A DIVIDED PROFESSION:

AN ANALYSIS OF THE TWO CULTURES IN

 MIDWIFERY EDUCATION AND PRACTICE

Elaine Emmons

This Thesis is presented in part fulfilment of the requirements for the Degree of Doctor of Philosophy University of Surrey February 1993
ABSTRACT

In this study the researcher attempts to examine the theory and practice relationship by analysing the two sets of beliefs, values and attitudes in midwifery education and practice.

The study was conducted in two phases. From phase one of the study it was evident that student midwives generally felt that there is a gap between theory and practice as they strongly assert that while they are taught in 'school' certain beliefs, values and attitudes, these are not always similar to those taught in the ward area.

Phase two of the research evolved from the findings of phase one. It was with this finding that the researcher became interested in exploring the role of the midwifery practitioner. As the researcher observed midwives as they went about their daily work and then talked to them about their beliefs, values and attitudes towards professional practice, the researcher could elicit broadly three types of midwives namely: 'crusaders', 'survivors' and 'nurse-midwives.' Each of these ideological types have their own espoused theory and theory-in-use.

In order to make sense of the data the researcher (with the help of her supervisor and colleagues) employed various established theories to interpret the findings. These are 'Argyris and Schon's work on theory in practice, the theory of the symbolic interaction and the theory of communicative action.

Argyris and Schon's work on theory in practice helped to explain why midwives who have undergone the same traditional form of training could subsequently end up with a different set of beliefs, values and attitudes.
The theory of symbolic interaction helped to put meanings to the way groups function through consensus. The researcher observed the behaviour of midwives in practice and came up with some interpretations of why midwives hold different beliefs and values.

The researcher also seeks to use a synthesis of some major contemporary theories of communication and communicative action to explain the way in which midwives structure their world of work. It is proposed that the language used by midwives is very specific in maintaining their professional status.

Another finding is that many midwives did not appear to understand that their reality is socially constructed by the prevailing values, beliefs and attitudes which are transmitted by language. Consequently they are caught in a spiral pattern of helplessness and a sense of despair. It is very important for midwives to come to a deeper understanding of their thought processes as shaped by language and by communicative action. Such an understanding would serve to free the individual practitioner of outer and inner forces and compulsions simply by making the person aware of them; this process is hermeneutical in nature.

The researcher ends this thesis with an agenda for future research as well as posing some very profound questions for the midwifery profession. For instance the appropriateness of the current model of training and education for midwives in view of what students say regarding the significance of the learning that they experience on the ward. The most important question that the researcher wished midwives of all levels (ie practitioners, managers and educators) to debate on is; is the midwifery profession divided? If the answer is 'yes' what exactly will be the consequences?
## CONTENTS

Abstract  

Contents  

Acknowledgements  

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chapter 1</strong></td>
<td>Introduction to the Research</td>
<td>1</td>
</tr>
<tr>
<td><strong>Chapter 2</strong></td>
<td>Background to the Research</td>
<td>7</td>
</tr>
<tr>
<td><strong>Chapter 3</strong></td>
<td>Phase 1 of the Research</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Introduction to Phase 1 of Research</td>
<td>17</td>
</tr>
<tr>
<td>3.2</td>
<td>The Student Midwives' Story</td>
<td>23</td>
</tr>
<tr>
<td><strong>Chapter 4</strong></td>
<td>Phase 2 of the Research</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>The Setting</td>
<td>42</td>
</tr>
<tr>
<td>4.2</td>
<td>The Midwives' Story</td>
<td>45</td>
</tr>
<tr>
<td><strong>Chapter 5</strong></td>
<td>The Theoretical Perspectives</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Introduction to Theoretical Perspectives</td>
<td>59</td>
</tr>
<tr>
<td>5.2</td>
<td>The Theory of Reflection-in-Action</td>
<td>61</td>
</tr>
<tr>
<td>5.3</td>
<td>The Theory of Symbolic Interaction</td>
<td>78</td>
</tr>
<tr>
<td>5.4</td>
<td>The Theory of Communicative Action</td>
<td>107</td>
</tr>
<tr>
<td>5.5</td>
<td>Conclusion to Chapter 5</td>
<td>128</td>
</tr>
<tr>
<td><strong>Chapter 6</strong></td>
<td>A Divided Profession - A Final Analysis</td>
<td>134</td>
</tr>
<tr>
<td><strong>Chapter 7</strong></td>
<td>Implications</td>
<td>163</td>
</tr>
<tr>
<td><strong>Chapter 8</strong></td>
<td>Final Conclusions</td>
<td>180</td>
</tr>
</tbody>
</table>
## Appendices

<table>
<thead>
<tr>
<th></th>
<th>Methodology</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hunting of the Paradigm</td>
<td>187</td>
</tr>
<tr>
<td></td>
<td>Research Technique</td>
<td>194</td>
</tr>
<tr>
<td>1.3</td>
<td>Embarking on the Research Journey</td>
<td>208</td>
</tr>
<tr>
<td>1.4</td>
<td>Data Analysis</td>
<td>211</td>
</tr>
<tr>
<td>2</td>
<td>Audit Forms</td>
<td>215</td>
</tr>
<tr>
<td>3</td>
<td>Evaluation Forms</td>
<td>221</td>
</tr>
<tr>
<td>4</td>
<td>Letters of Consent</td>
<td>233</td>
</tr>
<tr>
<td>5</td>
<td>RCM Document on 'A Philosophy for Midwifery</td>
<td>237</td>
</tr>
<tr>
<td>6</td>
<td>Interview Schedule for Student Midwives - phase 1 of the study</td>
<td>240</td>
</tr>
<tr>
<td>7</td>
<td>Example of notes taken during observation of midwife's work</td>
<td>241</td>
</tr>
<tr>
<td>8</td>
<td>Example of an interview transcript</td>
<td>249</td>
</tr>
<tr>
<td>9</td>
<td>Glossary</td>
<td>251</td>
</tr>
<tr>
<td>10</td>
<td>References</td>
<td>255</td>
</tr>
<tr>
<td>11</td>
<td>Bibliography</td>
<td>267</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

With regards to this project, the researcher would like to thank all the midwives and students who kindly took part in the research.

Thanks are also extended to Mrs C Tickell (Midwifery Service Manager), Mrs C Tucker (Principal of Avon College of Health Studies), Mr B Wilson (Nursing Advisor) for their support.

The researcher is also greatly indebted to Ms A Powell for proof-reading and to Mrs L Burt for typing the thesis.

Last but not least the researcher would like to thank Professor P Jarvis of the Department of Educational Studies at the University of Surrey for his help and guidance through this thesis.
CHAPTER 1

INTRODUCTION

For many decades there have been problems associated with education of midwives in the ward situation. As a midwifery educationalist the researcher had experienced some of the problems first hand and eventually became so concerned that she felt that she should attempt to do something about the problem.

While one option was to remain within the ivory tower of the College, and continue to teach the principles of good client care and the notion of being a 'good' professional midwife; an alternative was to research into what happens to midwifery theory as midwives face the realities of the clinical environment. The researcher chose the latter option.

This thesis is concerned firstly with student midwives' views of the role of the midwifery practitioner based on their learning experience and secondly with the values, beliefs, and attitudes which underpin this role.

The aim of the study is two-fold:

1 To obtain a view of the midwifery practitioner in action based on learning experiences of student midwives.

2 To examine the set/s of midwifery values, beliefs and attitudes that exist in the College of Midwifery and in the clinical setting.
These beliefs, values and attitudes constitute what is known as the culture of the profession.

The research issue is to what extent the set of beliefs, values, and attitudes taught in the classroom are common to those taught in the clinical area. If the commonalities are small then this would be reflected in the action of the midwives, hence a gap between theory and practice would be evident. But if they are congruent, then there would be a strong relationship between theory and practice.

The first phase of the research evolved from informal 'chats' with student midwives regarding the relationship between theory and practice. This was reinforced by background reading of nursing literature on this topic (Bendall 1975, Alexander 1980, Fretwell 1980, Orton 1981, Melia 1982).

In the first phase of the research the main objective is to discuss its findings as well as to evaluate the methodology of documentary analysis. The limitations of documentary analysis as a research tool are acknowledged, eg it being merely descriptive as opposed to being explanatory. Hence informal follow-up interviews were conducted, focusing on key areas deduced from the documentary analysis such as:

- the midwife as an autonomous practitioner
- the climate of the maternity unit: interventionist versus non-interventionist.
- rituals and routines in midwifery practice
- the definition of professionalism

The main finding from the first phase of the research was that there appears to be a set of values, beliefs and attitudes promoted in the clinical area which differ from those taught in the College of Midwifery. Therefore it appears that there are two cultures emanating from the same profession, that is one
from the education sector and another from the practice or service sector. 'Survival strategies' employed by students to fit into the organisation/profession were explored especially in relation to Hunt's 'Ethnographic Study of the Labour Ward' (1987). It does appear that students generally try to 'fit in' and survive the system by 'getting on with the work.'

In the beginning of their training students start by carrying out tasks that they already are competent at, such as 'doing the obs' (taking the client's temperature, pulse and blood pressure).

It was postulated by Davies (1988) that the very act of carrying out tasks that are part of their daily nursing routine encouraged the students to 'slip back to the nursing socialised behaviour.' This included being subservient to the doctors instead of acting as co-professionals. The work of Olesen and Whittaker (1968) on 'studentmanship' was discussed to see the extent to which the concept fitted with student midwives' careers during their training. Again student midwives like Whittaker's students want to have an easy life and often keep a low profile by 'keeping busy' with jobs that they are familiar with from the nursing world, such as tidying up the linen cupboard. It is postulated that the inherent reversal back to their nursing role stop these students from 'moving forward in internalising the midwifery behaviour.'

To summarise, student midwives generally do not like being on the outside. They would check out what the midwives' beliefs, values are, and if these are compatible with those propounded by the tutors it's great, but if not, they would follow the set of values and beliefs that belong to the midwives as they attempt to fit in with the latter.

The second phase of the research evolved from the findings of the first phase. It was with this in mind that the researcher became interested in exploring the role of the midwifery practitioner.
It is assumed that the actions of a practitioner are underpinned by a set of values, beliefs and attitudes. These may or may not be compatible with those taught in the College of Midwifery.

In this part of the research it was decided to use participant observation and informal interview within a natural setting. As the midwife/client relationship is the basis of midwifery care and much essential information is embedded in professional action, the researcher used event analysis to review the dimensions of this relationship. It might be argued that as a midwife practitioner and educator it is difficult to stand aside and objectively consider the implications of what midwives do. Certainly in phase two of the research the researcher was obliged to recognise her values and biases, and devise ways of improving objectivity and 'reflexivity.' Searching for meaning in situations with which the researcher was familiar was difficult at first. For instance, the researcher constantly focussed on those aspects of care that failed to reach her own standards, perhaps because as an educationalist the researcher holds ideals about midwifery care. However, gradually the researcher came to understand the notion of 'reflexivity' which accepts that the location and the social actors all form part of the social world being studied (Hunt 1987). Moreover, Beyer (1966:32) believes that "the fascination of sociology lies in the fact that its perspective makes us see in a new light the very world in which we have lived all our lives." Hence it is hoped that by using a sociological interpretative framework and naturalistic research methodology the impossible research task is made possible.

In the second phase of the study the researcher employed various established theories to interpret the data. The three theories adopted were:

1 Argyris and Schon's work on Theory in Practice
2 The Theory of Symbolic Interaction
3 The Theory of Communicative Action
The researcher has chosen these three theories with the intent not to use them in isolation from one another but rather as a framework to help to analyse the action of midwives and their cultural world. In fact the rationale behind using the three chosen theories was that they appear to have helped the researcher to understand central issues emerging from the data such as why there are different types of midwives whose action (known as theory-in-use) may be dissimilar to what they say they believe (known as espoused theory); how the different typology of midwives construct the reality of their professional world, and lastly what factors contribute to these different perceptions (for example the role language and gesture play). The researcher felt that having read through the work on the Reflective Practitioner, the Symbolic Interactionists and the Communicative Action, these theories lend themselves to explain to a great extent these issues.

Any research must somehow acknowledge and take into account previous work pertaining to the researcher's subject. Traditionally this is done by a review of literature pertinent to the research question. In this thesis the researcher has chosen to ignore this tradition and opted for the approach of integrating the literature review with the text so that reference will be made to other work pertinent to the discussion throughout the two phases of the research. In so doing, the aim of the researcher is to select relevant research and discuss its applicability to the concepts and theoretical formulations that are emerging from the data. This approach would seem most appropriate to a thesis that is to some extent examining a gap between theory and practice and is justifiable, as abstract theoretical formulations are transformed into meaningful empirical referents. To have a separate chapter on literature would in essence, be interrupting the integration of theory and practice in relation to this research project.
It was decided at the initial stage of report writing to refer in the text to those persons in labour as clients. The term 'patient' is not acceptable to most midwives (including the author) as it promotes the medical model of childbirth with a sickness orientation.

It was also felt that detailed explanations of jargon would prove to be clumsy and would interrupt the 'story', hence a glossary of terms is included in appendix 9.

In order to protect the anonymity of the maternity unit and the willing participants, all names and titles have been altered or omitted.
CHAPTER 2

BACKGROUND TO THE RESEARCH

The Struggle for Autonomy:

The history of midwifery in Britain is, in many ways, one of a profession struggling to develop and maintain its autonomy and to safeguard the contribution which midwives make to the care of childbearing women. Although midwifery is a very ancient profession, the present medicalisation of pregnancy and hospitalisation for delivery has left the midwife not only very uncertain of her/his role but also uncertain as to whether the profession will continue to exist. According to Walker (1976:4), "as the cultural patterning of childbirth becomes increasingly scientific the role of the midwife changes, and may disappear completely."

