, across whatever shift pattern comprised that week. Furthermore, it was intended that they should have no formal structure. In trying to achieve this depth of insight, I agreed with Coffey and Atkinson (1996) that:

“Qualitative analysis is as much about “how things are said” as about what is said” (p77)

It was hoped to avoid inflicting a structure, or even possibly eliciting certain types of response, by offering a small plain book and just asking participants to 'tell it like it was'. It is important here to recognize that the choice of diaries, as a method, is obviously dependent upon participants being reasonably educated and both confident and happy to communicate on paper. This makes it wholly appropriate for a study of new graduates. Furthermore, it is important to bear in mind that whilst diaries offer the opportunity for logging thoughtful entries rather than the immediate responses required at an interview, these were also designed to become 'public', unlike diaries written for personal use only. This therefore required ethical sensitivity and assurances of anonymity, both for the participant and for any individuals or settings that they may include (Hancock 1998).

The intention was to ask six participants to keep a diary, two at each stage of the project. Those chosen were selected as representatives of the different age ranges and were both with and without children. Five out of six diaries were returned; at least two of these contained a note saying how much they had enjoyed the opportunity to reflect on their week. The final diary remained outstanding despite contact to say it would appear. I suspect in this final case it was one job too many in the life of an already outstandingly busy woman.

The plan to leave the diaries totally unstructured and unguided, however, faltered very early on. The first participant asked to keep a diary was keen to do so but felt uncertain about having no directions whatsoever. Despite our discussion, she insisted she felt more comfortable if I just wrote something in the front in case she forgot when I was gone. I therefore wrote minimal guidance in the first one and then, to ensure equity of advice,

copied this into each subsequent diary (see appendix 2). Each participant also had a stamped, addressed envelope for ease of return. Finally, a small gratuity, in the form of a shopping voucher, was offered to all fifteen participants at the final interview.

Methodologically this demanded some consideration. Thinking and reading further on this point (Thompson 1996, Stanley & Wise 1993) led me to see this gesture as symbolic of the necessarily reciprocal nature of this, and other, qualitative research and the issue warranted closer scrutiny.

Reciprocity and research

Reciprocity is defined as ‘exchanging things with others for mutual benefit’ (Oxford Dictionary 2003). Reciprocity occurs at many different levels and in many different ways throughout the research journey (Harrison et al 2001). This is perhaps especially true of feminist, qualitative research based on an egalitarian epistemology. Gratuities represent just one manifestation of reciprocity, but are perhaps the most tangible if not to some, the most crude (Thompson 1996). Nevertheless, it is crucial to consider the importance of reciprocity, both as a methodological concern and equally importantly as an epistemological stance. These will be addressed in turn below.

The idea of offering a gratuity was not conceived at the research design stage. It is in one way, an exemplar of iterative research, as it was only as the project developed and the contributions of participants became fully appreciated, that it became a point for consideration. The fact that it was never offered as an incentive to participate, limits its function as a contributor to bias. However, it was gifted to participants before receipt of the final two diaries. This raises the possibility that it had an effect on completion of

those diaries. If this were the case, then as Thompson (op cit.) suggests, it is a “complicated matter” (p4) to know whether this would actually have made any difference to the data. However, the complication in Thompson’s case is that the participants in her discussion are economically vulnerable and the gratuity is, relatively speaking, a substantial one. This does not hold true for this instance. In this project the gratuity was a £10 voucher, hopefully enough not to seem derisory, although, given the commitment shown by the participants and their projected incomes, a relatively paltry sum. The importance of this is that it is unlikely that such a nominal sum would have influenced the data. However, it may have encouraged respondents to complete the final diaries.

Ultimately, the vouchers were received with both surprise and keen thanks.

Throughout this project, I, as the researcher sought to maintain a feminist epistemology.

Whilst initially this was not an intentional thrust, I soon realized that if it was measured by Maynard’s (1994) understandings, then this research is feminist research. This is specifically so because it links with all Maynard’s concerns; gender, as a central concern, is political in nature (albeit political with a small ‘p’) and most crucially, the intention of the pursuit, is to bring about change in women’s lives. I therefore attempted to maintain, as far as possible, balanced and reciprocal relationships with all the participants.

Appreciating that a truly non-hierarchical relationship between researcher and researched is virtually impossible (Skeggs 1994), I sought at all points to at least recognize and as far as possible ameliorate the power differential. This included trying to nurture relationships based on genuine prolonged interest, offering participants as much control as possible about locations, dates and times of meetings and involving them in ultimately reviewing and hopefully presenting findings. What transpired with many was a genuine moment of

opportunity for sharing, which many argue is absent in the rush of clinical practice (Kirkham and Stapleton 2000). In a variety of ways, this represented an opportunity for a reciprocal relationship, as whilst I was there to learn, I seemed to assume, for many, the position of 'sounding board'. Whilst Seidman (1991) warns against the development of any type of therapeutic relationship, it frequently became difficult for me to maintain neutrality and the boundaries between listening and counseling often became blurred. To this end, whilst recognizing from the outset that I was neither qualified, nor present to provide counseling, many participants seemed to agree with Finch's (1984) paper that, 'It's great to have someone to talk to', and that the research process had in itself offered them a beneficial period of reflection.

This development of reciprocal relationships, whilst not wholly unexpected, was in fact an element of the research that I had almost neglected to consider in detail. Whilst it is alluded to in many basic research texts and arguably pursued in more detail in feminist texts in particular, as a concept it seems to have suffered the same fate in research as Hunter (2006) argues it has in midwifery and is rarely satisfactorily unpicked. This feminist stance was adopted in part from a personal epistemology, but also incorporated a trajectory of realization that, in order to be a woman, studying women, caring for women and hoping to appeal to women and men alike (though one suspects this work will be of interest to many more women than men), I had to consider it's location as a feminist text. The following section reflects on this consideration.

Feminisms, Reflexivity and Midwifery: Feminist ‘ways of seeing’

“In due course no-one will attempt to define midwifery without acknowledging the feminist ‘way of seeing’. Only then we will move confidently to women-centered care and really mean it” (Hunt, 2004: pix)

As with all aspects of this thesis and indeed with any thought purporting to be post modern there is no single, definable unit of thought which can adequately represent the monolithic concept of feminism. There are instead “a plethora of feminisms” (Kaufmann 2004). However, in keeping with the foundational philosophy of this research I believe that this diversity can itself add strength and opportunity rather than detracting from the fundamental issue of women’s oppression. Furthermore, whilst recognizing women’s oppression as a keystone of the origins of feminism it has to be recognized that much feminist scholarship and practice may not even self-consciously identify as a feminist endeavour. Indeed it is suggested by Kaufmann (op cit) that;

“few women explicitly align themselves with any feminist theory or activism these days ... but much feminist thought is now considered mainstream commonsense” (p8)

Whilst commonsense is in itself a dangerous notion, the point the author is keen to make is that many practices and behaviours, such as domestic violence, which were almost acceptable until recent years, are now ‘obviously’ not so. Yet, as this acceptability has faded and a new consciousness permeated society, so too has recognition of the feminist struggles to reach this point. Nevertheless, this is not to say that feminist thought has died

or in any way abated. Whilst the visibility of feminism may not be what it was thirty years ago, feminist thought and research, in its various guises continues to expand, debate and challenge. Olesen (2000) reminds us of the very different contexts and challenges for the feminist agenda;

“Without in any way positing a global, homologous, unified feminism, qualitative feminist research in its many variants ... centers and makes problematic women’s diverse situations as well as the institutions that frame those situations” (p216)

Whilst feminist research and, more specifically, feminist qualitative research, is only one ‘variant’, it is in this guise that this study hopes to make a timely contribution. Whilst it may be true that women today have more control over their reproductive and working lives than they ever did before, their experiences are heavily affected by political, social and ideological forces that in many instances powerfully circumscribe the nature of those lived experiences.

In presenting the ontological and epistemological foundations of this research it is imperative to acknowledge that it is undoubtedly rooted in a feminist ‘way of seeing’. Given that the profession is overwhelmingly female, the women we care for are women, and my that my own career trajectory and gender reflect this, it was an intentional, and some may argue, unavoidable, perspective. The following discussion with regard to reflexivity, serves to strengthen not only the design of the research but also its contribution to feminist literature.

Reflexivity in qualitative research

“Self reflection and the self analysis of feelings are an important part of the research process, particularly in qualitative research” (Alvesson and Skoldberg, 2000: 217)

Quantitative research notwithstanding, it is of particular importance to appreciate the fundamental role that reflexivity plays in executing all stages of any qualitative research with rigour and credibility. Whilst ‘rigour’ is a concept more generally associated with the quantitative paradigm, Silverman (2000) assures us that;

“doing qualitative research should offer no protection from the rigorous, critical standards that should be applied to any enterprise concerned to sort ‘fact’ from ‘fantasy’” (2000: 12)

Reflexivity is one process that attempts to achieve this. Meanwhile true attention to reflexivity as an on-going contribution to the research process also contributes to the credibility both of the process and ultimately for any findings and the subsequent discussion also. Credibility as a concept is, as opposed to rigour, more commonly associated with the qualitative paradigm (Lincoln and Guba 1985). However, despite the different, if associated, concerns of rigour and credibility both demand due consideration of the reflexive nature of the work in hand.

Reflexivity demands that not only does the researcher explore what their own autobiography may bring to the project but also that they look both “inward and outward”

(Shaw and Could 2001:102) to explore their personal impact on every facet of the research process. However, I personally agree with Olesen (2000) that;

“what every researcher takes into his or her work is no longer a troublesome element to be eradicated or controlled, but rather a set of resources”(p229)

She continues that with sufficient reflexivity these resources can be used to guide much of the research process. Nonetheless, as with any other research strategy even reflexivity will have its limitations as one can only recognize and account for that which is visible to oneself. As Gorelick (1991) warns us, there may be other impacting relationships or structures that are at work, but that are neither apparent to the researcher nor the researched. Nevertheless, it is important for the core strength of this project that we make a reflexive journey across the project. This is in one sense an attempt at the ‘descriptive reflexivity’ identified by Stanley (1996), which serves to address the more detailed aspects of the research process, such as context and social relations. However, as a precursor to this, I offer a moment of ‘analytic reflexivity’, which Stanley (op cit) identifies as the complementary form of reflexivity addressing the ‘larger’ issues of epistemological and ontological assumptions and containing a considered reflection on my own autobiography.

Reflections on positionality

There is no doubt that just as the environment and context can impact upon the researcher, so too can the researcher impact upon them (Greene 1998). It is important therefore to consider how much ‘I’ may have influenced the project, not only at inception

but throughout. As a woman, midwife, academic, nurse, student and non-mother I brought, as all other researchers do, multiple selves to the research. Indeed the research idea itself stemmed from fifteen years in midwifery practice and three years as a midwifery tutor observing first hand the dilemmas of both midwives and student midwives. Personally, I qualified as a midwife in the early 1990's, when 'training' was considered mostly instrumental and when we were arguably taught to 'do' rather than to think. According to the requirements of the time, I first qualified as a nurse, despite the fact that I had little interest in nursing and was determined to be a midwife. Thereby, I was previously socialized into the nursing model of support and its deference to medicine. This role was unquestioned in my initial midwifery training. It was not until I entered Higher Education three years later and began to explore social theory, health policy and feminist writing that a new way of understanding became apparent to me. It was a watershed. Initially, I could identify myself as a reluctant feminist, only over a course of time and development have I come to aligned myself increasingly with feminist epistemology, now embracing the diversity this entails. Correspondingly, over a similar time span, midwifery education has undergone dramatic change, now firmly established in Higher Education as a rapidly emerging academic discipline. The pseudo-scientific certainty that underpinned my initial training has increasingly come into question. So too has the masculinist knowledge base that has driven the increasing medicalisation of childbirth. As a result, many midwifery developments over the past fifteen years have had a fundamentally feminist thrust, attempting to create (or some argue recreate) woman-centered care.

Hence, as I developed personally within a profession that was itself developing a critical consciousness, my reluctance abated and I now clearly identify with a feminist ‘way of seeing’. Furthermore, recognition of the diversity within feminism and the strength within that diversity has strengthened my alliance with a post-modern stance. Developments within the profession itself have also supported this as the “univariate orientation of modernization is increasingly contested ... and [midwives are] seeking to generate more polymorphous societies in which multiple knowledge and belief systems can coexist” (Davis-Floyd 2005).

Completing the final interview was in part the “bittersweet” experience described by Glesne and Peshkin (1992). There was an overwhelming sense of achievement and relief combined with a sense of trepidation about what to do next and how to make sense of it all. Whilst the interpretation had been necessarily iterative and ongoing, there was still some sense of understanding that the biggest part of the task lay ahead. This uncertainty was compounded by memories of warnings from Silverman (2000) that analysis is imperatively a pervasive activity. Indeed so, but the material reality of the field also gave a sense, albeit it an illusory one, of end point. It is to this fundamentally important issue of analysis and interpretation that we now turn.

Analysis and interpretation

Whilst the term ‘analysis’ may be viewed as uncomfortable within some qualitative research Denzin and Lincoln (2000) remind us in the introduction to their handbook that both analysis and interpretation are parallel and complementary strands of enquiry in trying to make sense of one’s findings. Whilst analyzing is arguably more ‘concrete’ and

may involve the sorting and coordination of data, interpretation is “endlessly creative and ...both artistic and political” (p23). Despite the positivistic undertones associated with the word ‘analysis’, it remains an essential stage for trying to gain an understanding of ones data and provides the foundation for any interpretation that follows. Silverman (2000) recommends that data analysis begins as soon as possible and remains a continuous, iterative process. This was the approach adopted throughout this project. Iterative analysis was supported by the design of the project itself in that data was collected along a twelve month continuum which allowed time between different points of data ‘collection’ for analysis and considered thought. This also meant that before data collection even commenced there had to be an appropriate, if flexible, form of analysis decided upon.

In searching the literature for the appropriate methods of analysis it soon became apparent that, as with many studies, a variety of perspectives might inform the data. As an intentionally mixed method project there was a combination of both qualitative and quantitative data. The first data to be collected was the results from the initial survey completed at the point of qualification. This provided a rudimentary set of descriptors and opinions presented as quantitative data. The survey generated a wealth of data, in fact, “more data than [could] be conveniently and easily analysed by hand” (Silverman 2000:16). Therefore, in keeping with the research design, the data were loaded into a quantitative software package for the social sciences, SPSS, and thereby the quantitative analysis facilitated.

The challenge of SPSS

As part of the reflexivity essential to the trustworthiness of this project, a brief reflection on the challenges of this section of analysis seems appropriate. As a researcher previously only truly familiar with the handling of qualitative data the use of a quantitative statistical software package thrust me beyond my own comfort zone. Prompted by the warning from Gorard (2001) that “a researcher who can’t do numbers is as dangerous as a researcher who only does numbers” (pxvi), I decided that the methodology would not be limited by my own current abilities, but chosen purely on the basis of best fit. Obviously once a survey was selected as the most appropriate tool for the first section of the study some analysis of numerical data was then wholly appropriate and even unavoidable. Once again Gorard (op cit) advises that when surveys are used; “it is perhaps better that they are used as part of a larger study also involving other approaches” (p80). This fitted my intent perfectly and I was thus committed to some form of statistical analysis.

However, given my own ontological and epistemological stance the data gathered by the survey tool was only ever intended to form something of a backdrop to the interview and diary data. In some senses this does offer a degree of triangulation (Mason 1996).

Nonetheless, in keeping with the postmodern stance of this work this was not in an attempt to find any single unifying truth. Whilst throughout this discussion, at times the survey data serves to uphold other findings, it is equally, at times, able to contradict. This is not recognized as problematic in any sense but in keeping with Fine et al (2000) I recognized that;

“different methodologies are likely to illuminate different versions of men’s and women’s understandings ... convergence is unlikely and perhaps undesirable. .. once men’s and women’s subjectivities are considered and sought after *as if* multiple, varied, conflicting and contradictory then the “data elicited” are self-consciously dependent upon the social locations of participants and the epistemological assumptions of the methods”(p119)

Consequently the survey data needed to be organized and analysed in such a way that agreement and dissonance could be sought, examined and subsequent explanations offered. A quantitative statistical package specifically for the social sciences provided the opportunity both to provide an appropriate “management facility” (Fielding and Gilbert 2000) and develop my own research abilities. In the event it did in fact do both successfully, if not entirely smoothly.

The data from the initial survey was fed into SPSS, which proved a time consuming but not difficult task. Each participant was allocated a number, with each question being allocated a code and answers input. The use of a quantitative software package allowed rapid exploration of the data. However, all of this was executed with the ever present echo that the survey method is a somewhat “blunt and unresponsive instrument” (Connell Davidson and Layder 1994:210)

The experience of using SPSS was indeed, for me, an attempt at “experimenting with the technological wizardry” that Parker (2002 :129) perhaps sensibly resisted. Within that project, Parker considered that software packages may be useful but also that they presented another onerous hurdle in a time constrained PhD project. As such, he

advocated relying on manual methods of analysis. Within my study it certainly took more time, persistence and anguish than I had anticipated. However, it also proved to be a useful and, I imagine, now an essential tool for data management. Beyond the (prolonged) initial awkwardness my research diary reveals; “great fun!” and if any part of this entire pursuit was about the “worthwhile learning experience” which Graves and Varma (1997) insist a PhD should be, then this small element certainly provided that. Subsequently, the qualitative data generated through a series of interviews and collection of participant diaries provided an altogether different challenge.

The challenge of qualitative analysis

Once again in order to decide upon the most appropriate form of analysis it is important to focus up-stream and consider the theoretical underpinnings of the qualitative data collection. Holstein and Gubrium (1995) use the term ‘idiom’ to describe four different approaches within the qualitative research field. Silverman (2001) describes these as particularly useful categories as they include “both the analytical preferences ... the use of particular vocabularies, investigatory styles and ways of writing” (p38). The idiom they detail are: Naturalism, Ethnomethodology, Emotionalism and Postmodernism.

Whilst in agreement that these are indeed basically useful categorizations that permit some structure and clarity for the research, they are also somewhat bounded and self-limiting. This, in fact, is a point not overlooked by the authors themselves who critique their own position. The interviews and diaries used to collect data for this project were to some degree emotionalist in that;

“interviewees are viewed as experienced subjects who actively construct their social worlds. The primary issue is to generate data which give an authentic insight in to people’s experiences.” (Silverman 2001: 87)

However, whilst the interviews, in this analysis, had been conducted from an emotionalist perspective, in that they were attempting to elicit the authentic experience, there remained a constant awareness that these were indeed ‘active interviews’ as defined by Holstein and Gubrium (1997). The concept of the ‘active interview’ implies that in the process of interviewing, the respondent; “constructively adds to, takes away from, and transforms the facts and details” (p117), therefore building or creating their own subjective experience. The implication of this is that all the qualitative data would undoubtedly contain some elements of ‘construction’ within the narratives. Here, we would witness a merging of Holstein and Gubrium’s (op. cit.) last two idioms as emotionalism, the authentic experience, envelopes some aspects of postmodernism by recognising how we all construct that very same experience for ourselves. This implies that, rather than purely privileging those experiences related to the researcher there is an ongoing attempt to unravel how, throughout the process, meaning is continually and mutually constructed and reconstructed. This, to some degree, complicates the analysis. Indeed, as these authors themselves are keen to remind us:

“The analytic objective is not merely to describe the situated production of talk, but to show how what is being said relates to the experiences and lives being studied” (p127)

This may require a dual focus. However, as becomes apparent from the detailed discussion in Silverman (2001), this dual focus, not only on the content of what is said (the '*what*') but also on the form in which it is told in (the '*how*') would require different analytic approaches. As the intention was to use the interview data to provide some insight into the curriculum of the workplace and the formal and informal learning experiences of participants, it seemed preferable to concentrate on 'what' was said rather than 'how' it was said. As such, the more intricate forms of narrative analysis such as discourse analysis or conversation analysis were deemed inappropriate. It is partly in agreement with Silverman (op cit.) that this decision was made, as he reminds us that;

“Some ambitious analytic positions ... may actually cloud the issue if your aim is simply to respond to a given social problem” (p113)

Despite the fact that the research topic may only be in part deemed “a social problem”, the advice seemed to hold good for the analysis of these interviews in an attempt to describe and interpret multiple perspectives on what is indeed a “social experience”. The analysis needed to be focused and designed to clarify rather than cloud the issue.

A simple form of content analysis was considered. Content analysis at its most basic is;

“ An accepted method of textual investigation [within which] researchers establish a set of categories and then count the number of instances that fall into each category” (Silverman 2001: 123)

To some extent this is a gross oversimplification as it denies the complexity within the genre of developing both conceptual and relational analyses. Silverman is highly critical

of content analysis claiming it potentially neglects or at least obscures the “interpretive processes that turn talk into text” (Denzin and Lincoln 2000: 640). Despite the fact that it offers a clear and systematic method for analyzing descriptive data it remains, by nature, inherently reductive. Furthermore, there is the risk of disregarding the context within which data were collected. Given the earlier recognition of an emotionalist perspective, any potential disregard of context would only serve to weaken the analysis and seriously reduced the possibility of this as an analytic position. In order to retain something of the clarity offered by content analysis but more scope for the recognized constructivist elements, a method was required which, whilst analyzing ‘what’ was being said in the interviews, also had the flexibility to permit the exploration of emergent themes and embrace the inherent subjectivity of the accounts. The framework of grounded theory seemed most appropriate.

Since Glaser and Strauss published their book ‘The Discovery of Grounded theory’ in 1967, the whole concept, has developed and diversified (Cluett and Bluff 2000, Charmaz 2000). Not only has the basic premise come under attack, but the original authors themselves have taken the concept in somewhat different directions. At its simplest, grounded theory offers an approach for analyzing and collecting data which allows theory to be generated from, and grounded in, the data. This involves iterative analysis as data is collected and analysed, whilst emergent themes are considered and explored in further data collection. The positivistic premise of this methodology has been attacked (Denzin 1994), as it can be construed as assuming an objective truth, out there, waiting to be ‘found’. However, when one of the original authors, Anselm Strauss, teamed up later with Juliet Corbin grounded theory seemed to offer a further development;

“ Their position move[d] into postpositivism because they also propose giving voice to their respondents, representing them as accurately as possible, discovering and acknowledging how respondents’ views of reality conflict with their own, and recognizing art as well as science in the analytic product and process” (Charmaz 2000)

This offers an opportunity for working systematically with qualitative data whilst keeping a firm grasp of the importance of context and constructed reality. Charmaz (op cit) suggests taking this one step further and offers us ‘constructivist grounded theory’. She contends that this strategy enables the researcher to occupy a middle ground, between postmodernism and positivism, maintaining the power of grounded theory but rejecting its “formulaic procedure” (p510). This more flexible, heuristic grounded theory is then combined with constructivism which;

“assumes the relativism of multiple social realities , recognizes the mutual creation of knowledge by the viewer and the viewed, and aims towards interpretive understanding of subjects’ meanings.” (p510)

It is suggested that this combination can step away from positivism, to successfully and usefully explore subjective experience whilst maintaining the rigour expected of good qualitative research. Consequently, this modified version of grounded theory, a constructivist grounded theory approach was ultimately adopted. This meant that iterative data analysis was essential in order to define the emerging themes or codes then these were explored at subsequent interviews. This of course has implications for sampling.

Sampling issues

In many senses theoretical sampling is a hallmark of classical grounded theory.

Theoretical sampling enables development of theory, as it emerges from the data, by the enlisting of new participants in response to the analysis (Cluett and Bluff 2000).

However, the sampling for this study was purposeful. LeCompte and Preissle (1993) prefer to call it criterion-based sampling in that participants are chosen as they fit certain criteria in advance of the study. The criterion for this project of being a newly qualified midwife, within a designated geographical area, at a given point in time, deemed that the sampling was inevitably purposeful. Both theoretically and practically this limits opportunities for theoretical sampling of participants. Nevertheless, whilst this deems a static research population and whilst the fifteen participants in this project did, in fact, remain constant throughout this project, this purposeful sample still allowed for theoretical sampling of *ideas*. As Charmaz (2000) describes;

“the aim of this [theoretical] sampling is to refine *ideas*, not to increase [or decrease] the size of the original sample. Theoretical sampling helps us to identify conceptual boundaries and pinpoint fit and relevance of our categories” (p519)

This meant that rather than changing the size or ‘fit’ of participants, what was refined and theorized throughout was the *ideas*. In turn, these ideas helped to frame each successive interview and lead to a continual distillation and clarification of categories or themes. Silverman (2001) points out the potential pitfalls of this “funnel” approach (p70) yet advocates its usage to avoid losing detail if that is what is required within any given project. However, he conversely warns against any simplistic attempts at reducing

complex social phenomenon to a single variable. By refining the ideas or themes emerging from the interviews whilst allowing for the differing interpretations of those themes, and by presenting a cross section of them for consideration, I hope to have steered the precarious course between the over complex, which clouds the analysis, an approach Silverman terms 'kitchen-sinking' (p70) and the risk of over simplification. Whilst I must admit to harbouring some of the philosophical reservations described by Silverman (2000) in that I was concerned computer aided analysis may "impose an alien logic" (p155) on my analytical procedures I nevertheless felt compelled to discover for myself if the benefits might outweigh the disadvantages. Therefore, choosing a qualitative software analysis package for the analysis of the interview data seemed most appropriate to navigating this precarious course.

Choosing NVIVO

In choosing an appropriate software package I had to consider not only the array of technology available but also the appropriateness of each package to the task in hand (Weitzman 2000). Having had some previous exposure to NUD•IST, about six years ago, I had found it unwieldy and over complicated however, I was reassured that packages have since improved. Nevertheless, as a novice researcher once again straying into relatively unfamiliar territory, an overwhelming consideration for me was choosing a package with which I could quickly become familiar and with which research and academic colleagues had some familiarity. As it was NVivo, version 2 seemed appropriate.

NVivo is a qualitative software package designed to store, organize and handle vast amounts of qualitative data (Darlington and Scott 2002). Within this project it was chosen firstly for its appropriateness to the task in hand. However, from my own researcher's perspective it also offered another learning opportunity. Whilst I remained acutely aware that it is 'only' a data handling tool and whilst having the advantages described by Weitzman (2000) of consistency, speed, representation and consolidation these are only in the context of the data exploration, and not to be confused with the similar issues within the data analysis. The jobs of analysis and theory building, whilst supported by the tools on offer within computer software, remain firmly the role of the researcher.

However;

“If the design of the program is such that it allows the researcher to move from one intellectual activity to another with minimal effort, and carry over the results of one sort of thinking to others, it can both free up large amounts of energy for the critical tasks and help the researcher to see and keep track of connections that might otherwise easily fall through the cracks.” (Weitzman 2000, p807)

Certainly in using NVivo for this research project, this has been my experience.

Nevertheless, the practical issues of the qualitative data analysis were perhaps not as clear cut as this suggests, beginning with transcribing.

Transcribing

In order to operationalise NVivo all the interviews had to firstly be transcribed and formatted into documents appropriate for importing into the software package. The

transcribing of the interviews was started as soon as the first interview was complete. This timely transcription ensured that I remained familiar with that interview and was able to mediate some of the inevitable “weakening” (Silverman 2000:10), which occurs when crucial pauses or overlaps may be ignored and hence lost in their contribution to the conversation. However, I retained the awareness that this familiarity, in itself, may contribute to the portrait of participants which each transcript will ultimately depict. Stronach and MacLure (1997) offer a critique of how the authority of the author and the “tyranny of the text” (p53) may in fact problematise the emergent stories. It was with due respect to this critique and an emerging awareness of the realistic time involved in transcribing interviews up to an hour long, that I gave thought to enlisting the help of experienced transcribers. However, the advantages of using an experienced transcriber could only come with some relative costs. If the transcribing was outsourced I felt, deeply and philosophically that I, as a researcher was already taking one step back from my data. As Atkinson & Heritage (1984) state the production and use of transcripts are essential research activities. The process involves lengthy, close and repeated listening to conversations. This offered me the opportunity, albeit a time consuming one, to ‘hear’ the conversations again and, as it transpired, begin some simultaneous analysis.

The emergent web of qualitative analysis

Whilst the explicit tool of analysis for the interview data was the NVivo software package, the reality of the research process was somewhat more complex or ‘messy’ as Robson (2002) describes it. In many senses the analysis was so iterative that it was difficult not to begin it during the interviews. Whilst the interviews were initially very

loosely structured, in keeping with my framework of modified grounded theory, the ideas that emerged were then adapted to generate themes for subsequent interviews. This is in keeping with the ideas of Collins (1998) who recognizes that even the most unstructured interview is structured at several levels, particularly when the research is of longitudinal design. For example, the researcher and participants become increasingly acquainted and thus the entire study becomes structured by that developing relationship and by ongoing interpretations. To this end, I include in appendix 3 a sketch of the refining *ideas*, which helped steer the interviews. Furthermore, it is important to consider that the context of the lives of both researcher and researched impacts upon the interview interactions.

Skeggs (1994) reminds us of the inevitability that research relationships are hierarchical on the grounds of power and difference. Nevertheless, as a reflexive researcher I attempted to ameliorate these differences. At the time of the research I was a full-time student working occasional clinical 'bank' shifts on a central delivery suite. All participants were aware of my history as a university midwifery tutor. Most seemed happy enough to accept me as a practising midwife and PhD researcher interested in current practice, and seemed to identify with me predominantly as someone who had 'been there' and remained at least peripheral to practice. I continued (and still do) to enjoy practising midwifery and actively resisted assuming that any flaws I may see in everyday practice were either relevant, or even evident, to any of the participants this, whilst at times difficult, was in keeping with the advice offered by Silverman (2001) who reflects that;

“ Paradoxically , by refusing to begin from a common conception of what is ‘wrong’ in a setting, we may be most able to contribute to the identification of both what is going on and thereby, of how it may be modified in the pursuit of the desired end” (Silverman 2001: 9)

Indeed to assume that there is a single ‘wrong’ or unified ‘truth’ to be uncovered would be antithetical to the epistemology of this project. Nevertheless, when I emailed five participants with a synopsis of my findings, prior to writing up, all replied positively. However, in recognition of the multiple ‘rights’ and ‘wrongs’ identified throughout this work I hope that through a variety of strategies, as described, I have been able to construct an account which whilst self-limiting in some respects is considered “thorough, careful, honest and accurate (as distinct from true or correct)” (Mason 1996). That said, evidently no methodological discussion is complete without some reference to the assumedly ‘gold standard’ criteria for research assessment; validity, reliability and generalisability.

Validity, Reliability and Generalisability.

Generally assumed as the ‘gold standard’ assessment criteria for research, these three concepts sit problematically within the qualitative research paradigm. Alternative criteria for the evaluation of qualitative research has been suggested by various authors (Lincoln and Guba 1985, Denzin and Lincoln 2000) and adopted fairly successfully. To some extent issues of validity were addressed within this topic by some degree of triangulation in method of data collection, participant evaluation (Mays and Pope 1995) and attention to disconfirming evidence (Silverman 2000) nevertheless the concept still sits

uncomfortably. Suggestions include substituting ‘trustworthiness’ or ‘truth value’ for validity. However, the latter, in some respects still remains problematic in assuming a unified ‘truth’ to be discovered. For this project, and much qualitative research, the suggestion by Scheurich (1997) seems wholly appropriate when discussing postmodern research evaluation he suggests that ‘validity’ or ‘truth’ is reconceptualised as many sided, complex and dynamic (p88).

Reliability and generalisability present somewhat different challenges but are equally applicable to all stages of the research process indeed as Silverman (2000) again reminds us;

“doing qualitative research should offer no protection from the rigorous critical standards that should be applied to any enterprise concerned to sort ‘fact’ from ‘fancy’” (p12)

Whilst the assumed clear distinction here between ‘fact’ and ‘fancy’ is in itself questionable the maintenance of rigour is the important point. Janesick (2000) vehemently contests the applicability of these terms, particularly generalizability, in that in its traditional view generalizability; “falls short, and in fact may do serious damage to individual persons... [and] limits the ability to reconceptualise the role of social sciences in education and human services” (p394). This has resonance with the recent call within the midwifery literature to consider “unique normality” (Downe and McCourt 2004) as a future manifesto for framing childbirth. Both approaches advocate stepping away from the tyranny of generalizability in assessing the credibility of qualitative research. Certainly within this project, looking at everyday lives of midwifery practitioners,

generalizability was never an aim neither is it an appropriate evaluative criteria. Perhaps as Kvale (1996) suggests all three concepts could be re-conceptualised for more appropriate application to specific, personal, local and community forms of truth with a focus on everyday life and local stories.

The above notwithstanding, it is nevertheless imperative that any scholarly work be upheld to evaluation of its quality and rigour. Whilst many suggestions exist in the literature for how this may be done, I hope that by close thought and attention to every stage of the process, by declaring underlying positions and assumptions and by the practice of ongoing reflexivity I have been the projects “intellectual critic” (Janesick 2000) throughout and achieved my goals of “thorough, careful, honest and accurate” (Mason op. cit.). Finally I offer a summary of what this chapter has tried to achieve.

Conclusion

This chapter has attempted to offer a path through the thought processes, decisions and actions that marked, and became, the methodology and process of this project. However, in attempting to offer this clarity there is the risk that the some of the complexities and enduring issues are marginalized. One such possible omission is the multiplicity and depth of reciprocity. Areas where complexity has been sacrificed for clarity may be more apparent in the presentation of the findings and ultimately the deeply interwoven, complementary and perhaps necessarily complex interplay of methodology and the realities of fieldwork fully addressed. Having now explored how this research evolved and operated we can begin to explore what was uncovered.

PART TWO

This second part of the thesis forms the empirical contribution to expanding the knowledge that has been discussed. It consists of five chapters, four findings chapters and a conclusion. Chapters four and five present an analysis of some macro issues relating to the positioning of midwifery and emotion work in midwifery. In chapters six and seven there is a more micro level analysis of issues of relationality in practice, concentrating on inter- professional and intra-professional relationships in turn. The final chapter sets out the conclusions of the thesis.

PART TWO

Chapter 4

Midwifery, 'Medwifery' and Identity

Midwifery, ‘Medwifery’ and Identity

Introduction

It is the aim of this chapter to explore issues of identity in contemporary midwifery practice. Concurrently, the meanings emerging from practice are considered. This dual existence and interplay of “learning as becoming” and “learning as experience” is portrayed by Wenger (1998) as an integral aspect of a situated social theory of learning (p5). Therefore, from an initial consideration of the process of ‘becoming’, the analysis broadens to the consideration of the contextual nature of the identity formations possible within current practice. Using a framework suggested by Griffiths (2005), the concepts of ‘socio-political structure of power’ and ‘diversity’ are used to frame the initial analysis. This permits an exploration of the essentially situated and circumscribed nature of identity, meaning and, as a result, learning. In doing so, this chapter highlights the usefulness of the concept of communities of practice. However, it also addresses a gap in the literature by combining COP with a specific example of workplace power relations and considering the implications for both identity and meaning. Although identity and meaning are parallel processes, this chapter will predominantly focus on the former, leaving the exploration of ‘meaning’ to the subsequent chapter.

‘Becoming’ as an essential process

“Human beings are essentially relational. Our identity is formed in webs of affiliation within a shared life world ... It is within the context of these

relationships, governed by existing and changing cultural paradigms, that we become the persons we are” (Mezirow 2000: p27)

It is important, in considering the experiences, that we are to see them as part of a process of becoming. The experiences recounted are all part of a larger narrative of personal development for which ‘becoming’ involves both stability and change (Baxter Magolda 1992, 1999).

Despite spending three years preparing to adopt the role of qualified midwife, at the point of qualification all midwives necessarily face this new element of their personal identity. However, ‘identity’ itself is a complex and contested notion. Issues of self and identity are prominent features in contemporary research in the social sciences (Ashmore and Jussim 1997) and increasingly any developments or changes in personal identity are recognized as a complex interplay of both personal agency and public discourse (Woodward 1997). Whilst these sociological concepts and debates would themselves warrant in-depth exploration, it is the intention of this chapter to explore, rather, how issues of identity are played out in practice in the transitional learning and the process of ‘becoming’ of newly qualified midwives.

In order to facilitate this and in accordance with the fundamentally feminist thrust of my argument, I adopt the framework suggested by Griffiths (2005).

Griffiths suggests three themes often to be found in feminist philosophy: socio-political structures of power, diversity and embodied relationships. Firstly, she identifies ‘power’ as both structural and relational, recognising that “power relations and structures

constrain who may belong in any social sphere” (p6). Secondly, she sees ‘diversity’ as presented as essential to any feminist understanding, where any identity or any practice “is crosscut by other markers of difference” (p6). Lastly, ‘embodied relationships’ are presented as foundational, in that any identity or experience (female or otherwise) is embedded within a variety of relationships. Each of these, as a defining theme of practice, contributes to the formation of identity for these women as they struggle to become midwives. For the purposes of this chapter, I would like to focus specifically on the issues of power and diversity, exploring each individually and then examining their combined effects on transitional learning in midwifery and thus their explanatory powers for a social theory of learning. The final concept of embodiment, whilst not addressed specifically in this chapter, provides the rationale behind chapters six and seven which focus on the impact of workplace experiences of relationships.

Socio-political structures of power

Socio-political structures of power are of relevance to women and midwives in a variety of ways. Kaufmann (2004) utilizes the notion to demonstrate how ideological forces clearly still prescribe women’s experiences whereas, Leap (2004), in the same text, adapts the notion to consider her own personal journey. These examples demonstrate the broad potential application of notions of socio-political structures of power, which may simultaneously be both political and intensely personal. Furthermore, it is vital that these receive due consideration in any analysis claiming a feminist epistemology. Wenger’s (1998) COP framework fails to do justice to aspects of power in the workplace (Myers 2005), but as Griffiths (op cit) makes clear,

“the effects of socio-political structures on [any] practice need to be taken explicitly into account or else they bias perceptions of expertise ... especially given the ubiquity of hegemonic masculinity” (p1)

Therefore it becomes apparent why a consideration of the socio-political structure of power is essential in addressing research question two. This question asks; what is the curriculum of the workplace in terms of organizational and professional mores and expectations and how are these institutionalized as transitional learning for newly qualified midwives? The guiding concept of legitimate peripheral participation here reveals how newly qualified midwives negotiate (or surrender) their identities, quickly learning the most acceptable, or easiest, way of being, in a familiar if busy and politically riven practice.