The history of midwifery is fascinating as one reads about midwives, such as Sairey Gamp. The image of midwifery was contaminated by Sairey Gamp who was portrayed by Dickens as a garrulous, tippling, waddling 'mother midnight' who was 'of the earthy, unwashed humanity flavoured with gin' (cited in Donnison 1977). However, those who point a finger at Sairey's ineptitude would do well to remember that she had to deal unaided with all manner of obstetric and neonatal complications. She had to face accusations of incompetence and cruelty but often her learning experience came through trial and error as she had no formal instruction.
There were some competent and intelligent midwives like Sarah Stone who made a positive contribution to midwifery in Britain by attempting to promote some form of education. The profession has evolved and midwives have changed: from being self-appointed monopolists to being state licensed practitioners of normal midwifery who are qualified to give the necessary care and advice to women during pregnancy, labour and the postnatal period as well as conduct normal deliveries on their own responsibility. Indeed, according to the Code of Practice (1991:2) the midwife should be able to carry out the following duties subsequent to her midwifery education programme and training:

"S/he must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help."

Midwifery attained legal recognition as a profession with the passing of the first Midwives' Act in 1902, which made provision for the training and registration of midwives. Under the provisions of the Act, women were entitled to register with the Central Midwives' Board (CMB) until March 1905 if they possessed a certificate approved by the board, or if they possessed evidence of some kind that they had been in practice for at least a year and were considered to be of 'good character'. Hence after 1905, the title of 'midwife' could only be used by midwives registered with the CMB. The proportion of midwives registered with the board increased steadily from 30% in 1905 to 74% by 1915 (CMB 1916).

In the early years following the 1902 Midwives' Act, the majority of midwives continued to work as independent practitioners,
earning their keep from fees paid to them by women that they had attended. Some were employed by nursing organisations which also provided a midwifery service, usually in sparsely populated rural areas. There were also a group that worked in voluntary maternity homes, teaching hospitals, poor-law infirmaries and local authority maternity homes. Provision of a salaried service was brought about with the passing of the 1936 Midwives' Act; the service was to be under the control of local supervising authorities.

The years between the Midwives' Act of 1936 and the introduction of the National Health Service in 1948 have been described as the heyday of the community midwife and the small maternity home (Barnett 1979). This period saw a continued increase in the proportion of women delivered in an institution, a trend given further impetus by the war, with expectant women transferred to nearby hospitals to be delivered (Bent 1982). By 1946, the hospital delivery rate had reached 54% and correspondingly the proportion of midwives in hospital rose, reaching 31% by 1944 (Robinson et al 1985). However, by 1947 a working party set up by the Ministry to enquire into the shortage of midwives had sounded a warning note on an issue which was increasingly to dominate the profession, that is the erosion of the midwife's role by general practitioners and obstetricians.

By the 1920s the obstetricians had greatly extended their role in looking after, not only women with complications in childbirth, but women whose pregnancies were normal. They were represented in some strength on the Ministry of Health committees investigating maternal mortality. A statement issued in 1944 by the Royal College of Obstetricians and Gynaecologists stated:

"Midwives should not be regarded as competent to undertake unaided the antenatal care of the pregnant mother, but should always work in collaboration with a general practitioner or an obstetrician" (RCOG 1944:2).
Changes occurred mainly in the provision of antenatal care. The proportion of antenatal care given by doctors rose, hence community midwives had to provide some of the antenatal care in doctors' surgeries rather than visiting the woman at home. Moreover most women went to their general practitioner to confirm their pregnancy and so the midwife was no longer the women's first point of contact (Bent 1982). Hospital midwives worked alongside the obstetrician and were only able to exercise a degree of clinical independence in some cases.

In the 1960s and 1970s, a number of interrelated changes in the organisation of maternity care led to the fragmentation of care and to reduced opportunities for midwives to provide continuity of care. The Cranbrook Committee, set up to investigate the maternity services, recommended that provision should be made for 70% of births to take place in hospital (Ministry of Health 1959). Eleven years later the hospital birth rate was at 80%. The Peel Committee (Department of Health & Social Security 1970) then recommended increasing hospital births to 100%, and that all women should be seen by the obstetrician once or twice during pregnancy. Changes in policies for the maternity services led to a loss of opportunity for midwives to provide continuity of care, at the same time curtailing their freedom to use their clinical skill and expertise in caring for the well pregnant woman.

Midwives became increasingly concerned about the erosion of their role by the medicalisation of childbirth, Brain (1979:6); Garcia et al (1990), expressed concern that "midwives in some clinics are only used as receptionists or chaperones and to test urine and weigh women." A large number of midwives worked in delivery suites in which certain decisions that are basic to the management of labour were made by the obstetrician. A survey by Robinson et al (1985) showed the decreased role and responsibilities of the midwife. The fragmentation of care and shortage of staff also prevented midwives from making their full contribution to the care of childbearing women (Robinson et al 1985).
According to Kitzinger (1981:40) "the midwife... is subservient, has lost professional status, job satisfaction and dignity." In a study by Jean Walker (1976:3) "the doctors, all obstetricians thought of midwives as nurses who assist obstetricians but have a little more decision-making delegated to them by doctors than other nurses." This medical take-over also affected the training of student midwives as it limited opportunities for them to witness the 'true role' of the midwife. An official report on the maternity services published in the early 1990s based partly on visits to 13 district health authorities, found evidence to support the findings of the Robinson et al study. The National Audit Survey (National Audit Office 1990:12) found 'doubts in all these health authorities about whether midwives were being used to their full potential.'

The Turning Point:

The end of the 1970s signalled the turning point for the midwifery profession. From the 1980s there was a move to restore the independence of midwives and innovative schemes were set up to increase continuity of care (Flint 1982, Morrin 1982, Stuart and Judge 1984). The profession's concern was not just focussed on effective use of midwives' skills but also on the extent to which midwifery educational programmes could contribute to the revitalisation of the midwifery profession. Midwifery educationalists saw their primary role as being 'guardian angels' of the profession and that they had a mission to fulfil; to pass on a set of values, beliefs, attitudes and a knowledge base which would restore the 'true role' of the midwife. Consequently, the midwifery curriculum has been designed to deliver a practitioner who at the end of training is competent to be 'a practitioner in her own right', with considerable decision-making autonomy in the area of midwifery practice. Educationalists propound the need to have critical thinking,
reflective practitioners who will research and innovate in their own field in order to re-establish the profession of midwifery.

The educationalists may well be able to achieve the above aim if students are only exposed to the formal teaching in a classroom environment. However, the educationalists have to face the reality that "midwifery is an art and is, in the main, learnt from the role model of the practising midwife" (Hallworth 1983:1). Hence education does not only occur formally but informal education also occurs through the transmission of the culture by practitioners of midwifery. Culture is defined in this context as the assumptions underpinning the beliefs, values and expectations which give character to the midwifery world as experienced by the members ie the students and midwives. Therefore, students learn practical knowledge and skill, consciously and unconsciously as they observe the midwifery practitioner in action and undertake certain procedures for themselves. This unstated teaching of norms, values, and attitudes to students through exposure to the clinical environment is defined as a 'hidden curriculum'. The 'hidden curriculum' can help to make the formal or college curriculum relevant or a gross hypocrisy (DeSchepper 1987).

For example if students find that midwives are indeed practitioners in their own right in the clinical area the 'hidden curriculum' is consistent with the formal curriculum and the student will embrace that particular value and belief in her/his own practice (DeSchepper 1987). In order that the 'hidden curriculum' should support the formal curriculum the values, beliefs and attitudes taught in both the College and clinical setting must be compatible.

The research issue is 'to what extent are the set of values, beliefs and attitudes taught in the College common to those taught in the clinical environment?'. If the commonalities between the two sets of values, beliefs, and attitudes are small then
these differences are likely to be reflected in the actions of the practitioner. Consequently there will be a gap between theory and practice. If the commonalities are great then the gap between theory and practice should be small.

A fundamental belief and value propounded by midwifery educationalists is that the midwife's role is unique in as much as s/he is a practitioner in her/his own right. However a survey carried out by Robinson et al (1983) revealed a number of problems encountered by midwives in the fulfilment of their role. Data on the role and responsibilities of the midwife was collected through a national survey of midwives, and the three groups of health professionals with whom they are most likely to work: health visitors, general practitioners and medical staff in obstetrics. The research was commissioned and funded by the Department of Health and Social Security, and the data was obtained by means of questionnaires sent to staff in 60 health districts, randomly selected from health authorities in England and Wales.

One of the findings was that midwives were not utilising their skills fully when giving antenatal care to women. Nearly two-thirds of the midwives worked in clinics where the general practitioner carried out the examination of the pregnant women. The midwife is qualified to make this assessment on her own responsibility, but if the general practitioner assumes this instead, then the main clinical role of the midwife is to assist the doctor by taking the blood pressure or testing the urine, (both tasks that could be carried out by an enrolled nurse). Midwives are also qualified to assess and manage normal labours, but again in the survey it was found that these functions were taken over by the doctors. The result is that although midwives are highly trained, at considerable cost to undertake the care of normal childbearing women, once qualified that part of their training concerned with decision-making in pregnancy is often wasted (Robinson et al 1983). In the same study Robinson et al
(1983) found that only 24% of newly qualified midwives were actually practising midwifery. This is a major concern to educationalists who strive to re-establish the profession of midwifery.

For the past six years, the researcher has been teaching midwifery both in the classroom and clinical settings, hence was in a position to receive first hand information from student midwives about their learning experiences on the wards. These informal 'chats' revealed that there is a gap between theory and practice. For instance students have reported that while the 'College' taught about the practice of individualised care, they found that this was far from the truth on the wards. A student midwife actually reported that a midwife said "I know the tutor teaches you that in the College but here we have our own way of doing things." The above statement implied that there is a difference in beliefs and values between midwifery educationalists and practitioners. On another occasion, the researcher was informed by a student that she wished to support a client's wish to remain as mobile as possible in labour. However, the supervising midwife imposed a sanction on this wish as a result of the consultant obstetrician's blanket policy of continuous cardiotocograph tracing which necessitates bed rest. Consequently the student sidestepped the obstacle by not granting the wish of the client. This resulted in the student internalising a different set of attitudes.

It can be inferred from these accounts of student midwives' learning experiences that there appears to be a gap between theory and practice. This is supported by research carried out in the nursing discipline (Bendall 1975; Alexander 1980; Fretwell 1980; Orton 1981; Melia 1982; Ogier 1982). These studies document the daily occurrences of deviation from the procedures taught in the College; and such discrepancies between college and ward practices have been a perennial source of difficulty for nurse learners.
While these nursing studies comment on the gap between theory and practice as far as deviation from 'procedures' and 'techniques' is concerned, they fail to examine the underlying beliefs, values and attitudes which underpin these actions. The present research seeks to address the commonalities of the two sets of beliefs, values and attitudes; those taught by the midwifery educationalists and those taught by the midwifery practitioners. Unless these commonalities are great the midwifery educationalists will be propounding beliefs, values and attitudes that are vastly different from those of the midwifery practitioners. Since a substantial amount of the student midwife's time is spent with her mentor who is a midwife practitioner, any conflicts of beliefs, values and attitudes will inevitably influence the learner. Moreover the values of the formal curriculum are called into question if what midwifery educationalists propound are not what midwifery practitioners believe in or practise.

Summary:

This chapter begins by providing an insight into the historical struggle for autonomy by the midwifery profession. A brief account is given of the 'turning point' whereby some members of the midwifery profession attempted to restore their independence by the setting up of innovative schemes to enhance the midwives' autonomy and accountability to their clients.

The profession's concern extends not only to the effective use of midwives' skill but also to the extent to which midwifery education could contribute to the re-enactment of the autonomy of the profession. Some midwifery educationalists saw their role as that of 'guardian angel' of the profession and their main mission is to pass on a set of values, beliefs and attitudes which will restore the 'true role' of the midwife. However, as midwifery education and training occurs not only in the classroom but also
in the clinical area, the learning experiences in both settings need to be explored. The learning experience that student midwives are exposed to in the clinical setting is usually unstated and ill-defined and exposure to such cultural norms, values and attitudes is defined as the 'hidden curriculum.' This form of curriculum may or may not be compatible with the more explicit 'official curriculum'. A literature review from the midwifery and nursing sources does suggest that there is a discrepancy between theory about care and practices as espoused by the educationalists in the form of theory and practice which is what students acquire as their theory-in-use in the clinical ward area.
CHAPTER 3

PHASE 1 OF THE RESEARCH

3.1 Introduction:

The aim of this chapter is two-fold: firstly to discuss the methodology of documentary analysis and secondly to present the findings of phase one of the research. Documentary analysis consists mainly of the examination of evaluation forms completed by four sets of student midwives who undertook their training between 1989 and 1991. In addition the audit forms used annually to monitor the clinical learning environment between 1990 and 1991 were also analysed.

Educators and mentors have a duty to consider critically all aspects of the curriculum that contribute to student midwives' learning. In this way both strengths and weaknesses can be highlighted and action taken to enhance those experiences which have proved successful and to remedy those which have been deficient. This responsibility rests with all those who contribute to midwifery education programmes. Hence, as a midwifery educator the researcher was involved in evaluation of both the midwifery programmes and the ward learning environment.

Defining Evaluation:

The English National Board (cited in Moore 1989:106) defines evaluation as "the collection and use of information in order to make decisions about an educational programme." Evaluation is
the process by which educational experiences, and the course overall, are judged to be of value and its purpose is to provide information that can be utilised to effect development and improvement of the educational experience. The key characteristics of evaluation are that it should be "planned, systematic, focused and utilised" (Moore 1989:107).

In the College where the researcher works, a formative and summative evaluation is used to enhance the meaning and utility of evaluation. Inevitably there are elements of learning experiences, not least achievement of objectives, which cannot be evaluated until the end of the course, dictating a summative or terminal approach. Evaluating learning experiences as they occur enables instantaneous minor modifications to be made to the structure and process of the course which will benefit the current students.

What should be evaluated?

Evaluation can and should take place at different levels of specificity (Moore 1989). At the macroanalytic level, evaluation is concerned with the analysis of the value of the curriculum overall. At the microanalytic level, individual teachers or mentors might be concerned with evaluating the success of a single teaching session or a period of learning experience in a clinical setting.

In the College of Midwifery three methods of evaluation are used: self evaluation, peer evaluation, and evaluation by students. Student evaluation of teaching and learning experiences is the formalised method of evaluation employed by the institution and a form is used for this purpose (appendix 3).

The significance of the clinical environment in midwifery education cannot be underestimated (Ho 1989). It provides the
most substantial part of midwifery programmes and serves to create many of the important opportunities for learning. Historically, because of the apprentice-style model of midwifery training, there exists an assumption that placement in clinical areas will lead to learning by a process akin to osmosis. That is by placing students in a clinical setting with skilled practitioners, skills would flow down a gradient from qualified practitioner to student until an equality in competence was achieved. This notion needs to be challenged. Nurse researchers (Alexander 1980; Fretwell 1980; Orton 1981; Ogier 1982) have investigated the factors that influence learning during clinical allocations and these factors need to be considered critically when the midwifery educator evaluates the ward learning environment.

The College of Midwifery has developed an audit tool (appendix 2) for evaluating the clinical areas used for midwifery training. The main factors considered are as follows:

1. The experience available (number and types of clients, deliveries).

2. The quality and quantity of supervision available (number of midwives in whole time equivalents, years of experience of midwives, number of midwives who have undertaken further professional courses).

3. The organisation of midwifery care (the use of individualised care plans, team approaches, the concept of 'partners in care' with the clients).

4. The existence of a complementary midwife-obstetrician relationship.

5. The learning climate (identification and utilization of
The evaluation of midwifery programmes occurs at the end of every term and the evaluation of the clinical area annually. The evaluation and audit forms are kept as permanent records in the Department of Midwifery Education. As a result, this documentation formed a rich source of information when the researcher decided to investigate more fully the views of student midwives', based on their learning experiences, of the role of the midwifery practitioner. The analysis of this documentation forms the first phase of the research which evolved from informal 'chats' with student midwives regarding the relationship between theory and practice.

Angell (1945) argued that documents can be used in a variety of ways: to secure conceptual hunches, to suggest new hypotheses, to obtain a historical understanding of a person, group, or institution, and to provide an exposition. As the evaluation questionnaires and audit forms were not devised initially for the purpose of research these form secondary sources.

While it cannot be denied that these documents have provided an invaluable understanding of the students' perception of the midwifery practitioner's role, nevertheless they have specific flaws as a research tool. Samuel (1975) maintains that documentary evidence needs to embrace personal experience and oral testimony, if one is to interpret the past successfully. Other questions that should also be raised concern the reliability, accuracy, representativeness and validity of these written accounts. The researcher needs to consider: is the material trustworthy? Is the material atypical? Has the material been edited and refined? The documents used for analysis in this preliminary phase of the research were collected for the purpose of evaluation and therefore only addressed specific issues and certain areas of midwifery practice. The
information is descriptive, it does not seek to explain, for instance, why midwives in some areas were found to base their care on routines and rituals.

Because of the limitations of documentary analysis as a research tool the researcher decided to conduct a series of unstructured interviews with post registered student midwives at various stages of their training. The interview schedule addressed issues derived from examination of the evaluation forms and audit report. The main issues deduced from documentary analysis which were followed up in interviews were:

- The midwife as an autonomous practitioner
- The climate of the maternity unit: interventionist versus non-interventionist
- Rituals and routines in midwifery practice
- The definition of professionalism

The purpose of this exercise was to refute or confirm the findings of the documentary analysis and to find out from students what they perceived is the rationale behind the actions of the midwifery practitioner. For instance in the audit reports and evaluation forms, there was consistent criticism of care fragmented and routinised. The researcher was given the view that the ward learning environment is not conducive in promoting the 'true role' of the midwife or being a 'practitioner in her own right.' This is because there are rules, regulations and policies which constrain the midwife's ability to make autonomous decisions. It also appeared that student midwives think that most of their mentors would prefer to have an easy life and conform than to fight the current system. If the above is true then the consequence would be damaging as students would be exposed to learning experiences which would not enhance their confidence to take up the 'true role' of the midwife as prescribed by statutory regulations. Therefore the central research issue of whether the 'hidden curriculum' supports the
'official curriculum' in terms of the two sets of values, beliefs and attitudes being similar in both the College and clinical setting is explored extensively during these interviews.

The sample of 10 students was drawn from another training institution. The researcher was concerned that drawing a sample from her own training institution might prove to be invalid as the student midwives would know the researcher as the Head of the Midwifery College. Instead, to increase the validity of this phase of the research, the researcher arranged to go into another training institution as someone who was interested in investigating certain aspects of midwifery training. The researcher did not reveal that she was also a midwife teacher. Permission was sought from the Director of Midwifery Education of a midwifery college to interview 10 student midwives. The student midwives were at different stages of training: four were completing training, three were half way through their course and three had just started. A semi-interview schedule was used (appendix 6). The questions in this interview schedule focussed on themes that the researcher elicited from the analysis of the audit report and evaluation forms. Some of these themes are: the students' perception of midwifery practice; the degree to which theory relates to practice; and the students' opinions of the future of the profession. The interviews were tape-recorded and transcribed for analysis.
3:2 The Student Midwives' Story:
Main Findings of Phase One of the Research

The Midwife as an Autonomous Practitioner

One of the themes to emerge during the informal interviews, in response to a question on why the students had chosen to enter midwifery training, was their notion of the midwife as a 'practitioner in her own right.' The question of the part which the midwife should play in the maternity services, and the education she requires in order to make her contribution, have both been the subject of enquiry by the profession at large (Robinson et al 1981). When asked, student midwives generally felt that the majority of midwives currently working in consultant units are uncertain about their role in the provision of maternity care; this view was expressed by many of those who participated in the evaluation of clinical practice (ie from the documentary analysis) and those who were interviewed. As well as referring to the way in which they felt the midwife's role had been eroded, the student midwives said that they felt disillusioned because of the lack of opportunity to utilise all the unique skills and knowledge which a midwife possesses as a result of her education and training.

For instance, students were highly critical of the care given by midwives to women in the antenatal period. They felt that while some midwives were able to give total antenatal care (especially in midwives' clinics) in most instances midwives were giving fragmented care. As one student remarked: "at best she is giving a few bits of advice about feeding or pain-relief, and at worst she chaperones the doctor." The study by Robinson et al (1981) documents varied responsibilities of midwives delivering antenatal care in hospitals. The study shows that midwives indeed
under-utilised their skills by assisting the doctors in carrying out tasks such as testing urine, taking blood pressure and weighing the client. A large proportion of midwives in this study (Robinson et al 1981) said that while they did conduct abdominal examinations and examinations for oedema, these examinations were repeated by the doctor (60.7% and 64.4% respectively). Robinson et al (1981:23) state in the report:

"...it is interesting that the hospital antenatal clinic is probably the part of the maternity service which is most criticised by the consumers, the main complaints being of impersonal fragmented care, overcrowded clinics and long waiting periods, yet it seems from our data that in some clinics time is wasted in repetition of work, and the skills of the midwife are spent in acting as little more than a chaperone for the medical staff."

This study was conducted in 1979 to analyse the role and responsibilities of the midwife and the findings from the students' evaluations and interviews in this current study suggest that the picture is unchanged.

Students also felt that while the major part of the curriculum is concerned with preparing the midwife to take responsibility for normal childbearing, many students trained for a large proportion of time in consultant units where the philosophy that childbearing is only normal in retrospect.

The Climate of the Unit: Interventionist Versus Non-interventionist: Students reported that there is considerable variation in the extent to which the midwife uses those skills which she is expected to acquire during training. The level of decision making and the amount of responsibility taken by the midwife
depend on a number of factors, which may include the perceived lack of support from midwifery managers, strong influence of medical interventionist policies and the number of consultant obstetricians; it was generally felt that the more obstetricians there are, the more power they accumulate. Certainly the research carried out by Golden et al (1981) confirms that where a unit has strict obstetric policies regarding the management of all pregnancies and labours, the midwives are given less opportunity to make decisions.

In this study it is reported that the amount of active intervention in a normal labour is dependent on the midwife in charge. Students reported that "some midwives will stand up to the doctors and use their own clinical judgement while others will call for medical aid without a moments hesitation." When one student questioned a sister about the overuse of intervention in normal labour, the sister expressed disillusionment and helplessness as she felt 'trapped by the system' which was very much imposed by her manager who was afraid of the consultant obstetricians. Some students reported that they felt that some of their mentors did strive hard to maintain their autonomy and to teach them the normal and 'true' midwifery role but the "hierarchical system does not allow it." Some midwives are frightened to make decisions because of the perpetual threat of disciplinary action by their managers. Hence while midwives are theoretically autonomous and accountable for their own decisions they nevertheless have to work within a rigid hierarchy in which they must defer to those above them or risk censure. Therefore, despite the cherished legal and professional definitions of the midwife as an autonomous practitioner, within such a power structure her actual position can be easily reduced to that of a 'handmaiden' to the obstetrician.

Student midwives reported a 'sense of disillusionment' at having received an intensive training to be autonomous practitioners when in reality they may never be able to utilise these skills
fully. Three student midwives interviewed expressed anger and frustration at having to conform to blanket policies such as active management of labour and performing routine electrocardiography in the clinical area. They felt that what the tutors taught them bore so little relation to what they witnessed in practice that they felt unable to reconcile the two. On the other hand they did appreciate that what was taught to them by the tutors was the kind of care midwives should be delivering. This often led to a deeper sense of disappointment as the students wondered if they would ever 'get there.'

The student midwives who expressed a deep love of midwifery appeared to find it harder to cope with this gap between theory and practice. Throughout the interviews they appeared to seek reasons as to why midwives that they had worked with would not 'fight the system.' These students were also trying to find strategies to evade the pressure to conform. One student reported that she kept a low profile when working with one of those midwives who rang the doctor everytime there appeared to be a problem. On the other hand she did discuss current research findings and consumer demands with her mentor when the latter was a midwife who was not afraid to stand up to the doctors and managers and practised true midwifery.

Dingwall (1977) asserts that midwives are encouraged in training and by official theories of their occupation to define themselves as 'professionals' and hence, on a par with doctors. This appeared to cause considerable confusion for students in this study; it had been drummed into them that midwives are practitioners in their own right but they have to deal with what they perceived to be the contrary in practice. One such official voice is that of the Royal College of Midwives, who in their statement on antenatal care point out that a midwife should be able to refer a client for whom she has professional responsibility to other professionals (RCM 1988). The researcher would point out that the permissive 'should' implies that at
present the midwife may not find it possible to behave as a 'professional'; therein lies the problematic nature of midwifery's claim to a 'profession' and 'autonomy'.

Rituals and Routines in Midwifery Practice:

All ten students interviewed commented on the gap they perceived between theory and practice. One frequent remark articulated was: "What is the use of learning research-based practice when on the wards all you see is routine, ritualistic care being given?" This type of ritualistic care is well described in Hunt's study (1987) 'An Ethnography of a Hospital Labour Ward'. Another student felt demoralised because her mentor "gave care without seemingly any thought processes being involved." This type of care was delivered by midwives in the antenatal, intranatal and postnatal period. When asked, the students failed to provide an explanation or any insights into why this could be happening. However, Henderson (1984) suggests that midwives deceive themselves to some extent as to the reasons for their actions. She states: "They were not aware of why they did things and imagined they had more autonomy then they did, so whilst thinking they were using their own judgement, in practice they unwittingly followed a routine" (Henderson 1984:145). This assertion by Henderson appears to be supported by some of the students' remarks: "The midwife cannot see what is wrong with the way she gives care", "My mentor thinks that her way is the best way because her years of experience have given her a safe routine" and lastly "I think my midwife thinks that she is practising as an autonomous practitioner when all the time she is doing things routinely to make the doctor happy."

Davies (1988) also identifies how in nursing, routinised care protects the nurse from dealing on the one hand with the emotional strain of continuously working through new interactions with the patient, and on the other from the strain of having to
negotiate from a position of weakness with the medical staff. This situation appears to be the case in midwifery as student midwives felt that one of the skills which they had to learn was being able to "get to know new clients/patients" almost every day of their working life. This was described by most of the students interviewed as a 'strain' and 'stressful'. Another skill was that of interaction with medical staff. As one student commented: "... it's difficult to know where the normality of birth ends and when abnormality arises so the process of referral is not clear-cut." Another student asserted "... we will never get away from the inferior position of working under the doctor as we are always thought of as nurses by them (meaning the doctors), in fact most of them call us 'nurses', which I think is very insulting."

Another student comment was:

"I don't see any change in what I do since I started 6 months ago. I'm doing exactly the same tasks as when I was a staff nurse. I do 'obs', talk to patients, do doctors' rounds, then carry out their instructions etc, so what is different? I asked the tutor this but even she could not answer my question."

Another perceived gap in the theory/practice relationship is that of the client as an individual versus institutionalised care. While the educators propound the value of individualised care and this is supported by some midwives, students reported that within hospital wards with fragmented care structures and low staffing levels this task was difficult to achieve. The optimistic view given by some students was that some midwives did try to give individualised care (knowing that childbirth is an unpredictable, individual and unique event) in spite of having to work within a framework of hospital policies which aimed to standardise and thus control that event.
On the other hand students felt that some midwives did not believe in planning care with their clients or encourage the use of birthplans because these midwives liked to be 'in charge all the time.' The view was expressed that these midwives failed to "appreciate the notion of partners in care because they basically believed that, being a professional, they have an automatic right to do things to women." Students felt that these midwives often "behaved as if they know it all" and were arrogant in their attitude to anyone that they perceived as being subservient to them ie student midwives and clients. Firth (1981) comments on the strains of being 'a captive' within the hospital setting. From the interviews transcripts came statements that suggest that women and their partners were often treated as if they were prisoners. One student quoted a midwife as saying to a husband "When you want to go to spend a penny, you need to ask me to show you out, you are not permitted to wander around the labour ward."