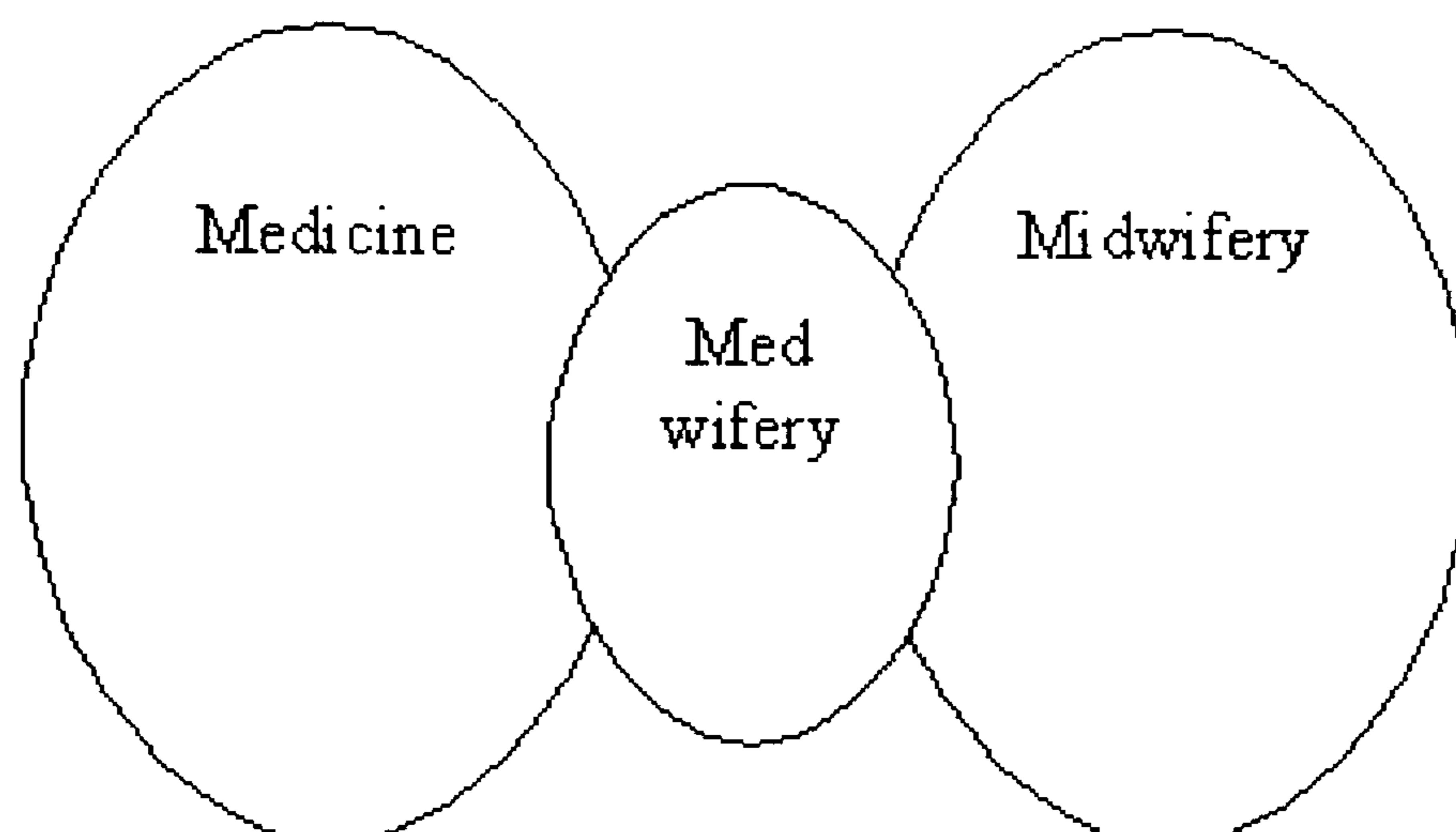
Lave and Wenger's (1991) work on situated learning rejects the more individualistic notions of learning in asserting that all learning is not only specifically situated in any given place and time but also inevitably linked to social practice. As demonstrated in chapter two, midwifery practice, like many other communities of practice, is steeped in political and social history. Furthermore, the everyday of practice remains riddled by politics both strategically and personally. It is, in part, through analysing this complex interplay of power and dynamics that this thesis hopes to contribute to the literature on communities of practice (COP) and legitimate peripheral participation (LPP). Unlike the assumed trajectory of LPP, which presents an unchallenged centripetal dynamic of development; novice to expert or periphery to centre, midwifery and the politics therein offers the opportunity to reverse this 'centre focused' logic.

Firstly, I build the argument that what emerges from this exploration of contemporary midwifery practice is that the current practice described within the data fulfils all the requirements for the community of practice identified to be described as what Wenger (op cit) terms a boundary practice(p115). That is, “an ongoing forum for mutual engagement” (p114) that has emerged from the connections at the boundaries of two different enterprises. It is possible to conceptualize that in a historic attempt to bring together midwifery and obstetrics the connections have grown exponentially and a boundary practice has emerged. Whilst this boundary practice, here labeled as ‘medwifery’, is specifically neither midwifery practice nor obstetrical practice it provides a forum for mutual engagement. However, whilst mutual engagement has flourished within this boundary context, the community of practice previously associated solely with midwifery practice has atrophied. Figure 1 below shows the relations of this type of boundary practice to those practices it emerged from in its attempts to connect them. For the purposes of this analysis I have called the emergent boundary practice ‘medwifery’. This is intended to clarify the combination of the two communities whilst leaving no doubt as to the leading force. The term has been used before in the Canadian/American struggle to maintain legal midwifery provision. My intention to try and define a practice governed by obstetric norms is reflective of this previous usage, but I also intend to provide a crucially different and extended conceptualization of ‘medwifery’ in terms of identity formation and transitional learning.

It is initially important to conceptualize where this boundary practice may sit. The following figures provide a crude developmental perspective. Figure one shows how

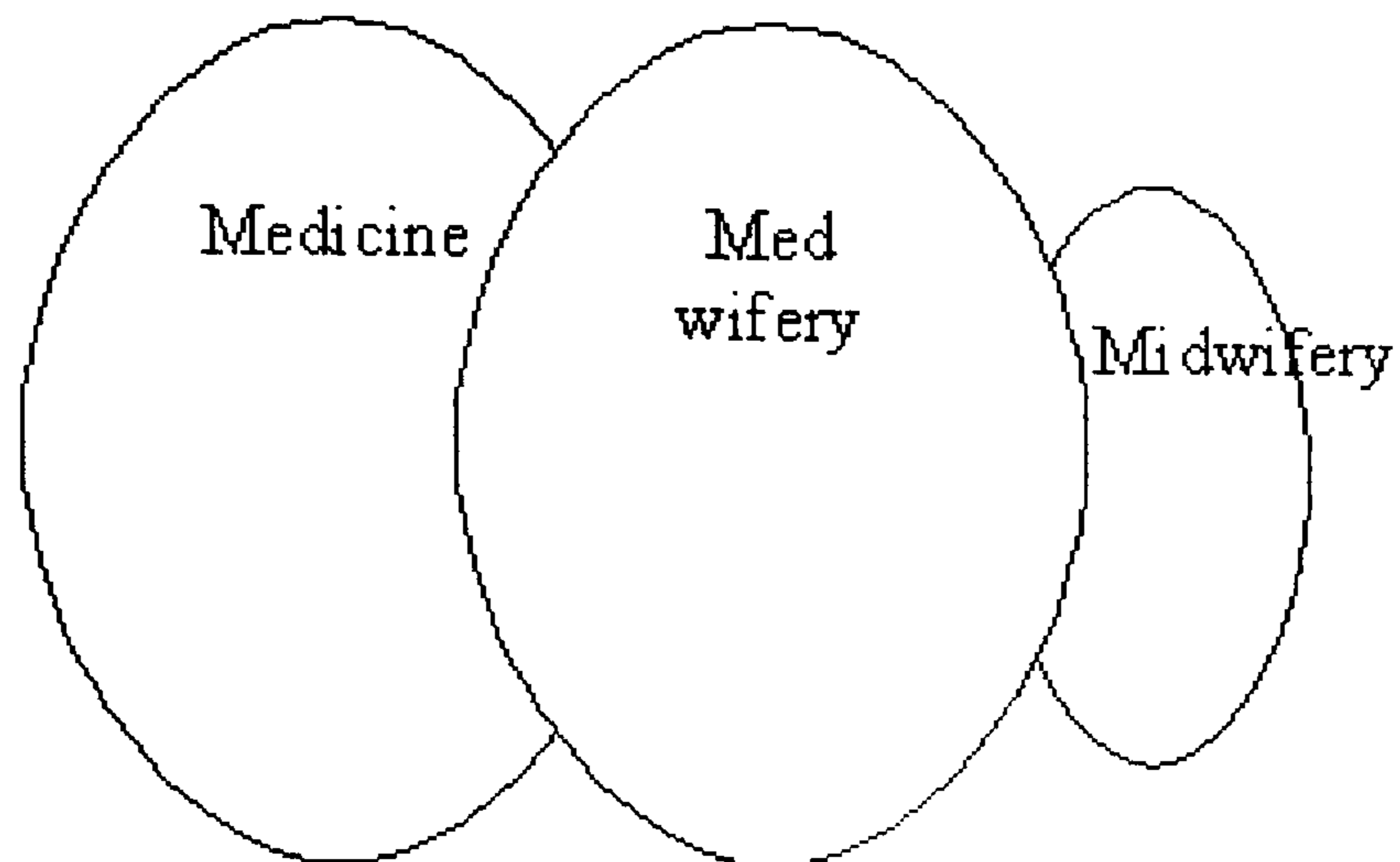
historically a boundary practice emerged to provide a ground for the mutual engagement of medicine and midwifery.

Figure 1: Conceptualising 'medwifery': a boundary practice



Theoretically this allows the two separate communities of practice to continue virtually unaffected and a boundary practice 'straddles' the knowledge and practice between the two communities. However if the current domination of medicalized childbirth was reflected in the diagram it may look more like figure 2.

Figure 2: Conceptualising the growth of 'medwifery'



This reflects the exponential growth since the 1970s of obstetrically regulated childbirth and, despite resistance, the simultaneous contraction of the midwifery profession (Mander and Fleming 2002).

Conceptualised as such, the emergence of 'medwifery' has had profound implications for the legitimate learning that can take place within any of the communities of practice represented. Furthermore, it has profound implications with respect to peripheral learning, as there is more than one periphery and more than one centre. This notion is explored further in the next chapter. Nevertheless, the symbiosis of these communities is crucial to the identities that newly qualified midwives are able to either construct or resist.

Wagner (1994), himself an obstetrician, argued that the “global struggle for control of pregnant and birthing women” (p5) had gone too far. His argument aimed to counteract the injudicious use of birthing technology, calling for a reassessment of human values in healthcare ethics long before Fulford et al (2002) were to do so more explicitly. However, if recent statistics are a reliable indicator (DOH 2005), with the caesarian section rate resuming an upward trend to almost 23% of all births, over 20% of deliveries induced and the ‘normal’ birth rate staying well below 50%, then the march of medicalised birth has been far from halted. In this context, it is easy to see why current hospital-based midwifery practice may more easily fulfil the criteria of medwifery than midwifery. Indeed, this is borne out by all aspects of the data collection. As already discussed, 100% of respondents were planning to work in the NHS, with few viable alternatives for employment as a midwife. They were all to be predominantly hospital-based and certainly attached to a large obstetric unit. Data collected from the surveys begins to reflect the environment within which these participants are practicing midwifery. Some of this data is shown in the table below.

Table 5: Survey questions and responses: context

Question	Survey 1	Follow-up survey
	% of participants that agreed	% of participants that agreed
Do you feel you have been adequately prepared to take on the role and responsibilities of a qualified midwife?	66%	75%
I feel that protocols may (did) restrict my ability to provide the type of care I want to.	63%	40%

I feel I will be (was) able to provide the type of care I want.	85%	62%
I am worried by the increasing threat of litigation.	82%	71%
I feel that insufficient staffing levels frequently compromise client safety.	90%	94%
I feel I will be (was) able to finish work when my shift ends.	27%	29%
I feel that my physical and/or mental health may (did) suffer because of my work.	42%	48%

Whilst the majority felt adequately prepared for their role, a majority also expected to have their practice restricted by hospital policy. Paradoxically, one year later, there was a marked decrease in those who in fact felt that hospital policy had restricted their practice, whilst there was a parallel decrease in those who felt able to provide the type of care that they wanted to. Furthermore, in a context where the evidence supports a persistent fear of litigation it is of concern that the vast majority of respondents anticipated that staffing levels would “*frequently compromise client safety*”. This position remained little changed a year later. As practical points of concern, few felt able to leave work when their shift finished and ultimately almost half not only anticipated that their health would suffer but a year on, some actually reported this to be the case. These findings, in part, support the continuing existence of the unsatisfactory working environment and culture described in many midwifery texts (Hunt and Symonds 1995, Begley 2002, Kirkham and Stapleton 2004, Walsh 2005). Furthermore they support and help explain some of the qualitative findings.

It was quickly apparent from the interviews that the skills these midwives found most essential in practice were similar to the findings of Miller and Blackman (2003) and included prioritization of work, learning task orientated clinical skills and the ‘doing everything’ that was equated with being a successful midwife. One particularly unhappy midwife, after being qualified for three months, described the clinical environment as “rarely civilized” (Int. 11(a)), meaning it was intensely busy with little time for anything but basic care. She concluded;

“As newly qualifieds we haven’t got that skill of prioritizing... so we think ‘gosh we have got to do everything’ ... and it is all bitty, bitty care ... really awful ... you just spend time apologizing” (Int. 11(a)).

This description of fragmented care was almost universal and has been an ongoing issue for midwives and maternity care as well as consumers (Warren 2003, Bates 2004, Mahony 2005). The data from this project strongly suggests that this dilemma remains unresolved. When considering midwifery practice, Fahy (1998) drew the distinction between ‘doing’ midwifery and ‘being’ a midwife. She presented the philosophy of ‘doing’ as predominantly tied up with patriarchal rationale science and gathering evidence, whilst the philosophy of ‘being’ was presented as much more connected to the art of midwifery and waiting. Furthermore, the requirement to be continually engaged in ‘doing’ meant that there was little time for ‘being’. This is reinforced by the data from this study, where participants reported that clinical ‘doing’ tasks, like blood pressure and temperature readings often took precedence over the ‘softer’ skills of ‘being’, such as simply listening or observing, despite that fact many participants felt that it was often

these latter, more fundamental, midwifery skills which they are still unsure of. As we shall see in the later chapters, task orientation frequently takes priority.

However, for many, the incentive of being able to 'do' midwifery well is clearly career progression. This provides a clear and explicit framework to support their learned assumptions about what constitutes a 'successful' midwife. Some participants felt the focus on the medical tasks or "physical stuff" (Int. 8(a)) took priority above learning the less visible midwifery tasks that often required "intelligent inactivity" (Gaskin 2003).

The skills of vigilant watching and waiting seemed to form no part, either of the criteria for promotion, or for the identity midwives were actively encouraged to adopt. Indeed, in terms of identity formation their learning efforts seemed to be actively steered in the direction of midwifery. As an experience of practice, this is similar to some of the findings of Becker et al (1961) when they explored the learning efforts of medical students. They explore the importance of clinically identified values in shaping the learning effort; "the important immediate effect of the ...experience perspectives lies in their influence on the direction of ... effort" (p270). Hence, we see an explicit directing of learning efforts into the task orientation of midwifery, leaving less and less space for learning the associated, but very different, skills of midwifery. Furthermore, if learning this taxonomy of skills absorbs all effort, then as Heaney (1995) contends, this prevents any further learning, as "we do not learn when we are otherwise engaged" (p3). The advance of science-led medicine and the resulting midwifery has led to the degeneration of midwifery practice and hence an increasing invisibility of an entirely alternative modality. Whilst some may argue that this has been an intentional and strategic advance (Turner 1994), others present it as a more subtle loss of consciousness;

“As a discipline we need to be more *conscious* of the way in which our discipline has been subsumed into techno-rational science and away from our 'with woman' focus.” (Fahy 1998, italics added)

Whilst this section has begun to demonstrate how socio-political relations of power influence learning opportunities and hence identity formation, it is the important notion of consciousness that I will engage with later in concluding the chapter. Firstly, though, it is important to expand the consideration of the second theme of diversity.

Diversity

Issues of diversity are assuming increasing importance throughout society and for healthcare (Scambler 2002). Yet ‘diversity’ as a term has been adopted so widely that it is important to clarify its meaning. Whilst I will use it in its most literal sense to identify categories of difference, such as gender, age and motherhood, it will also imply the potentiality for multiple crosscuttings of identity. This complexity entails that every individual carries numerous aspects of ‘being’ in one personhood. Each identity will necessarily entail membership of numerous different communities and this will impact upon the community under study. For instance, one midwife may also be a mother, a wife, a sportswoman, a sister and a lesbian. Each identity will affect the other, yet each also stands as an individual part of that identity. As Griffiths (op cit) states, “different cultures and practices leak into each other” (p7), a situation she depicts as both an avenue to progress and a cause for celebration. In this chapter, some aspects of diversity will initially be suggested and explored. This leads to a consideration of what some aspects of diversity contribute to the individual experiences reported and whether, for the state of

learning, they do indeed result in progress and celebration or to the individual's 'learning' in fact, something quite different.

Diversity manifests itself in a multitude of ways. In part, sociological study is the exploration of similarity and difference between and amongst different groupings (Stacey 1993). Furthermore, much work on women and women's health is both marked by diversity and further cross-cut by it (Graham 1993, Doyal 1995). In exploring learning, and certainly for any situated social theory of learning, it is vital to consider how manifestations of diversity are able to impact on identity formation in the process of 'becoming' a midwife. This is, of course, both diversity of individuals and diversity surrounding individuals. By its very nature diversity is both easy and difficult to see. Within this project, diversity could have been tackled in numerous ways. However, in deciding which elements of diversity to discuss, it was most logical to return to the words of participants to explore which elements of self identified diversity emerged as recurrent themes. In doing this, the most prevalent individual themes were gender, age and perhaps not surprisingly, motherhood. It is, therefore, these three elements of diversity that will constitute the framework for the first section of the exploration. The discussion around individuals and diversity focuses very much on the lack of diversity, which theme, consequently, will form the basis of the latter part of this section.

Gender diversity: Women in a Mans world

The midwifery profession always has been and remains predominantly female. In fact 99.7% of the current practicing population is women (NMC 2005). This was certainly reflected in my own sample, where initially, of the ninety potential recruits, only one was

male. Also, not surprisingly, throughout the period of the research none of the participants interviewed worked directly with a male midwifery colleague. Accordingly, gender difference was something I was unable to explore directly amongst participants, as the only potential male midwife was lost to the study for personal reasons at the point of qualification. Griffiths (op cit) discusses diversity briefly, mostly with reference to gender difference, although she is keen to emphasize the importance of diversity to issues of belonging and becoming. Indeed, as an issue of belonging, being a woman, in the context of midwifery practice is usually seen as an advantage if not a necessity (Murphy-Lawless 1998) and whilst the discussion about male midwives and their issues of ‘belonging’ continues (Beckett 2004, Powell 2005), it is once again beyond the remit of this discussion. However, the visible advantages of being female were not lost on these midwives.

“That is what we think is going to give a good outcome [female support] ... I mean you can see and research is backing it up that the more women aren’t supported emotionally, the more likely they are to need these interventions in the first place. If you can support her is best... and I’m not wholly convinced that fathers are the best person to be in there with a labouring woman in the first place. I think she is much better off with a female birthing partner”. (Int. 13(a))

Interestingly, a year later this same participant offered two potentially conflicting explanations for midwifery as ‘women’s work’;

“I think there is something in the female psyche that automatically is able to understand another woman when it comes to childbirth”. (Int.13(c))

However, later in the interview she began to identify with some of the possible structural disadvantages of being female when she added;

“I think it is a culture that had been propagated in many walks of society not just in medicine. It is male dominance; I mean how many female consultants do you know? I have worked in two hospitals and only know of two consultants”. (Int. 13(c))

It is interesting here that it is not just the lower status of midwifery that is in question but also women in medicine. Indeed, whilst medicine currently remains a male dominated profession, this looks set to change as female entrants to medical schools continue to increase (McManus 2002). However, as seen in chapter three, current obstetric practice stems from a history of patriarchal dominance led by techno-rational science and the boundary practice of midwifery that we are exploring maintains many of these traits. The greatest gender diversity in evidence from this data remains that between midwives and medical colleagues. Whilst this is explored more thoroughly in chapter six, the relevance of this here is how these differences (and similarities) contribute to identity formation in these newly qualified midwives.

Historically, the midwifery and obstetric division of labour was perhaps clearer.

Midwives, whilst still practitioners of normal childbirth, have been encouraged both professionally and politically to take on ever-extending roles. This has led to increasingly blurred boundaries between midwifery and obstetric practice. Midwives now site intravenous lines, prescribe and administer selective drugs, provide support in operating theatres and even perform assisted deliveries. As these boundaries blur, so too do the

opportunities for the formation of distinct professional identities (Donovan 2005). In keeping with the post-modern ethos of this thesis, no 'identity' can be considered singular or unitary, indeed, "the notion of a unified self begins to stand out like a relic from a bygone era" (Rowan and Cooper 1999). However, as a fragment of the whole person, the professional identity is crucial to the 'becoming' of these women. Within this study it is that process of 'becoming' as a midwife which effects participation. It seems that these midwives are increasingly encouraged to be medwives and hence adopt the identity of an efficient colleague. However, this is often not a conscious move but simply part of the orchestration of a days work, carried out in order to 'fit in'. The implications of this will be explored in the conclusion of this chapter after we have considered some of the other impinging elements.

Age diversity

Age was something that participants referred to time and again. A simple text search of the interviews finds 347 specific references to age. The vast majority of currently practicing midwives are between 30 years of age and 50 years of age (NMC 2005). This is not reflected in my own sample population, where, as shown previously in table 2, the age split, between those participants less than 25yrs old and those greater than 25, was roughly even. The largest sub-category of the more mature entrants was the 'thirty somethings'. This is to be expected in a project intentionally exploring newcomers to a profession, but what is surprising is that, despite the success of direct entry midwifery programmes (where entrants can be younger than ever before) and an increasing yearly recruitment, the percentage of practicing midwives under 40yrs of age continues to

decline (NMC 2005). In fact, in spite of any developments, the percentage of practicing midwives under 40 has almost halved in the last ten years from almost 60% to 31.5%.

Whilst some of this will be attributable to the ageing of staff already in the workplace, it supports the suggestion of Ball et al (2002) that we may be failing to retain our younger members. It seems particularly urgent, therefore, that some of the age issues are given due consideration.

Looking closely at the data it emerged that 'age' represented multiple opportunities and challenges for these midwives. Indeed, 'age' was often used as a metaphor for wisdom and experience, whilst at other times it was a metaphor for cynicism and authoritarianism.

Here are just a few examples. Older midwives sometimes represented protection;

“They all look after me ‘cos I work nights and I always work with a lot of the older school midwives ... I was there as a student ‘cos I was the only one that did nights ...so I was very protected by them” (Int. 5(c))

or wisdom;

“I think midwives are very knowledgeable and I don't mean academically, I mean in their field. Some of the older midwives that haven't got degrees things like that. They know by looking at a lady she's not far off. Whether that is intuition I'm not sure, I'm not sure what it is.” (Int. 6(a))

but sometimes haste & disapproval;

“I think they [older midwives] see things differently ... they are there to see each woman quickly ... I mean they have done all their women and I have only seen two and they say ‘hang on, you have had all that time’ ... but they just get on with it and don’t spend as much time talking to the women or finding out things” (Int. 4(a))

or authoritarianism;

“She is going to retire anyway ... But even the older midwives who have been there a long time will just bow down to what she says. And what she is doing ... so much of it is not quite right.” (Int. 5(a))

What is interesting is that the concept of an ‘older midwife’ was never clearly articulated. Despite the probing of the researcher, nobody could specify a particular age or length of service. Once again it seemed to be a relative concept tenuously linked to both chronological age and years in practice. In this context, ‘age’ operates as a metaphor. What it is interesting to consider is that as the entry age to midwifery education is not capped, it will become increasingly difficult in practice to clearly delineate this definition. Nevertheless, the phenomenon had powerful implications for these learners. Therefore it is important to look further at how the metaphor of age operated within this study.

Age as metaphor

Whilst participants frequently referred to ‘age’ or ‘older’ midwives it seemed that what indeed was happening was that these terms were being used as representative of some

other concept. In this study, derivations of 'older' were frequently aligned with either, support and wisdom, on the one hand, or cynicism, authoritarianism and bullying, on the other. However, the attempts to interpret 'age' were widely disparate. For some, 35 was old, whilst for others, 'old' meant approaching retirement. The diversity found amongst the interpretations of age is inevitable in a practice consisting of so many individuals. Yet as a metaphor for a way of being, or a way of becoming, be that 'wise' or be that 'a bully', both offer a representation of the paradigmatic trajectory explored in chapter seven. This means that in each case newly qualified midwives are envisaging ways of being as an 'older' midwife. They could hope to adopt the mantle of wise protector, hurried authoritarian or any other stance they see played out before them. Furthermore, it is probable that these interpretations of 'age' are affected by their own chronological age and identity as a 'youngster' or otherwise. Yet 'age', as an indicator of any specific traits was unreliable.

The survey, though, revealed some interesting cross tabulations with age groupings. For instance, less than half of all participants, 38 out of 88, had responsibilities caring for dependants. This may seem surprising given the age groups involved, but may reflect the space in the lives of women generally to undertake higher education. Perhaps unsurprisingly, those with responsibilities for dependants were clustered in the 30 – 45 age group. In response to a question on balancing work and private life these participants were no more likely to find this important than their younger contemporaries. One young participant demonstrated this sentiment in her diary saying; "I hate working weekends – really interferes with my social life" (Diary 2, p1.) and refers to it again in her first

interview but specifically with reference to the lack of control that she has over her own shift pattern;

“I find it really awful ... you go to work and you look at your hours and you think ‘what on earth do they think they are doing with my life?’” (Int. 10(b))

Kirkham and Stapleton (2004) comment on how focusing on these somewhat superficial manifestations of control and areas of discomfort, continue to distract from the need to address change at a much deeper level. Nevertheless, superficial though they are, as a pedagogy of the everyday, they impart an important ‘lesson’ to new members of the profession, regardless of their chronological age. This is not to say that more mature midwives coped any better with having little or no control over their own working hours, despite this group’s greater propensity to work part-time. In fact, of the responses received after one year of practice, 100% of respondents under 25yrs of age had worked full time, whereas across all other age categories the rate of part time and full time was 50: 50. Indeed, many saw cutting their hours as an essential coping strategy and this was not restricted by age;

“I really do think that there is something to being full-time at that place. I find that the part time people like myself are a lot more bubbly and positive than the ones who work there full time and are just fed up of it.” (Int. 11(b))

and;

“Even some of the young girls that don’t have families are working four days a week. I think it is one way that you can keep your sanity” (Int. 12(b))

It is interesting then that 'age', when referring to 'older' or maturity was most commonly aligned with wisdom, authority or cynicism whereas 'young' had very different connotations and therefore was used metaphorically in different ways.

Being 'young' was referred to by a number of participants. Once again 'young' was a relative concept of varying interpretation. At times, and usually in reference to themselves, it was used as a metaphor for 'inexperienced':

“because I am younger, I feel like that is against me because I feel that life experience, well I haven't got it ... not like other people have, I haven't had children of my own, I don't own my own house ... I feel I am up against that in a way, they are more interested or interesting because they have got more in their own lives than maybe I have. Even though I have a busy life I feel 'cos I am not as old as them and 'cos I am not experienced and 'cos I am young and new that... my opinions ... they are not as valid in a way. (Int.10 (a))

Evidently it was also at times associated with being undervalued. This is obviously not an isolated feeling, as evidenced by Wickham (2003), now a notable British academic in midwifery, who as a younger newly qualified practitioner recounted;

“No-one could see past my newly-qualified-ness to discern anything I might be able to offer to women as a midwife” (p6)

In her case, it led to her leaving to practice midwifery in another country, where she hoped to find a different perspective. A similar form of undervaluing was apparent when one younger participant had her decision to be a midwife questioned by colleagues;

“People say, “You are so young, what are you doing in this profession?” and I say, “because I love it, I absolutely love it and I wouldn’t want to do anything else”. Like I am quite good on computers and things and I have helped other midwives on the computer and they say “Why don’t you do IT?” (Int. 8(a))

This midwife was astounded and insulted to have her choice questioned and found that, for her, it often felt unsupportive. Nevertheless, ‘young’ also appeared in the data as a metaphor for innovative and dynamic. In this context ‘young’ sometimes also implied agents of change;

“A lot of the G grades that have come in now are younger and it is not as cliquey as it originally was” (Int. 5(c))

It seemed that the presence of younger midwives fostered the hope that they might stimulate innovative development.

“I think it is a shame for the midwives that are in the cycle of ‘Oh, get a lift-out, oh, get an epidural’ instead of being a midwife being ‘with woman’ like it should be. I think that they have gone now; you are never going to get them back as midwives, but like young or new midwives ... there’s hope”(Int. 10(a))

Additionally, ‘young’ was also related to an almost naïve enjoyment of the job, which was in contrast to the cynicism often associated with ‘older’ colleagues. One participant describing her enjoyment of the job repeatedly said she often felt ‘different’. Asked then if midwives generally seemed to enjoy the job she replied;

“I think probably the younger ones do but I don’t think the older ones do. The ones I have spoken to say ‘Oh, it’s not like it used to be’” (Int. 12(b))

Evidently, although age was used as a metaphor throughout the study, it proved an unreliable point of reference in many ways. ‘Age’ in itself was an unclear concept, such that falling into either ‘old’ or ‘young’ definitions were no guarantee of either a positive or a negative reference. Another participant makes this clear as she struggles with explaining and understanding the promotion of some ‘young’ colleagues ahead of their ‘older’ peers;

“We have got a lot of new G grades which also it’s quite hard to take because a lot of the older midwives don’t like that fact that a lot of the new G grades have taken over who are all quite young. I can see it from both sides, there are some that have been there that are 40 or 45 now and that should have got the G grades because of the knowledge that they have got. With the women and the students they are brilliant ... and they should have got it over one or two of the G grades that have got it ... It is like everybody is competing for their ideas to be used and none of us are quite sure what should be going on.” (Int. 5(a))

This final statement, “none of us are quite sure what should be going on” is perhaps one of the most telling here. As mentioned earlier in agreement with Kirkham and Stapleton (op cit) it could be that the whole ‘age’ thing serves as a smoke screen detracting from deeper issues of concern to midwifery.

Whilst 'ageing' is unavoidable in any community and chronological age bestows no guaranteed attributes, an increasing length of time absorbed in any one community of practice will inevitably affect the process of 'becoming' which one can undertake. Age then may only, and at best, reflect a given amount of time spent participating in a community of practice, itself encouraging alignment with the philosophy of those mutually engaged. However, this factor is likely to be clouded by the further diversity of work location and working hours. Participants themselves also regularly referred to another aspect of diversity that heavily influenced the identities they were or were not able to develop, motherhood.

Mothers and non-mothers

At the outset of this project, motherhood was one aspect of diversity I rather naively, and unintentionally, failed to consider. In all likelihood, this most probably reflected my own status as a non-mother, what Greene (1998) refers to as an influence of my own history.

Yet motherhood has a profound effect, not only on the individual's sense of identity, but also on the practical considerations of how that individual proceeds to live their life and hence their learning opportunities. Whilst Kaufmann (2004) considers the complex web of maternal privilege, maternal power and maternal drudgery, she is quick to recognize that being a mother is not a precondition of being a feminist, in the same way that motherhood or a feminist identity would necessarily be preconditions for being a midwife. In fact, less than half, only 43%, of the survey population identified themselves as having dependants as they came to the end of their training. Unfortunately, the survey tool does not permit differentiation between children and other dependents, such as

elderly relatives. Nevertheless, the statistic is probably also a reflection of the time and effort required to commit to a three year degree programme. In addition, in the qualitative data collection, nine out of the fifteen interviewees had dependant children at the time of the interviews. Notwithstanding the importance of the expanding body of literature on informal social support networks of those in higher education, including family and friends (Blaxter 1994, Wilson 1997), motherhood remained an important issue for participants in this study.

Being a mother held the ambiguous position of at times, contributing to their developing identities, and at others serving as a restriction to limit current and future possibilities. It remains an issue of contention, in the literature and in practice, as to whether being a mother and therefore having experienced pregnancy, birth and hopefully motherhood imparts benefits to being a midwife (Downe 1998, Taylor 2000). However this question is beyond the remit of this study. Whilst participants certainly mentioned it, it was not the main aspect of motherhood that was of concern. When motherhood was raised in this study it was in keeping with the article by Sandall (1998) which discusses the competing demands and continuing compromises that are required. This is not dissimilar to the paradoxically powerful but potentially destructive notion of motherhood offered by Nicolson (1993). Trying to be the best midwife they could be, whilst also being the best mother was a constant tension for many;

“I feel guilty about not being the best mum that I could be. I feel I do a pretty good job but it is difficult”. (Int. 1(c))

Whilst this is by no means a new issue (Oakley 1985), it still has an obvious impact on the identities that these midwives, both mothers and non-mothers can ascribe to. Once again the role of mother was something of a paradox. Some participants felt that it facilitated a greater confidence, particularly when it came to ‘juggling’ work;

“It’s hard ... whether it’s because I’m a mum and I have learnt to juggle, I am quite good at it.” (Int. 5(a))

Another participant, from a traditional Asian background, felt that her working set a good example to her children, particularly her daughter;

“They are actually glad that I go out to work, it sounds horrible, I sound like a bad mum but they are really glad that I go out. My daughter especially, she is really, ‘oh I want to be this when I grow up, I want to do this or this’. Before she never used to say that now she does...” (Int. 4(a))

However, whilst these mothers were able to identify positive aspects of motherhood, which they absorbed into their identities, for many others, the major aspect they perceived was that of continuing compromise. A single mother of one son felt torn between earning a good income and spending time with her son;

“I think it is important that I am a good mum as well and I don’t think I am giving a great deal at the moment ‘cos I am too tired. My days off ... two days a week, one is in the garden and one is doing housework “(Int.12 (b))

She was already considering her compromise;

“Working full time and being a single mum is hard and I am going to drop my hours in September to four days a week.”(Int. 12(b))

Others felt that it potentially limited their career choices and sometimes led to discomfort in the workplace. One participant, who requested an early finish due to unusual family difficulties not only felt covertly ‘disciplined’, but her request remained unfulfilled;

“I had to leave at 2 ‘o’ clock to fetch my kids from school ‘cos for once my mum couldn’t ... she [senior midwife] came on the ward ... and she said “Why haven’t you warded the lady?” and I said ‘cos I wasn’t happy with her B.P’ ... she was quite sharp with me; “I’ll get somebody else to take her because you have got to go” and I said “Well I asked about this a week in advance, you knew I had got to go” but in the end nobody came to relieve me anyway so I ended up being late” (Int. 13(a)).

Obviously situations such as this are unsustainable for mothers who have caring responsibilities outside of their work. Two of the mothers expressed their desire to find alternative work models, but recognized that with young family and no locally available options, their opportunities for more flexible midwifery work were limited. Within the large obstetric units that they seemed destined to remain in, it seemed that the easiest option for them was what Kirkham and Stapleton (op cit.) referred to as “going with the flow” (p124) or, as one of the two midwives referred to above phrased it, “put up and shut up” (Int.11 (a)). Inevitably, this impacts on the identity they are able to inhabit as a midwife and the meaning their work can have for them. These are points to which we will return in the conclusion. However, at this point I want to re-visit the notion of

‘consciousness’ introduced earlier and explore the potentially conscious or unconscious nature of the learning to which those things considered so far may contribute.

Conscious or unconscious learning ?

Many approaches to learning have tried to explore the acquisition of knowledge through non-traditional and frequently non- formal routes (Dale and Bell 1999, Coffield 2000).

Eraut (2000), in particular, makes a strong and enduring case for exploring beyond what is not ‘obviously’ learnt in professional practice. However, for the purposes of this

analysis, Rogers (2003) draws a particularly useful distinction between certain types of

learning in professional practice. Whilst avoiding a detailed examination of ‘unconscious’

learning, what he does offer is a distinction between learning which is *task* conscious and

learning which is *learning* conscious. The former is offered as a form of acquisition

learning where there is really only focus on ‘getting the job done’ and what is learnt is

unconscious, whereas with the latter, there is a conscious focus on what is to be learnt

and indeed “learning itself is the task” (p27). In Rogers’ presentation, there is a

continuum between both types of learning, with no clear distinctions between either end,

but rather, a merging of all levels. However, although offering an interesting and useful

analysis, the explanatory power of this particular concept is increased if combined with

the type of dualistic thought that is essential for understanding communities of practice.

Wenger (1998) implores that in considering situated social learning we attempt to think of formally conceived dichotomies as dualities;

“a duality is a single conceptual unit that is formed by two inseparable and mutually constitutive elements whose inherent tension and complementarity give the concept richness and dynamism” (P66)

If, as this suggests, we take Rogers’ opposing typology and conceptualize them as a single unit it is possible to explore how the interplay of these may contribute to the professional learning experiences within this study. It is important to remember that with a duality, unlike a dichotomy, more of one does not necessarily imply less of another. High task consciousness may be combined with low learning consciousness on the other hand and depending on the circumstances both may be high. What is important to consider is the implications for learning of the possible combinations and furthermore and most crucially, what is the assumed task?

For the purposes of this analysis I argue that during this first year of qualification the receptiveness to task conscious learning is high. This correlates with the findings discussed earlier of Miller and Blackman (2003), wherein newly qualified nurses do just the same as these midwives and equate being successful with “getting everything done”. This potentially makes them very receptive to the unconscious learning associated with task consciousness. Furthermore, like many of the apprentices studied by Lave and Wenger (1991), they are acutely aware of the necessity of self-transformation from ‘rookie’ to ‘old timer’. However, it is then important to consider briefly the different potentialities for learning if the complementary aspect of learning consciousness is either high or low. Before we can proceed with this, though, it is vital to consider what ‘the task’ is.

The task: Medwifery of Midwifery?

It is important to consider what the perceived task here is, as this, once again, effects the direction of learning effort. If medwifery is dominant in the community of practice then the necessity of learning the objective tasks of medwifery demands the prevailing effort. On the other hand, if learning midwifery is the task then the objective requirement to master techno science would constitute less of a demand, as learning effort would be directed to learning other skills. However, in practice what realistically appears to be happening is some uncomfortable combination of the two, a discomfort that these midwives have to live with and ultimately somehow reconcile.

It was quickly apparent from most of the participants that their primary focus was on learning the skills which provided them with objective 'facts' upon which to base any further actions or decisions. One of these skills was perceived as of paramount importance for the vast majority of participants. This was the skill of the vaginal examination (V/E). Despite the fact that there are many other signs that may indicate a woman's progress in labour, the majority of respondents felt that there was a pressure to know, objectively, how advanced the labouring woman was. Whilst in more experienced practitioners there may be more room for consideration (Hanson 2003) and questioning of any real 'objectivity', for newcomers the V/E tops the hierarchy of 'evidence';

“There are all the other things but to begin with you forget all about them ... the first few times you forget to look for the other tell-tale signs, the involuntary pushing, the pouting, the show ... all those things. You depend on a good V/E”

(Int. 13(a))

This demonstrates how the supposed ‘evidence’ of a digital, internal examination quickly supercedes other forms of evidence in quick moving practice. Indeed, waiting for and observing other “tell-tale” signs generally takes more time. Time, again, is something that all participants repeatedly felt there was not enough of. However, in a different context, the primary task was construed somewhat differently.

For the purposes of considering what the primary ‘task’ might be perceived to be in a different context, I intend to employ data given by the only participant who, by her own recognition, had gone to work in a low-risk midwifery led unit. Whilst still located within a big regional unit, this small separate ward area functioned as a low risk birthing area for women and their families. This was the only participant who felt she had been able, at the end of twelve months, to contrast two very different, whilst surprisingly similar ways of working. This participant spent the first nine months of her qualified practice in a midwifery led unit. For the final three months of her first year she then moved onto an obstetrically led mixed ward area in the same hospital.

When she initially reflected on how and what she had learnt in the midwifery unit she offered;

“It is being part of it ... it has been ideal to use a pinards and be able to pick up the heartbeat and recognize the normal ... just listening as opposed to having to look on a monitor” (Int. 14(b))

Here it is evident that she does not yet value the reification of the heartbeat, an issue explored in depth in the next chapter. In fact, in stark contrast to the other participants

most of whom regularly saw the use of continuous fetal monitoring in labour, this participant rarely employed this technology. When asked, she suggested that in nine months of midwifery practice only about five of all the women she had cared for had been continuously attached to a monitor. Her learning efforts had been directed at looking for the other tell-tale signs of labour. She added; “Body watching is really important ... how they are progressing” (Int. 14(b)) and added;

“I think there is a lot more freedom to develop here as a midwife ...whereas downstairs you might have been more cornered into a certain path of midwifery” (Int. 14(b))

Indeed this certain path is defined by a different participant when she says;

“It is conforming to the regime of the ward and you are sort of indoctrinated into one way of thinking” (Int. 4(c))

It seems that these findings suggest that whatever the ‘path’ of midwifery it entails some degree of peripherality. One either conforms to the institutional ‘regime’ and remains therefore arguably peripheral to ‘real’ midwifery or else, given an accommodating context, one may move centrally to the practice of midwifery but this might suggest remaining peripheral to the dominant hospital culture. These aspects of peripherality are also expanded in the following chapter, but it is important here to pay some attention to learning on the periphery and resist the assumption that this is always a disempowering position.

Learning on the edge

Ultimately then, it seems that much of the learning that actually takes place is located within a nexus of diversity and almost inevitably at one periphery or another. Figure 2 earlier in this chapter illustrate this position. Newly qualified midwives embarking on a career in contemporary practice have to reconcile the tension between medwifery and midwifery as played out in the everyday of practice. We have seen how they are actively encouraged by a series of political and structural pressures to move from their initially peripheral location toward the centre of current medwifery practice. In doing this they become increasingly peripheral to midwifery. However, one participant, in contrast, was fortunate enough, in her opinion, to commence her qualified practice in an area with a strong and vocal midwifery philosophy. This participant felt that her initial experiences had drawn her strongly towards the centre of midwifery practice. Yet in doing this, once again, she moved into the periphery of medwifery, hence she felt a medically led and orientated delivery suite, despite being only one floor away was indeed “another world” (Int. 14(a)).

Yet it is important to reflect on learning opportunities at either periphery. Just as both medicine and midwifery are vital to the existence of a safe childbirth service for women so too learning aspects of both is vital to the continuation of a safe midwifery service. Nevertheless, it is the emphasis of the learning that is under scrutiny here. We can be reassured by Heaney(1995) who suggests that generally the centre of any practice is possibly too busy and too responsible to facilitate creative, effective learning. He suggests that, “On the edge is where learning is most vital, most urgent and creative”

(p7). Perhaps the existence of organizations such as the Association of Radical Midwives (ARM) is testimony to this. Having existed as an organization challenging obstetric hegemony since the 1970's they facilitate meetings, conferences and gatherings of midwives to provide learning opportunities which centre a midwifery perspective. Their existence, whilst central to many of their members, is peripheral in terms of membership to the wider midwifery community. So in terms of analysis, using the existence of midwifery as an heuristic may help enlighten and even structure opportunities for workplace learning in midwifery. If midwives could locate themselves within the model then perhaps they would be better able to understand what elements of peripherality impinge on their practice. However, once again this notion risks oversimplification.

Peripherality is frequently linked with marginalization (Merriam et al 2003). However, the one need not necessarily imply the other. Whilst peripherality may offer excitement and a degree of freedom (Heaney op. cit.), marginality on the other hand can be a fundamentally disempowered and disempowering position (Merriam et al op. cit 2003:170). The differences between peripherality and marginality have implications both for currently practising midwives and for the future of midwifery practice. Whilst I argue that contemporary midwifery practice entails a persistent element of peripherality, the evidence does not extend to the suggestion that this yet manifests as blanket marginalization. However, recognizing and theorizing the two aspects, may help avoidance of the latter. This is crucial if future maternity services are to rise to the challenges of the National Services Framework (DOH 2004). If peripherality were to inevitably entail marginalization, the result could see a totality of disempowered midwives. And as Edwards (2000) made clear, "Disempowered midwives disempower

women” (p80). Notwithstanding the many aspects of marginalization evident throughout this study and the fact that much of the oppression discussed is self policed, I argue that whilst peripherality is abundant, current positions evidenced within this study generally fall short of complete marginalisation. Other authors may well have interpreted these findings differently. Nevertheless, in this very real sense, I hope to communicate possibilities for future midwifery practice.

Conclusion

This chapter has explored how through a combination of socio-political factors and individual issues of diversity, midwives are located in a variety of peripheral spaces. Increasingly, I have argued, this peripherality involves maintaining a peripherality to ‘real’ midwifery’ and a midwifery philosophy which the following chapter demonstrates as important to many of these participants. Whilst, for the majority, this peripherality is portrayed as integral to practice, the learning inherent in this position constitutes elements of professional identity and how these participants learnt what it is to be a midwife. As we saw with the case of motherhood, one identity necessarily impacts upon another and if the constraints of motherhood go unattended, then participants are left necessarily curtailing the professional identity they are able to inhabit. Only one participant emphasised the learning of what she called “body watching”, which are skills more aligned with midwifery than medwifery. Furthermore, we have considered how much of the learning that occurs is conscious or unconscious. Joining the call from Hughes et al (2002), this data suggests that whilst some cultural change is undoubtedly required to facilitate different types of learning, this will ultimately only occur through a process of

“consciousness raising” (p51). Offering communities of practice and legitimate peripheral participation as a framework for consideration is one way in which this study hopes to contribute to that very process. However, whilst this chapter has explored identity, or ‘learning as becoming’, thoroughly, this analysis is incomplete without due consideration of the complementary theme of meaning or ‘learning as experience’. This perspective permits a wider consideration of how meaning and practice are mutually constitutive and inter-dependant. It does not rest on a premise of ‘learning from experience’ as would underlie an experiential learning approach. It is instead founded upon a situated social theory of learning approach wherein we “experience our life and the world as meaningful” (Wenger 1998:5). Much of the meaning of practice which was reported in this thesis and permeated all aspects of the data collected throughout the study relied heavily on aspects of emotion. Being a midwife and practising midwifery is both emotive and requires emotion work, to which we now turn our attention.

Chapter 5

Emotion Work

Emotion Work

Introduction

The impact of emotion and the negotiations involved in emotion work were a recurrent theme throughout the data collection for this study. This chapter engages with the inherently emotional aspect of midwifery practice, and theorises the impact this has on the possibilities for practice, and the nature of learning contained therein. Utilising Hunter's (2006) notion of 'balanced' and 'out of balance exchanges', the data is analysed to demonstrate aspects of emotion work which either promote or alternatively circumscribe learning. Furthermore, it is suggested that these encounters often function either as opportunities to promote the learning of midwifery or, less frequently, to promote the learning of midwifery. This is clarified by adopting Wenger's (1998) form of analysis to show how the duality of participation and reification in practice, combine to create the actual lived learning experiences encountered by these midwives. In analyzing these experiences it is suggested that, in one sense the structure of the workplace and the resulting emotion work entailed ensures them a degree of ongoing peripherality. Simultaneously, when they frequently experience 'out of balance' workplace interactions, these may contribute to the choice to remain peripheral. Finally, I considered how this contributes to newly qualified midwives developing from the periphery of practice to a more central role, or conversely, how they may remain peripheral. Consequently, this chapter expands the original notion of COP by demonstrating the vital role of emotion in situated social learning theory. This challenges the uni-directional premise of LPP by

reconceptualising peripherality, which at various times, can be both enforced or a position of choice.

As demonstrated in chapter two there has been exponential developments in the literature concerning the status and implications of 'emotion' in the workplace. Whilst it is Hochschild (1979, 1983) who is credited with instigating much of this concern, generally it is the combined work of Sandall (1997, 1998) and Hunter (2002, 2004) who have developed its specificity to midwifery. The experiences and management of emotion work form part of the everydayness of midwifery practice (Hunter 2002, Deery 2003) furthermore, the successful negotiating of, or failure to negotiate, the intricacies of this emotional work has been implicated in midwives' protracted decisions to exit the profession (Ball et al 2002).

Certainly, throughout this research, different facets of emotion and emotion work were recurrent themes. This was summed up by one participant in her first interview:

"I think the emotional side; I don't think you can get away from it ... because you put your whole self into it. You can't just take yourself back out as easy as that"
(Int. 10(a))

However, what was startlingly obvious to me as the researcher, were the different experiences and therefore associated meanings related to differing workplace encounters. These had parallels with the 'balanced' and 'out of balance' exchanges reported in Hunter's (2006) findings. Whilst Hunter (op cit) was researching relationships between women and their community midwives, she identified the varying degrees of emotional

work required by different types of relationships and how they were experienced. This was reflected within the findings of this thesis. The legacy of out of balance emotional encounters has been well documented. The work of Sandall (op cit) alluded to the negative emotions leading to stress and burnout amongst midwives, whilst Kirkham (1999) more directly articulates a culture of NHS midwifery imbued with negativity which has profound effects on both the work of midwives and the meanings they are therefore able to ascribe to their professional identity. However, it is Hunter (2006) who offers the most appropriate theoretical framework for exploring the data in this context. Hunter's (2006) paper reports the findings from a qualitative study of 19 NHS community-based midwives exploring their emotion work experiences. Whilst this is very much about relationships between community midwives and the women they care for, the findings still have resonance for my study. Hunter proposes a model for understanding these relationships based on the concept of reciprocity (2006:1). Whilst she in fact offers four key situations, they fundamentally represent 'balanced' exchanges or 'out of balance' exchanges.

“Balanced exchanges occur when there is ‘give and take’ on both sides; these are emotionally rewarding for the midwife. The other exchanges are out of balance, and require emotion work by the midwife” (p1)

Balanced exchanges were reported as emotionally rewarding, whereas out of balance exchanges required emotional work by the midwife (p9). Both resulted in different meanings being ascribed to that relationship. This chapter demonstrates that this finding is analogous with the relationships experienced by these newly qualified, predominantly

hospital-based midwives. This applied both to their relationships with women but also extends usefully to consider their workplace relationships with colleagues. Furthermore, the presence of 'balance', or alternatively 'lack of balance' affected the workplace learning which resulted. Whilst there will generally be some learning on either side of an encounter, these newly qualified midwives experience these exchanges from a relatively peripheral and subordinate position, so that it could be subsequently argued that the emotional impact may be felt more strongly for them, and the emotion work required, greater (Begley 2002). Furthermore, these encounters help circumscribe the meanings they are able to form of midwifery and therefore the forms of participation which they are more or less likely to become involved in. Subsequently, this contributes to their own developing sense of professional identity. Whilst the complexities of professional identity were examined in the previous chapter, this will be complemented and extended by consideration of the emotion work involved in midwifery.

In order to unpick the importance of emotion work in this study I will initially look at the presence and role of both 'balanced' and 'out of balance' exchanges in clinical everyday encounters. I will then extend the discussion by locating this 'work' within the context of Wenger's (1998) suggestion that learning as experience contributes to building meaning. Therefore, I will assess what this emotion work means for everyday practice and the learning contained therein. This, in turn, is crucial to a full understanding of how a situated social theory of workplace learning contributes to our current knowledge of the learning process in midwifery.

Balanced exchanges and emotional reward

Balance and emotional reward were most often experienced in connection with being ‘with the women’:

“I love that relationship that you can build up quite quickly really ...it is that part of midwifery that I just find so special” (Int. 3(a)).

or;

“It’s being there for the women, especially if I can communicate with her ... [if she] has just come in and has no understanding about the language and I am there for her, the response you get is overwhelming. It is absolutely magic” (Int. 4(c)).

Feeling emotionally rewarded was closely related to the meaning that these midwives derived from practice and was identified as one of the major satisfactions of doing the job. Furthermore, the creation of these positive emotions often came from either the ability to form a meaningful relationship with women and their families, or a positive birth experience. Many participants identified the combination of these two as ‘ideal’;

“ I look at community midwives as well, and yes, an idealistic world for me is the whole lot; ante natal care, intrapartum and post natal care and that caseload of being a community midwife and being able to facilitate that, but quite often that is not always attainable” (Int. 14(c)).

However, the data would suggest that this was rarely attainable;

“I think you have this idea that you are going to go out and deliver these babies ... be there at the beginning and at the end and offer all this continuity of care but it is just non-existent in the hospitals. You deliver a lady that you have never met before, she has never met you and you probably won't meet again” (Int. 5(b)).

Nevertheless, recognizing that the opportunity to build meaningful relationships with women only occurred as a rare opportunity was also usually accompanied by a resigned acceptance. This comment about handover time, when one shift of midwives hands over care to the next shift, typifies the depersonalization of women and is reminiscent of Hunt and Symond's (1995) ethnographic findings. However, it also demonstrates the resignation of the participant and suggests coping strategies at the everyday level of this practice

“I hate calling people B2, B3 and B4 but it is the only way I can visualize who I am talking about when I am handing people over, it's dreadful but that is just the way it is” (Int. 11(b)).

Yet the data from the initial survey established at the outset that this was going to be an important aspect for the majority of participants.

When asked on the initial survey, “Which aspects of midwifery work are the most important to you?” the vast majority identified “Building continuous relationships with women and their families” or “The privilege of being part of women's birth experiences” as either the first or second most important factor, in fact over 60% in the first case and nearly 70% for the second. Pairman (2000) argues that the kind of relationships

contributing to positive experiences of midwifery care for both women and midwives have “many elements in common with the notion of friendship. These include reciprocal love and intimacy, trust, warmth and genuine concern” (p225). However, the opportunities to establish these kinds of meaningful relationships are limited in the currently medicalised, fragmented and over worked system of childbirth (Kirkham 2000). This was certainly noted by numerous participants, especially when they felt unable to participate in “genuine concern”. Again, this was frequently related to time constraints and, just as importantly, to fragmentation of care. In her final interview, one very frustrated participant noted;

“ It would be easier doing checks and things when you know them before instead of just looking at them ...It feels just like a conveyor belt, you know, get them delivered, done, check their perineum” (Int.15(c)).

It was this inability to participate in care on anything more than a superficial level that often mediated the capacity for positive emotional feedback. This is important to remember when we proceed to consider participation, as well as non-participation, as constructive of meaning. It may well be that the care that some midwives are *unable* to participate in is equally as defining as that in which they regularly participate. However, in this study there was one notable exception. Both in her own right and in the search for ‘disconforming evidence’ (Guba and Lincoln 1989) this participant warrants further comment here.

Only one participant had had the opportunity to practice immediately in a midwifery led ‘birth centre’ as opposed to the medically led central delivery suite and wards within the

same building. I refer specifically to this interview here as it represents the one interview that initially contrasted starkly with the others conducted after three months experience. She herself identified her own feelings as different to her peer group who were working in the same unit but outside of the birth centre;

“I am sure there would be a vast difference in what I am saying to what somebody round the corner would be saying ... I think if you go round there it is very sort of ... you have got the doctors and the labour ward co-ordinators ... and they can give you a plan of what you have got to do” (Int. 14(a)).

Despite recognizing that the work could be “extremely busy” she felt “overwhelmingly positive”;

“It is very positive for staff and women; the whole environment is to create a better atmosphere” (Int. 14(a)).

Furthermore, she also described positivity as “being able”;

“What makes me stay positive is being able, it really is, it is just really basic and it is being able to make a difference to somebody. It is all about making a difference and making something in a positive way, whatever the care intrapartum, postnatal, antenatal the same, for me personally that is the main thing” (Int. 14(a)).

This interview represented disconfirming evidence, particularly in the sense that the positive emotion described not only related to the relationships with women but also, and

predominantly, to the work context. Unfortunately however, this was more frequently not the case.

Lack of balance and emotion work

Out of balance exchanges requiring emotion work were most frequently cited as experienced in relation to either work context or relationships with colleagues within work. This echoes the findings of Hunter's work (op cit.), which suggests that, "The professional rhetoric of 'with woman' practice means that criticism of the client is taboo" (p5). As discussed, the context of practice for all these participants was midwifery within the National Health Service. Furthermore, the vast majority practiced immediately within large hospital maternity units. The fact that midwives within these institutions experience considerable pressures to conform is not new (Kirkham 1999, Kirkham and Stapleton 2004) and indeed was borne out throughout all the interviews. Quite what this contributes to their learning is overdue for exploration. Furthermore, the participants in this study were relatively new, in that they had left the 'protection' of their student status and were beginning to explore their own possibilities in qualified practice. This was both scary and exciting and despite the overwhelmingly positive attitude that most felt towards the women they cared for, this was often balanced by the recognition of and accompanying frustration at the kind of midwifery that they could practice in their current context. Many described this as frustrating and quite quickly they learned what was expected of them. This was sometimes combined with enduring enjoyment of the job and sometimes not;

"I am enjoying it but it is a different ball game ... handover is so quick and it's just like getting the women in and shipping them out" (Int. 4(a)).

Whereas another felt;

“The feeling, out of control, I couldn’t do my job. And I have never felt that way. Never felt stressed. Not under that pressure, I felt such immense pressure and I couldn’t do it and I hated it” (Int.3 (a)).

The frustration of the inability to practice as they hoped they could was summed up by one midwife with a forceful analogy;

“You know, it is like learning to drive and your car is smashed up and you can’t drive it...you have either got to put up or shut up” (Int. 11(a)).

Very soon it seems that many felt the dissonance between the midwife they were still hoping to be and the practice they experienced everyday. This finding was partly supported by survey data and responses to the first statement concerning midwifery. The statement offered initially was, ‘I feel I will be able to provide the type of care I want’. At qualification, 85% of the sample agreed or strongly agreed with the statement whilst 15% disagreed. Interestingly, no one felt that this was not an issue, whilst no one strongly disagreed with the statement. Here, it is disappointing that the two possible participants who had chosen to leave midwifery immediately were none responders, as this may or may not have influenced their choice to leave. Certainly Ball et al (op cit) suggest that this kind of issue is often a big factor in protracted decisions to leave midwifery. It is therefore of concern that one year later there was a definite shift in response to this statement. This is shown in table five. Whilst acknowledging the small sample size and the even smaller follow up sample, the figures still provide an interesting shift. One year

later in response to, 'I feel I have been able to provide the type of care I want', the percentage that disagreed had more than doubled. Whilst again nobody thought it was not an issue for them, and whilst the majority still agreed, there was a significant shift from 15% initially disagreeing, to 38% of respondents one year later, including 2% who strongly disagreed. This suggests a growing proportion of potentially frustrated new recruits. And whilst it would be methodologically unsound to attempt to draw any conclusions from this it does however provide a thought provoking backdrop for the contexts of the lives which are at the centre of this exploration.

Intimately linked to the context are the resultant relationships with work colleagues. These relationships were ambiguous, being both a powerful source of negative emotion, but at times also, a greatly appreciated source of support. Hence, this warranted the further individual exploration provided later in chapter seven. However, for the purposes of exploring emotion work, it is important to give the topic further separate attention and hopefully any imbalance here towards negativity will be read purely as applicable to this part of the study and balanced with the findings in the later chapter.

In the initial survey, forging a good relationship with midwifery colleagues featured to a much lesser extent than did the building of continuous relationships with women and their families. In fact, when asked what aspects of their work were most important to them and to rank nine different statements in order of priority, less than 14% identified "good [work] relationships" as either their first or second concern. Whereas, in both the first and follow up surveys, relationships with women was the main concern for over half

of the respondents. These findings changed little one year later in the follow up survey.

This is demonstrated below.

Table 6: Relationships in midwifery: survey findings.

Statement	1 st . survey. Priority 1 or 2.	2 nd . survey. Priority 1 or 2.
Having a good relationship with my midwifery colleagues.	13.6%	11.5%
Building continuous relationships with women and their families.	62.5%	51%

This supports the findings from the qualitative data that indeed the ‘with woman’ elements of midwifery care remained the most important to the majority of respondents.

Yet it was often the relationships with colleagues that were reportedly out of balance, lacking any ‘give and take’ and requiring emotion work. These were sometimes hierarchical relationships with medical colleagues and related professionals or inter-collegial midwifery relationships, also frequently hierarchical (Begley 2002). Once again, though, the data from the initial survey with regards to the relationships with medical colleagues, suggested that expectations were matched by experiences.

Disappointing though it may seem, only about 50% expected doctors to respect their midwifery skill and indeed one year later about the same proportion of respondents had felt this to be the case. However, the qualitative findings, although detailing this experienced as at times uncomfortable, showed that these appeared to evoke more manageable emotional responses from respondents than did corresponding difficulties

with intercollegial relationships. For instance, in the example given later in which a participant had cared for a woman who consequently experienced a nasty tear, when the doctor suggested the midwife should have controlled the head more, she felt “very guilty ... but I said it wasn’t the head, that came out beautifully, it was the shoulders” (Int. 5(a)). However, when a midwife suggested the same, she reports that, “I just felt worse”. Despite reassurances from her mentor, she dwelt on what she perceived to be the negative perception from her midwifery colleague and whilst she felt able to defend herself to the doctor, this was not the case in the face of peer criticism.

Accordingly, when these newly qualified midwives felt ignored, abandoned or generally mistreated by midwifery colleagues it seemed to have the greatest capacity to evoke powerful negative emotions and demand some level of emotion work. One particular participant was doubly vulnerable, as shortly after qualifying she moved to a different workplace. At six months qualified, she was still struggling to find her place and felt that her work colleagues were; “in fact ... actually quite rude” (Int.15 (b)). Staff rudeness is by no means new (Hyland et al 1988, Begley 2001). Here, though, it is interesting to note that these two studies deal with the perceptions of student nurses and student midwives, whilst the findings presented here suggest that this ‘rudeness’, and lack of balance, sometimes continues beyond qualification. This participant acknowledged her relatively subordinate status in the hierarchy and was reluctant to ask questions to try and improve her knowledge due to the way she felt this was received;

“it’s the staff ... it’s when I have to ask them something, sometimes they make me feel like, ‘you should have known that’ ... the support is OK as long as you can forget the rudeness bit of it” (Int. 15(b))

This led to her describing herself as feeling “quite heated” at times but she felt that to challenge may cause confrontation and she felt that, “I best not have an argument just yet”. Another participant described a situation where she had been waiting to have a drug checked so that consequently it had been out of the fridge slightly longer than anticipated whilst she waited. When her senior colleague finally arrived the participant reports, “She was really abrupt, banging things and shouting at me” (Int. 10(a)). This evoked powerful feelings and memories; “it makes you feel small, picked on in a way, and I was picked on at school” (Int. 10(a)). As a result this participant studiously avoided the colleague in question as she “couldn’t face being humiliated again especially if she was going to say it in front of the woman”. It is these kinds of exchanges demonstrating a lack of ‘give and take’ and therefore privileging the more senior clinician that generated negative emotions for the newly qualified midwives and demanded varying degrees of emotion work.

It is important to remember that exchanges such as these are inherently powerful.

Whether they are balanced and therefore offer emotional reward or are out of balance and therefore demand emotion work circumscribes their potential as vehicles for learning.

Nevertheless, given the powerful potential of relationships with midwifery colleagues it is interesting to consider the initial ambivalence with which they are considered. They formed a large part of the experiences of practice which correspondingly impact upon the ‘invisible curriculum of the workplace’.

Therefore, we see that in forming understandings of meaning about their practice, relationships were a central issue as was the context of practice. It was frequently the meaningful interaction with women and their families that provided the greatest meaning and reward for these midwives. Conversely when it was difficult to experience any meaningful interaction with women the midwives experienced less personal reward and frequently felt frustrated. This was described by all participants at some point and often related to time and workload pressures. One midwife was asking for time to care rather than having to adopt a task orientated approach;

“Give them a bit of care, rather than rushing and thinking ‘oh my goodness’. We have got so many little things that we ... I know we shouldn’t have a checklist but we have, we check this, check that, check the other and sometimes if you have got too many people you just go dizzy ...[But] if you have got time you can find it all out by sitting and talking to them” (Int. 11(a)).

It seems therefore that much of the meaning that the participant attached to being or becoming a ‘good’ midwife was associated with their ability to form relationships with the women. Nevertheless, as Wenger (1998) points out, this in itself is not a concrete or static concept as “the meaningfulness of our engagement in the world is not a state of affairs, but a continual process of renewed negotiation” (p54). Fundamental as it may seem then, one of the central tenets identified by these participants is in fact a position only achieved or achievable through negotiation. Indeed every workplace context and person involved in that workplace brings elements to any given experience, such that, as Wenger (op cit) reminds us, “the experiences ... reach far and wide in time and space”

(p54). Whilst we must consider the macro context of the profession and the particular location, we must also consider the micro context of everyday life. If, as Wenger suggests, the negotiation of meaning is the convergence of participation and reification, it is important to consider these individually as processes of transition for newly qualified midwives learning midwifery. For clarity I will initially consider each separately and the relevance it may contribute to this study.

Participation

Participation foregrounds the relationality and connection of learning within any given community. It has long formed the backbone of many preceding studies into workplace learning (Becker et al 1961, Hochschild 1983, Keller and Keller 1996). In effect it underlies the epistemological foundations of workplace learning theory per se. In a more obvious way it also underlies the beliefs, once again, of all, these newly graduated midwives. They were all acutely conscious that in some sense as their full participation as a midwife began, so too did their access to further learning:

“You know when they say the real learning starts when you qualify they are absolutely right” (Int. 2(a)).

It is interesting to note that this participant refers to the *real* learning that comes with practice. This was alluded to by many and sometimes used to make a hierarchical comparison with their formal training for instance;

“I have learnt more this twelve months than I actually ever did before ... not that I didn't learn anything those three years 'cos I did” (Int. 5(c)).

However, this learning was frequently related to learned tasks, such as scrubbing for theatre, locating intravenous cannula and suturing perineums. The more amorphous learning was understandably harder to express. Fahy (1998) discusses exactly this point, that midwifery in the western world has become increasingly defined by what midwives do, rather than by who or what they are. Definition in turn confines meaning. If participation is a fundamental part of the process through which midwives build their meanings, then the boundaries and limitations of that participation will inevitably shape the meanings which emerge. Therefore, in a system imprisoned by biomedical definition, the scope for negotiating meaning will be at least covertly if not overtly circumscribed. Furthermore, in this study, each participant is inexperienced as a qualified midwife, so that their participation, at this level, is new and unfamiliar. Although Lave and Wenger (1991) agree that in some ways this ‘peripherality’, as a springboard towards full participation, may be empowering (p36), they also note that in a wider sense it can be a disempowering position. Disempowerment together with the historical and professional subordination of midwives, begins to reveal the narrowing of options for ‘meaning’ available to these women. Furthermore, in a working experience that many describe as “hectic”, “mad” and “non-stop” the opportunities to experience balanced and emotionally rewarding relationships (Hunter 2006) and develop meanings around these interactions are seriously curtailed. As Hunter (op cit), suggests the emotional ‘climate’ of maternity care seems to be changing with midwives facing increasing pressures to provide a more “emotionally connected service” (p13). However, she also recognizes that given the current context of these relationships, in particular those relationships existing within hospital midwifery, the chances of achieving these types of relationships are

“increasingly improbable” (p13). This leads to the development of transitional, superficial interactions which may become the only experiences upon which to base understandings of meaning. This has inherent dangers, as Hochschild (1983) warns us;

“When an industry speed-up drastically shortens the time available for contact ... it can become virtually impossible to deliver emotional labour ... deep acting will be replaced by surface displays that lack conviction” (p121)

Inevitably this will lead to a different meaning being afforded to interactions that, given more time, may herald a fundamentally different perspective. This may serve to drive hospital based midwives to seek emotional reward elsewhere;

“The work of hospital-based midwives [is] dominated by institutional goals and processes with the consequence that work was emotionally rewarding when tasks were completed and women and babies were discharged home safely” (Hunter 2006:2)

This suggests the possibility of a skewing of priorities and meaning through the experiences of practice, particularly as this hospital based scenario is presented in opposition to the emotionally rewarding relationships community midwives are sometimes able to form with women.

To even begin to negotiate their own ‘meanings’ qualified midwives must participate in practice. However, that participation in itself is complicated. It is bounded on one level by practical issues such as location, hospital policies, staffing demand and time constraints. On another level it is bounded by the “far and wide” (Wenger 1998: 54)

effects which constantly shift and constantly come to bear on any experience. This all has implications for how this participation can contribute to negotiating the meaning of either what they do or who they are. Lastly of course (or perhaps it should be firstly?), as we considered in the previous chapter, participation in midwifery is only one aspect of these lives. Wenger (1998) is eager to communicate that although any study may be focusing on some particular aspect of particular lives, the on-going negotiation of any meaning happens in a wider social milieu. And both the work of Sandall (1995, 1998) and Durham (2002) thoroughly portray this. Moreover, meaningful practice is directly connected to professional identity. Nevertheless, it is this problematic and expansive nature of participation that must be borne in mind as we move to consider the second convergent process offered by Wenger.

Reification

Reification is the partner in this duality. However, used in the context of negotiating meaning Wenger (1998) takes it beyond the dictionary definition “to refer to the process of giving form to our experience by producing objects that congeal this experience into “thingness.”” (p. 58). Yet reification is not presented as opposing practice, in fact the opposite is true. Though they may be partially defined by opposition, they also depend on each other and enable each other. Unlike contrasting ends of a continuum, more of one does not depend on less of the other, nor can one evolve without the other. If thought of as mutually constitutive processes one can begin to understand how their interplay can underlie negotiated meanings. Indeed;

“On the one hand, it takes our participation to produce, interpret and use reification; so there is no reification without participation. On the other hand, our participation requires interaction and thus generates shortcuts to coordinated meanings that reflect our enterprises and our takes on the world; so there is no participation without reification” (p66)

The challenges for learners in any given community of practice thus stem from both experiencing and accommodating the fluidity of participation whilst simultaneously and continuously grappling with the reification which both forms part of and is formed by just that participation. This ‘reification’ then is fundamental to the everydayness of practice and the learning therein as it is frequently by the daily routines, paperwork and processes that we experience who we are in the world.

In order to clarify the transposition of this theoretical framework onto the transitional learning experienced by newly qualified graduate midwives, it may be most useful to consider the processes involved in negotiating meaning through a couple of familiar examples. I use the term familiar here advisedly, in that the chosen examples will be familiar and ‘everyday’ to most practicing midwives. The chosen issues are; the use of cardiotocography (CTG) for fetal heart rate monitoring and the development of collegial relationships. The first topic focuses predominantly on the experience with labouring women. This issue arose at some point in the conversation with most participants and furthermore continues to present a stubborn and interesting challenge for contemporary midwifery practice (Blincoe 2005, Beech 2004, Mainstone 2004). The latter is an attempt

to demonstrate reification in a more abstract form and in relation to a topic which was central to various elements of this project.

Reification in midwifery: ‘real’ realities

To use cardiotocography (CTG) as the first example of reification risks oversimplifying the concept. Indeed, reification can be a process as much as it can signify a product. It can be as much a telling glance or long silences as it can a written policy or a set of notes. However, this choice also brings the issue under discussion into sharp focus. CTG is both process and product and can form part of midwives’ record keeping which is both a formal requirement of the profession (NMC 2004(a)) and an everyday encounter in all aspects of practice. As a process it involves connecting a pregnant woman to a CTG monitor, ensuring adequate connection with both the fetal heartbeat and the fundus of the uterus (to record uterine pressure changes) and establishing a recording output. This output is the ‘reified’ product, a CTG recording, or graph, representing the fetal heart rate over an extended period of time. In this manner it becomes easy to begin to regard the fetal heart rate as substantially existing or as a ‘thing’ rather than as an audible reflection of a physiological process. Not only does having the tool to perform the task change the nature of that activity, but also, by reifying the fetal heart we “change our experience of the world by focusing our attention in a particular way and enabling new kinds of understanding” (Wenger 1998:60). As a frequent procedure in midwifery care both the process and product of CTG monitoring continues to be an area of contention (Beech 2004). Despite guidelines issued by the National Institute for Clinical Excellence in 2001 practice still seems to be anything but uniform (Blincoe 2005). Part of the difficulty with

challenging the over usage of continuous electronic fetal monitoring relates entirely to the 'concreteness' in practice that it seems to provide, in other words the reification of which it is part. This in turn provides a challenge for practitioners as to what this means in practice and what that practice teaches about being a midwife, which is the essential interplay of participation and reification. We shall pick up this thread after the second example.

A less obvious form of reification in midwifery is the development of collegial relationships. This is perhaps a more difficult concept, as although it is both process and product and is inevitably a process of ongoing negotiation, unlike a CTG recording, there is no 'thing' to see or touch or hold at the end of it. Yet 'it' is fundamental to the meanings that these midwives are able to ascribe to their practice. As demonstrated earlier in this chapter, 'out of balance' experiences or relationships impact harshly on the 'sense' these midwives are able to make of their practice. Furthermore, the whole area is complex and cut through by numerous other considerations. Simultaneously, this reification itself is multilayered and complex.

At one level, simple 'coding' is used to represent a collegial hierarchy. Using pay scales as representational 'codes', colleagues are referred to as E's or F's or G's, with each representing a different level of responsibility. Beyond that, the participants often picked up on ways that they perceived they were treated in order to understand what that relationship was to mean in their everyday practice. Just as we saw that on one occasion an experience of 'humiliation' meant that the colleague was to be studiously avoided on other occasions participants found opportunities and experiences which for them held

positive meaning. Often these included praise. In one instance, a participant had cared for the daughter of a health care assistant; “she told me how well I had looked after her and that meant a lot” (Int. 3(a)), whilst praise from other midwives was appreciated too; “other midwives coming up and saying “thanks for a nice shift” ... that bucks you up” (Int. 3(b)). Kirkham (2004) importantly identified the fundamental if subtle role of praise in counteracting the corrosive effects of guilt and blame encountered within contemporary midwifery practice. In coming to understand intercollegial relationships as reifications of practice, it must therefore be hugely important whether the hallmarks of these relationships are positivity and praise or negativity and blame.

I will now extend this consideration of meaning in learning to explore the interplay of participation and reification and how, in this study, the convergence and combination of the two gives rise to learning opportunities. These opportunities are at times obvious and blatantly apparent to the participants, whilst at others, appearing more oblique and amorphous.

Participation, reification and learning

The connection between these three concepts is evident throughout the data. By taking one of the examples I used earlier, CTG's, we find an exemplar of these connections;

“I hadn't put one lady on the CTG admission trace because she had had one upstairs. She had come downstairs within ten minutes of having the trace upstairs, which was beautiful, there was nothing ... and all they had done was trace upstairs because they know they do them downstairs, 'cos we were busy they

thought they would help out, put her on the trace upstairs and send her down with a trace. So I didn't but she [the midwife] said "Yes, but we need our own doing" but I said "Why? it's ten minutes, you can see it is beautiful". Same machine upstairs as we use here but she came into the woman then and said ... sort of made out that I was putting her baby in jeopardy because I hadn't put her on the CTG." (Int. 5(a)).

This is a prime example of reification, both in examining the CTG aspect of the example but also the intercollegial aspect. Whilst a CTG had been performed and there was 'evidence' of a satisfactory fetal heart rate, further reification and tangible 'thingness' was sought by the second midwife. The reasons for this are unclear and seemed to remain unclear to the newly qualified midwife. Presuming there were no complications here, this resort once again to technology directly contradicts not only the NICE guidelines (2001) but in fact the perfectly acceptable and appropriate professional practice that the newly qualified midwife was trying to maintain. Whilst participating in care, this colleague was demonstrating the long and frequently criticized resort to technology which litters contemporary midwifery practice (Wagner 1994, Murphy Lawless 1998) and is a hallmark feature of midwifery. In doing so, she presented the 'learner' with multiple dilemmas and learning opportunities. To comply with the wishes of the more senior midwife may be all too easy, as Bosanquet (2002) explains. However, in this case, this opposed not only her own knowledge and understandings but the woman's wishes too. Perhaps this also reflected a hierarchy of importance, that one needs to 'learn' whose wishes are paramount? Furthermore, the opportunity to learn about means of retort presented itself. The participant felt embarrassed and angry to have her clinical decision

questioned, particularly in front of the woman and especially when there may also have been a safety implication. In fact her response in the interview was not subtle; “I felt, well almost like throttling her but the words wouldn’t come out, you know when you can’t express and because you are newly qualified you don’t feel you can argue” (Int. 5(a)). However, she identified that beyond the incident she still found this particular colleague “very hard” and was unable to discuss it as “even the older midwives who have been there a long time will just bow down to what she says” suggesting that they too collude in reifying this collegial relationship as a known and accepted ‘fact’ of that community. Yet to some extent, this is an example of a case that highlights the limitations of Wenger’s (1998) notion of negotiating meaning. Wenger has failed to adequately consider the hierarchical and powerful relationships which constrain any negotiation. Although the ‘learner’ was able to negotiate with the woman, with herself and with some other colleagues she felt unable to negotiate with at least one person whom she perceived as more powerful. In addition, it was apparent to her that this was a negotiating position abandoned long ago by other colleagues and perhaps therefore not a fruitful avenue for her to pursue. However, hierarchy and power were not the only limiting variables in this encounter.