In Hunt's Ethnographic Study of a Labour Ward (1987:23) she describes the way that women are subjected "to a routine procedure which begins with the removal of their clothes and ends with them being rendered powerless and attached to a fetal monitor."

Hence the value of 'partners in care' and active participation by the clients as propounded by the tutors were felt to be concepts poorly understood by midwife practitioners. In fact the student midwives interviewed felt that most midwives did wish to feel superior and were often 'bossy to women and their partners.' These midwives were more concerned with 'getting through their work' at their own pace rather than to meeting the needs of the clients. For instance one student midwife reported that her last mentor "never let a mother breastfeed her newborn baby straight after delivery because she (the midwife) wants to send the mother and baby to the postnatal ward and this means her case is completed and she can have a cup of tea." Roth (1978) explains how uncertainties often result in ritualised procedures that
depend more on convenience and ease of administration, than on rationally deduced probabilities.

One student expressed anger at the attitude of these midwives because in her opinion "they are often inflexible, dogmatic and out of date with current ideas and practices." The need to keep up-to-date and to read research was expressed by eight student midwives as being a significant hallmark of professionalism.

The Definition of Professionalism

It was interesting to note both from the documentary analysis and the interviews transcripts, the frequent mention of the term 'being professional' by student midwives. From the documentary analysis of audit reports the students often criticised midwives as being unprofessional in the way they gave care, for instance in labelling articulate women as 'the NCT type' or 'the trouble makers.' They felt that this form of labelling was the midwives' way of tackling the clients who 'know enough to ask for information' i.e. a way of 'putting these women in their place.' This they felt was unprofessional because to be professional the midwives should have treated these women like any other clients and met their need for information as well as their other needs. The student midwives that were interviewed also commented on this aspect of care. They felt that report-giving was the most common time when midwives labelled women. One student quoted a midwife as saying "Well, you are welcome to that one, she wants to conduct her own delivery but when the time comes she will probably scream the place down." In Hunt's study (1987) she reports that at handover or report-giving women were often labelled as para 1, multigravida etc which suggests that midwives were treating these clients not as persons but as cases. She further reports that there was often some kind of story-telling by the midwife handing over. A student midwife interviewed from the current study commented: "I can never understand how a
midwife who is supposed to be so caring can be so unkind towards her client." Here the student was actually criticising the midwife who refused to believe that the woman she was caring for was in a lot of pain and required some pain relief. The student further commented that this midwife appeared to lack the knowledge base to practise and hence in her eyes the midwife was not considered to be 'a professional.'

Another interpretation of the term 'professional' is to keep up-to-date with current issues and research. One student commented "I find it difficult to believe my mentor midwife not knowing anything about the White Paper. How can professionals like her control their own future: no wonder the profession is dying." When probed further this student in fact did not believe that the midwifery profession is dying because she felt that there are midwives out there who are 'real professionals', ie those who care deeply about midwifery, who practise midwifery by making decisions and who base their care on up-to-date knowledge.

One student felt that to be a professional "is to be able to hold one's own head up", ie to be able to conduct a discussion with a doctor about a case and follow through the argument. She felt that many midwives are unable to follow an argument through because of lack of knowledge. In her view midwifery is not yet a profession because it lacks academic rigour (this student has a science degree).

The 'Game of Survival'

In order to cope with the conflict between what is taught in 'school' and what actually occurs in the clinical environment, student midwives developed 'survival strategies.' One way appeared to be that student midwives actively constructed and reconstructed their world based upon their interpretations and meanings they attributed to their environment. In the course of
the research the researcher had to adopt a position that permitted analysis of the students' existential encounters in which the students appeared to define, choose and act on their choices. This particular position allowed the researcher to note that once students had defined, chosen, and acted on their choices, the action not only had implications for behaviour with respect to others and to themselves, but also had consequences that became part of the experience and a basis for further choice. In short, one is concerned with the 'human condition' of the student, a variable arguably neglected in some studies (Olsen and Whittaker 1968).

It appeared that as the student midwives interviewed were registered nurses undertaking a post-registration midwifery course they had to undergo a fairly rapid metamorphosis in order to demonstrate that they were 'absorbing' and internalising the values and beliefs propounded by the educational sector, i.e. that the work of a midwife is essentially health oriented and hence the role of the midwife is one of autonomy whereas nurses have to work under a doctor. The following statements illustrate this occurrence:

"Right from the start we were bombarded by beliefs like 'midwifery is different from nursing', it's really brain-washing."

"I feel as if I am being forced to change, and to change rapidly, the pressure is constant, even on the wards there are some midwives who say they are different from nurses."

"The first few weeks I was really irritated by my community midwife, she kept telling me to look at things from a midwife's view because pregnancy is not an illness, so every time I slipped and called a mother 'patient' I got told off."
To a large degree student midwives had to learn what Davies (1988) described as 'the articles of faith' from their tutors. These 'articles of faith' are the values and beliefs that are fundamental to the midwifery profession, one of which is that midwives are 'practitioners in their own right.' For instance students are constantly exposed to the rhetoric of the professional status and autonomy of the midwife are equal to that of the obstetrician. The belief that a midwife could and should make decisions independently of medical staff is usually canvassed by one 'segment' of the profession known as 'the school' or 'the tutors'. Midwifery tutors' beliefs and values distinguish them from the 'workers' (meaning the midwives who give direct care to the clients) or 'service side' in ways similar to those which Bucher et al describes in the classic literature on 'segmentation' within professions (1966). However the educational values and beliefs are seen as rhetorical as students asserted that their clinical experience only served to exemplify the myth of the 'autonomous' midwife.

Davies (1988) addresses the perceptions of student midwives during their initial encounters in a school of midwifery and provides insights into the folk culture which is unfolded during the first 18 weeks of a status passage from nurse to midwife. She supports the view that the midwife's claim to independent practitioner status is mythical and rhetorical. Davies (1988) further argues that the competition between doctor and midwife for role and status highlights the existence of this myth. Another of Davies' observations is that the service side directs students to a more 'work load approach' which involves the need to perform tasks and routines in order to get the work finished as quickly as possible while the educational side canvasses a more client-orientated approach based on a model of meeting clients' needs.
Davies (1988) gives the following reasons for concern about the status passage of student midwives from being nurses to being midwives. First, there is the notion that the students' initial experience fits them for continuation of nurses' work rather than midwives' work as they carry out ritualistic activities with which they are familiar for example 'doing the obs' a routine that can be seen enacted in any hospital ward by nurses and midwives alike. While many of these observations of physical phenomena are of questionable benefit in the surveillance of uncomplicated childbearing women and hence should not be a routine task applied to all clients/mothers they are nevertheless a common occurrence. This could be seen as a remnant of the nursing culture as 'doing the obs' is very much the domain of nurses' work. Second, there is the uneasy compromise between the training on the wards, (which is evidently often a matter of unsupervised, 'trial-and-error'), student/patient interaction and the teaching staff's idealised version of midwifery practice. In Davies study (1988) the midwifery sisters in the clinical areas and the teaching staff were perceived by students as having different aspirations and different approaches to the care of pregnant women. Furthermore Davies' work shows how the practice of midwives is curtailed within the hierarchical organisational structure of maternity services, in which care is prescribed and controlled by obstetricians and supervisors of midwives: the latter are also usually managers of the service. It is arguable that this denies the education segment's claim to independent practice in which the 'professional' midwife is portrayed as accountable for her own actions. Third, there is the notion that students abandon any public expression of 'patient' advocacy in an effort to 'fit in' and 'get on' with those whom they perceive to have power and control over their training and the ultimate goal of gaining the professional qualification.

The students' position is shown by Davies (1988) as contingent upon their creating a good impression on staff midwives, sisters and doctors, despite being unsure what is expected of them.
Indeed one of the researcher's own respondents re-emphasised this by the following:

"I am usually anxious the first time I step onto a ward because I don't know about the 'set-up' you know, one tries to get as much information about the sisters and staff beforehand. In fact we spend a lot of time in class filling each other in about various personalities, for instance, there was this notorious midwife called... Several midwives were attributed with reputations of a varying nature; like one was described by a past set of students as being 'knowledgeable' and another as being 'nice', I've still got to meet the 'dragon' (laughter)".

"... like I soon learned that Miss W likes a mug of tea when she is receiving the report, you are in when she say things like 'you are getting good at making tea'..."

This type of 'fitting in' is evident in other types of training, for instance in district nursing as demonstrated by McKenzie's (1990) research.

The tactics the students described at interview illustrate their feelings of anxiety in the face of the realities which they encountered during their transition from being students to midwives. Like the medical students in the study by Becker et al (1961:422) student midwives entered training openly idealistic about the profession.

One student asserted that she saw herself as occupying a relatively inferior and weak position in the clinical area, as "being at the bottom of the heap;" in addition she confided 

"when I first started I had to tread carefully, one problem is that one is always moving around from ward to
ward so you lose the strength of having sussed things out, it's really frustrating, having to start all over again.

These strategies remind one of Goffman's work (1971) on initial encounters and rule inculcation, which points out how individuals entering the presence of others for the first time make inferences and seek new information about the other as well as bringing into play information already possessed. The primary functions of initial encounters are seen by Goffman as sense-making and information-gathering.

Davies' study (1988) shows that students have to learn to deal with strangeness, feelings of inadequacy and loss of self-esteem during their initial phase of training. Dingwall (1977) asserts that health visitor students despite being older and more socially competent are paradoxically more anxious on entering the course and facing novel situations. Davies (1988) argues that as midwifery students in general, like health visitors, are older and have considerable social competence gained as wives, mothers and responsible nurses, they would experience the same anxiety which puts them in a position of relative weakness as they negotiate their way through training. Their anxieties and complex strategies for coping with stress are well explored by Davies (1988). The additional burden of family commitments usually associated with mature students is one reason why students felt the need to detach themselves from the 'politics.' As students who were interviewed for the current research confessed:

"... it's very difficult trying to hang on to your beliefs and to have an easy life. I'm constantly torn between trying to give care the way the tutor taught us and trying at the same time not to tread on anybody's toes.... but after a while you give up because it's such a struggle."
"... soon I learned that the most important thing is to gain approval of the sister, she is at the top of the hierarchy and has a lot of influence, she can make your life pleasant or hell..."

"... I think I have learned to stop upsetting the midwives who don't believe the things taught by the 'school' by just getting on with the work, after all I do think that midwifery is the happy end of nursing. This belief that midwifery has no link to nursing but is something totally different is just a myth."

It is interesting to note the 'rationalization' process adopted by the last student. By reconciling her belief that midwifery is no different to nursing and indeed her statement suggests that there is an occupational link between the two professions, she then felt that 'just getting on with the work' was the ultimate task in hand. Strategies of how students manipulated the clinical situation while 'just passing through' the various departments or wards are well documented in nursing and medical studies (Becker et al 1961; Bendall 1975; Atkinson 1981; Gott 1984; Melia 1982).

Olesen and Whittaker (1968) also describe the above process of learning the survival game as a form of 'studentmanship'. The main aim is to be 'in' with the staff especially those who are seen to be in a position of power to make life 'nice' or 'hell' for the student. Although it is seldom made explicit, student midwives understand how to behave appropriately when confronted with constantly changing ward experiences. As Olesen and Whittaker identify:

"These norms, inherent in the lifestyle of all students exert recognisable influences on the manner in which students cope with the (clinical) situation. Studentmanship, therefore, functions to suggest answers to a perpetually
problematic issue: how to get through (training) with the greatest comfort and the least effort, preserving oneself as a person, while at the same time being a success and attaining the necessities for one's future life”.

(Olesen and Whittaker 1968:149)

Olesen and Whittaker further describe 'studentmanship' as:

"A form of underground student behaviour that plays a prominent part in shaping interactional styles, operational values and staunchly-held attitudes among students. It is an undercurrent of understanding that, although apparently well comprehended by the students, is seldom made explicit."

(Olesen and Whittaker 1968:45)

Davies (1988) goes on to suggest that the role of the student midwife is set, in part, by the expectations of the clinical staff and by the tutors as well as by other factors such as by the members of the student group themselves, by the individual personality of each student and by their previous socialisation as nurses. It would appear that students are faced with conflicting role expectations which, until they are able to 'learn the ropes' or 'the survival game', cause them stress. Just as Olesen and Whittaker (1968) witnessed discrepancies in the ability of students either to meet or clearly inhibit the demands of the nursing school, so the students studied in this research were also involved in determining what constitutes becoming or being a midwife.

Melia (1982:3) describes how in her study senior nurses kept vital information about patients from students which meant the latter were 'nursing in the dark'. Davies (1988) demonstrates that student midwives underwent the same process and further
shows that these students were able to cope with their state of ignorance by drawing on previous experience and reverting to a nurse role in order to save face and fit in. In the current study one student midwife confessed:

"I was scared of that sister at first because you hear so many stories about her, but I soon got on with her, I knew this when she called me by my first name, (pause) as I was saying I got on with her by constantly being seen to be working... when nothing much was happening on the ward, I would go and tidy up the linen cupboard or check the baby charts or something... soon she would come and tell me bits of gossip and ask me to have a cup of tea with her... another sign that I am in her good books (laughter)."

These types of action described above, tidying the linen cupboard and checking the charts, are typically nursing in origin. What is of concern is not so much the actions themselves as the behaviour and attitudes which accompany these types of action. It appears that as long as students keep reverting back to their nursing role they cannot move forward with internalising the midwifery values. As one tutor stated:

"It's disheartening since students can easily revert back to their nursing role under pressure, it's like this student I have who knew in her heart of hearts what midwifery is all about until she was bullied into a form of submission, this happened to her after training when she delivered an unexpected stillbirth, now she is practising like an obstetric nurse..."