The participant was also keen to ‘fit in’, particularly as she hoped to secure a permanent position in this area. Here, the participant would be keen to display aspects of what Wenger (op cit) calls competent membership in order to smooth her transition and acceptance into the centre of that practice. This might entail not openly questioning or challenging the ‘bastions’ of that practice but seeming to engage in what Wenger terms “community maintenance” (p74), the contributing to the smooth running and cohesive

nature of that community. Therefore with all these social pressures at work what is 'learnt' and how that is learnt reaches far beyond the "put up and shut up" response noted initially.

Evidently then, whilst most participants identified the meaningful relationships with women and families as the core element of their job reward nevertheless it seemed that it was successful relationships with colleagues that permitted successful and comfortable entry into the community of practice. There may indeed be an element of 'talking midwifery' here (Hunter 2006), in that participants may have been offering me, as the researcher and experienced midwife, information which they felt was the 'best' presentation of themselves. It is possible that they may have been trying to present what they perceived *should* be most important to a practicing midwife. Certainly it was refreshing to hear that so many of them, despite the difficulties, placed great emphasis on their relationships with women. However, as we have seen, the quantitative survey data serves to confirm this finding. The survey findings in table 6 support the qualitative findings and make it less likely that they were indeed just 'talking midwifery', but that in fact relationships with women were of paramount importance. Furthermore, this echoes the findings of many previous studies (Sandall 1997, Stevens and McCourt 2002). Yet if, as suggested earlier, many of their colleagues have either displaced, replaced or at the very least complemented the emotional satisfaction derived from meaningful relationships with women with an equal one achieved by 'getting the work done', what implications does this have for learning in practice? Furthermore, as new midwives initially practising on the periphery of the community, their personal trajectory depends

upon how they consider, either consciously or unconsciously, any movement toward a more central role and what type of central role they perceive that to be.

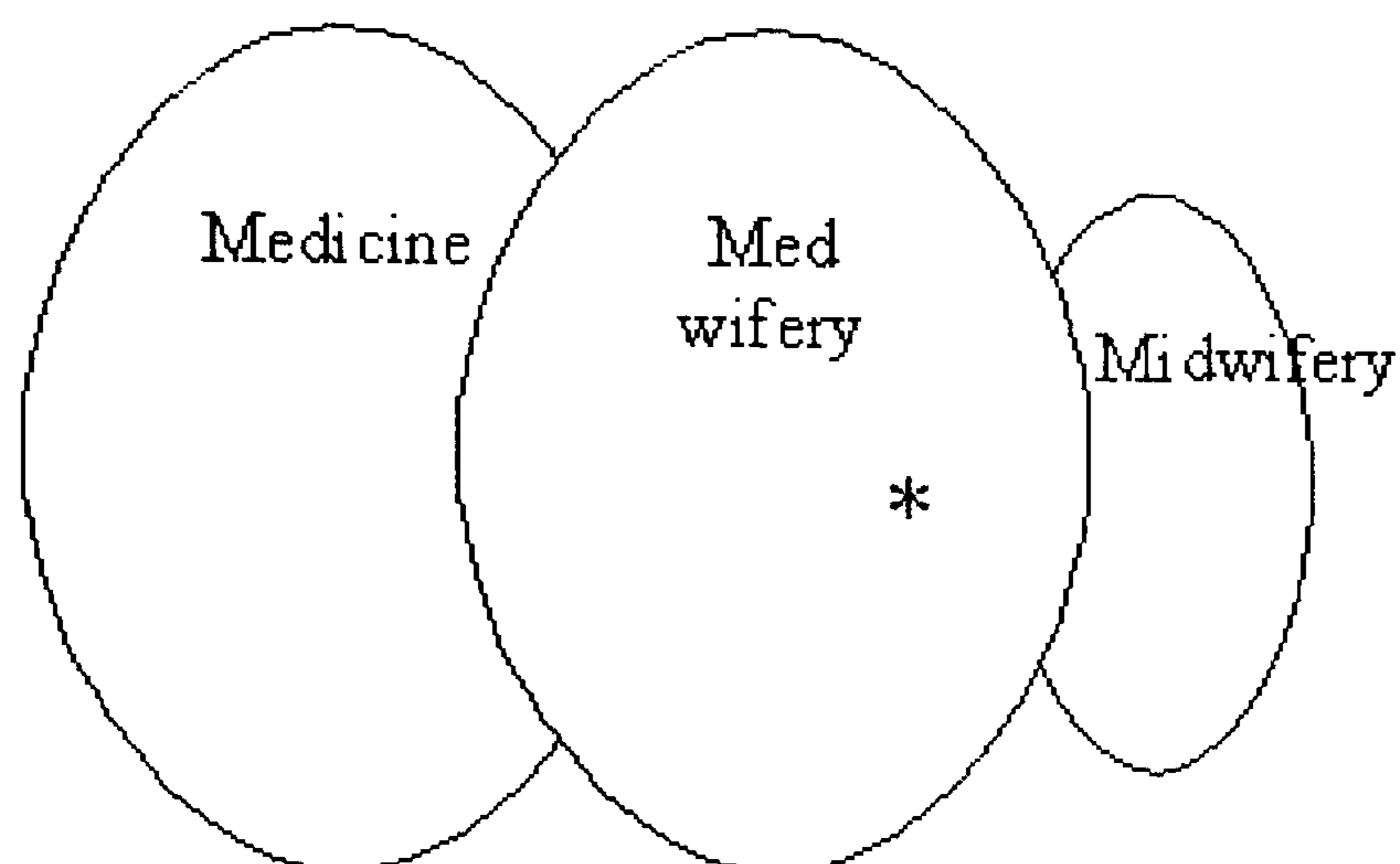
Peripherality and centrality

Using Lave and Wenger's earlier (1991) concept of legitimate peripheral participation we will now explore how some participants sought to manage their own workplace relationships and the attendant emotion work involved in order to progress their own identities, from peripheral newcomer to a more central practice. However, unlike the relatively simplistic assumption of Lave and Wenger which "posits a largely unidirectional movement of novices from legitimate peripheral participation to full membership of a community of practice" (Colley and James 2005), the findings of this study reveal a somewhat more complex picture.

Firstly, given the analysis of contemporary practice offered in chapter four, peripherality, whilst still being a generally disempowering position, also becomes a relative position.

Revisiting the diagrammatic representation of the conceptualization of midwifery & midwifery gives this statement more clarity;

Figure 3: Positioning peripherality



It must be recognized that whilst this one dimensional pictorial representation risks being grossly over-simplistic, it offers a useful heuristic in this context. Evidently newcomers enter legitimate practice as officially recognized qualified midwives on the periphery of midwifery and medwifery alike. This is symbolized above by the position of the small star. However, if midwives wish to precede centripetally in medwifery this means inevitably migrating to an increasingly peripheral stance in midwifery. Conversely, midwives wishing to proceed centripetally in midwifery almost inevitably risk remaining peripheral to medwifery. This suggests that for midwives continuing to practice in current hospital environments there may always be some level of ‘persistent peripherality’ and discomfort associated with whatever identity they are able to adopt. Also, whilst identities are never fixed and individuals may oscillate amongst a variety of states of ‘being’, in this context, the ability even to oscillate may perhaps only ever represent

varying levels of dissonance. With regard to emotion work, this dissonance will inevitably reflect upon the relationships that these midwives are either able or unable to establish and those from which they are able to derive emotional reward. The learning contained here may therefore potentially involve recognizing some degree of inevitable and persistent dissonance.

Secondly, contrary to the assumption within Lave and Wenger's (1991) study of apprenticeships that every apprentice aspired to be a master, some of these participants chose to remain, at least temporarily, as peripheral members of the community.

Furthermore there were clear examples of strategies employed to try and ensure that participants could engage in emotionally rewarding work, even if at times this exacerbated the discomfort of their role. This gives rise to two interrelated but different positions experienced by these newly qualified midwives. The first represents a more enforced position and I have termed it 'persistent' peripherality, whereas the latter represents more a position of choice which is therefore discussed as 'choosing peripherality'. Both impact differently on the workplace learning they engender. In order to understand the complex and dynamic nature and impact of these two points, I will now consider them individually before attempting to draw some conclusions.

'Persistent' peripherality

I use the notion of 'persistent peripherality' not to suggest that it is an ever present, conscious, spectre in the workplace, but more to suggest that being central to one thing may inevitably involve peripherality to another. Moving toward the centre initially requires a sense of belonging. Whilst most participants of the survey data, described a

sense of 'belonging' at the point of qualification, 20%, or one in five, still did not feel that they 'belonged' anywhere. A year later, only 8% of respondent still felt that they did not 'belong' anywhere. However, one also has to reflect that those feeling alienated and with no sense of belonging to the profession may well have been overrepresented in the surveys that remained unreturned. However, in the qualitative data, many suggested that this sense of belonging usually came with both benefits and costs.

The benefits of a sense of belonging were often cited as "security" or "confidence". Many participants had achieved the security at least. Confidence was a much more amorphous and labile concept. Nevertheless both were deemed important and contributed to belonging to the community. Not surprisingly, they were frequently referred to in the context of task orientated achievement. All participants, barring the one who worked in a birth centre, were encouraged to master technical clinical skills such as cannulation, suturing of perineums and scrubbing for theatre. As we saw in the previous chapter, for many this was organizationally attached to a structure for promotion. However, whilst some participants recognized that there were other midwifery skills that they would like to master, for many, this security of structure was perceived as a benefit:

"I want to be skilled on delivery suite .. I will be more useful" (Int. 1(b)).

Interestingly this participants understanding of 'useful' was one based on technical ability which reflects the technical imperative of the practice of midwifery. As becomes apparent in chapters six and seven, delivery suite was reported as an area of particular relevance for interprofessional relationships, an area that initially demanded the most

specific technical learning. Whilst this did in one sense offer a sense of security and order, most participants were aware that it came at a cost.

That 'cost' sometimes involved not practicing entirely as they might have wished.

Despite the fact that forming relationships with women was reported as paramount to the emotional reward of the job, many felt that this aspect was one of the first casualties of the hospital environment;

“I have come to feel like these aren't women, they are just people that we have got to sort ... it is do this, do that and get on with it ... if somebody asked me the names of any women on the ward the next day I probably wouldn't remember them. You don't see them as actual people and it is nothing like what I wanted to do. You are working flat out and I would actually say it is manic, that is the word I would use and sometimes it frightens the life out of me” (Int. 6(c)).

One participant reflected on the consequence of trying to resist this assembly line mentality (Walsh 2005) when she was asked to do some physical observations on a woman in the care of a senior colleague.

“Some people will go in and do some observations on a woman straight away without stopping and conversing. [She] asked me, on a busy night, to just go and do some observations but I went in and this lady was tightening, so there was no way I was going to take her blood pressure while she was tightening. So I waited and I was just chatting to her to see how she was and how she felt and of course I had only got half the observations done when that very person came back in. She

asked was it done and I said “No” and she was abrupt, like “just give it here”.

[participant smacks her forehead] (Int. 2(c)).

Walsh (2005) suggests that talking or chatting, whilst not task related or problem centered “captures something of the essence of ‘with woman’ that midwifery is predicated on” (p1334). This demonstrates how in trying to forge her identity as a midwife and practice some element of being ‘with the woman’, albeit briefly, she acutely felt the mis-match with the hurried demands of a medwifery environment. This echoes the further sentiments of Walsh (op cit) who states that;

“When maternity services endorsed an industrial model to manage labour care nobody appeared to foresee the intractable dilemma it would pose. One-to-one care and centralized birthing facilities under one roof are virtually irreconcilable forms of care” (p 1332).

This situation perpetuates the dilemma that if these newly qualified graduates seek to practice midwifery, as many of them understand it, they risk remaining peripheral to medwifery, which is predicated more on task related success and, as demonstrated in chapter four, represents the bulk of contemporary practice. Some of them in their final interviews saw this dilemma quite clearly yet still felt enthusiastic and able enough, at times, to resist behavior they felt was more aligned with the assembly line. One gave the example of flexibility with breaks;

“It can be really busy on delivery suite or on the ward and we have our lunch maybe 3 or 4 ‘o’ clock in the afternoon whereas the managers have their lunch at

12 'o' clock and it's almost like no matter how busy the ward is they just go for their lunch and that is that I just think if that is what it is takes [to fit in] then I shan't bother" (Int. 7(c))

Another looked to the future practising in this type of environment and once again qualified her sentiments with thoughts about the women we care for too.

"I remain optimistic about my future because I know that I am not going to get into the same trap that I see where midwives have lost the faith in the job. I am not going to be that because I don't want to be. But if you ask me the question in five years time maybe I will be, maybe that is the culture we work in, maybe it drags everybody down. But I think it is a shame for the midwives that are in the cycle of 'Oh, get a lift-out, oh, get an epidural' instead of being a midwife being 'with woman' like it should be. I think that they have gone now; you are never going to get them back as midwives ... So for me I feel happy but ... for the women that are coming here to have their babies, who knows what they are going to get really. What kind of midwife are they going to get?" (Int. 10(c))

Those participants who did describe resisting a midwifery orientation in their practice also recognized that to do so was tiring and emotionally draining. This echoes Hunter's (2004) findings which she stresses are amplified within the first year of practice (p266).

Whilst the impact of intraprofessional relationships is examined in greater detail in chapter seven, the emotional toll of imbalanced exchanges is relevant here. It was not uncommon that the newly qualified midwives either found a space such as the toilet or coffee room within the work environment in which to express their frustration, or more

worryingly, took it home. One participant felt, that despite trying to handle it, it was in fact affecting her overall demeanour;

“Well I have to handle it. I go somewhere, maybe in the coffee room ... I just have a little paddy as I call it and then I am alright. Then I just get on with it and then I might have another paddy, but everyone says I am not as chirpy as I used to be” (Int. 9(c)).

Another participant who was having a much more difficult time settling into midwifery felt far more strongly about how it was affecting her as a person. This woman had moved from one unit to another on qualifying and felt unpleasantly surprised at the lack of welcome she felt from the other midwives. As we have already seen, she maintained throughout the entire year that colleagues were ‘rude’, both to her and often to women in their care. As the year progressed she felt she was becoming equally rude and this spilled into all aspects of her life.

“It makes me not a very good person either ... I tend to ignore things more ... if you have to do it at work and work is half your life you tend to bring it home as well ... I tend not to be as caring at home ... if somebody is down at home and I am not in the mood for talking whereas I would have said “what is wrong?” I just go “alright then I will see you later” and leave them to it ... sometimes it is horrible” (Int. 15(b)).

It seems that by persistently trying to practice midwifery as they had come to understand it throughout their education, many felt that they were in fact making their own

everydayness harder and at times this extended beyond the workplace. Given that work is only one facet of their lives this is surely an untenable situation. It certainly seemed to impart the harsh lesson that “frustration goes with the job” (Int. 4(c)) and as Ball et al (2002) described, this is a large contributory factor to why many midwives ultimately leave the profession. It was disappointing to uncover such levels of frustration and such emotional hardship so early in the careers of these women.

As a point which will shall revisit in chapter seven, it seems that standing up for themselves seemed to get easier as the year progressed, although frequently, standing up for the woman giving birth was still something that was done in a more closeted fashion. This quote returns us to that notion;

“Sometimes they ask you to do things that you perhaps wouldn’t ordinarily so sometimes you have to either a) do it in order to fit in... or b) ... said that I will but then I haven’t done it anyway” (Int. 2(c)).

Participants recognized that to be an ‘outsider’ and not fit in has consequences for everyday life;

“I don’t think I am an outsider but you can see some other people really on the edge of everything and I feel sorry for them just like they are really left out from all the laughs that you have here.” (Int. 10(c)).

It then becomes increasingly apparent why many of these newly qualified midwives seeking practical and emotional support and the respect of their senior colleagues seek to distance themselves from any feelings of peripherality. This, for the most part, would

mean moving centrally into the dominant culture of midwifery and becoming increasingly peripheral to midwifery. Some had evidently accepted this situation. Nevertheless some participants, for various reasons, actively chose to remain peripheral.

Choosing peripherality

In the original text by Lave and Wenger (1991) there is the implicit assumption that the novice will be on a unidirectional track from periphery to centre. Whilst this is demonstrated as being achieved in a variety of ways there is no suggestion of remaining peripheral unless, of course, this is associated with failure. However, throughout this study, many of the participants suggested in a variety of ways that peripherality was for them a viable, and at times attractive, choice.

Whilst many participants were seeking to ‘progress’ along traditional lines others were choosing to stay peripheral. However, in this context, this was not associated with any level of failure. This highlights one of the limitations of LPP, as choosing peripherality is seemingly not an option. In this sense, it may be apparent why Kupferberg (2004) preferred Becker’s (1960) concept of ‘commitment’ as a form of analysis. Nevertheless, whilst these women had most certainly made some form of commitment to midwifery they were balancing this with other commitments in their lives. Whilst one of the most obvious commitments was to the family, children represented only part of the picture. Some were caring for elderly dependants, one had a recently disabled husband and many also, and quite simply, valued their own free time. Some aspects of this kind of diversity were explored in the previous chapter. However, in terms of participation and peripherality, choosing to remain peripheral cut across many categories of diversity.

Furthermore, choosing to remain peripheral was just as often associated with workplace factors as it was external personal ones. In examining workplace learning it is these factors that are of particular interest. Choosing to remain peripheral was evident in the data in a variety of ways.

Those participants choosing to remain peripheral predominantly reported doing so in one of two ways. The first was a strategy of non-participation, which is dealt with in detail in chapter seven. The second was a more practical strategy of reducing hours, which has obvious implications for retention, as whilst midwifery may retain individuals it may be only at much reduced hours. However, this finding was mostly borne out in the qualitative findings. The survey data actually showed only a slight increase in part time work over the first year. This is demonstrated in the table below.

Table 7: Changes in working hours.

	Full time work	Part time work
Initial Survey	75%	25%
Follow up survey	70%	30%

This being the case it is interesting to note how widely this finding differs from the general constitution of the NMC (2005) register within which over 50% of the workforce work part time. As a statistic which has steadily increased over the last ten years and continues to do so, it is informative to reflect on some of the reasons why, after just one year, the qualitative data suggests a number of the participants in this study were themselves considering reducing their hours. Furthermore within the remit of this thesis it is important to analyse what, if any, workplace learning has led them to these decisions.

The qualitative data suggests that the option of reducing hours was at the forefront of many minds. Also, for most, this was connected to the emotional and physical demands of the job. For instance, just six months after qualifying one midwife was experiencing work as “draining”;

“Really draining, and it wouldn’t be so bad if I could afford to work three days a week, then I could give it everything and really enjoy it” (Int. 12(b)).

She obviously saw reducing her hours as an option to aid coping and, as we shall see further in chapter seven, also reported seeing others using this as a coping strategy, regardless of age or responsibilities outside of work. One particularly frustrated younger participant was negotiating reducing her hours and tied that decision to the lack of job satisfaction;

“ultimate job satisfaction isn’t there ... I like going to work but the whole reason for dropping my hours is ‘cos I can’t be bothered, this is how I feel, I can’t be bothered to work my arse off for 37 and a half hours a week ... when I don’t really have to. So I am going to drop my hours ... and I am going to see if that makes me feel happier” (Int. 10(c))

Another perspective came from somebody already working part time. She had been working annualized hours giving her school holidays off. Nevertheless, working full-time hours in term time left her “absolutely knackered” (Int. 1(c)) and it increasingly looked like even this option was going to be withdrawn as her understanding was that,

“ they don’t have to give it to you if your child is over six and [child’s name] is soon ... I am willing to compromise but it does look like it will mean going down to three days ... money will be tight ” (Int. 1(c))

It was interesting to note that this participant only felt that her accommodating hours were offered out of obligation and would be withdrawn once that obligation expired. This put her in the situation whereby she felt forced to choose reducing her hours and tolerate not only the financial implications but also possibly an increased peripherality. She refused to return to a full time hospital role as her initial experience of this almost twelve months earlier was that,

“I found it really hard to cope in such a busy environment ... I pushed myself just to the limits and then came home like a zombie” (Int. 1(c))

Other authors have clearly demonstrated that the type of disillusionment and ‘burnout’ described above is closely linked with the structure of care and related issues such as collegial support, fragmentation of care and workload (Sandall 1997, Hunter and Deery 2005). Unsurprisingly then, given the context of practice described in the previous chapter, nearly all fifteen participants mentioned reducing their hours as a possibility. In some cases personal circumstances dictated against this as a realistic choice, nevertheless at the end of one year having started with four part time participants, two more were in the process of negotiating down their hours and two others, including the midwife above, were seriously considering it. If these four midwives all reduce their hours then the sample statistic would become much more aligned with the NMC (2005) register considered earlier and just over 50% would be working part time.

This is not to imply that being part time inherently ensures peripherality although Sandall (1998) insists that it does and depicts a workforce “where full time staff are valued, and staff who work part time are left on the periphery” (p5). Were this to be the case, then there are even greater implications of this strategy for the future of midwifery. However, for these midwives, both the reduction in hours and the persistence of peripherality were positive choices. This was suggested by statements such as;

“Being part time I am able to escape it” (Int. 11(a)).

One then has to question if in fact full timers are recognized as valued if remaining peripheral is preferable. Furthermore, whilst non-participation is dealt with in chapter seven the complex nature of practice ensured that sometimes both strategies were enlisted together to maximize peripherality. It seemed that for many the implications of remaining peripheral were preferable to the implications of central involvement in practice. This has resonance with Colley and James (2005) theoretical notion of “unbecoming”, wherein they suggest that professionals, in this case teachers, may return to the periphery of a profession having once assumed a central position. In the two case studies they explore, this is due to an increasing dissonance between the values and meaningfulness through which each teacher experiences their work and their workplace experiences. However, both these teachers had experienced full membership and central positions in their careers. This data suggests that these midwives may be experiencing or understanding a similar dissonance but much sooner in their careers and, the data suggests, as a consequence some are resisting full participation.

Conclusion

Through an exploration of the important emotional aspects of practising as a midwife in contemporary practice I have demonstrated that as a form of “learning as experience” the creation of meaningfulness for these newly qualified midwives is severely circumscribed. The combination of task orientated participation in midwifery and forms of reification which appear at times contradictory to their understandings of meaningfulness in midwifery are set against a backdrop ensuring a persistent lack of balance both in relationships with women and with colleagues. The context which they therefore find themselves in perpetuates a high level of emotion work and draws heavily on their emotional reserves. I have argued that this level of sustained emotion work is rarely feasible and frequently not something their experiences of practice encourage. This potent combination occurring within everyday workplace experiences ensures that these newly qualified midwives frequently struggle to reconcile the meaningfulness they seek in practice with their everyday experiences of being a midwife. Consequently, they seek strategies to manage the emotion work whilst continuing to practice.

The notion of peripherality is expanded to suggest one possible strategy. Whilst in one sense it is theorized as an unavoidable position which in itself has implications for emotion work, it is also offered (using the word ‘choice’ advisedly) as a coping strategy of choice. Sometimes, being or remaining peripheral was presented as avoiding the worst of the emotional demands. However, this too was problematic. Ironically, remaining peripheral rarely nullifies the pressures to conform (Kirkham 1999), or the desire to belong to the community and as such, at times, only magnifies any perceived dissonance.

Evidently some level of emotion work was inevitable and this inevitably impacted on the workplace learning.

Whilst this provides an original contribution to the literature on LLP in that it portrays peripherality unassociated with failure, it also suggests new possibilities for understanding something of the current retention crisis in midwifery. By beginning to map the ground linking emotion work in midwifery, workplace learning and retention, it is hoped to suggest both new possibilities for further research and contribute to the literature suggesting new workplace solutions for those midwives who continue to inhabit the peripheral spaces and places of practice.

Chapter 6

Inter-professional relationships: Medical power and control

Inter-professional relationships: Medical power and control

Introduction

Building on the context described in chapter two and reconceptualised in chapter four this section of the findings will focus on the relationships between medicine and midwifery and medics and midwives in the context of current practice. As has become apparent, these participants experienced these relationships predominantly in hospital-based locations. In analyzing these relationships this chapter suggests the contribution they make to the implicit learning from practice. Furthermore, it critically engages with the debate that sees power and relationality very much at the centre of workplace learning (Kupferberg 2004) and addresses this omission in Wenger's original analysis.

Consequently, it specifically addresses the first section of research question one: How does the interprofessional structure of the workplace – doctor-midwife ... affect the experiences in the work setting?

Drawing on the work of Abbott (1988) the concept of jurisdictional boundaries is employed to consider the actualities of practice and the lessons being learnt at these boundaries. To strengthen the argument, I return to Wenger's (1998) concepts of engagement, alignment and imagination (p181), in order to explore what opportunities or restrictions are placed upon the identities and meaningfulness that participants could draw from their experiences at jurisdictional boundaries.

Finally, I draw upon two other studies, by Allen (2000) and Stevens et al (2000), to offer a complementary, but more micro-focused analysis of the workplace learning that both

overtly and covertly surrounds the interprofessional encounters experienced everyday in practice. Allen's (op cit) work allows the opportunity to re-frame the data in terms of occupational demarcation, whilst the perspective offered by Stevens et al (op cit) via the notion of 'domain consensus' permits for the extended consideration of the impact of boundaries of consensus within midwifery itself. Finally, I investigate how much scope for negotiation these participant encounter at professional boundaries and ultimately what the implications for learning are.

Current midwifery practice

Whilst chapter two revealed the journey through which practice became what it is today, it is important that a more thorough picture of the context of current midwifery practice is described in order to provide an understanding of the rich and complex backdrop within which the participants of this research project were constantly and actively trying to negotiate their activities and identities. In doing this, it is important to consider the, often experienced, dissonance between role expectations and lived everyday practice.

“In theory, the relationship between different ... care professionals should be mutually beneficial, based on consensus about their respective functional territories or work domains. In practice, however, this is rarely the case.” (Stevens et al 2000: 432)

Stevens et al (op cit) construct a strong case for what they consider to be a sociological return to 'middle range' studies that examine the ways in which “contemporary occupations as interacting collective entities actually organize their work and perform

specific tasks within specific work domains” (p433). This position does not deny the influence and importance of a long tradition of sociological studies looking at issues of professionalisation and macro power issues within professions (Freidson 1988, Witz 1992, Light 1993). However, it does re-emphasize the importance for a continuing vigilance as to how these issues ‘play out’ in everyday lives. Therefore, within the context of this study, it is important to consider how the relationships between medicine and midwifery both frame the opportunities for practice and influence the everyday activities and resulting everyday pedagogy (Luke 1996) within which practitioners are immersed.

Surveying the literature surrounding authoritative knowledge in childbirth in Britain today leaves one in no doubt as to the predominant *modus operandi*. The medical model of childbirth remains dominant and has been critically examined by many scholars (Ehrenreich and English 1973, Oakley 1975, Jordan 1978, Witz 1992, Graham 1993, Wagner 1994, Anderson 2004). These explore how institutionally, professionally and ideologically the medical model of care has assumed dominance. Much of this work explores the emergence and ongoing struggle of two competing and fundamentally opposed discourses of childbirth; the medical and the social model. The medical model is identified as being predominantly patriarchal, hierarchical and male whereas the social model is portrayed as more communal, connected and female (Murphy –Lawless 1998). Whilst this serves as a basis from which to explore current dilemmas in practice, it risks presenting a gross oversimplification of a complex and dynamic situation. However, whilst this debate provides a useful starting point, the following analysis will explore the complexity and subtlety of the interactions that suffuse practice. Nevertheless, it is

important to appreciate that in their everyday work lives, these participants overwhelmingly encountered midwifery practice constrained within a medical model of care. There have been certain points in time and threats to this hegemony which are important to understand.

As a result of the Peel report of the mid 1970s, childbirth was removed virtually en masse into the hospital environment. Correspondingly, community midwifery services inevitably declined and a culture of hospitalized birth began to flourish. However misguided this government led strategy towards centralisation seems today, it paved the way for the establishment of contemporary midwifery practice. Again, over a decade ago, Turner (1994) identified the controlling influences of the hospital structure with hospital management and physicians. Despite a rhetorical demise in the power of physicians and an increasing focus on interprofessional relationships in both education and practice (Finch 2000), there is substantial evidence that the field of obstetrics and obstetric power remains alive, well and thriving in our current risk averse, litigious and hospital-based midwifery service (Sandall et al 2001, Kirkham and Stapleton 2004, Bones 2005). Simultaneously, the threat posed by managerialism to medical dominance during the 1990s, has also seemingly had much less impact than anticipated (Bones 2005). Some view these developments, amongst others, as a strategic ploy to maintain medical power;

“Centralising midwifery services is at best an ill-conceived way to save money and at worst a politically divisive move to sustain the dominance of obstetrics over childbirth” (Bones 2005:563)

Others may consider it simply 'progress'. However, as Davis – Floyd (2005) points out this kind of 'progress', associated with the "narrow canal" (p32) of Westernised modernity, assumes one fixed point towards which progress is being made. In health care, she asserts, this is Western biomedicine, furthermore;

"In modernising societies, traditional systems of healing, including midwifery, have become increasingly regarded by members of the growing middle and upper classes as 'pre-modern vestiges' of a more backward time that must necessarily vanish as modernization/biomedicalisation progresses" (p32)

It is possible to argue, however, that by assuming such a dominant and persistent presence within midwifery not only, has obstetric biomedicine contributed immensely to the increasing disappearance of midwifery it has also rendered itself so familiar and so populist, that it is itself virtually invisible. The practice that remains is no longer perceived, by many, as a medical model of care, but has simply become everyday practice. This everyday practice is fraught with rules, policies, personalities and boundaries that new members are constantly required to negotiate. The existence, of a community of practice, which is neither specifically midwifery practice nor specifically medical practice, but one which links the two, is a concept that is fundamental to this thesis. For reasons that should already be clear, I shall refer to this community as 'medwifery', as diagrammatically represented in chapter four. Medwifery, I will argue, represents the context within which most of these participants have spent their first year of practice. It is their experiences within this and the learning that this environment facilitates or disables, combined with how this impacts on their commitment to a long-

term career as a midwife, which is the focus of this thesis. There are three related concepts that can be useful employed here to illuminate participants 'experiences in the work setting': these are, 'jurisdictional boundaries' (Abbott 1988) as considered in the literature review, 'occupational demarcation' (Allen 2000) and 'domain consensus' (Stevens et al 2000). Whilst the former is somewhat dated now, it forms a fundamental framework for understanding the formation of this particular community of practice. As such, I will concentrate initially on jurisdictional boundaries before extending my critique into the more specific notion of occupational demarcation and finally domain consensus.

Jurisdictional boundaries in action

Jurisdictional boundaries is the term Abbott (1988) uses to define the recognized boundaries between one profession and another and sometimes also between one professional and another. Whilst Abbott presents them as firm, professional demarcations, he also recognises the essentially fluid nature of a firm concept. By this I mean that whilst various claims to jurisdiction remain firm and hence permit jurisdictional boundaries to remain, exactly what is laid claim to changes over "time and place" (1988: 9). Hence the dynamic nature of jurisdictional boundaries contributes to the lack of clarity I will evidence in this chapter. This perpetuates the uncertainty and discomfort which is experienced at these boundaries. The point of qualification marks a change of boundary for these participants, as they officially enter a different arena of defined jurisdiction as a qualified midwife.

It seemed for many that the transition from student to qualified midwife was accompanied by an acceptance of the elevation of their status and for many, this manifested in a changed relationship with their medical colleagues.

“I think doctors look at you differently... once you have got a blue uniform on ... they’ll speak to you for a start” (Int. 1(a))

Whilst some felt that they ‘belonged’ more as part of the team in practice, it was still made startlingly apparent to many just what their place was in the professional hierarchy. One participant in particular highlighted this when discussing her care for a woman who had experienced an extensive perineal tear. The midwife was the only professional present at a normal birth. The birth of the head apparently was unproblematic, although, there were subsequent difficulties with the shoulders. This resulted in the tear to the woman’s perineum. When the newly qualified midwife referred to her obstetric colleague for advice, she recounted the following experience;

“The doctor said, ‘Well you should have controlled the head’. I said ‘it wasn’t the head, I got the head out beautifully, it was the shoulders’ ... but he made me feel very guilty and of course I questioned, should I have done it any differently?”

(Int. 5(a))

This is a simple example of how the participant felt competent but subordinate. Also it demonstrates a blurred jurisdictional boundary. Whilst attending normal birth is unquestionably the midwife’s role, the fact that this woman experiences ‘extensive’ perineal trauma encroaches on the abnormal and hence the midwife correctly seeks

obstetric advice and assistance. However, in practice 'extensive' is undoubtedly subjective. Whilst some trauma is obviously severe enough to require suturing by an obstetrician, on many other occasions it may not be so clear. Furthermore, the decision is usually made by the midwife, often with reference to a senior midwifery colleague and their decision will no doubt be effected by their own knowledge and experience. As Walsh (2002) makes clear in his article discussing his own experiences of interactions with obstetric colleagues;

“normality is an intensely political phrase where conflict often ensues and where professional boundaries have to be negotiated ... normal midwifery in practice is determined by structures and people” (p12)

However, the crucial point here is that in finding herself at the jurisdictional boundary between midwifery and obstetrics, her experience was one of professional subordination. This midwife's practice, even when conducted within the confines of a birthing room with no other health professional present, was immediately subject to criticism and assumption. Furthermore, as this criticism came from an 'elevated' medic it carried sufficient weight to cast doubt and feelings of guilt. Interestingly, in the initial survey it was roughly a 50:50 split as to whether these midwives expected that doctors would respect their midwifery skills. Whilst the results a year later suggest a slight improvement from this position, 35% of respondents still reported their belief, that doctors did not respect their midwifery skills.

Another participant revealed the discomfort that this causes, although on further probing she felt unable to vocalize it to them but preferred to live with the discomfort. She

explained her experience of interactions with fairly junior medical staff. In this case she discusses senior house officers (SHO's). An SHO is a qualified doctor who has usually been qualified a minimum of one year, which normally would be spent covering general surgery and general medicine. This would be their minimum experience prior to arriving in obstetrics. They may be seeking a career in obstetrics, although frequently it is a short but essential element of some other training, such as training to become a general practitioner (GP). Practically, the education of midwives gives a far greater exposure to and experience of childbirth than basic medical education, so that in practice, midwives have a greater knowledge of normal childbirth both theoretically and experientially (Walsh 2002). Yet, as the representation of a jurisdictional boundary, the following participant most certainly felt that this went unrecognized;

“I don't even think doctors really respect midwives either. When you are talking about an SHO who is just starting, like the new ones starting now, they could be coming onto delivery suite saying this is this and that is that and you think 'hang on, how long have you been doing obstetrics for, two days maybe, what do you know that I don't know?'" (Int. 10(a))

The hierarchy of the workplace ensured that this junior midwife actually felt unable to challenge this equally junior medic. This returns us to the issue that, whilst gaining their experience, these midwives are also seeking to 'belong', at the same time that they are seeking the meaning of practice. However to 'belong', or 'fit in', as we saw in chapter five, frequently meant avoiding conflict, particularly with anyone deemed senior to

themselves. In order to tease out the implications of this for workplace learning, it is usefully to consider this in the context of the communities of practice literature.

To explore this within Wenger's framework of belonging requires us to explore it within the context of engagement, alignment and imagination. Wenger (1998) conceptualises these three elements as mutuality constitutive of "relations of belonging" (p181) and each element impacts on the others. However, a full analysis also requires a consideration of how issues of interprofessional power are interwoven. This element of power, which is for the most part absent from Wenger's (1998) notion of communities of practice, complicates and shapes the implicit professional learning which may be occurring.

Medicine: Engagement, Alignment and Imagination

Obstetrics and midwifery, whilst closely allied, are fundamentally two different areas of expertise. Whilst a midwife, by definition (NMC 2004(a)), cares for women and families experiencing normal pregnancy, obstetrics is the practice of medicine specific to women and families experiencing any abnormality of pregnancy. The definitions seem clear cut, with clearly defined boundaries, but as the history of the professions reveals in chapter two, this often has been, and remains, an unclear and often uncomfortable distinction. In terms of engagement, understood as "the active involvement in mutual processes of negotiation of meaning" (Wenger 1998:173) and in this context, experienced through clinical practice, the major 'progress' of contemporary midwifery has assured midwives of an increasing engagement with their obstetric colleagues. This is the case for all midwives working within the NHS, which is in fact 99% of the profession in the UK, and particularly for those midwives that practice within hospital settings (Hunter 2004). This

dynamic engagement is important for the consideration of both the community of practice within which it occurs and in relation to the learning opportunities it provides.

Engagement with obstetric colleagues, as a formative part of a community of practice, involves mutual engagement in pursuit of a common enterprise, shared activities and interpersonal relationships, yet it also combines very different histories, shared but different activities and most certainly the precarious management of boundaries.

However it is within this engagement that the opportunity and perhaps necessity of alignment occurs.

Alignment “requires the ability to coordinate perspectives and actions in order to direct energies to a common purpose” (Wenger 1998, p186). However, difficulties arise with alignment when the professionals involved may disagree on the meaning of this common purpose. This potential conflict of ideologies (Hunter 2004) may result in different professionals involved in the same situation striving towards different purposes. For instance, one participant was still distressed following an incident wherein she felt she had been the only ‘professional’ who was aligned with the woman. She recounted the following experience;

“they were reluctant to go for a [caesarian] section with her and then she ended up with a ventouse and it was a tiny little doctor who was doing the ventouse and she was pulling so hard that the woman was almost coming off the end of the bed and we had to keep hoisting her up. The shift leader [midwife] was in the room with me luckily and she [the doctor] was pulling so hard that she fell off her stool.