It does appear from the interviews that student midwives saw their main priority as getting 'in' with the crowd when they were in the clinical area. In so doing they often had to, in the words of one student 'sacrifice their belief' and the day they 'stopped struggling' was when the 'pain ceased.' To assist this
process students rationalised their action and consequently reconstructed their reality. The following statements bear out this situation:

"... no one likes to be on the outside, so to be in one needs to suss out what is the prevailing belief at the time. It's great if that belief is the same as the one taught by the school, as there are midwives out there who think like the tutors, but these are few and far between... at the end of the day as a student I have to choose which belief would gain me acceptance into the group".

"I learnt early on not to be too clever for my own good. Never mind what the teachers teach us, if my mentor disagrees I keep my opinions to myself, otherwise I am asking for trouble. (Pause) Yea, yea I can live with that because I feel that the tutors don't know what they are talking about, they certainly don't have to live with the situation, they can withdraw from the clinical situation any time they feel like it, whereas we are kind of trapped... also the tutors should teach us strategies to overcome being 'put down' by the midwives or even ousted from the group which was what happened to one of the students in my set... she left training in the end, couldn't tolerate the animosity towards her, so what good is it believing in all those things my tutor said about 'good care'."

"Some days when I am working with midwives I really have to be ultra-polite, asking permission for almost everything I do until I have worked out what their expectations are... you know the rules etc..."

"I have suffered from great conflicts in the past, that is whether to say something or to keep my mouth shut, either of these seem difficult (pause)...."
Windsor (1987) indicated that it was of great significance to student nurses' learning that their relationships with trained staff were positive thus providing a pleasant atmosphere in which to work. The same seems to apply to student midwives. Indeed it could be argued that this is a natural pattern of behaviour: as midwifery students have been socialized into steering a way through real and imaginary pitfalls in interaction with their mentors during nurse training, hence they are merely utilising the same technique when undergoing midwifery training. Whether the student midwives' attitudes and behaviours learned during their ward based training would become major influences on their future behaviour was an interesting question that the researcher sought to explore in the second phase of the research.

**Summary**

This chapter started with introducing the two aims ie to discuss the methodology of documentary analysis and to give the findings of phase one of this study. The limitations of documentary analysis as a research tool was explored, and the justification for follow-up interviews with students focussing on key issues arising from the documentary analysis was put forward. Three themes emerged ie the climate of the unit: interventionist versus non-interventionist; rituals and routines in midwifery practice; and the definition of professionalism. Lastly, student midwives described using various 'survival strategies' to cope with having to work on the ward and to 'fit in' with their midwife mentors. The chapter ended by discussing the relevance of Davies' work on 'fitting in' and 'sussing things out' as well as Olesen and Whittaker's research on studentmanship.

The findings of phase 1 of this study led the researcher to be interested in exploring the role of the midwifery practitioner, hence phase 2 of the research evolved from the findings of phase 1. The next chapter describes the setting used for phase 2 of the study.
PHASE 2 OF THE RESEARCH

The aims of this chapter are firstly to describe the setting in which the second phase of the study, i.e., the observation and informal interviews, took place, and, secondly, to describe the midwives' interpretation of why some of the beliefs, values and attitudes that they hold are similar to those propounded by the educational sector, while others are different.

4.1 The Setting:

This section describes in some detail the maternity unit where phase two of the study took place. The maternity unit is a fully self-contained two floor unit in good decorative order. About 300 metres away across a road is the district general hospital with the usual laboratory and radiology facilities. The maternity unit is close to the town centre and serves the needs of a wide social class mix in the area. The unit has been extended three times although the main part of the building has been in existence since 1960. There are antenatal beds, postnatal beds, first stage and delivery rooms and a special care unit comprising special care cots and intensive care cots. At the time of the study the unit was again being extended to meet the demands of the growing population that has moved from London. The special care unit had been moved to occupy a postnatal ward while the extension work to this unit was carried out. Consequently some of the postnatal beds were moved to a prefabricated unit adjacent to the maternity unit. This unit also has an obstetric 'flying squad' which convenes on demand.
Each ward has its own office which is the hub of the ward life. This is where the staff (midwives, student midwives, ward clerks and doctors) do office work ie writing, telephoning, filing and typing. It is usually in the office that the handover takes place as a new shift of staff reports on duty. It is also the place where, behind closed doors, 'atrocity stories' as described by Dingwall (1977) are told and where staff have a 'post mortem' discussion of the current cases. The office is also used as an informal classroom where the mentor midwives meet with their students to 'chat over their progress' and to fill in their continuous assessment file. Also in the office are: the controlled drug cupboard, filing case with the clients' notes and noticeboard covered with notices of varying kinds (for example informative and instructive). In addition, on the delivery suite there is a board which records the progress of each woman in labour. The board is written in obstetric/midwifery jargon (for example gravida 2 para 1) clearly understood by those working in the unit. This board is kept up-to-date whatever the pressure of work. The midwife who does not do so will often be reprimanded by the midwife in charge. After the client has delivered and transferred to the postnatal ward the midwife will wipe the client's name off the board, this signals the attending midwife's final act in completing the work. According to Roth (1978), this is a ritualistic act: it is a formal action following a set pattern which expresses a shared meaning through a symbol.

Each ward also has its own treatment room for the storage of intravenous solutions and injections, sluice, kitchen and rooms for storage such as the linen room. Clients and their visitors are not permitted to enter the treatment and storage rooms. Most of the wards with the exception of delivery suite have a dining/sitting room for the clients. The postnatal wards also have a nursery.
The unit is managed by a Maternity Services Manager and two Senior Clinical Midwives. In addition there is another senior sister in charge of the Special/Intensive Care Baby Unit. The unit is served by midwives of all grades (grade E to G) and the total establishment of midwives is 88 whole time equivalents. In addition the post-registration student midwives (18 full time students) and six pre-registration student midwives also make a contribution to the service. There are three consultant obstetricians based mainly at this unit with another being peripatetic from a nearby maternity unit. Each consultant has his own team of registrar and senior house officer.
4.2 The Midwives' Story

One of the consequences of observing how midwives went about their daily work was that the researcher was led on to wonder about the midwifery world, intrigued by the mysteries of its own nature. Suddenly the commonplace activities of the midwives' professional life, those realms of thought and action that the researcher thought were well known to her became puzzles of a great magnitude as she tried to conceptualise them.

In this section the researcher describes the way midwives operate in their working environment, ie their attitudes, behaviour, underlying values and beliefs. These beliefs, values, attitudes and behaviour were elicited through informal interviews with midwives as well as observing them at work, interacting with their clients. The midwife-client relationship is the basis of midwifery care and much essential information is embedded in social actions which could be elicited by the researcher. Hence this relationship was studied in depth by a technique known as event analysis (Pelto and Pelto 1978). As in all significant social events there are features that are repeated a number of times or there are sequences that involve a number of different combinations of people. Analysis of these events of interaction reveals the dimensions of the relationship as well as physical spacing and factors relating to decision making, status, power and responsibilities.

A midwife is a practitioner of normal midwifery and has full professional and legal responsibility for her actions. The Midwife's Code of Practice of the United Kingdom Central Council (1991:2) states:
"Each midwife as a practitioner of midwifery is accountable for her practice in whatever environment she practises."

She is the senior professional person present at 70% of deliveries and is therefore able to carry out emergency treatments in the absence of a doctor - for example a breech delivery, the management of a haemorrhage and neonatal resuscitation (Robinson et al 1985). The midwife makes her own judgements regarding supervision, care and advice to women before and after delivery; she is responsible for the care of the newborn baby until the 28th day after delivery.

Midwives' training and education takes into account this range of skills and the knowledge base deemed adequate to practise. The assessment strategy is designed to test a list of competences which register that the student qualifying is ready to be a 'practitioner of normal childbirth'. However a large scale study by Robinson et al (1983) suggested that midwives are not always fully utilising their skills and practising as 'practitioners in their own right'. The two main conclusions were:

1. Substantial proportions of midwives practise in situations in which they are not required to exercise fully the degree of clinical responsibility for which they are trained, particularly with regard to the provision of antenatal care.

2. The proportion of midwives who fully exercise clinical responsibility differs significantly according to the type of practice situation in which they work, being highest in a general practitioner unit and lowest in consultant teaching units.

The latter point is also supported by the research carried out by Kirkham (1981) entitled "Basic Supportive Care in Labour." Furthermore while these studies were carried out in the early
1980s, there has apparently been little change since. A recent survey by Midwife, Health Visitor and Community Nurse (Editor 1991) showed that 81% of midwives feel that their role has been eroded; a concurrent 95% in the whole study argue that they should be able to pursue their professional independence more actively. In the present study the earlier documentary analysis and interviews of student midwives also supported the view that midwives are not fully practising the role for which they have been trained. Student midwives criticised midwives for being 'maternity or obstetric nurses', 'doctors' handmaidens' and 'unprofessional.' Almost all the students interviewed commented that most midwives they worked with in the consultant units were "scared of making decisions" and that they practise by "following policies and routines, not using their own clinical skills."

These are some of the comments which emerged from audit reports, evaluation forms and subsequent interview transcripts made by student midwives who appeared to have a rather poor image of their mentor midwives. However in the second phase of the study the midwives' story was different. These were midwives that the researcher was privileged to observe working in a consultant unit.

After observing the way in which midwives went about their daily work and questioning them about their beliefs and values, it appeared immediately from the data that there are broadly three groups of midwives, each carrying their own set of attitudes, beliefs and values which may or may not be mirrored in their practice. The researcher has devised a typology of midwives. There are three types, and they are named (i) 'The Crusaders', (ii) 'The Survivors' and finally (iii) The 'Nurse-Midwives'.

The researcher illustrates and discusses each of the ideological types in turn.
(i) 'The Crusaders'

These are midwives who appear to have a deep commitment to the profession. They articulate the need to 'rescue the profession', and 'not let midwifery die' as well as 'bring midwifery back to its true state.' These midwives also see the profession as being 'under threat' and they identify that there is a tremendous amount of interprofessional rivalry between midwives and doctors (ie obstetricians and general practitioners) as well as between midwives and nurses.

The 'crusader' midwives see themselves as autonomous practitioners and speak of the need to practise true midwifery, that is, to use their own clinical judgement, make decisions and be accountable for those decisions. In addition they believe that the way forward is to make practice research-based. Hence they emphasised continuing their education and keeping up-to-date.

Some of their fundamental beliefs are:

- that midwives are autonomous practitioners and must be accountable for their actions

- that the midwifery profession is independent and not a branch of nursing

- that clients are significant partners-in-care and their interests must reign supreme

- that there must be a shift of power from professionals to clients: these midwives believe that they are there to serve the clients

These midwives are usually proactive members of the Association of Radical Midwives (ARM), the Association for the Improvement
of Maternity Services (AIMS) and the National Childbirth Trust (NCT). A large number of them are unhappy about their current working conditions in hospital and are "looking for a way out." Some of these midwives have gone into teaching and see this as being a positive step in crusading for the restoration of the profession. Two tutors admitted that they saw their role as influencing the students (ie the future generation of midwives) "to think and act like midwives." Others were determined to stay within the clinical field to act as 'good mentors' to the students. As one midwife argued "if every good midwife goes into teaching, who would be left to practise true midwifery?" She saw her role as a clinical midwife as giving her the opportunity to be a 'good role model' to her student. This is an important point as several of the tutors expressed their concern regarding the exposure of students to a clinical environment in which midwifery mentors are poor role models ie failing to use their own clinical skills and relying on the doctor's instructions.

Some of these 'crusader' midwives are hoping to be employed as domiciliary or community midwives as they perceive that the latter are given more opportunity to practise midwifery autonomously without the influence of the obstetrician. Another point emphasised was the lesser contact between the practitioner and the manager; therefore the latter was seen as having less opportunity to influence practice. This is illustrated by the following comments:

"...when I am out there in the community, I do as I please, often I bend the rules to meet my patient's needs, what they (meaning the manager) don't know won't harm".

"I think in hospital it is difficult because the management is there all the time, you have to practise with someone in the upper echelon looking over your shoulder all the time."
A few of these midwives have considered going independent but are afraid to give up a stable job in return for self-employment.

Nevertheless whatever the long term career intentions are for this group of midwives, their outlook for the profession is optimistic as illustrated by the following statements:

"I do not think that midwifery will die as a profession because as long as women continue to give birth, they will need us."

"I don't believe the doctors could eliminate us because the increase in litigation has meant that more and more doctors are not choosing obstetrics to specialise in so midwives will always be needed in this country. Look at what happens to those countries like the States which did away with midwives. They are gradually bringing them back."

"Midwifery will never die. At least not if I can help it."

While the 'crusader' midwives share some of the fundamental beliefs with the profession at large, for example that midwives are practitioners in their own right, they also have beliefs that are unique to them. The notion of handing power and authority back to the consumers and giving them as much information as possible are just two of such beliefs. In other words the 'crusader' midwives appear to be a sub-group within the midwifery profession with a sub-culture of their own.

(ii) 'The Survivors'

The second group of midwives are the survivors. While they share many of the values and beliefs of the midwifery profession (refer to appendix 5), these are not always mirrored in their behaviour
and attitudes. Although these midwives do believe that midwifery is an independent profession separate from nursing and that midwives are practitioners in their own right, in their practice they do not always 'act independently', that is use their own clinical judgement and make decisions. The reasons given are varied, for instance: "being frightened that the midwifery manager will tell me off", "the obstetricians are more powerful and could do me harm if I do not follow their instructions", "afraid of bad references" and "fear of litigation by the consumers of maternity care."

This group of midwives can be described as suffering from professional conflict in that while they hold one set of beliefs and values they are operating on a different set. It is evident that they often experience difficulties in resolving this conflict as the following statements illustrate:

"I worry about the student because we are not permitted to practise midwifery hence I cannot teach her how to make decisions."  "I feel sorry for the state of midwifery. When I was practising years ago in the community, before I had my children, things were very different then, one could make decisions, now they (meaning the doctors) always tell you what to do and if you don't do it you could get into trouble."

"I believe that midwives should practise independently (meaning make decisions and be accountable) but at the end of the day it is like beating your head against a brick wall and to save my own sanity I give up trying."

"Of course sometimes I worry about not being able to practise midwifery. At first when I first came back to hospital to practise I hated having to call the doctor at every turn and rebelled against it, but eventually I had to go along with it because I was frightened of losing my job"
and after all we all have to live, especially being a single parent with a mortgage.

From the above statements it is apparent that while the 'survivor' type midwives believe that midwives should be autonomous practitioners and be accountable for their actions, there are reasons why they themselves find it difficult to practise according to as their beliefs. The result is that they espouse one type of theory which is based on a set of values, beliefs and attitudes that is different from their theory-in-use. This forms a significant theoretical issue that requires further analysis and this is addressed in the next section in which the work of Argyris and Schon (1974) on theory-in-practice and the reflective practitioner is considered.

One interesting aspect of the interview is the affective experience as the researcher could perceive a sense of sadness and regret expressed by these 'survivor' midwives although often these midwives were at great pains to justify the reasons given for their actions. The reasons given for not practising their true role is wide ranging; such as fear, apathy and lack of confidence.

The researcher chose the label for this group of midwives from the following assertion made by a midwifery sister:

"Some days I feel like a traitor to my profession. The students are so refreshing and eager to be midwives but I know that the system will let them down sooner or later. I work within this system and will be one of those who will be a disappointment to the students but I've got to survive..." (meaning she has to hang on to her job for the sake of the financial reward).

This group of midwives do literally survive on a day to day basis. They often feel unhappy about their work but feel unable
to do much about it. Hence unlike the 'crusader' midwives, this group of midwives have a rather pessimistic outlook on the profession. Midwives made the following comments:

"I feel that midwifery will eventually disappear in this country and be replaced by obstetric care. I don't feel happy about this but there is nothing I can do about it. I am tired of fighting and now just plod on until I retire which is not too far into the future...(laugh)."

"It is the students I feel sorry for... coming into a profession that is dying."

"I can still remember about the good old days when I practised truly as a midwife but that is in the past, midwives will never be able to regain their autonomy, they (meaning the obstetricians) are too powerful."

Another interesting feature is the way in which the 'survivor' midwives constantly try to rationalise their actions and to reconstruct their reality to fit in with them. The following is an example:

"I have to give a reason to my student as to why I do something like call a doctor because students are critical about midwives referring too early... I remember once I had a heated discussion with a student... but I think at the end of the day the student came to understand the constraints that midwives on the ward are faced with, we are practitioners in our own right to a limited extent, but it is only a job... really it is not worth fighting everybody all the time. The student soon realised that like most of us, she has give in to the system."

Most midwives work full-time which means that they spend 37½ hours per week in their working environment, hence the latter is
very much part of their social world. Consequently they hold a reality that is socially defined by this working environment both on and off duty. The issue of how some midwives re-construct their reality and survive in the midwifery world will be further discussed in the next chapter on 'The Theoretical Perspective.'

(iii) 'The Nurse-Midwives'

These midwives are in the minority. While they work as midwives they openly articulate that they do not see midwives as being autonomous. They do not for example see anything wrong in following a doctor's instructions in the case of a normal labour/delivery. While the nurse-midwife is happy to make decisions on her own in the management of normal birth she nevertheless gives up this right as soon as the doctor starts to issue an order. Hence this type of midwife perceives that the doctor is superior to her/him. In following the doctor's instructions s/he may be overruling the client's wish but this does not disturb the midwife as s/he perceives that the professionals are 'the experts' and therefore the client should do as the professional advises. This is contrary to one of the fundamental beliefs of the midwifery profession, that is, that the midwife is an advocate for the client and that the two of them are partners-in-care. This group of midwives prefer to work in a hierarchical system where there are clear divisions of control/power.

This group of midwives who have undergone a traditional nurse training programme previously, have for some reason failed to make the transition from being a nurse to being a midwife. Most of them have undertaken a rigid nurse training and have since held on to most of the beliefs and values that they acquired during their nurse training. Some of these beliefs have already been discussed above, others include the orientation to performance of the tasks and the need for routines/rituals/policies to dictate their practice. Some dismiss the use of
research as "fashionable for today" and "a waste of time." This group of midwives places great emphasis on "doing the job." They consider themselves "practical midwives" and "not intellectuals." They believe that getting on with the job is the most important aspect of midwifery hence the emphasis on "getting the woman delivered", "cleaning the delivery suite", "wheeling the next one in" and "tidying the linen store cupboard."

This group of midwives are called nurse-midwives because their underlying actions suggest that they still see themselves as nurses first and secondly as midwives. Indeed one of these midwives declared "...but I am proud of being a nurse although I do midwifery work." This statement suggests that this individual midwife saw little or no difference between the two professions. These nurse-midwives do appear to hold beliefs that are contradictory to those held by the midwifery profession at large (RCM/221/91 - refer to appendix 5). For instance in the document 'A Philosophy for Midwifery' (RCM/221/91) some of the values and beliefs outlined were:

- each mother is an individual with her own rights, needs, hopes and expectations.

- altruism which focuses upon the child bearing woman

- integrity which is reflected in honesty and moral principles

- the midwifery profession has the power to influence both the nature and delivery of services to the child-bearing woman and her family.

Implicit within this is the intention to empower women during their child bearing experience, to provide holistic care and to maintain professional credibility. Yet the behaviours and actions of the nurse-midwives appear to work against the above beliefs and values. For instance one nurse-midwife stated: "I do
not think that women should tell me what to do since I am the expert on childbirth - I did years of training and have years of experience." She went on to assert that she can tell exactly when a woman is in true labour and not merely wasting her time. When probed at interview she admitted that since she has not had any children herself she cannot imagine what labour would feel like but she still insisted that she would know when labour starts. Some of the nurse-midwives felt that catering for the women's needs is not a good idea as "they will be telling us how to do the job next." The researcher elicited from the interviews with this group of midwives that they do not see that they are there to serve the child-bearing woman and her partner but rather the system, as illustrated by remarks such as:

"We are here to do a job and in my mind if I get on and deliver the woman and her baby safely then I will have done the job... all this fuss about wanting a satisfying birth experience is just fashion... like having a water birth."

"I absolutely refused to let the children in on the delivery... after all this is a hospital not their home."

"I like the women to undress and change into a hospital gown before they see the doctor because it saves him (meaning the doctor) time."

When asked by the researcher how she would feel if a woman refused to change into a hospital gown the midwife retaliated: "I think if we start off by telling them what to do they will do as we say."

In the above case the midwife appears to have the doctor's interests at heart rather than the client. She does not see herself as an advocate for the client. Since the word 'midwife' means to be 'with woman' it is difficult to see how the above midwife could be considered as being with her client if she
acknowledges the interests of the doctor first. These nurse-midwives do see their role as primarily to assist the doctors, for instance, a midwife stopped helping a mother to breastfeed as soon as the consultant obstetrician arrived on the ward to do a ward round. This midwife saw the role of assisting the consultant obstetrician to do a round as being more important than being with the woman during a breastfeeding session. This belief of serving the doctor is one acquired when these midwives were exposed to the traditional form of nurse training. Indeed one of the interesting points about these nurse-midwives is their need to hang on to the nursing status, for example their use of the term nurse instead of midwife. It appears that they see the term as being synonymous with midwifery and when probed at interview one of the nurse-midwives declared: "I really don't see why some midwives feel so upset about being called a nurse, I am proud of being a nurse." This was despite not having practised nursing for 17 years because of taking up midwifery.

Another characteristic of these nurse-midwives is the way in which they perceived childbirth as being a potentially dangerous event necessitating the best hospital/medical facilities. One midwife admitted that she finds it difficult to "understand why women would wish to have a baby at home when they can have the best in hospital." When the researcher suggested that perhaps these women wish to be in their own surroundings so as to be in control of the birth process the same midwife argued "but she (meaning the woman) does not have the same knowledge as us, the professionals so how can she be allowed to be in control?"

Summary:

In the second phase of the research, emerging from the participant observation and informal interviews, was the 'midwives story'. This story appears to support to an extent the findings from phase one of the research. Midwives do admit that
they are not practising as 'practitioners in their own right' and in many instances will turn to more senior colleagues or to a doctor for decisions which the midwife should be making herself, but this is not because they do not believe that it is their right to do so. Indeed these midwives are fully aware of their autonomous status as prescribed by law in Great Britain but their espoused theory is different from their theory-in-use. The reasons given by them for this phenomenon are varied and complex. Constraints range from micro to macro structures. There are also sub-groups of midwives with their own sub-culture. Such sub-groups of midwives work religiously at holding on to their beliefs and propagate these in the students. Other groups of midwives would seek to re-construct their reality in order to rationalise and harmonise their beliefs and values with their actions. From a student midwife's perspective it would seem that generally students would prefer working with midwives who espouse the same set of beliefs and value system as those which the tutor espouses as this creates a sense of harmony. In cases where the espoused theory is different from the theory-in-use the student midwives appear to be able to tolerate this inconsistency as they realise the constraints of the clinical setting. Generally student midwives are very critical of nurse-midwives as the beliefs, values and attitudes of this group of midwives are very incongruent to those that are espoused by the tutors, hence creating a very real conflict in the two cultures of education and practice. This causes great dissonance in the students who have then to employ tactics to dispel this feeling. The researcher will further explore this aspect of the research by using the Festinger (1956) theory of cognitive dissonance in Chapter 5.2.
CHAPTER 5

THEORETICAL PERSPECTIVE

5.1 Introduction

An interesting aspect of the research is that student midwives felt that midwives practising on the wards were not basing their actions on a set of beliefs, values and attitudes that were congruent with those propounded by the educationalists. This set of beliefs, values and attitudes constitutes a form of culture. The student midwives asserted that there is a gap between theory and practice, or to put it another way, a conflict between the culture of the 'school' and that of the ward.

In phase two of the research, after observing the midwives in action, and following in-depth informal interviews, the researcher discovered that while there are both similarities and differences in the two sets of cultural values, beliefs and attitudes, nevertheless midwives' practice does not always mirror these beliefs, values and attitudes. There appears to be different types of midwives whose action (known as theory-in-use) may be dissimilar to what they say they believe in (known as espoused theory). Therefore it is appropriate for the researcher to use the work of Argyris and Schon on theory and practice to address the differences in the theory-in-use and the espoused theory.

The different typology of midwives also led the researcher to question why there are differences in the way midwives construct the reality of their world of work and what factors contribute to
these differences in perception. This phenomenon seems to be adequately explained by the self-concept theory as propounded by the symbolic interactionists. The researcher would assert that the cultural beliefs, values and attitudes from the educational and service sectors are transmitted via both verbal and non-verbal communications. Hence, the theory of communicative action is discussed to illuminate the role language plays in the perpetuation of some of the cultural beliefs, values and attitudes held by different sub-groups of midwives.

The researcher believes that the value of research is not just confined to describing phenomena but in explaining them. In this study the researcher accomplished this task by employing established theory to explain the data obtained. The strength of this study lies in the researcher's effort to achieve the knowledge 'how' as well as the knowledge 'why'. The latter is accomplished by using a sociological interpretative framework. The researcher may be criticised for being too ambitious in choosing to use social science theory to explain the data of a study which is predominantly to do with education, however, the researcher feels that this is justified. As Mills (1970) asserts that the use of a sociological imagination could free oneself from seeing the obvious and to enable one to search for hidden meanings of individual action, hence with the help of her research supervisor and colleagues, the researcher has chosen established theory to explain the data.
5.2 The Theory of Reflection in Action:

Over a period of some fifteen years, Argyris and Schon have produced a series of writings based on their work with individuals as well as organisations. Reflection in relation to learning has been extensively researched by Kolb and Fry (1975), Boud et al (1985), and Kemmis (1985), but Schon's work reveals a new dimension to the topic.

Reflection-in-action in the context of reflective practice is firmly embedded in the conceptual model of model 1 and model 2 behaviour, where model 1 is seen as the traditional client/professional relationship and model 2 as the foundation of reflective practice.

Model 1 which was found to be by far the most common type, has the following characteristics, as described by Argyris and Schon (1974:102).

- the defining of goals and trying to achieve these.
- the maximising of winning and minimising of losing.
- the minimising of the generation or expression of negative feelings.
- being rational.

These lead to action strategies such as:

- unilateral design and management of the environment.
- ownership and control of tasks.
- unilateral protection of self.
- unilateral protection of others.
Therefore, Model I learning produces a view of the professional as expert (as viewed by the nurse-midwives) taking unilateral decisions and giving advice, where problems are seen in clear-cut terms and amenable to solution by routine and ritualistic methods. It does appear that the nurse-midwives who have been exposed to Model I learning have developed a set of habits and rituals to guide their work. These midwives maybe unable to deal with the unfamiliar and any change is perceived as being unnecessary, for example the midwife who declared that 'research is just a passing fancy.' Change can also be perceived as being stressful and these midwives tend to protect themselves from stressful situations by generalising their perceptions and adhering to the familiar. Therefore they need to base their practice on routines and rituals, as demonstrated by Henderson's study on whose decision it is to rupture the membranes in labour (Henderson 1986) and Hunt's 'Ethnography of a Labour Ward' (Hunt 1987). The latter illustrates how midwives make individual decisions and carry out actions in their practice. The use of rituals and routines reveals the stunted moral development: moral conflicts are not resolved and rules of the organisation are arbitrarily applied. For instance one nurse-midwife said to a student midwife; "you must make sure that the woman is on the couch ready for the doctor to examine her" or on another occasion a nurse-midwife said to a woman on the postnatal ward; "you are not allowed to carry your baby around the ward" (the rule of the hospital is to wheel the baby in her/his cot). They further developed defence mechanisms that made their attitude rigid and conformist. They rarely isolated their true sources of conflict and acted upon them, instead they relied heavily on peer support.