When the cup popped off the baby’s head she decided to do a forceps and she was

pulling whether the woman had a contraction or not. I was looking at the shift leader going ‘ohhhh!’ you know, ‘cos I had only been qualified about three weeks by then. I felt the shift leader was sort of in control even though it was my lady that I was looking after. She should sort have been in control saying whether things were OK or not, so I kept looking at her and all she said was “Are you OK doctor? do you want some help?” She said “No fine”. And she just kept pulling and pulling and pulling. This poor woman was screaming, she was in tears and her sister was in tears and in the end I put my arm over her and I said “Please stop, she hasn’t got a contraction just stop!” but the doctor threw my hand off and said “It’s OK”” (Int. 12(a))

In this example, the newly qualified midwife felt that in aligning herself with the distressed mother and her own notion of best practice, rather than with her professional colleagues, she had been both ignored and chastised. Indeed, this participant felt alienated from the meaning of this situation and was therefore, to some degree, unable to participate. As Wenger (1988) reminds us, “with insufficient participation, our relations to broader enterprises tend to remain literal and procedural: our coordination tends to be based on compliance” (p187). This highlights where, within the work of alignment, the operationalisation of power and authority has the capacity to impose one view above another. This suggests one possibility as to how the ‘with institution’ mentality which prioritises the needs of the institution above any other and has been observed by both Hunt and Symonds (1995) and more recently Hunter (2004) manages to not only persist but thrive. Nevertheless, this is not a position that necessarily remains unchallenged. It has been suggested that the capacity for imagination and creativity may offer scope for

adjustment in this institutional way of being and progress toward a 'with woman' way of being (Walsh 2004). This may serve not only to increasingly align maternity services with current government policy (DOH 2004), but also to increase opportunities for midwives and potentially overturn many aspects of the workplace learning with which this thesis is concerned.

Imagination: liberation or frustration?

Imagination as understood by Wenger (1998) "concerns the production of images of the self and images of the world that transcend engagement" (p177). This is not imagination as opposed to fact, but imagination that allows extrapolation from experience to imagine what the "working lives of other people are like" (p176) and perhaps how one's future working life may develop. As such, imagination may offer opportunities and excitement, or, conversely, suggest limitations and frustration. It is important, therefore, to consider how imagination and creativity sit within this current community of practice. Davies-Floyd (2001) explains that one of the major restrictive features of the technocratic paradigm of health care is its intolerance of other ways of thinking. This reinforces Rosser's (1998) forceful argument that she, like all midwives, is governed by two sets of rules that are frequently in opposition. These are the national professional rules applicable to all midwives and local unit policies applicable to all employees in that area. So forceful is her argument that she attests: "Every time I work a shift on labour ward I break the rules. I expect you do too" (p4). She explains that this is not borne out of intent, but through a professional accountability to do what is in the best interests of the woman which sometimes conflicts with and contradicts local labour ward policies. She cites the

admission cardiotocograph (CTG) as one specific case. The CTG, as a process involves connecting a pregnant woman to a CTG monitor, ensuring adequate connection with both the fetal heartbeat and the fundus of the uterus (to record uterine pressure changes) and establishing a recording output. Although Rosser's article was published long before the NICE (2001) clinical guidelines for fetal monitoring, even then, the process of doing a routine CTG on a woman arriving in normal labour was questionable practice. The NICE guidelines, three years later, supported the use of intermittent fetal monitoring in women with normal labours and were a huge step forward for policy. Nevertheless, as we later explored earlier, in chapter five, this continues to be a site for contradiction and conflict now, almost ten years later. It seems perhaps that the room for manoeuvre within and around these two sets of rules is effectively the space for imagination and creativity. Furthermore, and perhaps more specific for this study, is the acceptability or tolerance of imagination and creativity in practice. The survey, in this respect, reveals just how difficult newly qualified midwives both anticipated, and subsequently experienced, this to be.

At the point of qualification over 60% of respondents anticipated that hospital protocols may restrict their ability to provide the type of care they wanted to give. Bearing in mind that these women have three years experience of care whilst training, this is not an uninformed position. Nevertheless, one year later the results were somewhat more equivocal. At one year qualified, the split was very similar between those who agreed that hospital protocols were restrictive in practice and those who disagreed. This may reflect a position where policy is increasingly aligning with midwifery philosophy and less dissonance is experienced. However, it may also reflect a position whereby new and

vulnerable members of the profession in the face of complexity and uncertainty retreat to a position of relative ‘safety’ by doing things ‘by the book’ and hence quickly absorb the position and philosophy espoused by local policy (Eatherton 2002). This limits both the space and indeed the need for any imagination or creativity, as standard formats of care are prescribed and predictable trajectories expected. Indeed, the interview data reflected a very limited amount of encouragement or acceptance of creativity. As one midwife put it;

“I don’t think they like me suggesting things, different practical things. I think they find it threatening that is all I can imagine it is.” (Int. 8(c))

The same participant, who had in fact already left the Midlands in search of an opportunity to experience more flexible, woman orientated case load care, continued by explaining how in reality she still felt opportunities for creativity were limited.

Describing a recent team meeting, she explains;

“I hoped it would feel like a safe environment to say “I don’t feel like you are providing me with an empowering environment here” but it doesn’t feel welcomed. It’s like they would just put their hand up in front of your face. There are things that I might have suggested just little things ... but I don’t feel I can suggest things. I hold back” (Int. 8(c))

A similar scenario was recounted by another midwife who had remained in the Midlands in a hospital-based post. In her second interview she seemed optimistic about her opportunities to contribute to developing practice. She said;

“I am starting to think about the way that you could do your job differently really ... I have been trying to think of different ways that we could do it and at the ward meeting today I am going to bring up a few things” (Int. 10(b))

However, in her diary three months later, she presents a virtually undiluted account of a practice circumscribed by frustration and defensiveness.

“When I am away from work I feel that I am able to change the job/system/world but when I get there I realise that I can’t change anything! I am restrained in the NHS/ [hospital name] by politics

-staff bitching

-not feeling supported

-not being able to stand up for myself

- working to get ‘experience’ before moving

I also feel restrained by a lack of autonomy and people (old school midwives) constantly questioning me” (Diary 2, p9)

It seems that the frustration associated with being unable to contribute creatively to the development of practice was far from unique. It is therefore unsurprising that perhaps a proportion of these newly qualified midwives simply retreated to the relative safety of the known system and the current practice. Straying from these confines amounted to risky behaviour as the following incident shows.

In the interviews conducted at six months qualified, one participant was describing her fear of challenging practice. She recounted a recent incident wherein a midwife, who had been qualified longer than herself, had been experiencing a problem with a woman who, having safely birthed her child, had subsequently retained the placenta. Correctly, after a period of time, the midwife sought obstetric advice. Frequently the outcome of this would be a trip to theatre and an anaesthetic for manual removal of the placenta. However, whilst considering the options, the obstetric registrar suggested an innovative (and possibly unsubstantiated or dangerous) alternative involving administration of a drug via the cord. The midwife checked with her senior colleague and the doctor sought the consent of the woman. Rightly or wrongly the procedure went ahead and the placenta subsequently delivered vaginally with no apparent complications. Nevertheless, the aftermath from a management point of view signaled a clear warning;

“The managers got hold of those notes, heard what happened and it is terrible ... I think they are saying as they weren't acting under the guidelines, under the protocol, they are being investigated. It is quite serious actually” (Int. 7(b)).

One of the most alarming aspects for this midwife was that she felt that with the ‘cover’ of an obstetric registrar and agreement from a senior midwife she too would most probably have taken this course of action. She was aware therefore, that she too would have to be professionally accountable and bear whatever consequences ensued. This scenario imposes many questions and dilemmas. As a creative solution it seemed to be effective practice. However, if lacking in due consideration, it may not be considered safe practice. Furthermore, whilst this newly qualified midwife was acutely aware of the

implications for those midwives involved, she was not so sure of the implications for the medical registrar involved. This returns us to the complexity of the jurisdictional boundaries that we are considering. In this case it seems unclear whether the jurisdiction was medical or midwifery. This is despite the fact that usually a retained placenta, and certainly drug administration is an obstetric concern. Nevertheless, the disciplinary result rings loudly within the midwifery forum. This case could, and may still, serve as an opportunity to develop creative practice. However, the knee-jerk reaction was evidently one of surveillance and control, which can either be argued convincingly in the name of safety (Cahill 2001) or equally as convincingly as a patriarchal, institutional measure of oppression (Stafford 2001). The blurred jurisdictional boundaries of practice developed as a concept by Abbott (op cit) is useful when considering this case. I will now turn to examine the analytical contribution of the more specific notion of occupational demarcation.

Occupational demarcation

The concept of occupational demarcation is complimentary to that of jurisdictional boundaries, but different in that it;

“may be understood as micro-political strategies through which work identities and occupational margins are negotiated.” (Allen 2000)

As such it offers a tool for looking at the more detailed minutiae of everyday practice which serve to reinforce the boundaries between occupational roles. One interesting concept which served as a tool of occupational demarcation within Allen’s study was “the

rhetoric of holism” (p343). She suggested that in the course of identity work both medical and nursing managers constructed the devolution of tasks differently in order to align the shifting boundaries with their own respective occupational identities. Consequently, in her study, when nurses took on the task of inserting intravenous cannulas, medical staff typically downgraded the tasks whilst nursing staff elevated it to an essential component of the provision of holistic care. Similar occupational demarcation strategies permeated the data collected for this study and while some were based around task ability, others reflected the divided nature of the workplace. Rather than foregrounding the rhetoric of holism, these midwives saw both issues as conversely contributing to an increasing fragmentation of care. We shall briefly consider both.

Tasks, the structure of care and occupational demarcation

As referred to in the previous chapter, newly qualified midwives quickly focused on the tasks that they were required to learn in order to establish ‘competence’. These tasks included intravenous cannulation, suturing, scrubbing to assist in theatre and occasionally topping up epidurals. These were usually related to a form of career progression that would be reflected in promotion and ultimately their pay. Whilst these might be absorbed into the rhetoric of holism, there is also a convincing argument that in fact they represent some of the cultural props of medicine (Machin and Scamell 1997), or in this case, midwifery. Evidently then there is pressure to conform quickly to the midwifery model of care in order to progress within this community. One participant explains;

“we have got to do things to get the F grade ...like on delivery suite we are supposed to scrub... We have got to be able to cannulate at the end of it too.

Things like that which I think at the moment I don't need. I want to get into understanding what I am doing in the normal labour bit. ..But now I have to learn to cannulate and I have got to go round on the wards to find people to cannulate”.

(Int. 5(a))

Despite the fact that this midwife, who had only been qualified three months, felt that she wanted to “understand the normal labour bit”, her efforts were directed into task accomplishment. Essentially this potentially detracts from learning and understanding the “art of doing nothing well” which Kennedy (2000) extols as at the heart of exemplary midwifery practice. Furthermore it perpetuates a practice absorbed by doing rather than being which once again Fahy (1998) demonstrates as counterproductive to establishing a woman centered midwifery philosophy. Evidently in relation to occupational demarcation this will inevitably have a detrimental effect on the skills of midwifery, indeed;

“As a strategy of occupational demarcation this serves to marginalize the skill sets more directly associated with midwifery and results in midwives “checking not listening” (Kirkham and Stapleton 2004).

This implies that much of the learning associated with practice marginalises the ‘being’ elements of practice and overemphasizes the importance of ‘doing’. The structure of current care additionally supports this philosophy of fragmentation.

We have seen that the usual provision of care experienced by these midwives was hospital based, although some did work in the community. Nevertheless, midwifery work is divided into antenatal care, either in the community or at hospital antenatal clinics

(usually a combination of both), intrapartum care, which occurs most frequently in a hospital-based delivery suite, and postnatal care, which is initially provided in hospital and then transferred back to the community. Each of these areas is staffed by different midwives, meaning that by the time a woman is discharged from maternity care, she could well have seen ten midwives or more. Consequently, this provides little opportunity for both women and midwives to experience any continuity of care (Bates 2004).

Despite the complex issues associated with the concept of continuity, its absence, if viewed as a strategy of occupational demarcation, serves to fundamentally redefine midwifery. Indeed the combination of these two issues, task orientation and fragmentation of care, has served, in part, to redefining exactly what it is that a midwife does, and as such demarcate the boundaries of the occupation. No longer is a midwife a family friend (Leap and Hunter 1993), nor do women often expect to even know the midwife who cares for them during birth (Purkis 2003). Whilst some still argue that factors such as this continuity of carer, are not detrimental to women or to normal child birth (Freeman 2006), a mounting body of evidence suggests otherwise (DeVries et al 2001, Kirkham & Stapleton 2004). Furthermore, it is this body of evidence which informs the most recent government directive for maternity services in the National Services Framework for Children, Young People and Maternity Services (DOH 2004). This document, whilst explicitly encouraging a 'woman-centred' philosophy and advocating increased choice, for women falls short of advocating any substantial change. Even those statements that are offered unambiguously such as;

“Local options for midwife-led care will include midwife-led units in the community or on hospital site” (p28)

seem hollow in the current N.H.S. fiscal crisis, which often sees midwifery led units caught in the first line of cut backs (NCT 2006). Such strategic outcomes serve to underline that midwifery practice must continue to struggle with micro-political battles of occupational demarcation in contexts that are weighted heavily against midwives. This leaves one to question whether any sense of domain consensus has been reached and if so does this have any implications for activities occurring on the boundaries?

Domain Consensus?

Stevens et al (2000) define domain consensus as “agreement among participants in the system of professions regarding the appropriate role and scope in inference, diagnosis and taking further action of an occupation” (p442). At one level it is easy to suggest that midwifery and medicine have a comfortable domain consensus in that midwives are practitioners of normal childbirth whilst medics are practitioners of abnormal childbirth. However, as we have already seen to some extent, the reality of the agreement amongst participants in the system of professions is somewhat more complicated (Abbott 1988). Such complications can arise between participants of one profession or between participants of different professions. I shall first consider the evidence for domain consensus between the professions of midwifery and medicine and then, equally importantly, the evidence for domain consensus amongst midwives themselves.

It seems from the data there was some level of discomfort about domain consensus between midwives and medics. However, at the outset it must be borne in mind that these are newly qualified, junior midwives and as Wallace et al (1995) reminds us, this is often the position from which midwives experience the most discomfort in their interaction with medical staff. Whilst for some, personal relationships with medical staff may have been a positive experience, there was still some evidence of disagreement about the domains each inhabited. It was generally assumed by these midwives that they were to inhabit a midwifery space, which they associated with waiting and watching, rather than intervening as much as possible. However, when the medics demonstrated these qualities the midwives seemed surprised, one, for example remarked;

“I have a laugh with some of the doctors and say “My God are you sure you are not a woman in disguise?””(Int. 13a)

Yet when the medics replicate their care it caused frustration. For instance there were many accounts of doctors repeating internal examinations to verify findings. Involved in one particularly arduous labour one midwife had spent the entire shift caring for one woman and was very confident of her situation but the newly arrived doctor wanted to repeat all her investigations. She responded;

“I found that really frustrating and with people not listening and coming in and having to do re-assessments for no reason and doctors coming in and doing the same thing you have just done.”(Int. 8b)

It may have been precisely because these midwives were newly qualified that the doctors felt compelled to check results. Nevertheless, it demonstrated uncertainty as to whose domain was whose. The participants also witnessed this in reference to length of labour.

There had been concern for a long time that arbitrary time constraints on labour are inappropriate (Albers et al 1996), yet many hospital policies still dictate 'preferred' lengths of time for each stage of labour and this is often reflected in the documentation for labour and the almost universal adoption of the intrapartum partogram. This documentation requires the midwife to chart progress in labour and has an 'action curve' superimposed upon it to suggest to the midwife that 'action' may be appropriate. This 'action' implies referral to obstetric colleagues. However, as this has increasingly been demonstrated to be inappropriate, time constraints have, in theory, become increasingly flexible. Laudable though this is, it contributes to confusion about domains. One participant recounts seeing this in action;

"I have seen the midwives saying, "No, you don't need to do that yet, leave them alone" and the doctors have said "Alright then we will give them another couple of hours and see how it goes." You know ... if at the end of the day it is still required [an intervention] then fair enough but they [the midwives] have been able to buy that extra bit of time" (Int. 13a)

It becomes evident that the theoretical boundary between midwifery care of 'normal childbirth' and obstetric care of 'abnormal childbirth' is indeed a site of movement and negotiation. Frequently, nevertheless, these encounters were managed smoothly in the clinical environment. Certainly the consideration of domain consensus can take on a

whole new light when considered from the different perspective of looking for domain consensus between midwives themselves.

For the purposes of this study it is perhaps important to first consider how much consensus was apparent between the newly qualified midwives themselves. Analysing the survey data participants were asked to put a tick in one of four boxes between two opposing statements. The statements were;

A. “For most women giving birth the risks are small and the midwife just needs to be there for support, standing in the background, keeping an eye on things” and

B. “For most women giving birth, there is always the danger that things might go wrong and the midwife often needs to step in and manage things”. The responses at the point of qualification and at one year qualified were as follows;

Table 8: Domain consensus amongst midwives

Survey	Agree with statement ‘A’	Agree with statement ‘B’
First	78%	22%
Follow-up	69%	31%

The four boxes provided for answers meant that participants, if responding at all, had to fall on one side or the other. The statements were the same as those used in the ‘Why do Midwives leave report’ (Ball et al 2002) and were specifically designed to suggest either a fundamentally midwifery based philosophy suggested by the statement ‘A’ or a fundamentally obstetric philosophy suggested by the statement ‘B’. Only six respondents in total either failed to put a tick or ticked both sides. Nevertheless at the point of

qualification it can be seen that 78% of those responding to the question agreed with statement 'A', which suggests a high domain consensus within the research population at this point. One year later the percentage agreeing with statement 'A' had dropped to 69%. Whilst wary of the small numbers involved and acutely sensitive to the use of percentages in this context, this does suggest a declining domain consensus within the population. This is perhaps unsurprising when considering the medical and hospitalized nature of the majority of their experiences across their first year of practice. Furthermore there were instances in the qualitative data where the participant's understandings of midwifery practice fundamentally clashed with what they were experiencing. For instance one participant felt constantly irritated by midwives she perceived as not practicing midwifery as she understood it. For instance, whilst she perceived midwives' priorities as support and connection with the women, she reported comments from colleagues longer qualified than herself which unsettled her. She recounted;

“She said it to me and I cringed ...she said “Oh, give me proper midwifery any day. Give them an epidural, knock them out, that's proper midwifery for you' ...

And the other one is very similar, anything for a quiet life. (Int. 3(b))

Whilst I suggested that this may be an instance of misplaced humour the participant insisted that this was not the case. This lack of agreement within the profession is supported by an increasing amount of literature describing midwives collusion in the perpetuation of the dominance of medicine and alignment with the institution above the woman. McCrea et al's (1998) report of exploring women's pain relief needs in labour, introduced “cold professionals” (p176). These were midwives who rather than working

with women “did things for them” (p177) and this they counterpoised with “warm professionals” who engaged with the women and the presence of whom enhanced the birth experience for women. This too suggests a lack of domain consensus, however;

“The really sad thing is that it is often done in the name of “being a good midwife”; that is, blindly following the rules designed for the needs of the institution rather than the needs of the individual” (Murphy-Black 1995)

The suggested lack of consensus within the profession, about how to ‘be’ a midwife, is perhaps even more worrying than any lack of consensus between the professions.

Inevitably then, this also means that midwives involvement extends to negotiating the boundaries between their different understandings of practice. Within this theoretical framework, I suggest that this is the work predominantly encountered at the boundary between midwifery and medwifery. From the previous chapter, we can see that being central to midwifery may involve being peripheral to medwifery and indeed visa versa. The result, as was demonstrated, entails an inevitable degree of persistent peripherality. Therefore, whatever position or identity is adopted will inevitably involve the work of negotiating boundaries. It is this element which we now consider.

Negotiating boundaries

Negotiation is an active process, which Wenger (1998) considers in a variety of ways throughout communities of practice. The complex importance of negotiability notwithstanding, it is with the negotiations that occur at the boundaries of practice with

which this section is concerned. Wenger terms these negotiating activities “brokering” (p108) stating;

“The job of brokering is a complex one. It involves processes of translation, coordination, and alignment between perspectives. It requires enough legitimacy to influence the development of practice, mobilize attention, and address conflicting interests” (p109)

Furthermore, the suggestion is that it is often these ‘brokers’ who act as the impetus for innovation (Wenger 1998, Eckert 1999). Herein lies the dilemma for these newly qualified midwives. Their clinical presence is legitimized in that they occupy the position of legitimate peripheral participant in the community of practice. Yet, whilst they may or may not be on an inbound trajectory to full membership, they initially, and most certainly during their first year of practice, lack sufficient legitimacy to ‘broker’ successfully. This has resonance with the sentiments of Wickham (2003)

“No-one could see past my ‘newly-qualified-ness’ to discern anything I might be able to offer women as a midwife” (p6)

Wickham describes her disempowering and frustrating experience of trying to find post-qualification employment, in Britain, that aligned with her philosophy of midwifery.

Unable to find such a position, she establishes the direct link with retention as she left the UK to practice in America. However, the survey data already points to an initial lack of legitimacy. As reported earlier in this chapter, 50% of participants, at the point of qualification, expected that their midwifery skills would not be respected. Similar

findings also scattered the qualitative data collected for this study. For instance one participant reported;

“to some of the older G grades we aren’t worth tuppence hapenny. They say “they send you to university, you come with all these new fangled ideas and you don’t even know how to deliver a baby”” (Int. 5(b))

Comments such as this served to ensure that this participant shied away from sharing her “new fangled ideas” and as such was excluded from introducing innovation. Others tried to demonstrate their understandings of best practice only to be discouraged. This was evidenced many times when participants attempted to discuss their desire for mobility for women and the use of alternative positions for birth. Whilst some areas, or more specifically, some colleagues, did promote and support these ‘innovations’, frequently participants reported feeling uncomfortable or unsupported in trying to facilitate these choices. Many linked this to their own lack of confidence but it is equally appropriate to consider this as their lack of personal legitimacy within the community of practice. As Davies (2005) states;

“It is hard to imagine an outsider/peripheral participant having sufficient status to ratify an innovation. Such persons may display innovative practice, but surely a full participant (and presumably someone who is part of the hierarchy) must sanction its adoption by revising their own practice” (p16)

This gives rise to the situation wherein throughout their brokering activities at the boundaries of practice, the learning they encounter is predominantly unidirectional,

ensuring the maintenance of the dominant viewpoint. This would go some way to explaining the growth of midwifery as the historically technorational superiority of theoretical medicine has assumed superiority and most adaptations or revisions in practice have occurred within midwifery. Indeed it is Davies (op cit) that suggests that successful 'brokering' as described by Wenger (1998) is particularly unlikely to occur when, at any given boundary, there is potential for conflict of any kind. This therefore ensures that the negotiating or 'brokering' capacity of these newly qualified midwives remains minimal. Therefore, it is possible to see how they become increasingly removed from constructing their own meaningfulness in practice and occupy a disenfranchising position.

Conclusion

In this chapter I have argued that the interprofessional relationships experienced in the everyday workplace of contemporary midwifery have a fundamental role in shaping workplace learning for newly qualified midwives. The location of services, predominantly within a hospital-based system, permits the continuance of a hierarchy which results in the professional subordination of midwifery (Bates 2004). Despite an education which is designed to promote their professional identity (Benoit et al 2001) upon encountering the numerous boundaries operating in the workplace, these midwives lack the legitimacy and arguably the support to imprint their own meaningfulness at these peripheries. Instead they occupy spaces that in themselves are unclear and as such support from colleagues both medical and midwifery is unpredictable. Some of these boundaries exist between midwifery and obstetric practice and whilst at times these are

quite clear, at others, the political nature of 'normal childbirth' means that boundaries become unclear and positionality vague. This is particularly so for inexperienced qualified midwives, who are struggling to both establish their own professional identity and forge good working relationships with medical colleagues.

Perhaps of more concern are the suggested divisions amongst midwives. I have argued that there appears to be a lack of 'domain consensus' which given the contested nature of childbirth, the institutional context and the diversity of the midwifery population, is unsurprising. This raises the concern that a 'one size fits all' service will increasingly alienate sections of the midwifery profession. The view of midwifery as "a universal entity" has been criticized (Mason 2000). Nevertheless, Mason's suggestion of a further split in the profession into clear divisions of midwives and obstetric nurses seems as unrealistic and improbable, as it does unpalatable. However, in accepting and embracing diversity within and amongst the profession there is a need to establish a diversity of workplace environments to match. Otherwise some midwives will always need to inhabit a variety of peripheral positions.

This chapter has demonstrate that for these participants the periphery remains unclear, both in relation to obstetrics and sometimes also to a 'midwifery'. This has implications for their workplace learning. As Wenger (op cit) suggests (p110), the possibility is that the discomfort associated with these peripheral positions will sometimes be interpreted in terms of a personal inadequacy, which serves to exacerbate the discomfort. The result is that any innovative tendencies may easily be subsumed as newly qualified midwives learn how to adapt to the community of practice. This correspondingly and

simultaneously limits not only the development of the individual but potentially of future practice too. As Wenger (1998) warned;

“Through engagement, competence can become so transparent, locally engrained, and socially efficacious that it becomes insular: nothing else, no other viewpoint, can even register, let alone create a disturbance or a discontinuity that would spur the history of practice onward” (1998: 175)

As a result, the community of practice becomes an obstacle to learning as the individual becomes trapped between their own interpretations of meaningfulness and the power of the community to both define acceptable identity and accordingly accommodate any newcomers. Midwifery colleagues also participate in a key way to the formation of identity and this is the focus of the final findings chapter.

Chapter 7

Intra-professional relationships and 'G' grades

Intra-professional relationships and ‘G’ grades

Introduction

This chapter seeks to develop the intellectual argument of this thesis, that professional workplace relationships both influence and impinge upon informal workplace learning. In order to do this, this chapter will analyse the importance of intra-professional relationships and particularly hierarchical relationships with ‘G’ grade midwives, looking particularly at their ability to either expand or confine the learning and development of newly qualified colleagues. These relationships were chosen specifically from the data as those which were reported as having the most impact. Thus, the analysis, explicitly addresses the second part of research question one; how do ... midwifery hierarchies affect the experiences in the work setting? Furthermore it also addresses, in part, both research question two and three, as the curriculum of the workplace and the informal transitional learning of which this hierarchy and these relationships are a fundamental part, is uncovered.

Whilst the literature on communities of practice forms the backdrop of this analysis, it is important to expand upon this to take into account the power relations and differentials which operate in this specific work context. Therefore, the literature on professions and semi-professions is drawn upon, whilst trying to maintain the focus very much on health professionals. Midwifery emerges as a profession which perpetuates a form of internal self-policing and this leads specifically to a consideration of the concept of horizontal violence as offered by Leap (1997). The term horizontal violence was offered by Leap (op. cit.) to “represent a shorthand for a political analysis of specific forms of oppression”

(p689), which analysis this thesis utilizes and adds to in its concentration upon the politics of midwifery. Furthermore, this analysis extends to draw upon the literature on workplace bullying, whilst again retaining an explicit focus on the field of health. This allows engagement with the complex nature of facilitating learning in an inherently emotional, often fast paced and occasionally critical environment. Finally, the discussion is brought together to suggest how combining these fields of thought potentially extends the concept of communities of practice and necessarily allows for consideration of the influences of both power and emotion. This allows for the move beyond the persistent passivity of the subject that predominantly infuses the COP literature, in order to consider the agency of those continuing to learn.

Intra-professional relationships

Throughout this research, the importance of relationships with colleagues has held the paradoxical honour of being at times a major source of support and satisfaction, whilst at others, a powerful and persistent presence in experiences of frustration, fear, guilt and disempowerment. Wenger (1998) recognizes the power inherent in these relationships:

“More experienced peers are not merely a source of information ... they are living testimonies to what is possible, expected, desirable” (p156)

Experienced peers are the “actual people [and] composite stories” (p156) encountered in practice and represent “paradigmatic” trajectories (p156) or visions of possible futures for newcomers. Their trajectories are so much more than the reification of career milestones that:

“Exposure to this field of paradigmatic trajectories is likely to be *the most influential factor* shaping the learning of newcomers” (Wenger 1998: 156, italics added)

It is this complicated ‘exposure’ that helped in the formation of identities, as these initially ‘peripheral’ midwives (Lave and Wenger 1991) grappled with both establishing their own identities and attempting to develop their roles within the work setting. To return to the issues within belonging; engagement, alignment and imagination, should help clarify the potential of these complex relationships.

Firstly, what struck me, as both a researcher and a midwife, was that over the course of one year all participants spoke of their practice and their practice experiences, much more in terms of their midwifery colleagues, than of the pregnant women with whom they were involved. Surprisingly, in their accounts, the women they worked ‘with’ were frequently, although not totally exclusively, other midwives. On reflection, perhaps this can be understood in terms of engagement. The history of midwifery practice presents us with a situation whereby there had been increasing isolation from pregnant women and communities and moves towards hospitalization and professional power (Leap and Hunter 1993, Wagner 1994, Mander and Reid 2002).

Whereas historical accounts such as that by Worth (2002), portray women as central and colleagues as peripheral, in the current situation, and from these accounts, this seemed reversed. However, if engagement is taken as a fundamental tenet of the formation of a community of practice, then these midwives, given the fragmented nature of contemporary practice (Lester 2005), experience much more engagement with colleagues

than they do with pregnant women. In this respect, colleagues become “their primary reference group” (Lipsky 1980:47). It is therefore unsurprising if these relationships become fundamental in shaping the learning of newcomers.

In exploring the paradigmatic trajectories to which they are exposed (Wenger op. cit.), it is important to recognize that this theorizing goes beyond the more specific notion of role modeling. Paradigmatic trajectories suggest a broader possibility involving the dynamic relations of mutual engagement to represent multiple ways of being or becoming in practice. To this end, many of the participants absorbed lessons about ‘how to be’ through their encounters with colleagues. Furthermore, these were apparently most powerfully represented when enacted by ‘the G grades’.

‘G’ grade is simply a pay scale. To refer to somebody clinically as a ‘G’ grade, whilst fundamentally only reflecting their pay scale, also generally infers something about their status and experience. It is the term most usually adopted to replace the more outdated term ‘Sister’ although this itself is still occasionally retained. Current pay scale changes in the NHS in the guise of the ‘Agenda for change’ (DOH 2004(a)) may eventually see this term replaced too. Nevertheless, throughout the data collection for this research project, the ‘G’ grades were, without exception, the most senior clinical midwives encountered. Whilst many ‘G’s also hold managerial and organizational responsibilities, they often represent the most senior clinical midwives found practicing in the everyday face-to-face environment of midwifery practice. It is in this capacity that they exerted immense influence on the learning of these newly qualified midwives.

Generally they were recognized as powerful colleagues, regardless of whether this recognition was accompanied by respect. Often this recognition was related to both knowledge and experience.

“She is very, very clever, she is a G grade, and I thought ‘I can’t be up to this standard’. When I qualify I will not manage this and it took a while to sink in that she has got twenty five years or more experience behind her and that is what I wouldn’t have when I qualified. I would have all my basic knowledge and my experience had got to come.” (Int. 6(a))

This ‘experience’ is frequently measured by time since qualification. And it is often these ‘old-timers’ that newly qualified midwives are looking to for representations of how it is possible to be in this job in a currently unclear future. Indeed;

“As a community of practice, these old-timers deliver the past and offer the future, in the form of narratives and participation both. Each has a story to tell”
(Wenger 1998:156)

These narratives are powerful learning opportunities. The inherent power of these living narratives is magnified when newcomers have opportunities both to witness and participate in the mutuality of practice. Once again we return to the dualism of reification and participation in situated learning. Not only do the ‘G’ grades stand as a manifestation of what is possible with ‘experience’, but they also participate in the everyday activities which form the community of practice. Hence, support and recognition offered by these

'G' grades was often perceived as invaluable, whilst the more negative encounters were often harsher experiences.

The 'G' grades that were perceived as the most supportive were defined as "good leaders" but also "quietly supportive";

"it was good to have a supportive G grade there ... she is there but in a gentle way, you know that she is there for you and that gives you confidence, just in a quiet way" (Int. 3(b))

It was rare for their actual qualifications or even personal competence to be considered. In discussing the 'G' grades, there was much more likely to be an assessment of personal qualities and interpersonal relationships. This and their wealth of experience carried far more importance to these newly qualified midwives than the qualifications they had or did not have. It is important to remember that midwifery education to degree level is a fairly new concept; with even the diploma level award being fairly recent. As such, the vast majority of 'G' grades encountered clinically at the time of this research only a basic certificate in midwifery and many, whilst theoretically (and professionally) responsible for their own professional development, may have pursued no further academic studies since qualifying over thirty years ago. However, being academically qualified to any higher level seemed almost an insignificant achievement in comparison to 'experience';

"Me, coming into it ... I think what their knowledge is is just totally different to what we learn on a degree... But I don't know why these G grades would do it [degree level study]. Putting themselves through all that." (Int. 6a)

So whilst these newly qualified midwives could claim a certain equality of standing, from the fact that they too are qualified midwives, the esteemed 'experience' stands as something they have to patiently acquire. Whilst accumulating this 'experience' they interact with, observe and assist colleagues in everyday practice. It transpired very quickly that the participants placed a great deal of emphasis on the relationships that they maintained with colleagues.

In turn these relationships represented an omnipresent source of learning. Wenger summed this up concisely;

“No matter what is said, taught, prescribed, recommended, or tested, newcomers are no fools: ... they soon find out what counts” (p156)

For some this involved the discovery that, in opposition to their understanding that the first priority for midwives was the care of women, at times this either was not or could not be the case. In an increasingly busy and stressful environment organizational concern often came to the fore;

“I think the senior staff have a really hard job. I think they are paid to manage and not to look after women and to make them fit in the right boxes... We have been so busy lately that the onus has been on trying not to shut the unit and we have had to shut it and I think if they could have avoided that at all costs that is their main aim.”(Int. 2(c))

This reflects the current culture of midwifery practice described in detail by Kirkham (1999) and re-iterated by Stapleton et al (2002). This transfer of allegiance is facilitated

and in part demanded by a variety of historical, political, technological and social factors impinging on midwifery practice (Wagner 1994, Bosanquet 2002). Nevertheless, what is important for this analysis is how this is absorbed into the curricula of the workplace. As Paetcher (2006) reminds us “for many the benefits of conformity outweigh those of resistance” (p15). This is the implicit pedagogy, which, understood as such helps frame the transitional learning which occurs. Whilst one can maintain simultaneous allegiances (Sinclair 2006), it was quickly apparent that it was often external pressures that forced midwives of all grades to prioritise, often quickly. Philpin (1999), in a qualitative study of 18 qualified nurses, suggested that ‘acute’ hospital areas often resulted in ‘harsher’ and ‘less satisfactory’ professional encounters, a fact indeed corroborated by this study. Without exception, these newly qualified midwives felt the pressures of practice most acutely on delivery suite.

Delivery Suite

Delivery suite is the area of any maternity unit specifically identified as the chosen and therefore optimum place for women to give birth. The area is preferably at ground floor level for access and safety. It is usually directly connected to at least one obstetric surgery theatre and in close proximity to a neo-natal unit if the hospital has one. Also referred to in different units as ‘labour wards’ the explicit language and implications thereof have themselves been the source of repeated criticism (Martin 1987, Murphy-Lawless 1998). Nevertheless, these titles persist. Within the profession, either title readily identifies a designated area requiring specific skills and abilities. Hunt and Symonds (1995) described a particular culture on two delivery suites in an unspecified area of England in

the late 1980's and early 1990's. These findings have subsequently been supported by other investigations of NHS midwifery culture (Hastie 1995, Kirkham 1999, Tellier 2003). Unfortunately, despite isolated reports to the contrary (Wallace et al 1995), and the fact that this paper reports on interprofessional interaction rather than intraprofessional notwithstanding, much of the literature makes uncomfortable and disappointing reading.

Hunt and Symonds(1995) referred to their own ethnographic work over a decade ago as possibly a “sad reflection” (p154) of care which was not satisfactory and there has yet to be a substantial rebuttal from within the hospital-based system. This is not to ignore the strides that have been made in addressing these far from new findings. The birth centre movement, in the face of constant opposition, has crept forward so that some centres can now provide the unique, nurturing ethos a birth centre requires, Kirkham (2003) describes this unique ethos. Simultaneously, government rhetoric has continually supported change (DOH 1999, DOH 2004) and resulted in laudable pockets of innovation dispersed throughout the country (RCM 2006). Nevertheless, developments are slow and notoriously difficult.

Accordingly and perhaps then unsurprisingly, in this sample of newly qualified midwives, from one of the largest geographically defined local supervising authorities, 100% of respondents at one year had spent their immediate post-qualification period either working in, or closely attached to, a large obstetric unit. Such is the current dominance of hospital-based obstetrics, particularly in the West Midlands region. There are few, if any, alternative employment options available to midwives wishing to

continue to practice midwifery. Therefore, all of the research participants at some point, expected to practice within a hospital-based delivery suite. It is revealing to hear their expectations.

At the point of qualification all of these midwives had already had exposure to working in all areas of their hospital bases as students. From the initial survey results, 63% of respondents anticipated that as a newly qualified midwife, labour ward was going to be the most difficult area for them and nobody felt that this was not an issue for them. One year later a similar 60% of respondents reported that this had indeed been the case and a marginal 3% felt it was not an issue for them, perhaps reflecting those that had in fact not had any experience on delivery suite in their first year. This was supported by the interview data with initial comments such as;

“That’s the biggy [delivery suite] ... I want to be confident on delivery suite ... how can you be a midwife and be frightened of delivering babies?” (Int. 1(a))

Another participant went immediately to delivery suite upon qualification and recalls on her first day “feeling almost sick in the morning ... I was just so, so nervous” (Int. 3(a)).

Given the reported expectations, neither of these comments is surprising and as seen from the survey even a year later, many still felt that delivery suite was difficult.