The consequences for the behavioural world are far-reaching and lead to an increase in defensiveness by these individuals. This amounts to authoritarianism by those able to exercise unilateral control and to excessive self concern by those controlled. This subsequently leads on to distrust, conformity and antagonism while freedom to explore and take risks is also curtailed, hence
the loss of growth and development in the individual (Argyris and Schon 1974). This much is evident from the way in which nurse-midwives practise midwifery. Often they stick to practice based on custom rather than research. It is apparent that the midwives who determine policies and procedures are mainly from the nurse-midwife group. This could be because nurse-midwives are generally 'conformists' and are more likely to be selected by the organisation to be managers. This does mean that other midwives who wish to base practice on current research are faced with great difficulties as they are not policy makers and hence experience great difficulty in having their voice heard. Consequently day to day practice such as care of the baby's umbilical cord, breastfeeding and treatment of sore perineums is mainly determined by customs which maybe outdated. Student midwives constantly complained about the way in which mothers are advised about breastfeeding. The general advice is to feed by watching the clock even though there is sufficient research to document that breastfeeding should be on a demand basis (Salariya et al 1978; Howie et al 1980; Glaser et al 1984 and McNeilly et al 1983). Another practice observed by the researcher was the usage of dextrose fluid to complement breast-feeding even though this practice has been heavily criticised (Inch and Garforth 1989; Inch and Renfrew 1989).

One significant remark made by a newly qualified midwife was that "midwifery practice never seems to change because those who tell us what to do and how to do it are those who never update themselves and who think that they know it all... I personally think that these midwives should be made to go on study days, but then who should make them, since they are often in managerial positions themselves."

One of the most significant features here is that because Model I behaviour is the most common, especially in the professional world, it is difficult to change. Professionals like the nurse-midwife find rational behaviour most effective and are reluctant
to test assumptions publicly. This means that in the professional world of midwifery, Model 1 behaviour tends to become self-perpetuating, which Argyris and Schon (1974) refer to as self-sealing. As one 'crusader' midwife declared "the most despairing thing is that it does not take the student long to conform to the existing rules after she has qualified." This statement seems to support the notion that the cultural beliefs, values and attitudes of the ward are more prevalent than those in the 'school'. As one student asserted:

"It is much easier when one has finished training as one can then just adopt the way things are done on the ward and forget the ways the tutor taught us. This reduces the conflict and makes life much easier."

In the earlier chapter, the researcher described the three types of midwives. The researcher would postulate that the crusader and survivor midwives are the ones who have been exposed to a model 2 type of learning experience following their basic training.

Model 2 is an ideal model and has the following characteristics as described by Argyris and Schon (1974:105).

- maximisation of valid information.
- maximisation of free and informed choice.
- maximisation of internal commitment to decisions made.

These lead to action strategies which are very different from those of model 1 and consist of:

- bilateral design and management of the environment.
- bilateral protection of self and others.
- using directly observable categories when speaking ie not inferred categories of attribution and evaluation.
Model 2 learning promotes a view of the professional as one with specialised knowledge and experience, who may be helpful and who will work with the client towards meeting the latter's need. The experience of this, as well as continued conventional learning, will be used to help in forming solutions to future problems which have a similar feature but are equally individual. This form of experiential learning is evident in the 'crusader' and 'survivor' midwives. Their reservoir of knowledge derived from exposure to the 'unknown' grows as their confidence to encourage the client to take control and make decisions develops. The most important consequence is that learning tends to take place which involves change in the governing variables of the individual's theories-in-use. This is known as double loop learning (Argyris and Schon 1974).

The different perspectives held by the 'crusader' and some of the 'survivor' midwives reflect this philosophy of encouraging the clients to make the decisions and "to take control of the birth process." Encouraging a client to devise a birth plan, for example, is a way of handing control back to the client. The researcher met a midwife who confided that in the past she had told many first-time mothers not to push until they were in the second stage of labour (as taught by the tutors) but on many occasions the woman could not help pushing and before long the baby was born. Consequently this midwife believed that the theory that if first-time mothers push too soon the labour may be prolonged was not borne out by her experience. When this midwife revealed her experience to her colleagues she found that most of them had also had the same experience. In this way the practitioners of midwifery are re-defining theory.

The above adds weight to the idea that there will always be a gap between espoused theory and theory-in-use. Yet work carried out in both the educational field (Carr 1980; Darkenwald and Merriam 1982 and Cervero 1991) and in nursing (Fretwell 1980; Alexander 1980) suggests that the espoused theory ie that which is acquired
during the educational and training programme and practice which is based on theory-in-use, should be closely inter-related. The issue of the relationship between theory and practice is complex and is highly dependent on the typology of practitioner. For instance the nurse-midwives appear to base their practice on an organized body of knowledge and theory that was acquired during their training days. Moreover they acquired this body of knowledge via the model 1 way. This group of midwives tend to base their practice on a body of knowledge that is already outdated. Many of these practitioners go about their daily work by using 'common-sense' knowledge. In fact, some nurse-midwives have proclaimed that midwifery was better off before there was a systematic body of research knowledge. In a way the relationship of theory and practice is not even an issue to these practitioners. These practitioners rely on 'normative knowledge' in their practice. This form of knowledge is illuminated by the characteristic that even when the action of the practitioner negates the espoused theory and empirical knowledge, the practitioner continues to use this form of practice. For instance there is research which documents that routine artificial rupture of membranes is not beneficial to clients (Grant et al 1992, Romero et al 1992), yet many midwives continue with this practice because it is the consultants' policy. This form of practice based on 'normative knowledge' is found in particular in the 'survivors' and nurse-midwives.

Then there are 'crusader' and 'survivors' midwives who use espoused and empirical theory as the foundation of practice. In this case a body of knowledge and theory is generated through the systematic processes of scientific research to form a basis for practice. Some would argue that it is this systematic body of knowledge that gives midwifery its professional status. Some practitioners would hold the view that empirically-derived knowledge and theory are different from, and better than, the knowledge and theory that arise out of experience. Most of the tutors subscribe strongly to this type of theory and they strive
to bring this scientifically derived knowledge from the classroom to the clinical setting. It is interesting that the empirical form of knowledge is propounded to be the 'treasure of the profession' even though this form of knowledge does appear to individualise the professionals. Lastly, there is a minority group of crusader-midwives who appear to use their acquired body of scientific knowledge plus the knowledge generated from their practice. The theory is derived from practice by systematically articulating the structures of subjective meaning that influence the ways that typical individuals using pragmatic knowledge act in typical situations. These theories can influence the ways that practitioners understand themselves and open the possibility of change through self-reflection (Kemmis 1985). For example there was a case whereby a midwife was asked by a woman in labour for an epidural as a form of pain relief. This midwife instinctively felt that the woman was progressing rapidly in labour. However in 'school' she had learned that the espoused theory is that the client's wish reigns supreme and should be instigated at all costs so the midwife assured the client that she could have the epidural if she so wished. The midwife then employed various tactics to delay the setting up of the epidural until eventually the woman was in transition and consequently delivered without the need of an epidural.

When asked by the researcher why she did not just tell the client that in her opinion an epidural was not really necessary as the labour was progressing very rapidly, the midwife stated:

"It is difficult when one is taught in school about individualised care and meeting the needs of the patients. One is so brain-washed that even when something does not work out in practice or is not practical, one is still inclined to follow the beliefs instilled during training... I must say that your presence (meaning the researcher) did influence my decision as well, I kept
thinking that you would disapprove if I did not do as the patient wanted..."

The above presents a serious implication in that if midwives only practice based on the body of knowledge acquired during their training, then practice would in effect be 'static'.

Argyris and Schon (1974) in their book titled 'Theory in Practice: Increasing Professional Effectiveness', argue for practitioners to develop their "own continuing theory of practice under real-time conditions... microtheories of action that, when organized into a pattern, represent an effective theory of practice." Schon's concept of reflection-in-action is further developed by Argyris' work on theory in practice (Argyris 1983, 1986). The main feature here is the distinction between theory-in-use and espoused theory, where the former is the one actually used in the action and the latter the one professed to be used. These theories-in-use are significant as they are rarely explicated and yet they guide practice in a more significant way than the explicated espoused theory. It is interesting to note that in this research midwives on the whole were not practising their full role but when questioned by the researcher they espoused that they were. This is supported by Henderson's study (1986) whereby she found that midwives believed that they were given more autonomy when their very action belied this. Some midwives would further assert that the autonomy that they possess makes it possible for them to seek the wishes of their clients in determining care. For example on one occasion the researcher noticed that a midwife got ready an injection of Syntocinon to infuse into a bag of Hartmann's solution. The midwife carried out this procedure and subsequently connected the bag of Hartmann's solution (with the Syntocinon in it) to the client's infusion, then the midwife asked the client if the latter would mind having her labour 'speeded-up'. Later when the midwife was interviewed by the researcher the former asserted that she asked the client the question because she believed that it was the
client's right to have a choice as to whether she wished to have her labour accelerated. This is what the midwife said:

"Of course, that's why I asked her if she minded having her labour speeded-up..."

The midwife totally ignored the fact that by preparing the injection before seeking consent conveyed an impression that seeking the client's consent was merely a routine that she believed that she ought to go through. Hence in this case the midwife's theory-in-use and her espoused theory were different from each other. This type of conflict is frequently exhibited by the survivors and nurse-midwives. For instance the researcher overheard a senior midwife saying that midwifery is a separate profession from nursing and midwives are practitioners in their own right, but on several occasions the same senior midwife called her midwifery colleagues 'staff nurse.'

Theories-in-use appear to have different levels and orders; some are hierarchical while others seem to have been tested by the user and based on common assumptions. For instance Polanyi's tacit knowledge (Polanyi 1967), has meaning in terms of professional practice as many practitioners not only have theories-in-use different from their professed theories but also are often unaware of these and therefore unable to describe them. This is why the methodology of participant observation was useful in this study as it is the major way in which theories-in-use can be recognised (Polanyi 1967).

Argyris and Schon state that 'theories-in-use are means for getting what we want' (1974:15) and indeed can be seen in a sense as living skills or coping strategies. However they are also the "means of maintaining specific constancies" where they have a dual role in maintaining both constancy of governing variables and constancy of the world picture they provide. There are dangers in this as illustrated by their claim:
"The two orders of constancy - both of governing variables and of the world picture which theories-in-use provide - generate a special conflict. When our theories-in-use prove ineffective in maintaining the constancy of our governing variables, we may find it necessary to change our theories-in-use. But we try to avoid such change because we wish to keep our theories-in-use constant. Forced to choose between getting what we want and maintaining second order constancy, we may choose not to get what we want." (Argyris and Schon 1974:17)

The above implies that theories-in-use may inhibit development and lead to stagnated practice, which is all the more dangerous because the person is unaware of it.

A practitioner who reflects-in-action will be using theory and practice in an inseparable way as s/he will be thinking and redefining theory while the action is occurring. This is illustrated by the earlier example of the midwife who learned that contrary to what her tutor taught, letting a first-time mother push before the second stage of labour may not hinder labour.

The researcher was particularly impressed by the way some of the 'crusader' midwives reflect on their practice and the constant search for answers to situations that confront them. In this way these midwives are trying to make sense of the realities of their working environment. For instance on one occasion a 'crusader' midwife was engaged in deep thought about the need to constantly use the term 'patient' in addressing the consumer of midwifery care. Her final analysis led her to believe that the need of some midwives to 'feel more superior' than clients by calling them 'patients' seeks to legitimize the exercise of authority and power.
Professional practice is essentially individual and Schon's emphasis on this is welcome. His emphasis on individuality does not end with the thinking of the practitioner or even with that of the client, but also emphasises the nature of the problems of the client, where, in effect, he feels that the type of problem which requires professional help most is usually so complex as to be totally individual. He talks of the "swampy lowlands" and the "high ground" (Schon 1983:43) where the former are messy but very significant problems and the latter are narrow technical problems, solvable by technical, rational approaches.

Schon feels that many practitioners are unaware, consciously or unconsciously, of the 'swampy lowland' type problem, because professional education does not fit them to cope with these very individual highly complex problems for which there are no ready-made theories to assist the practitioner and where reframing of the problem may be essential in order that a manageable solution may be found.

As practice becomes routine, the practitioner may fail to think about her/his work and fall into rigid repetition. S/he may also fail to be aware of phenomena which do not fit her/his categories of theories-in-use. Schon refers to this as 'selective inattention' and describes both rigidity and lack of awareness as 'overlearning' (Schon 1983:61). This emphasises the importance of consciousness raising as part of reflection-in-action.

Several features emerge to define reflection-in-action and give direction to its application and development. The first is flexibility and experimentation in the solving of problems. In such experimentation changes may occur and these are welcomed by the reflective practitioner as continuing the inquiry or 'reflective conversation' (Schon 1983:136). For example a midwife found that first time mothers who push before the second stage of labour suffer no ill effects, hence now she experiments
in "letting first time mothers push early to see if the cervix will dilate up faster." She further commented "...now after every case I think about it more than I used to and try to learn from my experience, maybe because I am sceptical about what the tutors and textbook say... also my attitude has changed from "the experts know best" to "the woman knows best!"

Schon talks of reflective clients as well as of reflective practitioners and advocates "reflective contracts" where bilateral action, of both client and professional, leads to making sense of the problem, and where the client is involved in the solving of it. This is a significant characteristic of the 'crusader' midwives as their underpinning philosophy is that they are partners-in-care with the clients.