“There is a culture there[delivery suite], there is a culture to all the wards but delivery suite especially I think, and it is hard ‘cos ... there is a lot of bitchiness going on and the culture of delivery suite is so big you can’t get into it” (Int. 10(c))

It may be the case that this enduring difficulty is linked to the findings discussed in the previous chapters and that whilst the vast majority of these participants aligned themselves with a midwifery philosophy of care, their work experiences challenged this. These newly qualified midwives, as many others (Wickham 2003), found themselves in the paradoxical position of having to gain the vast majority of their experience around actual birth in large centralized, obstetrically-led units.

As the persisting bastion of hospitalized birth, delivery suite represents what more than one participant referred to as “the sharp end” of midwifery practice. Delivery suite is invariably busy, labouring situations are dynamic and unpredictable. Important decisions often have to be made quickly with only the information available to hand and in emergency situations, the consequence may, on occasion, literally be a matter of life and death. Work in this emotionally charged, rapid and high consequence setting is a manifestation of the dynamics of a community of practice (Wenger 1998) that potentially sheds new light on the concept. The potent combination of delivery suite and its most senior ‘G’ grade midwives, for many of these newly qualified midwives brought sharply into focus their vulnerability and their subordinate status. Supportive relationships with ‘G’ grades were especially valued, although these reports were in the minority. I found that just as Hunt (1995) reported;

“My informants were anxious to tell me more of the stresses and negative features of being a midwife” (p123)

Whether this is due to the potentially therapeutic role of the research relationship, or whether negative encounters are actually much more common is difficult to ascertain for

certain. One respondent hints at the latter when she identifies a particularly supportive ‘G’ grade whose approach ensured that she, even as a senior member of staff, remained outside of the mainstream culture;

“I mean we have got a fantastic one [‘G’ grade]... I would say she is seen as different by other sisters ... she will put herself out for the women” (Int. 2(c))

On further exploration of this comment the participant described a ‘G’ grade who seemed to demonstrate ongoing alignment with the women she cared for rather than “managing the ward to satisfy hierarchy” (Int. 2(c)). However, she recognized that this stance avoided the individual ‘fitting in’ completely. Regardless, nevertheless, of the reasons, these negative accounts of interactions with senior midwifery staff on delivery suite were frequently reported. As such, this phenomenon, within a project exploring workplace learning, demands deeper thought and analysis.

In order to consider this issue further, it is important to consider the interactions reported within an appropriate framework and with due consideration to the position and perspective of both the respondents and those with whom they are interacting. Newly qualified midwives form a section of the professional population who can be perceived to be particularly vulnerable (Ball et al 2002). Their need for support and guidance in a variety of capacities is sometimes obscured by their familiarity with the work location, with work colleagues and frequently by the degree of professional socialization that they have already experienced (Begley 1999). However, it is both interesting and valuable to consider not only how, but to what end, opportunities for support and guidance are being

experienced, are notably absent or, at worst, skewed into opportunities to dominate and control.

All fifteen participants appreciated their ongoing need for support during their first year qualified. In the initial survey 94% of participants expected that their midwifery colleagues would be supportive and indeed one year later a similar 94% reported that this had in fact been the case. However, it is interesting to compare these figures with those from the same survey, at the same times, but asking about bullying. In the initial survey only just over half did not anticipate bullying from their colleagues whilst a startling 35% anticipated this as a very real possibility. And, whilst a year later those reporting that they had in fact felt bullied at some time during their first year was in fact lower at 23% of respondents, this still represented one in four newly qualified midwives who had experiencing some 'bullying' incident. Initially these statistics read as somewhat contradictory: 94% agreed they were well supported, whilst within that 23% felt they had also been bullied. The issue was illuminated by findings within the qualitative data.

During the interviews I, as the researcher, never specifically raised the topic of bullying as I hoped to elicit only the interpretations of the interviewees. Yet incidents in which participants felt "humiliated", "scoffed at", "embarrassed" and "belittled" by colleagues were recalled by interviewees at each stage throughout the first year. These were, in fairness, interspersed with many positive reports of midwifery support, which will be explored later in this chapter, but against a backdrop where one in four felt bullying to be an issue, both aspects warrant further exploration. In view of these reports it is initially important to consider the concept of bullying. However, as should quickly become

apparent, a framework that considers bullying in isolation risks being over simplistic. Consequently, the more complex concept of horizontal violence will be employed to try and tease out the subtleties of the reported interactions. A case study approach is adopted in order to illustrate some of the issues discussed. This interview was actually one of those conducted at the end of the first year and is only singled out for it's clarity in illuminating some of the issues: there are many others that could have been substituted.

One year qualified: a difference of opinion

P = participant

R = researcher

P: "I came on a late shift and there was a girl that was in the latent phase of labour¹. I even took over from a 'G' grade who was in there and saying "Well I think maybe I started the partogram too early ... she is not in active labour ... I think I ought to stop this partogram²". She said it had been almost 4hrs since ... a V.E. [vaginal examination] but she was not contracting regularly and [now] didn't think she was truly in labour. I absolutely supported that. She said, "It is a shame she won't go home", but she wouldn't so she was on the labour ward ... it was fairly busy but there were a few empty rooms as well. Then the 'G' grade I was on with said ... "what is your lady doing?" and I tried to tell her ... but she said

¹ A normal phase prior to established labour which is often lengthy and in which contractions need to establish in length, strength and frequency.

² The document used for monitoring established labour.

“you should V.E. her” that’s it “you should V.E. her³”. ..she said it in such a way that I just didn’t feel that I had got a choice although I didn’t want to. She was waiting to know what this girl was doing. [So] then I V.E.’d her and she was still 4cms but coping fine and I popped her in the bath. I said ... “Come on, lets put you in the bath just soak in there and relax”, I thought that might help her along ... I didn’t think much of it and went out to the ‘G’ grade and said that she was 4cms. She said, “Right, I want you to do an A.R.M.⁴, she is not progressing” and it had already been mentioned earlier on, she [the woman] didn’t want it and [I thought] “Why?” you know baby was fine.”

R: “What, the woman didn’t want an A.R.M?”

P: “No, she didn’t want an A.R.M ... she just wanted to progress naturally.

... We were both stood at the desk and she said to me “Well you will have to go and rupture her membranes now”. I said, “She doesn’t want her membranes ruptured” and suddenly she just shouted at me, at the desk, “you don’t [shouldn’t] give your women a choice”... I was mad, I was angry, I was upset. I remember all these things going through me stood at the desk in front of people. I just thought that was so totally inappropriate. And she walked off. I went to the loo just to try and compose myself.” (Int. 3(c)).

³ Four hourly vaginal examinations are frequently accepted practice in established labour. However in the latent phase slower progress is expected.

⁴Artificial rupture of membranes; a process historically used to speed up labour but also known to commence a potential cascade of intervention

A difference of opinion or bullying?

At one level this story recounts simply a professional difference of opinion. There would be colleagues who would agree with either side of the argument. However, closer scrutiny raises a number of different issues. It overtly represents a perceived episode of bullying involving raised voices and the feelings the encounter evoked in the newly qualified midwife. However, I use the term *perceived* here, as one aspect fundamental to any discussion on bullying is how one defines the term. Hadikin and O'Driscoll (2000) go to great lengths to explain the difficulties in coming to any generally acceptable term, although they finally find a term of Randall's (1997) the most useful. That is;

“Bullying is aggressive behaviour arising from deliberate intent to cause physical or psychological distress to others”

According to this definition, it would be doubtful that the recounted episode qualifies as bullying, in that there seems unlikely to have been any deliberate attempt. However a more liberal definition such as that contained within the MacPherson report (1999) on the Stephen Lawrence enquiry which states that if a person feels they are being bullied then they are being, gives possibilities for different interpretations. As Houghton (2003) points out, this more liberal definition “affords no protection to those falsely accused”. She further suggests that a more objective definition might address any “imbalance of power, which may or may not be related to position in the hierarchy” (s125). It is this latter consideration of hierarchy which is fundamental to a useful understanding of this story. Therefore, it becomes imperative to broaden the analysis to include more structural considerations and this is where the concept of horizontal violence proves illuminating.

“Horizontal violence is not just a description of intergroup conflict or various forms of ‘bullying’: it embodies an understanding of how oppressed groups direct their frustrations and dissatisfactions towards each other as a response to a system that has excluded them from power” (Leap 1997: 689)

As the quote makes apparent, though, before we can consider and try to understand the causes which underlie horizontal violence, we need an understanding of oppression.

Accordingly, I will first explore the broader concept of oppression before looking more specifically at horizontal violence and ultimately it’s application in this context.

Oppression

As we saw from the statistics of this sample, every single midwife choosing to continue to practice did so under the auspices of an NHS hospital. Furthermore, the vast majority is expected, and indeed, themselves expect, to gain a period of ‘experience’ in this environment so as to consolidate their learning prior to progressing to community practice, which is frequently viewed as more responsible and autonomous. Whilst some hospitals have responded to concerns about initial experience being hospital based (Wickham 2003) and encourage more newly qualified staff into community posts, this is still fraught with concerns and challenges. Interestingly, much of this concern comes from within midwifery, both from more experienced colleagues and from the ‘inexperienced’ midwives themselves. This was certainly borne out in this study. Whilst some participants had had the opportunity to experience community practice early and were extremely comfortable with it others were convinced of the necessity to first acquire more ‘experience’;

“I agree with ‘them’ actually ... that you probably need some more experience before you go out there ... unless they have changed it ... it will probably be a few years yet” (Int. 2(a))

This sits uncomfortably alongside an education which purports to prepare them for a career in normal childbirth and a profession and government determined that the vast majority of care during normal pregnancies, if not childbirth, should be occurring in the community (DOH 2004). It is interesting, then, to consider that whilst the hospital perhaps signifies medical power, the ramifications of that medical power might well easily extend beyond the hospital walls. In keeping with an exploration of oppression it becomes important therefore to look beyond the overt structures of oppression (Downe 2005) and consider the more subtle and perhaps damaging role of internalized oppression.

As already discussed in chapter two, Young (1990) theorized five faces of oppression exploitation, cultural imperialism, violence, powerlessness and marginalization. The evidence of powerlessness, or at least feelings of powerlessness, resonated strongly throughout the data collection. However, it is a sad irony that, from the relatively disempowered position that this thesis argues midwifery continues to occupy what little professional power is exercised is frequently deployed amongst a hierarchy of midwives, with the suggestion by some that this may cascade into the relationships with the pregnant women they care for (Anderson 2002). Correspondingly midwives seemed to deploy controlling tactics upon themselves. This may be viewed as internalized oppression.

Internalized oppression exists when the oppressed group has ‘successfully’ internalized the oppressor’s values. Mason (1990) clarified the dilemma when discussing disability by asserting;

“Internalized oppression is not the cause of our mistreatment, it is the result of our mistreatment. It would not exist without the real external oppression that forms the social climate in which we exist”

Subsequently, current manifestations may be the result of historic mistreatment, although, whatever the root causes, the common result is some form of alienation from one’s own culture. In nursing, Dunn (2003) identifies that internalizing the value system of medicine leads nurses to “lack autonomy, accountability, and control over their profession”. It is interesting to note that a similar trajectory could be charted for midwifery.

As we saw from the history of the midwifery profession in chapter two, midwifery, whilst matching Etzioni’s (1969) definition of a semi-profession, may more recently be struggling to retain even this badge of status (Mason 2003). Midwives frequently find themselves in a disenfranchised position, increasingly alienated from their own professional beliefs and values. Whilst Downe (2005) implores that we move beyond “binary thinking (and specifically beyond the thinking that ‘it is all the doctors fault, and the fault of medicalised birth’)”, many midwives in contemporary practice find themselves trying to practice in a system where they often have little institutional power (Thomas 2002). This lack of institutional or professional power can result in power being recognized and exercised in very different ways. Often these ways are ‘horizontally’ (Leap 1997). And this is quite different from having no power at all. This leads us to

consider the possibility of horizontal violence and its possible manifestation within midwifery.

Horizontal Violence

As we have seen, within the work setting, 'G' grades represent 'powerful' clinical midwives, as they are often in charge of a given work area, are perceived as 'the boss' and frequently as a resource with both knowledge and experience. In fact one participant made a note in her diary about the presence of one particular 'G' grade;

“I am apprehensive when she is on duty as she seems so *powerful*” (diary 5, italics added)

Yet despite this aspect of their role they may feel, and indeed be, relatively powerless in the institutional context. As long as birth and midwives remain predominantly within a medically-led and patriarchally dominated hospital system (DeVries et al 2001), manifestations of available power will be severely circumscribed. However, as Leap (op cit) points out, it is this exclusion from strategic power which may result in frustrated use of power in the only directions available, most frequently towards subordinates. Directed in this way, the midwife may regain a sense of status and position, or lack of position, in the professional hierarchy. This is exacerbated when midwives are newly qualified and inexperienced. This returns us to the quote used in a previous chapter, and a new perspective, as Wickham (2003) explained;

“No-one could see past my 'newly-qualified-ness' to discern anything I might be able to offer women as a midwife” (p6)

This places newly qualified midwives firmly at the bottom of their own professional hierarchy, with perhaps only students below them (Begley 2001) and emphasizes their peripherality. Nevertheless, from this position of subordination they need to ‘learn how it is’ and ‘what is required’ to move from the periphery. This situation perfectly matches that described by Leap as fertile for horizontal violence wherein:

“certain members of the oppressed group can be enticed or intimidated by fear of losing or sharing the perceived power, into serving as tokens on behalf of the interests of the oppressor” (1997:689)

This, in part, may help explain why the newly qualified midwife in the example proceeded to perform a vaginal examination which she felt was not indicated.

Interestingly, despite the fact that she recognized the woman to be in the latent phase of labour, had this confirmed by another (senior) midwife and recognized that this precluded the necessity for any ‘routine’ vaginal examinations, her challenge to this request was minimal. She recognized that she “didn’t want to” but her resistance to authority at this point was nil. It was only when the newly qualified midwife perceived the intervention to be more extreme, such as with the ARM, when she tried, on behalf of the woman, to resist.

This returns us to issues of engagement, alignment and imagination mentioned at the beginning of this chapter and previously in chapter four. Ultimately, and in the face of tough opposition, this midwife tried to align herself with the woman in her care. Despite any structural or procedural limitations, she maintained her engagement in alignment more with the woman than with a colleague. It could also be argued that this is a function

of the imagination that Wenger (1998) insists is an essential component of belonging (p176). In this instance, the midwife is trying to imagine (and communicate) another way of being. She in part forms “an image of the world that transcends engagement” (Wenger op. cit: 177). Despite the fact that she is having trouble being heard she obviously maintains the belief that there is more than one way of approaching this situation.

Evidently this would not have been possible had the newly qualified midwives not had some exposure to paradigmatic trajectories, or to other senior colleagues who would handle things differently. Hence, these participants’ previous encounters with senior midwives with different approaches, powerfully influenced their learning in terms of engagement, alignment and imagination. It is to this opposing type of experience that we now turn.

Once again with recourse to the notion of reciprocity (Hunter 2006), I shall refer to these encounters as ‘balanced’ learning encounters. This is not intended to infer that everything learned from the previous analysis is necessarily negative, but rather to reflect the spirit in which they were offered, as recounted by the participants. Although, as has already been discussed, these encounters were less frequently recalled, they nevertheless became powerful vehicles for learning the construction of identity and imagining the midwife some participants might like to become.

‘Balanced’ learning encounters

In exploring the pedagogic implications of intraprofessional support, I adopt the notion used by Hunter (2006) of ‘balanced exchanges’ (p9). Whilst Hunter (op cit.) is exploring

reciprocity within midwives relationships with women, these provide direct parallels with the intraprofessional relationships of importance to this study. Particularly relevant, is that during ‘balanced exchanges’ in Hunter’s study “the midwife felt valued and appreciated”. So too, newly qualified midwives most often recounted instances positively where they also felt valued and appreciated. Just as the learning absorbed from the previous memorable, if uncomfortable encounters, was powerful, so too was the learning absorbed from supportive and positive encounters with ‘G’ grades on delivery suite. These were reported far less, the reasons for that have already been considered, but when reported, often included words such as “quiet”, “gentle” and “discrete”. In this respect, the pedagogical implications of these encounters, for everyone concerned, were a virtual anathema to those that have so far been the focus of this chapter.

This reversal of the use of power by ‘G’ grades is highlighted poignantly in diary 5. Finishing a shift led by one ‘G’ grade, the newly qualified midwife was handing over care to the oncoming shift leader (‘G’ grade).

“During the shift the ‘G’ grade never once entered the room ... [when] another ‘G’ grade took over she asked me several questions and I was able to reply ... this ‘G’ grade praised me saying how well I had done. When I left it was with mixed emotions, I felt totally unsupported by one ‘G’ grade I felt as though she was testing me ... I’d obviously upset her the previous day [but] it felt good that the ‘G’ grade taking over praised me” (Diary 5)

This aspect of praise is one that Kirkham (2004) picked up on when exploring positive aspects of midwifery culture that support an enabling environment. To support an

enabling environment, establishing an enabling culture is seen as fundamental.

Furthermore, in a different article, Kirkham (2000) describes building 'relationships' as a central tenet of this enabling culture. However, in that discussion, just as in Hunter's (2006), the focus is on relationships with women. The findings from this research project support the notion that the formation of enabling relationships between midwives is important to facilitating the enabling relationships with women that Kirkham (op cit) believes to be essential. It is important to explore, therefore, how 'balanced' learning encounters contribute to establishing an 'enabling' community of practice.

Interestingly, it was a lot more challenging to find overt descriptions of support and positive re-enforcement amongst colleagues from the data. It was more often the case that the researcher enquired after this sort of information, than it being spontaneously offered. This is in contrast to the haste and clarity with which negative incidents were reported. It could be that they are, in fact, experienced much less but this is not actually supported by the data. When asked about supportive senior colleagues and 'G' grades, most participants could identify at least one, if not many, supportive colleagues. This varied from unit to unit. Some enthused; "we have got some fantastic ones" (Int. 2(c)) or "everyone was so good" (Int. 10(c)) whilst in others it prompted thought and reference to one or two particular individuals. It seems unlikely, therefore, that the lack of reference to this phenomenon is necessarily a lack of its presence, particularly when in the follow up survey 94% of respondents felt that the majority of their midwifery colleagues had been supportive. It seems more likely that this quiet, solid, yet understated form of support, contributes by its very nature to its seemingly relative invisibility. This is highlighted by this description within one participant's recollections:

“She [G Grade] builds my confidence ...and I love being on with her ... she is there but in a gentle way, not in your face, she will come and knock on your door and just ask if you are OK and you know that she is there for you ... just there in a quiet way” (Int. 3(b))

Also, once participants had identified particularly supportive colleagues they drew parallels with how these individuals cared for and supported women in the same manner that they did their junior colleagues. Many also aspired to this kind of practice;

“I really aspire to [being like] her she really is always there with the woman and she never gets involved with what goes on in the staff room” (Int. 4(c))

This quote is also interesting in the way that it offers this particular practitioner as different and not involved in “what goes on in the staff room”. This has echoes of Hunt and Symond’s ethnographic work (1995) in which they described the importance of numerous ‘unofficial’ tea breaks to both help cope with the rigours of working on a delivery suite but also to maintain a collegial camaraderie. Whilst at one level this involvement in the “staff room” no doubt serves both these purposes, it is interesting to view this reported non-participation perhaps from another analytical perspective.

Non-participation

Non-participation is an inevitability of practice. As Wenger (op. cit.) confirms;

“In a landscape defined by boundaries and peripheries, a coherent identity is of necessity a mixture of being in and being out” (p165)

Furthermore, as relative newcomers to the authorized community of practice, one would anticipate a degree of non-participation as newcomers develop their abilities in the field. However this non-participation itself can take both positive and negative forms.

Furthermore, bearing in mind the theoretical stance of midwifery as a boundary practice, it is important to consider whether participation in one community necessarily implies non-participation in another. There were numerous examples in the data of non-participation. Some of these applied to practical issues, such as taking meal breaks or being expected to come in for meetings on days off.

“Then I have been expected to come on my days off and things and I thought that is not on, I am not doing that. (Int. 10(a))

Nevertheless, some participants explained that they had previously gone along with aspects of participation with which they were unhappy;

“I think I have just gone along with the culture from the beginning, just to get my head straight about work. Now I am seeing that there are flaws in it ... ‘cos I am thinking ‘well I don’t want’, I’ve only just started to stand up for myself and say “no I am not going to miss my break just because you are busy. Everybody else has had one I am not doing that” (Int. 8(c)).

Interestingly, this quote is from a final interview, suggesting the length of time it has taken this midwife to be able to demonstrate her non-participation. This echoes the findings of Kirkham (1999) who demonstrated a culture essentially containing an element of self sacrifice. However, it is important to consider the limitations of this particular

expectation especially when considered in parallel with the expanding diversity of the profession referred to in chapter four. Given the concerns of Durham (2002) who explores the tensions midwives experience in balancing work and home life and specifically in relation to mothers and part-timers, surely an expectation of self sacrifice is untenable. However, if midwives, such as those above, actively don't participate, this may have implications for them remaining peripheral to practice. This then constitutes the 'persistent peripherality' and its attendant ramifications previously considered in chapter five.

Beyond examples of practical non-participation there was also plenty of evidence of non-participation in a more philosophical sense. However, it seemed that the practical non-participation was easier to voice. This was often seen simply as 'standing up to people' and something that came with time, as we see below;

"I am totally different compared to how I used to be ... like standing up to people ... on the night shift the midwife in charge said "do you mind not going for you break?" and I said "well actually yes I do"" (Int.10 (c))

However, when these midwives sought to resist a particular philosophy of practice they recounted this as more difficult. Similar to the incident we explored in chapter four, describing the forceps incident, feeling aligned with the woman as opposed to aligning with either the institutional norm., or obstetric opinion, often gave rise to discomfort. If participants then chose to pursue what they felt to be best care, this was often done discreetly and at risk of rapprochement. For instance, this participant explained how she

pretended to do as asked, but was actually buying time for the woman she was caring for to finish breastfeeding.

P = participant

R = researcher

P: “When I am outside the staff in charge would always say “come on get your lady down” [to the post natal ward] ‘cos we are busy and we need the room” which is fair enough but she was breastfeeding... what are you going to do?”

R: “Do you feel that pressure a lot?”

P: “Quite a lot, yes.”

R: “What do you do? When you have got a woman feeding and you feel that you want to give her more time but you have this other voice telling you to get a move on, what do you do?”

P: “I tend to say “alright then I will do it as soon as I can” then keep out of the way [participant pulls a face].

R: What and then drag your feet a bit?

P: (laughs) “Yes, ‘cos ... what can you do if they are breastfeeding? You can’t really say ‘stop’”.

This type of strategy is reminiscent of both Kirkham's (1999) doing good by stealth and my own findings in a previous study exploring how women learn from childbirth. In that account, I referred to women as (con)forming (Purkis 2003). This implied a situation in which women chose to be seen to do what was expected of them whilst actually doing something quite different. It was adopted then, as it seems it is here, as a strategy for resisting authority. Yet what is interesting for the learning contained here is that it depicts the needs of the institution as the 'authority' to which both the midwife and the woman should be subject. The junior midwife has to straddle the boundary between the two and find her own, albeit uncomfortable, solution.

A second example of this includes direct reference to the consequences of overtly resisting the dominant culture from both a philosophical and participatory sense. Once again;

P = Participant.

R = Researcher

P: ... you are constantly battling with people, constantly. I had this idea that when I was qualified it would be so much easier 'cos I would be able to practice how I wanted, but it is really not like that.

R: When you say 'people', who do you feel you are battling with?

P: Shift leaders, superiors, doctors.

R: Do you find that you feel you are battling the majority of people or the minority of people?

P: The majority, definitely.

R: On what kind of issues?

P: On the normality thing really.

R: So a basic clash of philosophy?

P: Yeh, completely but it is not just philosophy it is more than that. It is just management I suppose particularly on delivery suite, that is where you see it the most.

R: Is that hard for you?

P: Yes. Because say for example, the one day I had a lady who had had a previous shoulder dystocia⁵. She had got a big baby and she was term plus and I wanted to encourage her to mobilize and adopt an upright position and everything. Well the shift leader came in just to check that I was doing everything I should and she said, “Why is she standing up, you have got to think about risk management and you have predicted predisposing factors for a complication now you have got to manage it properly. Get her on the bed where we can manage it properly”. And I said, “ No, I am trying to avoid that situation, if she is upright then the pelvis blah, blah, blah” and she said “Well that is not how we manage it in this hospital. What

⁵ An obstetric emergency in which the head is birthed but the shoulders remain lodged.

is the first thing you do? It's Mc Roberts⁶, you can't do that when she is standing up". I thought "yeh, but maybe she won't be having a shoulder dystocia if she is standing up" and it I just ... ohhh all the time.

R: What was the outcome of that?

P: I did it myself, how I wanted to and how the woman wanted to, standing and she didn't have a shoulder dystocia. The shift leader wasn't to know.

R: Is that difficult though? Difficult not to do what the team leader was telling you to do?

R: Face conflict? Yeh I suppose it was, what if it had gone wrong?

This example evidences the discomfort associated with occupying the peripheral space at the boundary of midwifery and medwifery. In terms of the brokering we considered in the previous chapter it exemplifies how this newly qualified midwife tried to display innovative practice but lacked the legitimacy to be taken seriously (Davies 2005). Nevertheless, this participant found it possible not to participate in what was presented to her as an institutional norm. As the outcome in this instance was uncomplicated, she could outwardly be seen as (con)forming (Purkis 2003). As she pointed out; "The shift leader wasn't to know". However, she does reflect on the potential consequences of having resisted the dominant culture. In a context where over 75% of participants both in the first and subsequent survey reported fear of litigation, this is of considerable

⁶ A position adopted by the mother in an attempt to free the shoulders.

importance. No doubt a question that continues to impact on contemporary midwifery practice and on the lessons that it imparts.

Conclusion

This chapter has highlighted the importance of engagement in practice with colleagues and the resulting intraprofessional relationships in shaping the understandings and meanings of contemporary midwifery practice. These in turn impact upon the curriculum of the workplace and how new midwives learn to 'be' and how to 'belong'. These are lessons they draw from their 'everyday'. However, in addressing the diffuse nature of the term 'everyday', this chapter focused on the area which participants identified as most important to them; delivery suite. This was firstly pragmatic for limiting the interpretation of 'everyday', but more importantly it was the area most participants both identified as important to them and referred to most frequently when recounting issues from practice. It is no coincidence that the two examples used within this chapter are both experiences from delivery suite. This is not to say that there were not examples from elsewhere but delivery suite was the main focus of reports of unbalanced exchanges and differences of opinion.

What emerges is a prevailing culture of continuing oppression wherein midwives paradoxically both wield power and are oppressed by it. Whilst their powerlessness is experienced at various levels (Bosanquet 2002), their powerfulness frequently manifests itself in relationships, occasionally with peers, but frequently with those deemed subordinate (Hastie 1995, Robinson 2000). This is discussed in terms of bullying and

horizontal violence, both of which I have argued perpetuate and proliferate in a high pressure, rapid, high consequence environment. Whilst episodes of praise and recognition are highly valued they were reported as forming a much smaller part of these midwives workplace experiences. Particularly as newcomers, this manifestation of workplace relations is both obvious to these midwives and frequently challenging. Whilst some seek to align with senior colleagues, others seek strategies of resistance including non-participation. This non-participation, it has been demonstrated, may be in a practical sense or it may be in a more philosophical sense, or indeed it may be a combination of both. There are direct parallels between the peripherality discussed in the previous chapter and the non-participation considered here.

Both remaining peripheral and non-participation have implications for the workplace learning that can, and I have argued does, take place. In consequence of the context of contemporary midwifery practice, they frame the identities these midwives are able to adopt and as such, what meaningfulness can be or is, drawn from practice. In terms of 'learning' this resonates with the work of Begley (2002) who suggests that with regard to development and intracollegial support midwives may in fact "always be their own worst enemy" (p315). The demonstrated continuance of a subculture of subordination and the survival strategies this entails indicates that the curriculum informing newly qualified graduate midwives models of practice includes "knowing their place" (Begley 2001), prioritising institutional norms and, for many, practising and living with some persistent level of dissonance. Whilst it has been demonstrated that acceptance of this model is resisted by some in a variety of ways, it has also been shown how widely and pervasively it infiltrates their everyday experiences. Thereby it becomes easier to understand how

these midwives may, fairly rapidly, become instrumental in reproducing these understandings through their own participation in practice and hence contribute to the cyclical progress (or lack of progress) of practice.

Chapter 8

Conclusion

Conclusion of the thesis

Introduction

The main aim of this chapter is to discuss the findings of this thesis and elaborate on the empirical and theoretical contribution of this thesis to the existing literature relating to workplace learning and midwifery practice. The original research questions are reviewed and an assessment of how the analysis tackles these questions and what new questions arise from this is offered. In addition, it demonstrates how my own thinking has developed through the doctoral process in terms of new insights into the issues of professional workplace learning. Finally, I consider the inevitable limitations of the study and suggest new avenues for research. I begin by reviewing the research questions.

The original questions

The research questions, in tandem with a ‘situated social learning’ perspective provided the framework for this study. Deriving from the concerns of the Ball et al study (2002), these sought to frame an empirical investigation that applied Wenger’s 1998 theory of social learning, communities of practice, and the associated concept of legitimate peripheral participation (Lave and Wenger 1991) in order to establish the implications of situated social workplace learning for the first year of midwifery practice. This was then used to inform a smaller but parallel discussion regarding the implications this may have for retention within the profession. The research questions were as follows:

1. How does the inter- and intra-professional structure of the workplace affect experiences in the work setting?

2. What is the curriculum of the workplace in terms of organizational and professional mores and expectations and how are these institutionalized as transitional learning for newly qualified midwives?

3. What learning, formal and informal, occurs in the everyday of the workplace and how does this affect commitment to a long-term career as a midwife?

Methodology and responses

This research study of newly qualified graduate midwives in the West Midlands addressed these questions with the use of a mixed method approach (Blaxter et al 1996) involving the collection of survey data, interviews and diaries. The data was organized as follows. The survey questionnaire was distributed to all the direct entry midwives qualifying in the West Midlands area in the summer of 2003 and re-issued one year later. Forty five interviews, occurring at three, six and twelve months post qualification, tracked fifteen participants across their first year of practice. Finally, five diaries were kept by five different participants across one week of practice and collected by the researcher. In combination, this provided the data used to address the questions.

Research question one asked; how does the inter- and intra-professional structure of the workplace affect experiences in the work setting?

This thesis demonstrates that that the work experiences of these newly qualified midwives are inevitably contained and to some degree constrained within the professional

structure of the workplace. Chapter four provides an analysis of contemporary practice adopting a structural view, that reconceptualises current hospital-based practice as a boundary practice (Wenger 1998) established to connect midwifery and medicine, but now a thriving enterprise on its own, termed for the purposes of this thesis as 'medwifery'. I argue that the enterprise of medwifery gives precedence to a particular socio-political workplace structure and hence necessarily impacts on the workplace experiences of these newly qualified midwives. The focus of medwifery encourages the adaptation of specific identities and perpetuates a specific type of meaningfulness attached to the work. In most cases, the structure of the workplace emphasises a task orientated, rushed and impersonal approach. These midwives, seeking acceptance in the community, begin to experience this as a way of being. Therein the everyday pedagogy (Luke 1996) drawn from those experiences is crucially circumscribed by the structure of the workplace. As Anderson says;

“If a midwife works in a midwifery service which embodies technocratic values, she will not be enabled to provide humanistic care to clients in that service. She may try, but surrounded as she is by technocratic values that predominate, the internal dissonance she will experience will be great, and the personal cost will be high” (2005:474)

I would additionally claim that the lessons she derives from practice will also not be those conducive to the provision of the humanistic care Anderson (2005) advocates. Whilst it is beyond the remit of this thesis to deconstruct the notion of humanism and humanistic care, Anderson (op cit) has adopted it here to clarify and describe an oppositional model

to technocratic care. She identifies it as based on a woman-centred philosophy of “partnership/professional friend” (p470). Furthermore, she hints at a link to everyday pedagogy, although the link to learning is implicit, when she explains that;

“Before a midwife can form a relationship with an individual woman based on humanistic values, she has to know what these values are. In order to know them she needs to experience them: she has to live them on a daily basis” (p470)

This thesis has demonstrated in a variety of ways, that for the majority of these participants, their experiences are still firmly lodged within a technocratic model of care. However, there was an occasional exception.

The one participant who experienced a different interprofessional workplace structure and a partnership model of care offered the opportunity to consider ‘disconforming evidence’ (Guba and Lincoln 1989) in response to this question. Working within a birth centre she experienced an environment which foregrounded midwifery and as a result her experiences were fundamentally different to the majority of participants. As a result the ‘meaningfulness’ and therefore ‘lessons’ she took from practice were somewhat different to her peers. This supports the argument that the persistence (or resistance) of midwifery is fundamental to their experiences and simultaneously fundamental to their workplace learning.

This argument is extended in chapters six and seven through a more detailed analysis of the doctor-midwife and midwife hierarchies. These highlight the persistence of firm jurisdictional boundaries (Abbott 1988), despite a lack of clarity in domain consensus,

which sometimes results in confused and confusing experiences for these midwives. This often leads to inconsistencies in their workplace experiences and hence the learning that these entail. Ultimately, it is argued, in chapter seven, that in this context their experiences are then closely bound up and negotiated through relationships with other, usually senior midwives. Highlighting the importance of balance (Hunter 2006) in these relationships and the frequent lack of balance, the findings contribute to the midwifery literature on professional subordination by indicating that this is indeed a learned position perpetuated by midwives themselves. Whilst this is a proposition similar to that of Hastie (2006), its originality stems from the framework of workplace learning. Framed as such, it addresses a specific gap in the literature by establishing a direct connection between everyday practice and workplace learning. Furthermore, as another tool which may illuminate the impact of the everyday experiences of midwives and frame them as a point of learning it contributes to “naming the issue” (Kirkham 2000) and creating the possibility for debate.

Question two asked; what is the curriculum of the workplace in terms of organizational and professional mores and expectations and how are these institutionalized as transitional learning for newly qualified midwives?

In part the answers to this second question are inextricably connected to the response to question one, in that it is demonstrated that the curricula of the workplace is mediated through the socio-cultural context of practice. The dominance of medicine has been little affected by the organizational threat predicted in the 1980s (Turner 1994) and the hospital, somewhat paradoxically, remains a crucial institution of health care provision

wherein medicine remains a dominant feature. This facilitates a plethora of institutional and professional boundaries to be encountered and negotiated by practising midwives. As a result, the curriculum of the workplace is demonstrated as medically mediated and institutionally led, hence the conceptualization of midwifery in chapter four.

Nevertheless, the data demonstrates that this is not a position (or curriculum) digested unquestioningly by newly qualified midwives. Some find it easiest, and in some senses most rewarding, to progress their careers in line with majority expectations. However, the findings for this study suggest that this is rarely a fixed position. Instead, these newly qualified midwives frequently struggle to find meaningfulness from their practice by seeking opportunities to align themselves with women or colleagues they see as representing aspirational trajectories. Evidently there is a crucial need for these types of individuals to be present in clinical practice to support exactly the type of informal workplace learning under consideration. It is in this everyday exposure, or lack of it, to living and practicing examples of midwifery or midwifery care that these participants absorbed acceptable and unacceptable cultural norms (Anderson 2005). Chapter seven demonstrated how influential senior midwifery colleagues were in this respect. The implications for transitional learning are apparent throughout the findings. This is particularly so when viewed in terms of Luke's (1996) conceptualisation of 'pedagogies of the everyday'.

“In this view, pedagogy relates to a micro-level analysis of knowledge production where the focus of attention is on the taken-for-granted, normalised relationships where we are simultaneously teachers and learners”. (Hughes 2004:527)

Consequently, the concept of pedagogies of the everyday, enacted through communities of practice, enables consideration of the individual as not only learning from society, but as also producing and reproducing the norms and values of that society. Chapters six and seven demonstrated how these taken-for-granted normalised relationships experienced in their everyday practice informed participants learning. Nevertheless, their peripheral status frequently entailed a lack of legitimacy and it was more often the case that they were expected to learn about practice than have the opportunities to demonstrate best practice as they understood it. This leads to limited opportunities to contribute to the development of practice and a perpetuation of 'normal practice' as it is understood, and arguably therefore will continue to be understood, by the majority of participants. It hence becomes apparent how, in turn, these midwives become generators of specific cultural values and mores that could continue unchallenged. However, many participants became aware of this dissonance, through their experiences of practice. Consequently, rather than participate in the reproduction of organizational and professional mores, which sat uncomfortably with their own meaningfulness some chose strategies of resistance. These were examined in the thesis in terms of non-participation and choosing peripherality.

The implications of this behaviour raises certain concerns, especially viewed in terms of a partial withdrawal from practice, be that physically, as in going part time or temporally, in declining to participate in midwifery. Either way, these have implications for both the individual and for midwifery as a profession. These concerns will be addressed later in this chapter after consideration of the final research question.

Question three asked; what learning, formal and informal, occurs in the everyday of the workplace and how does this affect commitment to a long-term career as a midwife?

The evidence provided by this thesis suggests that the formal learning experienced by the participants was predominantly connected to the tasks they needed to master in order to 'do' midwifery efficiently. This was both explicitly connected to avenues for promotion and occurred mostly in a pressurized environment. Such necessities ensured that the participants' experiences involved sufficient coercion, both explicitly and implicitly, for them to quickly prioritise their formal, task-orientated learning. Chapter five provides evidence of discomfort with this situation, but also reveals a form of resigned acceptance as their experiences are subsumed within the midwifery context.

The informal learning that accompanies and develops from their experiences has been a major concern of this thesis. Configured within notions of identity and meaning and drawing heavily on notions of situated social learning within the workplace (Lave and Wenger 1991, Wenger 1998), this thesis demonstrates how circumscribed identities and aspects of peripherality limit the meaningfulness these midwives can both, bring to and draw from, practice. As a result, much of the informal learning that is analysed reflects a learning of their place in the hierarchy (chapters four, six and seven) and how one can 'be' a midwife in these spaces. Furthermore, as chapter four evidenced, whilst learning effort is directed in any one specific direction, the ability to learn anything else is restricted. Chapter five complements these findings by analysing the importance of the meaningfulness of midwifery that these midwives were able to construct and again

highlights how this is affected by the everyday structure and practices of the workplace. It is in this chapter that the explicit link to retention is made.

Whilst the complexities of assuming or claiming to establish causality are manifold, this study does suggest that retention in midwifery is inextricably bound to learning in the workplace. Whilst this has been the suggestion of much previous literature (Stafford 2001, Ball et al 2002, Hastie 2006), this thesis addresses a gap in the literature by firmly locating midwives workplace experiences within a recognized framework of situated social workplace learning and evidencing the implications for retention. Whilst it has to be recognized that in fact none of these participants left midwifery during the study, nevertheless a considerable number were seeking to reduce their hours as a result of their first year experiences. Whilst this has implications in itself for service delivery, it may also suggest an “outbound trajectory” (Colley and James 2005), either physically or philosophically. This is an area that warrants further research, in order to establish whether this initial strategy heralds any form of solution, resolution or alternatively may demonstrate the beginning of the “protracted” disillusionment reported by Ball et al (2002). Furthermore, it is suggested that longitudinal research of this kind be conducted over a longer continuum in order to establish clearer links between workplace learning and retention. This represents a possibility for extending this work. However, as a doctoral journey and original contribution to the literature, it remains for us to ascertain, firstly, what contribution this thesis makes to the educational literature on workplace learning, and secondly, what the overarching conclusions and implications from this study are.

In terms of its contribution to the educational literature, this thesis not only offers a new workplace learning perspective on midwifery practice, but in doing so, critically engages with the concept of workplace situated social learning and both exposes and addresses gaps in the literature. For instance, one of the central analytic concepts was Wenger's COP (1998). Whilst this offered an original perspective on contemporary midwifery practice, its limitations soon became apparent. Firstly, Wenger's original concept fails to adequately address workplace power relations. Whilst notions of hierarchy are subtly present in his analysis of claims processing (1998), this falls short of the kind of hierarchy and jurisdiction found amongst professionals (Lipsky 1980, Abbott 1988). By demonstrating the ongoing and powerful nature of professional boundaries and the relationships occurring at these boundaries, this work extends the call for more attention to issues of power and conflict within communities (Barton and Tusting 2005). Furthermore, and with particular reference to chapter five, this thesis emphasises the absence of the impact of emotion in the original concepts of COP and LPP. Demonstrating emotion as an essential component in the workplace learning of midwives, particularly in their construction of meaning, extends the understandings available through these perspectives. Finally LLP is reconfigured in one essentially important way namely through a critique of its over simplistic assumptions.

LPP has informed the analysis throughout this project. However, the findings of this project critically extend the original concept. As is made clear in chapter five, through our engagement with emotion work, LPP as a concept over relies on an unquestioned unidirectional progression from periphery to centre. Remaining peripheral is only considered in terms of failure. However, the findings of this study suggest that this is an

oversimplification of situated workplace learning. Participants in this study experienced peripherality as, at various times, both an inevitable position, as well as at times, a position of choice. It is unclear whether peripherality may link to career paths and retention. Certainly, it hints at the possibility of a form of withdrawal whilst staying. This suggests a new dimension for LLP and is an area that warrants further research.

Nevertheless, whilst these gaps in the educational literature are addressed in an original way by this thesis, it is in 'lessons' from everyday practice that this thesis seeks to make its main contribution.

Lessons from Practice

Looked at together, these findings, I suggest, describe a form of contemporary midwifery practice that firmly establishes what Wenger (1998) called a "boundary practice" (p114).

Whilst originating from the will to connect the practices of medicine and midwifery, practice has possibly succumbed to the danger Wenger describes of having ; "gain[ed] so much momentum of their own that they become insulated from the practices they are supposed to connect" (p115). Hence, the findings suggest midwives educated

predominantly from a philosophy of midwifery, anticipating meaningful relationships with women and yet entering a persistently industrial model of care (Walsh 2005) where anticipated definitions of meaningfulness require adjustment. I have argued that, whilst midwives retain some elements of professional power (Crabtree 2004), they remain a subordinate professional group. The evidence suggests that everyday practice has supported, and continues to support, the internalization of this oppression and hence the practice of 'medwifery' perpetuates the self-policing required to maintain a system

increasingly criticised both by consumers and consumer representatives (Beech and Phipps 2004) and indeed, by midwives themselves (Lavender and Chapple 2004, Kirkham 2004(a), Walsh 2005). One may suspect that members of the midwifery community lack insight into these difficulties, yet the findings from this project support those of Lavender and Chapple (op cit) and Ball et al (2002) in suggesting that many midwives are in fact acutely aware of the discomfort. Whilst this may not be theorized or verbalized in any structured way in clinical practice, the dissonance is a daily lived experience. This project then suggests strategies that newly qualified midwives adopt to learn to live with this discomfort. For some, this is learning how to reconfigure 'meaningfulness' and gain satisfaction from "getting through the work", a strategy which is frequently modeled by their senior colleagues. For others, they witness and learn about strategies of resistance that include non-participation and "doing good by stealth" (Kirkham 1999). Even if Ball et al (2002) demonstrate that the decision to leave was a "protracted" one, in most cases, nevertheless the seeds of discomfort and frustration are undoubtedly evident from the early stage of midwifery careers. Nevertheless, the data leaves no doubt that many stay due to the support they find from colleagues and the emotional reward of the job. Paradoxically, it is often the senior midwives, who act, both as bastions of support, whilst also demonstrating the most powerful paradigmatic trajectories of living as a midwife. Those senior midwives who resisted midwifery and struggled to represent midwifery, whilst often identified and admired by the participants, were nevertheless generally perceived as "different" (Int. 2(c)). Hence, these newly qualified midwives were trying to establish identities that both aligned with the community of practice and satisfied themselves. Many seemingly achieved this, but often

not without some doubt or regret. The evidence here supported Walker and Gilson's (2004) suggestion that it is possible to be both bitter and satisfied. Whilst I argue that these participants have barely had time to become bitter, they have had time to learn and adapt to a particular community of practice and have themselves become important in the reproduction of meaning within this community. Many identified that they were already not the midwife they hoped or wanted to be, although there were moments of hope and reward which helped redress the imbalance (Hunter 2006).

Implications for staying

In terms of retention, and research question three, most of these participants do seem, for a variety of reasons, to have formed a commitment to midwifery and envisage staying within the profession. In fact approximately 80% envisaged staying as midwives for more than ten years and this figure altered little from the point of qualification to one year later. Whilst there will be numerous reasons for this, as I pointed out earlier, it was heartening to see that after one year of practice so many participants still "loved" their job. This was despite the dilemmas they all so clearly saw and felt. However, in the light of both the theoretical framework and the findings this in itself requires further consideration.

If, as is suggested by a notion of legitimate peripheral participation, these midwives have successfully moved towards the centre of practice, this might suggest that the most comfortable practitioners are those who have most easily accepted the current meanings of practice. Given my theorization of midwifery this would imply that those participants most willing to take on the philosophy on midwifery were immediately the most comfortable and committed. Nevertheless, this assumption, whilst in part true, both

oversimplifies the issue and underestimates these women. In keeping with the more dynamic notion of LLP explored by Colley and James (2005), these participants were able to adapt their working identities to suit the context in which they were immersed. Whilst they found themselves for the most part immersed in midwifery, certain times, certain women or certain colleagues gave them the opportunities to reconnect with what many termed “proper midwifery” and these occasions seemed to offer sufficient reward to sustain them through other dissonant experiences. This suggests that midwives may stay but not progress on a linear model and suggests the possibility that context could offer much more in terms of engagement. The benefits of this for learning are evident;

“Often we are over-determined and oppressed by jobs. It is easy for our potential for learning to be constrained in the name of efficiency and productivity, but such constraints are illusory. Our productivity increases in direct proportion to our vested interest in the outcomes of our work. Maintenance of control at the core may be an aim of corporate leaders, but it is not in any way in the interest of those on the periphery whose loss of control and powerlessness inevitably diminishes their potential to contribute to production” (Heaney 1995:3)

Whilst terms such as productivity and efficiency sit uncomfortably with the notion of healthcare there are direct parallels with involvement in midwifery care. As Hunter (2006) suggests, if midwives can engage more effectively and reciprocally with the women they care for ‘outcomes’ can improve.

Whilst Hunter (op cit) is specifically talking in terms of emotional outcomes, a growing body of literature also supports this in terms of physical outcomes for women, regardless

of the place of care (Hodnett 2002). Whilst midwives must accept their role in the perpetuation of a system that actively suppresses “vested interest in outcomes” (Heaney op. cit.), this study suggests that the focus must not only consider individual possibilities, but the structural limitations too. These are clearly linked, however, with a solid history of increasing obstetric hegemony and bureaucratic control (Walsh 2005). Whilst the literature review helped clarify this trajectory, the findings of this study, it is hoped, will facilitate a greater understanding of the ramifications of this for future generations of the profession. This may, in part, have fulfilled the requirement that;

“Any effort to make sense of the complexities of contemporary midwifery must deal not only with the biomedical and governmental power structures but also with the definitions such structures impose upon midwives and the ramifications of these definitions” (Davis-Floyd 2005: 37)

Accordingly, midwifery could perhaps be reconfigured, not only as part of the problem, but also as part of the solution.

Midwifery : part problem, part solution

It was over a decade ago since Hunt and Symonds (1995) suggested that midwives take some responsibility for what their study perceived as unsatisfactory care by saying;

“It is only when midwives openly acknowledge that in most instances it is they and not women who control birth, that we can begin to construct a clearer vision of the future” (p154)

This text, not surprisingly, was not well received at the time amongst some of the midwifery community. A brief moment of reflexivity acknowledges myself as part of that contingent, eleven years ago. However, I think a key word here is “openly”. Subsequent studies have uncovered that midwives are more than aware of the difficulties (Kirkham 1999, Lavender and Chapple 2004), but constrained in many ways about how they feel they can address them. Hughes et al (2002) described this phenomenon clearly and uncovered “long-standing cultural inhibitions to the effective development of midwifery care” (p51). However, one of their suggestions is that if these cultural inhibitions were made explicit, they might stand a better chance of being strategically addressed. I suggest that by taking a COP perspective and illuminating the practice of midwifery this study makes an original contribution to the literature by ‘making explicit’ the boundary practice which is currently so everyday and innocuous that it has become increasingly invisible. Whilst this study has made some suggestions about the invisible, informal curriculum of midwifery, by pursuing further and alternative explorations of midwifery it may be possible to reveal its further manifestations. Then perhaps, instead of feeling forced to inhabit midwifery, midwives could increasingly seek to inhibit it instead.

Ending or New beginning?

By looking closely at the transitional learning experiences of newly qualified graduate midwives in the West Midlands, this study has presented a microcosm of social learning in action. Simultaneously, it presents the frontline everyday workplace dilemmas associated with professions allied to medicine and ‘women’s work’. It was heartening to discover that after a full year of practice and despite many of the uncomfortable findings

of this study most of these midwives still passionately wanted to be midwives and felt committed to developing both themselves and the profession. This enthusiasm is laudable particularly set against the backdrop this study describes.

The study encounters the uncomfortable and constantly shifting jurisdictional boundaries which medical staff, midwives and to some extent the public, self-police. This policing is demonstrated as, at different times, both overtly conscious and hierarchical, or else as subtle, unconscious and even invisible. The result of this has been the formation of a boundary practice. As defined by Wenger (1998), this is a practice based connection emerging to connect two different forms of practice. In this study, the boundary practice is conceptualised as 'medwifery'. Medwifery, it has been argued, serves to straddle the uncomfortable jurisdictional boundaries between medicine and midwifery. However, it has become a community of practice in its own right and has grown to represent the majority of practical experience gained by these newly qualified midwives. Gaining their experience in medwifery is inevitably at the expense of experience in midwifery.

Furthermore, the learning that occurred through participation within the community of practice was in many ways as Light and Nash (2006) suggest "deeper, more powerful and more meaningful than that which occurred at [university]" (p91). Nevertheless many participants were acutely aware of this dissonance and used various strategies in order to try and establish a professional identity that both fitted the context of their practice and with which they could comfortably align. Participants sought ways in which they could engage in meaningful activity and at times this meant reconfiguring their initial conceptions of 'meaningful'. This process has been shown to be frustrating, emotional and at most only partially successful. 'Success' and 'meaningfulness' were often

measured in terms of relationships with colleagues, getting the work done and the resultant comfort at work. Senior colleagues were often extremely powerful and often well subsumed within extensive years of practice in midwifery.

Whilst there were innovative and positive pockets of midwifery practice, and experienced midwives, these were frequently regarded as iconoclastic and unrepresentative of mainstream practice or thought. As a result, some participants comfortably accepted their role in midwifery, some accepted it as a temporary state of affairs and a few demonstrated sufficient frustration to take alternative measures. However, throughout the duration of the study, none left midwifery entirely.

The findings of this study suggest that the majority of current midwifery practice is indeed midwifery in action. The resulting community of practice is a virtually self-policing service of midwives and allied health professionals struggling within complex power relations and resource limitations to provide a sufficiently adequate service.

Within this service they constantly engage in negotiations and boundary work. For a variety of reasons, some midwives accept their marginalized position and the illusory safety of midwifery. Some battle their own marginalized position and the assumptions of midwifery in order to try and retain their midwifery skills and provide what they believe to be the best service for women and families. Many have limited personal resources, which coupled with the many other demands that they face severely limits their resources for any ongoing professional struggle.

Ultimately what emerges is a picture of contemporary midwifery practice that serves to support a patriarchal system of medicine and, despite rhetorical progress and political

support, remains firmly lodged in a modern ethos of productivity, rationality and predictability. As a result, there is an increasing dissonance for midwives encountering a post modern education and envisaging a postmodern, flexible service. Yet this in itself could offer hope for the future.

Direct entry training and widening participation has provided British midwifery with a new diverse population of midwives. No longer are they previously socialized into the subordinate role of nursing this encourages many to bring new insights, experiences and ideas. This study suggests that, as yet, the service is failing to capitalize on this diversity. And this is despite the fact that the warning signs as given in reports such as Ball et al (2002), have been flagged. As Light & Nash (2006) tell us;

“The ability to adapt to changing membership and changing circumstances is the key to innovation and evolution in a community of practice” (p90)

Given that the provision of care remains generally standardized and unidimensional, the inability to accommodate change, is relatively unsurprising. However, the service itself faces a legacy of medicalisation which has successfully established obstetric science as a metaphor for predictability and safety. Machin and Scamell (1997) suggest;

“women in our culture would probably still need its presence to reassure in what is perceived by the UK culture as a life threatening, crisis ridden event of delivery.” (p83)

Maybe the “women” alluded to includes midwives. This study suggests that that is in fact the case for some midwives. Nevertheless, it also suggests that there are many more who

belligerently, and in the face of numerous challenges, insist on developing alternative perceptions. However, in order to continue to do this, alternative options to midwifery are required. Whether the hegemonic dominance of the science of medicine, which remains firmly secreted in much normal everyday current midwifery practice, can be altered, is just one challenge that faces midwives. It demonstrates yet another, “complex [and] frustrating situation” (Kirkham 2004(a): 287) which, this thesis has demonstrated, circumscribes the workplace learning opportunities for newly qualified midwives. In situations that offer no alternative forms of practice, many midwives, and hence midwifery, will remain peripheral. Consequently, midwifery will continue to flourish and the everyday lessons of practice be perpetuated. That is, of course, unless change becomes a reality.

Limitations of the study

Whilst this thesis offers a variety of new insights and contributes to new knowledge in various literatures, the limitations of the study must be recognized. Firstly, it is a geographically based, qualitative study and it would be methodologically unsound to assume these findings would unproblematically apply to another context. In addition, the timespan of the doctoral process, limits the insights and implications for retention, which it was initially hoped this study would make. Finally, the implications for learning are also only those acquired through a ‘snapshot’, and thus present a limited picture that may substantially alter and evolve over the longer-term career trajectory of midwives.

Suggestions for further research

In considering areas for further research it is important to address both the theoretical gaps that have been uncovered in the literature as well as making suggestions for further empirical studies.

Firstly, this thesis highlights the need for further conceptual work with regard to both COP and LPP. Communities of practice as a concept is both useful and popular (Barton and Tusting 2005). However, it has some disabling limitations. Certainly, in the context of this study, the failure to address, explicitly, issues of power and emotion stand as essential requirements for the development of the theory. I would also argue that, although not the only possible source of data, midwifery practice offers a unique and informative case study for this possibility. Similarly, critical engagement with the concept of LPP has exposed a number of ways in which it too would benefit from further conceptual development. In particular a more dynamic and diverse theorization of peripherality per se. would permit a development of the notion of a continued peripherality unassociated with failure. Such developments may foster a greater clarity for the conceptualization of the links between everyday practice and workplace social learning.

With regard to further empirical research, some suggestions have been made within the body of the text. These include the exploration of the long term implications of midwives reducing their hours due to the pressures of work. This study was unable to ascertain if this may lead to some form of resolution or should serve as a warning to the profession that midwives are commencing a trajectory of unbecoming and are unlikely to increase

their input at a later date. Accordingly, some further longitudinal, qualitative research analyzing situated workplace learning and its specific implications for retention was recommended. Such a project would need to consider a much longer time span. Similarly, it could be enlightening to repeat this kind of study with a number of midwives, who proceed, upon qualifying, into community or birth centre posts, in an attempt to identify if their experiences result in different lessons from, and for, practice. Finally, it would be illuminating to see if senior midwives recognize themselves in the terms described by these participants. Whilst this could potentially be quite a sensitive topic, anecdotal evidence gathered from my own continuing practice suggests that they do indeed recognize, and at times lament the issues, which, nevertheless, persist. I suggest that the very continuance of these questions warrants further research at the level of practice. As is the case with much research, this study opens up almost as many questions as it addresses. Consequently, it emerges that there is as much to know as is already known. Perhaps then, the final appropriate words to close this thesis are, as those of Michelangelo in his 87th year, despite his many great achievements he is credited with a statement with which I wholeheartedly identify:

‘Ancora Imparo’ – I am still learning.

References

References

Abbott, A. 1988. The System of Professions. An Essay on the Division of Expert Labor. Chicago: University of Chicago Press.

Albers, L. 2004. 'Clinicians perspectives on participation in research'. MIDIRS Midwifery Digest. Vol. 14, No. 2, pp 173-176.

Albers, L., Schiff, M. & Gorwoda, J. G. 1996. 'The length of active labour in normal pregnancies'. Obstetrics and Gynecology, 87(3), 355 – 359.

Allen, D. 2000. 'Doing Occupational Demarcation: The "Boundary – work" of Nurse Managers in a District General Hospital'. Journal of Contemporary Ethnography. Vol.29, No. 3 pp326 – 356.

Allison, J. & Pascall, G. 1994. 'Midwifery: a career for women?' In Evetts, J. (Ed.) Women & Career. London: Longman.

Alvesson, M. & Skoldberg, K. 2000. Reflexive Methodology: New Vistas for Qualitative Research. London: Sage,

Amos, D. 1999. Staff Nurse Role Transition: Reducing the Culture Shock. Unpublished Ma Thesis. University of Central England.

Anderson, T. 2000. 'Feeling safe enough to let go: the relationship between a woman and her midwife in the second stage of labour'. In Kirkham, M. (Ed.) The midwife-mother relationship. Basingstoke: Macmillan Press. pp 92 – 119.

Anderson, T. 2002. 'The misleading myth of choice: the continuing oppression of women in childbirth'. MIDIRS Midwifery Digest. Vol. 12, No.3, pp 405 – 407.

Anderson, T. 2004. 'The misleading myth of choice: the continuing oppression of women in childbirth'. In Kirkham, M. (Ed.) Informed Choice in Maternity Care. Hampshire: Palgrave Macmillan. pp 257 – 264.

Anderson, T. 2005. 'We're human too: humanizing institutional midwifery'. MIDIRS Midwifery Digest. Vol. 15, No. 4, pp 470 -474.

Ashmore, R. D. & Jussim, L. (Eds.) 1997. Self and Identity: Fundamental Issues. Oxford: Oxford University.

Association of Metropolitan Authorities. 1990. Women teachers: recruitment and retention. London : Association of Metropolitan Authorities.

Atkinson, J. M. & Heritage, J. C. (Eds.). 1994. Structures of social action. Cambridge: Cambridge University Press.

Audit Commission 2002. Recruitment and Retention: A public service workforce for the twenty-first century. London: C W Print Group.

Ball, L., Curtis, P. & Kirkham, M. 2002. 'Why do midwives leave?' Women's Informed Childbearing and Health Research Group: University of Sheffield.

Bandura, A. 1977. Social Learning Theory. New York: General Learning Press.

Barton, D. & Tusting, K. 2005. Beyond Communities of Practice. Cambridge: Cambridge University Press.

Bates, C. 2004. 'Midwifery Practice: Ways of Working'. In Stewart, M. (Ed.) Pregnancy birth and maternity care: feminist perspectives. Edinburgh: Books for Midwives. pp 121-142.

Baxter Magolda, M. 1992. Knowing and Reasoning in College. California: Jossey Bass.

Baxter Magolda, M. 1999. 'Constructing Adult Identities'. Journal of College Student Development, 40(6), pp.629-644.

Beard, C. & Wilson, J. 2002. The Power of Experiential Learning. London: Kogan Page.

Becker, H. 1960. 'Notes on the Concept of Commitment'. American Journal of Sociology 66(1), pp 32 – 40.

Becker, H. 1972. 'A school is a lousy place to learn anything'. American Behavioural Scientist 16, pp 85 – 105.

Becker, H., Geer, B., Hughes, E. & Strauss, A. 1961. Boys in White. London: Transaction Books.

Beckett, S. 2004. 'The men who deliver'. Times Magazine. 3rd January, pp 40-43.

Beech, B. 2000. 'The effects of mistreating women in labour'. MIDIRS Midwifery Digest. Vol.10, No. 4, pp. 467 – 469.

Beech, B. 2004. 'Electronic fetal monitoring. Inherited clinical guidelines'. In Wickham, S. (Ed.) Midwifery: best practice 2. Edinburgh: Books for Midwives.

Beech, B. & Phipps, B. 2004. 'Normal birth: women's stories'. In Downe, S. (Ed.) Normal Childbirth evidence and debate.: London: Churchill Livingstone.

Begley, C.M. 1999. 'Student midwives' views of 'learning to be a midwife' in Ireland'. Midwifery 15, 264 – 273.

Begley, C.M. 2001. ‘‘Knowing your place’’: student midwives’ views of relationships in midwifery’. Midwifery 17, 222 – 233.

Begley, C. M. 2002. ‘‘Great fleas have little fleas’’: Irish student midwives’ views of the hierarchy in midwifery’. Journal of Advanced Nursing, 38(3), 310 – 317.

Belenky, M., Clinchy, B., Goldberger, N. & Tarule, J. 1986. Women's Ways of Knowing: The Development of Self, Voice, and Mind. USA: Basic Books.

Benoit, C., Davis-Floyd, R., van Teijlingen, E., Sandall, J. & Miller, J. 2001. ‘Designing Midwives; A Comparison of Educational Models’. In DeVries, R., Benoit, C., van Teijlingen, E. & Wrede, S. (Eds.) Birth by Design. London: Routledge.

Blaka, G. 2006. ‘Newcomers’ learning of midwifery practice in a labour ward: a socio-cultural perspective’. Learning in Health and Social Care, 5, 1, pp 35 – 44.

Blaxter, L. 1994. ‘Part-time students and their parents: A life-long theme’. Adults learning, Vol.5, No. 7, pp 189 – 190.

Blaxter, L., Hughes, C. & Tight, M. 1996. How to Research. Buckingham: Open University Press.

Blincoe, A. J. 2005. 'Fetal monitoring challenges and choices for midwives'. British Journal of Midwifery Vol. 13, No. 2, p108 – 111.

Bones, E. 2005. 'The true cost of the centralization of maternity services'. MIDIRS Midwifery Digest. Vol. 15, No. 4 pp 559 – 564.

Bourdieu, P. 1993. Sociology in Question. London:Sage.

Bosanquet, A. 2002. "‘Stones can make people docile’; reflections of a student midwife on how the hospital environment makes ‘good girls’". MIDIRS Midwifery Digest. Vol. 12. No. 3, pp301 – 305.

Boud, D., Keogh, R. & Walker, D. (Eds.) 1985. Reflection: turning experience into learning. London: Kogan Paul.

Brannan, J. 2005. "‘Once more with feeling’: Ethnographic Reflections on the Mediation of Tension in a Small Team of Call Centre Workers". Gender, Work and Organization. Vol. 12, No. 5, pp420 – 439.

Buchanan, D., Boddy, D. & McCalum, G. 1988. 'Getting in, getting on, getting out and getting back'. In Bryman, A. (Ed.) Doing Research in Organisations. London : Routledge. pp53 – 57.

Cahill, H. A. 2001. 'Male appropriation and medicalisation of childbirth: An historical analysis'. Journal of Advanced Nursing. Vol. 33, pp334 – 342.

Callahan, J. 2005. '“Speaking a secret language’: West Coast Swing as a community of practice of informal and incidental learners’. Research in Dance Education. Vol. 6, No. 1/2, pp 3 – 23.

Carne, V. 2006. 'Announcing the launch of the MIDIRS Webinar'. MIDIRS Midwifery Digest. Vol. 16, No. 3, pp310 -312.

Central News report. 2006. 'Birth of baby Jake'. Central News at six 'o' clock. May 7th.

Chaiklin, S. 1996. 'Understanding the social scientific practice of *Understanding practice*'. In Chaiklin, S. & Lave, J. (Eds.) Understanding Practice: Perspectives on activity and context. USA: Cambridge University Press. pp 377 – 401.

Chaiklin, S. & Lave, J. (Eds.). 1996. Understanding Practice: Perspectives on activity and context. USA: Cambridge University Press.

Charmaz, K. 2000. 'Grounded Theory: Objectivist and Constructivist Methods'. In Denzin, N. & Lincoln, Y. (Eds.). Handbook of Qualitative Research. Thousand Oaks: California :Sage. pp 509 – 536.

Clarke, J. M., Maben, J. & Jones K. 1997. 'Project 2000: perceptions of the philosophy and practice of nursing: shifting perceptions – a new practitioner?' Journal of Advanced Nursing. Vol. 26(2), pp 246 – 256.

Claxton, G. 1999. Wise-Up: The Challenge of Lifelong Learning. London: Bloomsbury.

Cluett, E. & Bluff, R. 2000. Principles and Practice of Research in Midwifery. London: Bailliere Tindall.

Coffey, A. & Atkinson, P. 1996. Making Sense of Qualitative Data: Complementary Research Strategies. London: Sage.

Coffield, F. 2000. The Necessity of Informal Learning. Bristol: The Policy Press.

Cohan, D. & Prusak, L. 2001. In good company; How social capital makes organizations work. Boston: Harvard Business School Press.

Colley, H. & James, D. 2005. 'Unbecoming tutors: towards a more dynamic notion of professional participation'. Paper presented in ESRC TLRP seminar series Changing Teachers Roles, Identities and Professionalism, Kings College, London, 16 May 2005.

Collins, P. 1998. Negotiating Selves: reflections on 'Unstructured Interviewing'.

Sociological Research Online, Vol. 3. No. 3. <http://www.socresonline.org.uk/3/3/2.html>.

Connell Davidson, J. & Layder, D. 1994. Methods, Sex and Madness. London: Routledge.

Crabtree, S. 2004. 'Midwives constructing 'normal birth''. In Downe, S. (Ed.) Normal Childbirth evidence and debate. London: Churchill Livingstone.

Curtis, P., Ball, L. & Kirkham, M. 2003. 'Why do midwives leave? Talking to managers'. Women's Informed Childbearing and Health Research Group. University of Sheffield.

Curtis, P., Ball, L. & Kirkham, M. 2006. 'Why do midwives leave? (Not) being the kind of midwife you want to be'. British Journal of Midwifery. Vol. 14, no. 1, pp 27 – 31.

Dale, M. & Bell, J. 1999. 'Informal Learning in the Workplace'. DfEE Research Report 134. London: Department for Education and Employment.

Darlington, Y. & Scott, D. 2002. Qualitative Research in Practice. Stories from the Field. Allen & Unwin: Crows Nest.

Davies, B. 2005. 'Communities of Practice: Legitimacy, membership and choice'. Leeds Working Papers in Linguistics. School of Modern Languages and Cultures. University of Leeds. Accessible at <http://www.leeds.ac.uk/linguistics/WPL/WPL10.html>.

Davies –Floyd, R. 2001. 'The technocratic, humanistic and holistic paradigm of childbirth'. International Journal of Gynecology and Obstetrics. Vol. 75, supp. 1: S5 – 23.

Davis-Floyd, R. 2005. 'Daughter of time: the post-modern midwife'. MIDIRS Midwifery Digest. Vol. 15, No. 1, pp 32 - 39.

Davis-Floyd, R. & Sargent, C. 1997. Childbirth and Authoritative Knowledge. London: University of California Press.

Daykin, N. & Clarke, B. 2000. "'They'll Still Get the Bodily Care': Discourses of Care and Relationships between Nurses and Health Care Assistants in the NHS'. Sociology of Health and Illness 22(3): 349 – 363.

Deery, R. 2003. 'Engaging with clinical supervision in a community midwifery setting: an action research study'. Unpublished PhD thesis. University of Sheffield: UK.

Denzin, N. 1994. 'The art and politics of interpretation'. In Denzin, N. & Lincoln, Y. (Eds.). Handbook of Qualitative Research. Thousand Oaks: California :Sage. pp 500 – 515.

Denzin, N. & Lincoln, Y. (Eds.) 2000. Handbook of Qualitative Research. Thousand Oaks: California :Sage.

Department of Health. 1982. Maternity Care in Action parts 1 – 3: report of the Maternity Services Advisory Committee. London: HMSO.

Department of Health 1993. Changing Childbirth: report of the Expert Maternity Group. London: HMSO.

Department of Health. 1999. Making a difference. Strengthening the nursing and midwifery contribution to health and health care. London: HMSO.

Department of Health 2000. Improving Working Lives. London: HMSO.

Department of Health. 2004. National Service Framework for children, young people and maternity services. London: HMSO.

Department of Health. 2004 (a). Agenda for Change Proposal Agreement. London: HMSO.

Department of Health. 2005. NHS maternity statistics, England; 2003 – 04. Available at <http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/Publi>

ationsStatisticsArticle/fs/en?CONTENT_ID=4107060&chk=IY7Bqa accessed 2nd April 2005.

DeVries, R., Benoit, C., Teijlingen, E. & Wrede, S. (Eds.). 2001. Birth by Design. London: Routledge.

Dex, S. (ed.) 1991. Life and Work History Analysis: Qualitative and Quantitative Developments. London: Routledge.

Donnison, J. 1977. Midwives and Medical Men. New York: Schocken Books.

Donovan, P. 2005. 'Are we surrogate mothers, form fillers or practitioners?' British Journal of Midwifery. Vol. 13, no 5, p 329.

Downe, S. 1998. 'Practice and prejudice'. British Journal of Midwifery. Vol. 6, No. 1, p 19.

Downe, S. 2005. Contribution to Midwifery-research@jiscmail.ac.uk posted 20th October.

Downe, S. 2005(a). 'Rebirthing midwifery'. Midwives. Vol. 8. No. 8. August. pp 346 – 349.

Downe, S. & McCourt, C. 2004. 'From being to becoming: reconstructing childbirth knowledges'. In Downe, S. (Ed.) Normal Childbirth evidence and debate. London: Churchill Livingstone. pp 3 – 24.

Doyal, L. 1995. What Makes Women Sick; Gender and the Political Economy of Health. London: MacMillan Press.

Duguid, P. 2005. "The Art of Knowing": Social and Tacit Dimensions of Knowledge and the Limits of the Community of Practice'. The Information Society. Vol. 21, pp109 – 118.

Dunn, H. 2003. Horizontal violence amongst nurses in the operating room. AORN journal. Vol. 7: 977.

Durham, R. 2002. 'Autonomy and commitment to life outside midwifery; Women, work and midwifery'. In Mander, R. & Fleming, V. (Eds.) Failure to Progress; The contraction of the midwifery profession. London: Routledge.

Eatherton, H. 2002. 'Trust in women ... Don't trust the 'patient''. The practising Midwife. Vol. 5, No. 7, pp32 – 33.

Eckert, P. 1999. Linguistic Variation as Social Practice. Oxford: Blackwell.

Edwards, N. P. 2000. 'Women Planning Homebirths: Their Own Views on their Relationships with Midwives'. In Kirkham, M. (Ed.) the midwife-mother relationship. London : Macmillan Press. pp 55 – 91.

Ehrenreich, B. & English, D. 1973. Witches, Midwives and Nurses: A History of Women Healers. Old Westbury, N.Y.: The Feminist Press.

England, P. & Horowitz, R. 1998. Birthing from within. New Mexico: Partera Press.

Eraut, M. 1994. Developing Professional Knowledge and Competence. London: Falmer Press.

Eraut, M. 1998. 'Concepts of Competence'. Journal of Interprofessional care. Vol. 12, No. 2, pp 127 – 139.

Eraut, M. 2000. 'Non-formal learning and tacit knowledge in professional work'. British Journal of Educational Psychology. Vol. 70, pp 113 – 136.

Eraut, M. 2001. 'Do continuing professional development models promote one-dimensional learning?' Medical Education. 35, pp 8 – 11.

Eraut, M. 2002. 'Conceptual Analysis and Research Questions: Do the concepts of 'learning community' and 'community of practice' provide added value?' Paper given at annual conference, American Educational Research Association, New Orleans, April.

Eraut, M. 2003. 'Learning in the first professional job: the first year of full time employment after college for Accountants, Engineers and Nurses'. Paper given at annual conference, American Educational Research Association . Chicago, April.

Etzioni, A. 1969. The Semi-professions and Their Organization. New York: Free Press.

Fahy, K. 1998. 'Being a midwife or doing midwifery?' ACMI Journal. Vol. 11, no. 2, pp.11 -16.

Fielding, J. & Gilbert, N. 2000. Understanding Social Statistics. London: Sage.

Finch, J. 1984, 'It's great to have someone to talk to': The ethics and politics of interviewing women'. In Bell, C. & Roberts, H. (Eds.), Social Researching: Politics, Problems, Practice. London: Routledge & Kegan Paul.

Finch, J. 2000. 'Interprofessional education and teamworking: a view from the education providers'. British Medical Journal. Vol. 321, pp 1138 – 1140.

Fine, M., Weis, L., Weseen, S. & Wong, L. 2000. 'For Whom? Qualitative Research, Representations, and Social Responsibilities.' In Denzin, N. & Lincoln, Y. (Eds.). Handbook of Qualitative Research. Thousand Oaks: California :Sage.

Fink, A. 1995. The Survey Handbook. London:Sage.

Flint, C.1987. The 'Know your Midwife' report. London: 49 Peckermans Wood.

Foucault, M. 1973. The birth of the clinic: an archaeology of medical perception.
London: Tavistock Publications

Foucault, M. 1976. The History of Sexuality. Harmondsworth: Penguin

Foucault, M. 1977. Discipline and Punish: the birth of the prison. London: Allen Lane.

Fraser, D., Murphy, R & Worth-Butler, M. 1997. An outcome evaluation of the effectiveness of pre-registration midwifery programmes of Education. ENB. University of Nottingham.

Freeman. L. M. 2006. 'Continuity of carer and partnership: A review of the literature'.
Women and Birth: the Journal of the Australian College of Midwives. Vol. 19, No 2, pp
39-44.

Freidson, E. 1988. Profession of Medicine: A study of the Sociology of Applied Knowledge. Chicago: University of Chicago Press.

Fulford, B., Dickenson, D. & Murray, T. (Eds.) 2002. Healthcare Ethics and Human Values. Oxford: Blackwell publishers.

Galloway, S. & Winfield G. 1999. 'Using Diaries to Identify Nurses' CPD needs'. Final report of a pilot study to the Royal College of Nursing Institute. Coventry, CEDAR, November.

Gaskin, I. 2003. 'The art of doing nothing well'. Conference paper given at 'Being, Knowing and Doing' midwifery conference. Canterbury Christchurch University College. Sat. 15th November.

Giroux, H.A. 2005. Border Crossings: Cultural workers and the politics of education. Routledge: London.

Glesne, C. & Peshkin, A. 1992. Becoming Qualitative Researchers An Introduction. New York: Longman.

Glezerman, M. 2006. 'Five years to the Term Breech Trial: the rise and fall of a randomized controlled trial'. American Journal of Obstetrics and Gynecology. Vol. 194, no 1, pp 20-25.

Goffman, E. 1961. Asylums. Harmondsworth: Penguin.

Gorard, S. 2001. Quantitative methods in educational research: the role of numbers made easy. London: Continuum.

Gorelick, J. 1991. 'Contradictions in feminist Methodology'. Gender and Society. Vol. 5. No. 4, pp 459 – 477.

Gowler, D. & Legge, K. 1975. 'Occupational Role Integration and the Retention of labour'. In Pettman, B. (Ed.) Labour turnover and retention. Essex: Gower Press.

Graham, H. 1993. Hardship and Health in Women's lives. Harvester Wheatsheaf: Hertfordshire.

Graves, N. & Varma, V. (Eds.) 1997. Working for a doctorate. London: Routledge.

Greene, J. C. 1998. 'Qualitative Program Evaluation: Practice and Promise'. In Denzin, N. & Lincoln, Y. (Eds.) Collecting and Interpreting Qualitative Materials. California Thousand Oaks: Sage.

Griffiths, M. 2005. 'A feminist perspective on communities of practice' available at http://orgs.man.ac.uk/projects/include/experiment/morwenna_griffiths.pdf. Accessed 22nd October 2005.

Guba, E. G. & Lincoln, Y. S. 1989. Fourth generation evaluation. Newbury Park: Sage.

Hadikin, R. & O'Driscoll, M. 2000. The Bullying culture. Oxford: Books for Midwives.

Halliday, L. 1994. 'Is direct entry the right route to midwifery?' Professional Care of Mother and Child. Vol. 4, No. 4: 90-91.

Hammersley, M. and Atkinson, P. 1983. Ethnography: Principles in Practice. London: Tavistock.

Hancock, P. 1998. Reflective Practice – Using a Learning Journal. Nursing Standard. Vol. 13:17, pp 37-40.

Hanson, S. 2003. 'To V/E or not to V/E? That is the question'. Midwifery Matters. Issue 97.

Harrison, J., MacGibbon, L. & Morton, M. 2001. 'Regimes of Trustworthiness in Qualitative Research: The Rigors of Reciprocity'. Qualitative Inquiry. Vol. 7, No. 3, pp 323 – 345.

Hastie, C. 1995. 'Midwives eat their young don't they?' Birth Issues. Vol. 4, p5 – 9.

Hastie, C. 2006. Exploring horizontal violence. MIDIRS Midwifery Digest. Vol. 16, No. 1, pp 25 – 30.

Heaney, T. 1995. 'Learning to Control Democratically: Ethical Questions in Situated Adult Education'. Chicago. (ERIC Document Reproduction Service No. 397238)

Hochschild, A. R. 1979. 'Emotion work, feeling rules and social structure'. American Journal of Sociology. 85(3), 551 – 575.

Hochschild, A. R. 1983. The Managed Heart; Commercialization of Human Feeling. Berkeley: University of California Press.

Hodnett, E. D. 2002. 'Home-like versus conventional birth settings' (Cochrane review). Cochrane Library, issue 1. Update software: Oxford.

Holstein, J. & Gubrium, J. 1995. The Active Interview. Thousand Oaks: Sage.

Honey, P. & Mumford, A. 1992. The manual of learning styles 3rd edition. Maidenhead: Peter Honey.

Houghton, A. 2003. 'Bullying in medicine'. BMJ careers supplement. 12th April.

Hughes, C. 2004. New times? New learners? New voices? Towards a contemporary social theory of learning. British Journal of Sociology of Education. Vol, 25, No.3, pp 395 – 408.

Hughes, D., Deery, R. & Lovatt, A. 2002. A critical ethnographic approach to facilitating cultural shift in midwifery. Midwifery. Vol. 18, pp 43 – 52.

Hunt, S. 2004. Foreword. In Stewart M. (Ed.) Pregnancy, Birth and Maternity Care: feminist perspectives. London: Books for Midwives.

Hunt, S. & Symonds, A. 1995. The Social Meaning of Midwifery. London: Macmillan Press.

Hunter, B. 2002. 'Emotion work in midwifery: an ethnographic study of emotional work undertaken by a sample of student and qualified midwives in Wales'. Unpublished PhD Thesis, University of Wales, Swansea.

Hunter, B. 2004. 'Conflicting ideologies as a source of emotion work in midwifery'. Midwifery. Vol. 20: 261 – 272.

Hunter, B. 2006. 'The importance of reciprocity in relationships between community based midwives and mothers'. Midwifery (in press) accessed electronically 6.6.06.

Hunter, B. & Deery 2005. 'Building our knowledge about emotion work in midwifery: combining and comparing findings from two different research studies'. Evidence Based Midwifery. Vol. 3, No. 1, pp 10 – 15.

Hyland, M., Millard, J. & Parker S. 1988. 'How hospital ward members treat learner nurses: an investigation of learners' perceptions in a British hospital'. Journal of Advanced Nursing. Vol. 13, pp 472 – 477.

James, N. 1992. 'Care = organization + physical labour + emotional labour'. Sociology of Health and Illness. Vol. 14(4), 489-509.

Janesick, V. 2000. 'The Choreography of Qualitative Research Design: Minuets, Improvisations, and Crystallization'. In Denzin, N. & Lincoln, Y. (Eds.) Handbook of Qualitative Research. Thousand Oaks: California :Sage.

Jarvis, P. 1996. Adult and Continuing Education: Theory and Practice. London: Routledge.

Jarvis, P. 2004. Adult Education and lifelong learning: Theory and Practice. London: Routledge Falmer.

Jarvis, P., Holford, J. & Griffin, C. 1998. The Theory and Practice of learning. London: Kogan Paul.

Jordan, B. 1978. Birth in Four Cultures. Montreal: Eden Press.

Kapborg, I. & Fishbein, S. 1998. 'Nurse Education and Professional Work, transitional problems'. Nurse Education Today. Vol. 18 pp 165 – 171.

Katz Rothman, B. 1982. In Labour: Women and Power in the Birthplace. London: Junction Books.

Kaufmann, T. 2004. 'Introducing feminism'. In Stewart, M. (Ed.) Pregnancy, Birth and Maternity Care: feminist perspectives. London: Books for Midwives.

Keller, C. & Keller, J.D. 1996. 'Thinking and acting with iron'. In Chaiklin, S. & Lave, J. (Eds.) Understanding practice: Perspectives on activity and context. Cambridge University Press: Cambridge.

Kennedy, H. P. 2000. 'A model of exemplary midwifery practice: results of a Delphi study'. Journal of Midwifery & Women's Health. Vol. 45, No. 1, pp. 4-19.

Kent, J., MacKeith, N. and Maggs, C. 1994. An Evaluation of Pre-registration Midwifery in England. Department of Health. MRA. Bath.

Kirkham, M. 1999. 'The culture of midwifery in the National Health Service in England'. Journal of Advanced Nursing. 30(3), 732 – 739.

Kirkham, M. 2000. 'How can we relate?' In Kirkham, M. (Ed.). The midwife-mother relationship. London: Macmillan Press. pp 227 – 254.

Kirkham, M. 2003. 'Birth centres as an enabling culture'. In Kirkham, M. (Ed.). Birth Centres: A Social Model for Maternity Care. London: Books for Midwives.

Kirkham, M. 2004. 'Midwives: Praise and beyond'. The Practising Midwife. Vol. 7. No. 4, p18 – 20.

Kirkham, M. 2004(a). 'Choice and bureaucracy'. In Kirkham, M. (Ed.). Informed Choice in Maternity Services. Hampshire: Palgrave MacMillan. pp 265 – 290.

Kirkham, M. 2005. Presentation to NHS Perinatal Institute. Accessed at <http://www.perinatal.nhs.uk/rpnm/presentations/MavisKirkham.pdf>. Accessed April 2006.

Kirkham, M. & Ball, L. 2002. Conference proceedings. 'Renewing Midwifery – fulfilling our potential' RCM and Employing Nurses and Midwives, March 2002, York Racecourse.

Kirkham, M. & Stapleton, H. 2000. 'Midwives' support needs as childbirth changes'.
Journal of Advanced Nursing. 32(2), pp. 465 – 472.

Kirkham, M. & Stapleton, H. 2004. 'The culture of the maternity services in Wales and England as a barrier to informed choice'. In Kirkham, M. (Ed.) Informed Choice in Maternity Care. London: Palgrave Macmillan. pp 117 – 146.

Kitzinger, S. (Ed.) 1991. The Midwife Challenge. London: Pandora Press.

Kolb, D. A. 1984. Experiential learning: experience as the source of learning and development. New Jersey: Prentice Hall.

Kramer, M. 1974. The Reality Shock: - Why Nurses leave Nursing. St. Louis: Mosby.

Kupferberg, F. 2004. 'Professional Communities and the Life History Method: A Critique of the Lave – Wenger Paradigm of Learning'. Paper presented at the ESREA – Conference in Roskilde, 4 – 7 March.

Kvale, S. 1996. InterViews: An Introduction to Qualitative Research Interviewing. Thousand Oaks, California: Sage.

Lagache, E. 1993. "Diving" into communities of practice: Examining learning as legitimate peripheral participation in an everyday setting'. Paper presented at the annual

meeting of the American Educational Research Association, Atlanta , GA. (ERIC Document Reproduction Service No. ED360387)

Lave, J. & Wenger, E. 1991. Situated learning: Legitimate Peripheral Participation. Cambridge:Cambridge University Press.

Lavender, T. 2003. Report to the Department of Health Children's Taskforce from the Maternity and Neonatal Workforce Group. January.

Lavender, T. & Chapple, J. 2004. 'An exploration of midwives' views of the current system of maternity care in England'. Midwifery. Vol. 20, No. 4, pp. 324 – 334.

Leap, N. 1997. 'Making sense of 'horizontal violence' in midwifery'. British Journal of Midwifery. Vol. 5. No. 11, p689.

Leap, N. 2004. 'Journey to midwifery through feminism: a personal account'. In Stewart, M. (Ed.) Pregnancy, Birth and Maternity Care: feminist perspectives. London: Books for Midwives.

Leap, N. & Hunter, B. 1993. The Midwife's Tale. London: Scarlet Press.

LeBoyer, F. 1974. Birth without violence. London: Wildwood House.

LeCompte, M. D. & Preissle, J. 1993. Ethnography and Qualitative Design in Educational Research. Chicago: Academic Press.

Lester, A. 2005. 'The argument for caseload midwifery'. MIDIRS Midwifery Digest. Vol. 15, No. 1, pp 27 – 31.

Light, D. 1993. 'Countervailing power: the changing character of the medical profession in the United States'. In Hafferty, F. & McKinlay, J. (Eds.) The Changing Character of the Medical Profession. New York: Oxford University.

Light, R. & Nash, M. 2006. 'Learning and Identity in overlapping communities of practice: Surf Club, School and Sports clubs'. The Australian Educational Researcher. Vol. 33, No. 1. pp 75 – 94.

Lincoln, Y. & Guba, E. 1985. Naturalistic Enquiry. London:Sage.

Lipsky, M. 1980. Street-Level Bureaucracy Dilemmas of the individual in public services. New York: Russell Sage Foundation.

Luke, C. (ed.) 1996. Feminisms and Pedagogies of Everyday Life. Albany: State University of New York.

Lupton, D. 1994. Medicine as Culture. London: Sage.

Macfarlane, A. & Mugford, M. 2000. Birth Counts: Statistics of pregnancy & childbirth. London: The Stationery Office.

Machin, D. & Scamell, M. 1997. 'The experience of labour: using ethnography to explore the irresistible nature of the bio-medical metaphor during labour'. Midwifery. Vol. 13, Issue 2, pp 78 – 84.

MacMillan, M. 2001. 'Centenary celebrations – a century of professional midwifery'. RCM Midwives journal. October, Vol.4 No.10.

MacPherson, W. 1999 The Stephen Lawrence Inquiry: report of an inquiry by Sir William MacPherson of Cluny. London: HMSO.

Maggs, C. 1994. 'Direct but different: midwifery education since 1989'. British Journal of Midwifery. Vol. 2, no.12, pp 612-616.

Mahony, E. 2005. 'The need for change - the mother's perspective'. MIDIRS Midwifery Digest. Vol. 15, supplement 2, December, pp S9-S12.

Mainstone, A. 2004. 'Fetal monitoring advances'. British Journal of Midwifery. Vol. 12, No. 11, pp 704 – 707.

Mander, R. & Fleming, V. (Eds.). 2002. Failure to Progress: the contraction of the midwifery profession. London: Routledge.

Mander, R. & Reid, L. 2002. 'Midwifery Power'. In Mander, R. & Fleming, V. (Eds.) Failure to Progress: the contraction of the midwifery profession. London: Routledge

Martin, E. 1993. The Woman in the Body. Milton Keynes: Open University Press.

Mason, M. 1990. 'Internalized Oppression'. In Reiser, R. & Mason, M. (Eds.). Disability Equality in Education. London: ILEA.

Mason, J. 1996. Qualitative Researching. London: Sage.

Mason, J. 2000. 'Defining Midwifery Practice'. AIMS Journal. Volume 12. No. 4. pp 5 – 6.

Mason, J. 2003. 'An Analysis of Midwifery Education'. Midwifery Matters. Issue 96. Spring.

Maynard, M. 1994. 'Methods, Practice and Epistemology: The Debate about Feminism and Research'. In Maynard, M. & Purvis, J. (Eds.). Researching Women's Lives from a Feminist Perspective. London: Taylor & Francis. pp 10 – 26.

Mays, N. & Pope, C. 1995. 'Qualitative research: Rigour and qualitative research'. British Medical Journal. 311, pp 109 – 112.

McCrea, B., Wright, M. & Murphy-Black, T. 1998. 'Differences in midwives' approaches to pain relief in labour'. Midwifery. Vol. 14. No. 3. pp174 – 180.

McManus, I. 2002. 'Medical school applications - a critical situation'. British Medical Journal. 325: 786-787.

Merriam, S., Courtenay, B. & Baumgartner, L. 2003. 'On becoming a Witch: Learning in a Marginalized Community of practice'. Adult Education Quarterly. Vol. 53, No.3, pp 170 – 188.

Mezirow, J. 2000. 'Learning to think like an adult: Core concepts of transformational theory'. In Mezirow, J. & Associates (Eds.). Learning as transformation: Critical perspectives on a theory in progress. San-Francisco: Jossey-Bass. pp 3 – 33.

Middleton, S. 1993. 'A post-modern Pedagogy for the Sociology of Women's education'. In Arnot, M. & Weiler, K. (Eds.), Feminism and Social Justice in Education. London: Falmer Press.

Miettinen, R. 2000. 'The concept of experiential learning and John Dewey's theory of reflective thought and action'. International Journal of Lifelong Education. Vol. 19, No. 1, pp 54 – 72.

Miller, C. & Blackman, C. 2003.' Learning During the First Three Years of Employment' – The LiNEA Project. INTERIM REPORT FOR NURSING available at http://www.tlrp.org/dspace/retrieve/131/report_nursing.pdf accessed 13th December 2005.

Molander, B. 1992. 'Tacit knowledge and silenced knowledge: Fundamental problems and controversies'. In Goranzon, B. & Florin, M. (Eds.) Skill and Education: Reflection and Experience. New York: Springer – Verlag.

Morse, J. 1991. 'Strategies for sampling'. In Morse J. (Ed.) Qualitative Nursing Research: A Contemporary Dialogue. Newbury Park: Sage.

Morse, J.M. 1994. 'Qualitative research: fact or fantasy?' In Morse, J.M. (Eds.), Critical Issues in Qualitative Research Methods. Thousand Oaks: Sage Publications. pp.1-4.

Morse, J.M. 1994(a). 'Emerging from the data: the cognitive processes of analysis in qualitative inquiry'. In Morse, J.M. (Eds.) Critical Issues in Qualitative Research Methods. Thousand Oaks: Sage Publications. pp.23-42.

Morton-Cooper, A. & Palmer, A. 2000. Mentoring, Preceptorship and Clinical Supervision. Oxford, Blackwell (Second Edition).

Mulholland, H. 2002. 'Birth of a new breed?' Nursing Times. Vol. 98, No. 20, p11.

Murphy-Black, T. 1995. 'Comfortable men, uncomfortable women'. In Murphy-Black, T. (Ed.) Issues in Midwifery. Edinburgh: Churchill Livingstone.

Murphy-Lawless, J. 1998. Reading Birth and Death: a History of Obstetric Thinking. Ireland: Cork University Press.

Murray, R. 2002. How to write a thesis. Buckingham: Open University Press.

Myers, G. 2005. 'Communities of practice, risk and Sellafeld.' In Barton, D. & Tusting, K. (Eds.). Beyond Communities of Practice. Cambridge: Cambridge University Press.

National Childbirth Trust. 2006. NCT press office release - 19th May accessed 22.05.06
<http://www.midirs.org/midirs/midweb1.nsf/ZA5/D270B47465ECD903802571770036932>

1.

National Institute for Clinical Excellence. 2001. Electronic fetal monitoring: The use and interpretation of cardiotocography in intrapartum fetal surveillance. London: NICE.

Nicolson, P. 1993. 'Motherhood and Women's Lives'. In Richardson, D. & Robinson, V. (Eds.) Introducing Women's Studies Feminist Theory and Practice. London: Macmillan.

Nursing and Midwifery Council. 2004. The PREP handbook. London: NMC.

Nursing & Midwifery Council. 2004(a). Midwives rules and standards. London: NMC.

Nursing and Midwifery Council. 2004(b). Standards of proficiency for pre-registration midwifery education. London: NMC.

Nursing & Midwifery Council. 2005. Statistical analysis of the register available at <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=856> accessed September 1st 2005.

Oakley, A. 1975. 'Wise woman and medicine man; changes in the management of childbirth'. In Mitchell, J. & Oakley, A. (Eds.), The Rights and Wrongs of Women. Harmondsworth: Penguin. pp 17 – 58.

Oakley, A. 1980. Women confined: Towards a sociology of childbirth. Oxford: Martin Robinson.

Oakley, A. 1981. 'Interviewing Women: A Contradiction in terms'. In Roberts, H. (Ed.), Doing Feminist Research. London: Routledge and Kegan Paul.

Oakley, A. 1985. The sociology of Housework. Oxford: Basil Blackwell.

O'Dowd, A. 2000. 'Midwives need a carrot to return to the NHS'. Nursing Times. 96(37):5.

Olesen, V. 2000. 'Feminisms and Qualitative Research At and Into the Millennium'. In Denzin, N. & Lincoln, Y. (Eds.) Handbook of Qualitative Research. Thousand Oaks: California :Sage.

Oliver, R. 2005. 'Birth: hospital or home? That is the question'. Journal of Prenatal and Perinatal Psychology and Health. Vol. 19, No 4. pp 341-348.

'O' Neill, J. 1986. 'The disciplinary society: from Weber to Foucault'. British Journal of Sociology. Vol. 37, No. 1. pp 42 – 60.

'O' Regan, M. 1999. 'The Ann Kelly Case'. AIMS journal. Vol.11, No. 2, pp 12 – 15.

Oudshoorn, C. 2005. 'The art of midwifery, past, present and future'. MIDIRS Midwifery Digest. Vol. 15, No. 4, pp461 – 468.

Oxford Dictionary. 2003. Oxford: Oxford University Press.

Paetcher, C. 2003. 'Masculinities and Femininities as communities of practice'. Women's Studies International Forum. Vol. 26, No. 1, pp 69 – 77.

Paetcher, C. 2006. 'Power, knowledge and embodiment in communities of sex/gender practice'. Women's Studies International Forum. Vol. 29, pp 13 – 26.

Pairman, S. 2000. 'Women-centered Midwifery: Partnerships or Professional Friendships?' In Kirkham, M. (Ed.) the midwife-mother relationship. London: Macmillan Press. pp207 – 226.

Parker, A. 2002. 'Pressures, problems and the PhD process: Tales from the 'Training Ground''. In Walford, G. (Ed.) Doing a Doctorate in Educational Ethnography. Vol. 7. London: Elsevier. pp 119 – 134.

Parsons, T. 1951. The social system. London: Routledge and Kegan Paul.

Philpin, S. M. 1999. 'The impact of 'Project 2000' educational reforms on the occupational socialization of nurses: an exploratory study'. Journal of Advanced Nursing. 29(6): 1326 – 1331.

Polanyi, M. 1967. The tacit dimension. Garden City: Doubleday.

Polit, D., Beck, C. & Hungler, B. 2001. Essentials of Nursing Research: methods, appraisal and utilization. 5th edition. Philadelphia: Lippincott.

Powell, G. 2005. 'Welcome ladies... oh... and Glenn'. Australian Midwifery News. Vol. 5, no 2, Winter, p 30.

Purkis, J. 2003. 'The quintessential female act? Learning about birth'. In Earle, S. & Letherby, G. (Eds.) Gender, Identity and Reproduction. Palgrave Macmillan: Hampshire.

Purkiss, J. 1998. 'The medicalisation of childbirth'. MIDIRS Midwifery Digest. Vol 8, No. 1, pp 110 – 112.

Radford, N. & Thompson, A. 1988. Direct Entry: A preparation for Midwifery Practice. University of Surrey.

Radford, N. & Thompson A. M. 1994. 'A study of issues concerning the implementation of direct entry midwifery training'. In Robinson S & Thompson A.M. (Eds.) Midwives, research and childbirth. London: Chapman and Hall.

Randall, P. 1997. Adult bullying: Perpetrators and victims. London: Routledge cited in Hadikin, R. & O'Driscoll, M. 2000. The Bullying culture. Books for Midwives:Oxford.

Reason, P. & Marshall, J. 1994. 'Research as Personal Process'. In Boud, D. & Griffin, V. (Eds.) Appreciating Adults Learning: From the Learners Perspective. London: Kogan Paul. pp. 112 – 126.

Richards, P. 1986. 'Risk'. In Becker, H. S. 1986. Writing for Social Scientists: How to Start and Finish Your Thesis, Book or Article. Chicago: University of Chicago Press.

Ritzer, G. 2004. The Mc Donaldization of Society. London: Pine Forge Press.

Robinson, S. 1990. 'Maintaining the Independence of the Midwifery Profession: A Continuing Struggle'. In Garcia, J., Kilpatrick, R. & Richards, M. (Eds.) The Politics of Maternity Care. Oxford: Open University Press.

Robinson, J. 2000. 'Why are midwives turning nasty?' British Journal of Midwifery. Vol. 8, No. 3, pp 143.

Robotham, M. 1997. 'Nurse or Midwife?' Nursing times. Vol. 93, no 38:36 – 37.

Robson, C. 1993. Real World Research. Oxford: Blackwell.

Robson, C. 2002. Real World Research: a resource for social scientists and practitioner – researchers. Oxford: Blackwell.

Rogers, A. 2003. What is the Difference? A new critique of adult learning and teaching.

Leicester: NIACE.

Ross, M., Ridout, E. & Carson, M. 1994. 'The use of the Diary as a data collection technique'. Western Journal of Nursing Research. Vol. 16, No. 4, pp 414 – 425.

Rosser, J. 1998. 'Breaking the rules'. The Practising Midwife. Vol. 1, No. 1, pp 4 – 5.

Rowan, J. & Cooper, M. (Eds.) 1999. The Plural Self; Multiplicity in Everyday Life.

London: Sage.

Royal College of Midwives. 2005. 'Evidence for pay review body'. In News & Appointments. Royal College of Midwives: London. October, p5.

Royal College of Midwives. 2006. 'RCM awards 2005: the College's Oscars'. Midwives. Vol. 9. No. 1. p22 – 25.

Sandall, J 1995. 'Choice, continuity and control: Changing midwifery, towards a sociological perspective'. Midwifery. Vol. 11, pp 201 – 209.

Sandall, J. 1997. 'Midwives, burnout and continuity of care'. British Journal of Midwifery Vol. 5, No.2, pp 106 – 111.

- Sandall, J. 1998. 'The `double shift' - motherhood and midwifery'. British Journal of Midwifery. Vol. 6, No. 1. pp 4 – 6.
- Sandall, J., Bourgeault, I., Meihner, W. & Schuecking, B. 2001. 'Deciding Who Cares: Winners and Losers in the Late Twentieth Century'. In DeVries, R., Benoit, C., Teijlingen, E. & Wrede, S. (Eds.) Birth by Design. London: Routledge. Pp 117 – 138.
- Saunders, M. 2006. 'From 'organisms' to 'boundaries': the uneven development of theory narratives in education, learning and work connections'. Journal of Education and Work. Vol. 19, No.1, pp 1 – 27.
- Savage, W. 1986. A Savage Enquiry: Who controls childbirth? London: Virago Press.
- Scambler, G. 2002. Health and Social Change: A Critical Theory. Buckingham: Open University Press.
- Scheurich, J. 1997. Research Method in the Postmodern. London: Falmer Press.
- Seidman, I. E. 1991. Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences. Columbia University, Teachers College.
- Shaw, I. & Could, N. 2001. Qualitative Research in Social Work. London: Sage.

Shipman, M. 1988, The Limitations of Social Research. London: Longman.

Sinclair, M. 2006. 'Labouring women and birth technology: the midwife as conduit?'
Midwives. Vol. 9. No. 1, p4.

Silverman, D. 2000. Doing Qualitative Research. London: Sage.

Silverman, D. 2001. Interpreting Qualitative Data: methods for analysing talk, text and interaction. London: Sage.

Skeggs, B. 1994. 'Situating the Production of Feminist Ethnography'. In Maynard, M. & Purvis, J. (Eds.) Researching Women's Lives from a Feminist Perspective. London: Taylor and Francis. pp. 72 -92.

Smith, A.C. & Kleinman, S. 1989. 'Managing emotions in medical school: students' contacts with the living and the dead'. Social Psychology Quarterly. Vol. 52, No.1, pp 56-69.

Smith, P. 1992. The emotional labour of Nursing. London: Macmillan.

Spender, J. C. 1996. 'Organizational knowledge, learning and memory: Three concepts in search of a theory'. Journal of Organizational Change Management. Vol. 9, pp 63 – 78.

Spouse, J. 1998. 'Learning to nurse through legitimate peripheral participation'. Nurse Education Today. Vol. 18, pp345 – 351.

Stacey, M. 1993. The Sociology of Health and Healing. London: Routledge.

Stafford, S. 2001. 'Lack of autonomy: A reason for midwives leaving the profession?' The Practising Midwife. Vol. 4, No. 7, pp 46 – 47.

Stanley, L. 1996. The mother of invention: necessity, writing and representation. Feminism and Psychology. Vol. 6, pp 45 – 51.

Stanley, L. & Wise, S. 1993. Breaking Out Again Feminist Ontology and Epistemology. London: Routledge.

Stapleton, H., Kirkham, M., Thomas, G. & Curtis, P. 2002. 'Midwives in the middle: balance and vulnerability'. British Journal of Midwifery. Vol. 10, No. 10, pp 607 – 611.

Stephens, L, 2005. 'Worrying truth behind home birth figures'. British Journal of Midwifery. Vol. 13, No. 1, pp 4-5.

Stevens, F., Van der Horst, F., Nijhuis, F. & Bours, S. 2000. 'The division of labour in vision care: professional competence in a system of professionals'. Sociology of Health and Illness. Vol. 22, No. 4, pp 431 – 452.

Stevens, T. & McCourt, C. 2002. 'One-to-one midwifery practice part 2: the transition period'. British Journal of Midwifery. Vol.10, No. 10, pp 45 – 50.

Stronach, I. & MacLure, M. 1997. Educational Research Undone: The Postmodern Embrace. Buckingham: Open University Press.

Styles, M. 2004. 'A year less ordinary'. MIDIRS Midwifery Digest. Vol. 14, No. 4, pp 449- 452.

Taylor, G. 2000. 'What birth taught me about midwifery'. Birthplace. No. 70, pp 15-17.

Taylor, P. & Bain, P. 1999. "'An assembly line in the head': work and employee relations in the call centre". Industrial Relations Journal. Vol. 30, No. 2. pp 101 – 117.

Tellier, M. 2003. 'Why I left'. Midwifery Matters. Spring Issue 96, p4.

Tew, M. 1995. Safer Childbirth; a Critical History of Maternity Care. London: Chapman Hall.

Thomas, P. 2002. 'The midwife you have called knows you are waiting ... A consumer view'. In Mander, R. & Fleming, V. (Eds.) Failure to progress: the contraction of the midwifery profession. London: Routledge. pp 20 – 38.

Thompson, S. 1996. 'Paying respondents and informants'. Social Research Update, issue 14, Autumn. Available at <http://www.soc.surrey.ac.uk/sru/SRU14.html>

Tilly, L. & Scott, J. 1989. Women, Work & Family. London: Routledge.

Toombs, S. 2002. 'Bodies and Persons'. In Fulford, K. W. M., Dickenson, D. & Murray, T. (Eds.) Healthcare Ethics and Human Values. Oxford: Blackwell Publishers. pp36 – 40.

Turner, B 1994. Medical Power and Social Knowledge. London: Sage.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. 1998.

Midwives rules and code of practice. UKCC: London.

Wagner, M. 1994. Pursuing the Birth Machine. Australia: ACE Graphics.

Walker, L. & Gilson, L. 2004. "We are bitter but we are satisfied": nurses as street-level bureaucrats in South Africa'. Social Science & Medicine. Vol. 59, No.6, pp 1251 – 1261.

Wallace, E., Mackintosh, C., Brownlee, M., Laidlaw, L. & Johnstone, F. 1995. 'A study of midwife-medical staff interaction in a labour ward environment'. Journal of Obstetrics and Gynaecology. Vol. 15, pp. 165 – 170.

Walsh, D. 2002. 'What is a 'normal' midwife?' The practicing Midwife. Vol. 5, No. 7, pp 12 – 15.

Walsh, D. 2004. 'Feminism and intrapartum care: a quest for holistic birth'. In Pregnancy, Birth and Maternity Care; Feminist Perspectives. London: Books for Midwives.

Walsh, D. 2005. 'Subverting the assembly-line: Childbirth in a free-standing birth centre'. Social Science & Medicine. Vol. 62, No. 6, pp1330 – 1340.

Warren, C. 2003. 'Exploring the value of midwifery continuity of carer'. British Journal of Midwifery. Vol. 11, No. 10, pp S34-37.

Weitzman, E. 2000. 'Software and Qualitative Research'. In Denzin, N. & Lincoln, Y. (Eds.) Handbook of Qualitative Research. Second edition. London: Sage.

Wenger, E. 1998. Communities of Practice: Learning, meaning and identity. Cambridge: Cambridge University Press.

Wickham, S. 2003. 'Why I left the UK'. Midwifery Matters. Spring Issue 96, p4.

Wilson, A. 1995. The Making of Man-Midwifery. London: UCL Press.

Wilson, F. 1997. 'The construction of Paradox? : One case of Mature Students in Higher Education'. Higher Education Quarterly. Vol. 51, No. 4, pp. 347 – 366.

Witz, A. 1992. Professions and Patriarchy. London: Routledge & Kegan Paul.

Woodward, K. (Ed.) 1997. Identity and Difference. London: Sage.

Worth, J. 2002. Call the Midwife. Twickenham: Merton Books.

Young, I. M. 1990. Justice and the politics of difference. Princeton N. J.: Princeton University Press.

Appendices

Appendix 1

QUESTIONNAIRE

Section A

1. Have you secured employment after qualification? YES/NO (please circle)
(If NO please go directly to section B)

2. If so which of the following describes your post?

	<i>Tick</i>
NHS midwife	
Self employed midwife	
Privately employed midwife	
Other (Please explain)	
.....	
.....	
.....	
.....	

3. Please indicate which of the following describes your intended normal working hours.

	<i>Tick</i>
Full time	
Job Share	
Part time	
Occasional/Bank	
Other (Please explain)	
.....	
.....	
.....	
.....	

4. Will you be mainly working in: *(please tick one box only)*

Community	Hospital	Both	Other (please explain below)

.....

5. What is the main type of clinical work that you will be doing?
Tick only one box and explain as necessary.

Antenatal care	Intrapartum care	Postnatal care	SCBU	Combination of areas	Other (please explain below)

.....

6. Does your job mean that you will work as part of:-

Tick

A community based team-midwifery scheme	
A hospital based team-midwifery scheme	
An integrated team-midwifery scheme	
Other (please explain below)	

.....

7. What is your initial grade?

D	E	F	G	Other (please explain)

.....

Section B

In this section I would like to try and understand a little about your perceptions of midwifery and the aspects of midwifery work that are most important to you.

8. Please read the two statements below and indicate (*by placing a tick on the scale between them*) the point that **most closely** matches your own opinion:-
 Although this is a tough decision – **please use only one tick.**

Statement A	Strongly agree with statement A	Agree with statement A	Agree with statement B	Strongly agree with statement B	Statement B
For most women giving birth the risks are small and the midwife just needs to be there for support, standing in the background, keeping an eye on things.					For most women giving birth, there is always the danger that things might go wrong and the midwife often needs to step in and manage things.

9. Which aspects of midwifery work are the most important to you?

Please rank as many of the following factors as you feel apply.
 Please rank from '1' – '9' putting the most important first (i.e. most important = 1, next = 2 and so forth):-

	<i>Rank</i>
Building continuing relationships with women and their families	
Feeling appreciated and needed by the women I care for	
Having a good relationship with my midwifery colleagues	
Feeling that I am responsible for my own work	
Being able to balance my work with my private life	
Feeling that I am in control of my work environment	
The privilege of being part of women's birth experiences	
The feeling of pride in a job well done	
Feeling supported and valued by my manager	

10. Do you feel that for you midwifery is more than just a job ?

Please explain

Section C : About you

11. Are you

Tick

Female	<input type="checkbox"/>
Male	<input type="checkbox"/>

12. What is your age group?

Tick

25yrs or under	<input type="checkbox"/>
26 - 30	<input type="checkbox"/>
31 - 35	<input type="checkbox"/>
36 - 40	<input type="checkbox"/>
41 - 45	<input type="checkbox"/>
46 - 50	<input type="checkbox"/>
51 - 55	<input type="checkbox"/>
56 yrs or over	<input type="checkbox"/>

13. It would be helpful if you could indicate the ethnic group to which you feel you belong. Please feel free not to answer this question if you so wish.

Do you consider yourself to be:

Tick

White	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>
Black African	<input type="checkbox"/>
Black – other Black groups	<input type="checkbox"/>
Indian	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Chinese	<input type="checkbox"/>
None of these (please specify below)	<input type="checkbox"/>

14. Do you have responsibilities for the care of dependants, for example young children, a partner or elderly relatives?

Tick

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

*If NO please go directly to question 17
 If YES please explain*

15. Have these responsibilities been a major difficulty during your training?

Tick

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

Please explain

16. Was there any help or assistance in place to help you cope/continue?

Tick

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

Please explain

17. Have you suffered from any illness or injury during your training?

Tick

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If NO please go directly to question 20

If YES please explain

18. Do you consider that your training contributed in any way to this illness or injury?

Tick

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

Please explain

19. Were any accommodating arrangements necessary or indeed made?

Tick

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

Please explain

20. Prior to your Midwifery degree what is your highest educational qualification?

Tick

Btec National Diploma	
'A' levels	
Access certification	
AGNVQ	
Diploma/Degree	
Higher Degree	
Other (please specify below)	

Section D: Preparation for your role

21. Do you feel you have been adequately prepared to take on the role and responsibilities of a qualified midwife?

(please indicate where along the line you are currently)

Not at all well prepared _____ Very well prepared

Please add anything you would like to

22. Have you enjoyed your period of midwifery training?

(please indicate where along the line you are currently)

Not very much _____ Very much

Please add anything you would like to

23. At this point are you planning to stay in midwifery as your career?

Tick

Yes	
Probably	
Possibly not	
No	

Please explain

24. Do you envisage staying

Tick

0 – 3 years	<input type="checkbox"/>
4 – 6 years	<input type="checkbox"/>
7 – 10 years	<input type="checkbox"/>
More than 10 years	<input type="checkbox"/>

Please explain

In order for you to complete the follow up questionnaire in one year I will require an address to which this can be sent. In helping to maintain confidentiality I will collect these separately.

Once again **Thankyou**

I wish you the very best of luck and lots of happiness in your forthcoming career. Judy.

Statements concerning Midwifery

Statement	Strongly agree	Agree	Not an issue for me	Disagree	Strongly disagree
I feel I will be able to provide the type of care I want					
I feel that the majority of my midwifery colleagues will be supportive					
I feel I will be able to develop meaningful relationships with clients					
I feel that doctors will respect my midwifery skills					
I feel clients may be too demanding					
I feel I will be consulted by my manager about changes which affect my work					
I feel my manager will offer effective support					
I am worried about the increasing threat of litigation					
I feel I will have sufficient choice about <i>where</i> I work					
I feel I will have sufficient choice about <i>when</i> I work					
I feel the way my work is organized will foster a supportive team of colleagues					
I feel I may be bullied by some of my midwifery colleagues					
I feel my manager will be flexible enough to accommodate my needs					
I feel the way my work will be organized will support my confidence					

Statement	Strongly agree	Agree	Not an issue for me	Disagree	Strongly disagree
Overall I feel the women receive an appropriate standard of care					
I feel that protocols may restrict my ability to provide the type of care I want to					
I feel able to discuss any concerns about my work with midwifery colleagues					
I feel I will be able to finish work when my shifts end					
I feel I may be bullied by my manager/s					
I feel I may be made to feel guilty about work					
I feel that insufficient staffing levels frequently compromise client safety					
I feel that insufficient staffing levels may frequently undermine the quality of care I am able to provide					
I feel I will be able to discuss any concerns about my work with my manager					
I feel I will be able to discuss any concerns about my work with my Supervisor of Midwives					
I feel I will be paid enough for what I do					
I feel that my physical and/or mental health may suffer because of my work					
I feel I will have enough control over how my work is organized					

Statement	Strongly agree	Agree	Not an issue for me	Disagree	Strongly disagree
I feel I will have sufficient opportunity for further education and training					
I am satisfied with my starting grade					
I feel my promotion prospects are good					
I feel promotion is based on individual merits					
I feel I would discuss concerns I had about work with my Trades Union Representative					
I sometimes feel I may just be a 'gap filler' on the duty roster					
I feel I may not 'belong' anywhere					
I feel I will be valued by my manager					
I feel I will be treated fairly in relation to other members of staff					
I feel insufficient staff may cause my work to be disrupted					
I feel labour ward will be the most difficult area for me					
I feel I will be able to specialize in aspects of the job I particularly enjoy					
I feel my Supervisor of Midwives will provide effective support					

If you would like to add anything about your expectations of your first year as a qualified midwife please feel free

Appendix 2

Learning to be Midwives: beyond Qualification Summer 2004

The contents of this journal will remain confidential at all times. Any identifying names or places will be removed if any contents are replicated within this research.

Upon completion of the project you, the participant, may chose either that this journal is destroyed or returned to yourself to keep.

Project Midwife:

Judy Purkis
5 Ruskin Close
Hillside
Rugby
CV22 5RU
Tel: 07929 059035

Email: jcpurkis@btopenworld.com

Feel free to contact me at any time for help or advice.

Please keep this diary for *just one week*. You can choose whichever week suits you best. It is meant simply as a written journal to think about and reflect on how midwifery is going for you and your feelings about it.

It is intended to have no 'correct' structure, length or layout; just write what and how you want. The following points may help you if you feel stuck but are intended as a guide only. Either use them if you wish or ignore them if you prefer.

- How was each day?
- Much happened?
- How are you feeling about your job?
- How are you feeling about yourself?
- Were there any low points today?
- Were there any high points today?
- Is there anything you would like to change?

Upon completion please use the envelope provided to return it to myself. I do hope you enjoy keeping this diary. Thank you very much for your time and effort.

Speak to you soon

Appendix 3

The *ideas* that helped steer the interviews

Interview 1: three months after qualification

Tell me a bit about yourself

How is it going?

Have you felt well supported?

How are you finding your work environment?

Can you tell me the best and the worst things about midwifery for you so far?

Do you feel you are still learning?

Have you any advice for future midwives about to qualify?

Interview 2: six months after qualification

How is it going?

How is work fitting in with your life?

Can you say what it is that you are learning?

What relationships are important to you?

Can you tell me the best and the worst things about midwifery for you so far?

Interview 3: twelve months after qualification

How has your first year been?

Has it been what you expected?

Are there things you would like to change?

Do you feel you 'fit in'?

Do you enjoy being a midwife?

Are you planning to stay? If so can you say why?