At least one factor can be isolated from the above discussions to explain why the three types of midwives exhibit different values, beliefs, attitudes and behaviour. The three types of midwives are exposed to a training whereby they acquire a body of knowledge from their tutor on which they base their own practice. However, from the data there is evidence that the crusader midwives are more willing to 'take risks' and experiment with their clients and to learn from their practice by thinking through a case afterwards. In so doing they attempt to redefine the theory as taught by the educationalists. For instance, when a midwife declared: "I never thought that having her husband present would inhibit her labour from progressing because she (meaning the client) was too anxious that she would lose control and scream the place down... as soon as he was gone she relaxed and her labour speeded up before my eyes; the next time I will not make such an assumption and generalise in my practice, in fact, I arrived at the conclusion that my practice needs to be tailor-made for each case."

On the other hand the nurse-midwives, by following routines, customs and rituals fail to learn from their practice. The
theory that they acquire from their training days soon becomes outdated and their practice does not meet the clients' needs. Since they do not learn from their practice by a process of reflection their practice becomes static and unperceptive. The reason for the nurse-midwives not learning from their practice may be that they believe that the technical rationality type of knowledge is the most important and therefore they do not attempt to learn from experience because this is not valued by them as knowledge. This is illustrated by the following comments:

"I learnt everything there is to know about midwifery during my training days and since then I have also delivered over a hundred babies!"

"I've got more than enough to do without going for study days..., don't see why I should since I had a very good training."

"Of course I do learn from practice because I learn every day from the consultants... they are very knowledgeable."

These midwives have been exposed to an initial training and to post-basic courses based on a technical rationality approach, with emphasis on obtaining a body of knowledge which is tested by having unseen examinations. The usage of experiential learning and reflective approaches in midwifery education is still a very novel idea.

Argyris and Schon (1974) portray professional practice as a continuum between purely technical-rationality-based practice and practice using reflection-in-action as a major foundation. The former is mainly concerned with empirical laws and the latter with research in practice as a guiding force. Both, however, need extensive knowledge to be effective and a really effective practitioner should be aided by reflective practice and technical rationality, albeit with the emphasis on the former.
To summarise the above discussion, it would appear that while the three types of midwives are generally exposed to a technical-rational type training whereby Model I learning occurs, those midwives belonging to the 'crusader' group tended to be more 'thinking' in their practice. By reflecting on their practice, they are also learning from their experience to the point that some of these practitioners are redefining practice in order to meet their clients' needs. In so doing the gap between theory and practice is narrowed. On the other hand, the group of midwives belonging to the nurse-midwife category tend to hang on to the body of knowledge acquired during basic training and base their practice on this. Consequently their practice is ineffective in meeting client's needs.

Midwifery tutors are not the only professional educators, as student midwives are exposed to the clinical environment for a great part of their training, and hence have to rely heavily on the clinical practitioners for guided practice. The point being made here is that the ward environment may or may not increase the knowledge base, but may also provide a damaging experience in terms of learning as students are exposed to conflicting sets of values, beliefs, attitudes and behaviour. From phase one of the research there was evidence that the students felt that "what is taught in school is not what is generally happening in the clinical setting." This is due mainly to the fact that most midwives who set the standard of midwifery care and policies of practice are those who have been educated mainly in a mixture of traditional and hierarchical conformity and promote a technical-rational approach to midwifery. As these midwives do not continue their education after they have qualified, and fail to learn from a process of reflection on their clinical experience, their practice becomes static.

The static, rigid practice tends to perpetuate the same cultural beliefs, values, attitudes and behaviour in the ward area and conformity is ensured by the use of peer pressure. Consequently
most of the midwives conform to a specific way of practice even though some may not hold that set of beliefs as in the case of the 'survivor' midwives. In other words these midwives tend to have an espoused theory that is different from their theory-in-use, unlike the 'crusader' midwives whose espoused theory is closer to their theory-in-use. Hence the 'crusader' midwives who espouse the need to give clients control over their own birth process tend to encourage the use of birth plans so that clients can determine what happens to them in labour. However this is not a sanctioned practice as the pressure put upon these 'crusader' midwives to conform to 'standard practice' as blueprinted by policies is great. Techniques generally applied are the use of fear (such as the threat of litigation), the use of authority (the threat of not getting a good reference or promotion) and the use of peer pressure (such as being labelled a deviant or being treated as an outcast).

Change in midwifery practice has been described as a "drip, drip effect" (Ho 1989) but this change is only possible when the culture of the ward is determined by a dominant group who share the same values, beliefs and attitudes. For instance, in the early part of this second phase of the research there was a group of 'crusader' midwives working in the Delivery Suite who shared the set of beliefs that midwives and clients are partners-in-care and that women and their husbands/partners should be empowered to make decisions about their birth process. Subsequently these beliefs were translated into practice in the form of birth plans and joint decision-making in spite of the objections put forward by the senior midwife who believed that the midwives should make all the decisions as they are the 'experts'. As the 'crusader' midwives were the dominant group at the time, the authority of the senior midwife was ignored. Moreover the other nurse-midwives being in the minority group at the time had either to come into line with the practice of the 'crusader' midwives or at least to modify their own practice so as to gain implicit acceptance from the 'crusader' midwives.
This form of group action is significant as in social life within a professional setting individuals must align their behaviour with others and with groups (Blumer 1969:131). This latter point emphasises the significance of the next theoretical perspective that the researcher is going to discuss, that is the symbolic interactionist theory of human behaviour.

Summary:

Emerging from the data are three types of midwives. Each of these types of midwife hold their own professional ideology which could be related to the model of learning that they have been exposed to during training as well as to the professional socialisation process. The difference in the way midwives construct the reality of their world of work and the factors contributing to this difference in perception were explored. At least one factor could be isolated from the discussion of Argyris and Schon's work on the reflective practitioner to explains why the three types of midwife exhibit different cultural values, beliefs, attitudes, and behaviour. The three types of midwives are exposed to a training whereby they acquire a body of knowledge from their tutor on which they base their own practice. However, from the data there is evidence that the 'crusader' midwives appear to be more willing to 'take risks' and experiment with their clients to learn from their practice by reflecting back on a case. In so doing, they attempt to redefine theory. On the other hand the nurse-midwives, by following routines, customs and rituals appear to fail to learn from practice. The reason for the nurse-midwives not learning from their practice may be that they believe that the technical rationality type knowledge is the most important, and hence they do not attempt to learn from experience because this is not valued by them as knowledge. Consequently their practice becomes static. This group of midwives tend to hold key positions in the middle management strata and are major influence in policy making regarding midwifery care. Therefore
the most common complaint made by the crusader midwives is the uphill struggle to make changes to care as they failed to have their opinion translated into practice. This then led to a conflict in the cultural values, beliefs and attitudes which exist between the educational and service sectors.

Student midwives exposed to such learning experiences generally have to 'fit in' and conform to the static and rigid practice of midwifery care. As students spend a significant amount of time in the clinical area which forms their primary learning experience, the effect is that students tend to adopt the rigid type of care which is not congruent to the type of care espoused by the educationalists. While the work of Argyris and Schon has helped to shed some light on why the different types of midwives act in different ways, it does not address the issue as to why they are different in the first instance. This is an interesting phenomenon as most of the midwives interviewed and observed in this study have undertaken a similar form of training. It transpired that one explanation lies in the way in which individual midwives perceive the professional world that they are exposed to ie some take a view that they are being control while others tend to think of themselves being in control. Moreover, midwives also act towards things on the basis of the meanings they have on certain words or concepts. For instance, the meaning assigned to the word 'midwife' by the crusader midwives is that of an independent practitioner trained to look after women in normal pregnancy and birth. Consequently they behave as an independent practitioner and this behaviour is reflected in their autonomy and accountability. Hence to aid an understanding of the manner in which each type of midwives makes sense of their professional world the researcher has employed the theory of symbolic interactionist.
5.3 The Theory of Symbolic Interaction

George Herbert Mead (1934 and 1962), a social psychologist, advanced the symbolic interactionist school of thought by postulating a social process whereby a biological organism develops a mind and a self and becomes, through social interaction and society, a rational being. It is in social interaction that the individual achieves a sense of self. Through role taking, the individual is capable of being an object to self and achieves a sense of self. As the individual "takes the role of other" the ability to look back at self, a distinctly human capacity, is learned. This human capacity of seeing self from the perspective of others enables the individual to have a concept of self (Mead 1934). The concept of self is learned during childhood and through social interaction but this process is continuous throughout life (including the period of professional life).

Mead (cited in Blumer 1969) further elaborated on the symbolic interaction tradition. According to him, symbolic interaction rests on three fundamental premises:

- that human beings act towards things on the basis of the meanings that the things have for them. These things may be objects, other human beings, institutions, guiding ideals, activities of others or a combination of these.

- secondly, the meaning of such things is derived from, or arises out of the social interaction that one has with one's fellows (as cited in Blumer 1969:2).

- thirdly, these meanings are handled in, and modified through, an interpretive process used by the person in
dealing with the things s/he encounters (as cited in Blumer 1969:2).

These premises rest on the belief that, as Blumer asserts:

The human being is not a mere responding organism, only responding to the play of factors from his world or from himself; he is an acting organism who has to cope with and handle such factors and who in so doing has to forge and direct his line of action.

(1969:55)

Like Mead, Blumer focuses on the concept of self which is central to symbolic interaction. The concept of self leads to meaning and 'self-directed' behaviour. According to the symbolic interactionists, the concept of self is probably unique to humans. A human has a concept of self and also acts towards others and communicates with self. The human ability to hold a concept of self and for self-interaction is the basis for the formulation of meaning and experience in the (social or professional) world.

Symbolic interactionists view human behaviour as a result of process. Blumer asserts that "all human behaviour is the result of a vast interpretive process in which people, singly and collectively, guide themselves by defining the objects, events and situations they encounter" (Blumer 1969:132).

Hence in a professional context, for social life to occur, individuals must align their behaviour with others and with peer groups; therefore, meaning must be shared. As Blumer notes:

...an institution carries on its complicated activity through an articulated complex of such stabilised meanings... The process of interpretation may be viewed as a vast digestive process through which the confrontations of
experience are transformed into activity... it is, I think, the chief means through which human group life goes on and takes shape.

(1969:133)

Group consensus is reached when there is universal agreement by members on definitions of objects, events, and situations. Group consensus on definitions creates shared meaning in the group and hence individuals can plan their behaviour with those of others. Professional life is based on consensus and shared meanings about relevant phenomena and people. These shared meanings create collective behaviour. The individual as part of the collective adapts her/his self-definition with those others and acts according to shared meaning. In the current study the researcher found that midwives shared some fundamental beliefs and values. For example in phase one some student midwives confided in the researcher that they felt 'brainwashed' into believing that they are different from other health professionals because they are 'practitioners in their own right.' This is clearly one of the fundamental belief of the midwifery profession and in this study the crusaders and survivors midwives are shown to have such beliefs. They further sought to instil these beliefs and values into the new members of the profession ie the student midwives in the form of 'articles of faith' (Davies 1988).

In addition the researcher found that there were also different values and beliefs (defined in this context as a sub-culture). All phenomena and people are subject to redefinition and new meanings through interaction. Since meaning is created through the self as well as through language, new definitions of phenomena create new self-definitions (The role in which language plays in the construction of reality and hence makes professional life meaningful will be explored in the next section).
Experience changes self and hence, changes behaviour (Blumer 1969; Denzin 1970). This results in change within the profession over a period of time. Clearly change does occur in midwifery as illustrated by the following comments:

"I believe that some change is good, like midwives being allowed to do more things, you know, suturing etc.."

"...sometimes I feel that students are the driving force as they come up with the good ideas and then change occurs..."

"...when I did my training and it wasn't that long ago (laughter) husbands were not allowed in for the birth, now most husbands stay and I think such changes are positive as we involve the partner more".

The symbolic interactionist studies behaviour on two levels: the behavioural or interactional level and the symbolic level. Studies in this framework must include observations of behaviour in specific situations. In this study the use of a naturalistic research method by the researcher (the rationale for this is fully discussed in the methodology section - appendix 1) focuses the observation on the interaction since it is in both verbal and non-verbal behaviour that the symbolic meaning of an event is transmitted. Hence the observation directed at the interaction of midwives with other midwives, students and clients and the subsequent analysis focus on the symbolic meaning that is transmitted via action.

In addition the full range and variation of behaviour in a setting or in relation to a phenomenon are examined to produce self and group definitions and shared meanings. In order to do this, the researcher describes social behaviour as it takes place in natural settings. The actual setting is examined for social rules, ideologies, and events that illustrate shared meaning and
affect the behaviour of individuals for example midwives, in the interaction (Blumer 1969; Denzin 1970a and 1970b).

As the researcher sought to understand the behaviour as the midwives understood it, the researcher was able to understand the participant midwives' interpretation of self in the interaction and share their definitions. Subsequently this process has aided the researcher to explain to some extent the reasons why the three types of midwives having been exposed to a similar basic training ended up with a different sub-set of beliefs, values and attitudes that influenced their practice.

From observing the 'crusader' midwives go about their daily work the researcher sought to understand why this group of midwives felt that they should be an advocate to their clients at all costs; sometimes to the detriment of themselves as they could be treated as outcasts by the 'survivor' and nurse-midwives. It would appear that the 'crusader' midwives are generally articulate people who would not conform just for the sake of an easy life or for peace. This is illustrated by the following interactions:

Scene 1:

A 'crusader' midwife was looking after a woman in the second stage of labour. A doctor walked in and after consulting the notes and saying 'hello' to the client, he instructed the midwife to give the former some Syntocinon to accelerate the labour. The midwife asked the doctor to go to a corner of the room to discuss the case (but within earshot of the researcher, the woman and her husband)

Midwife: "I see no indication for accelerating the labour, the contractions are strong when they come and she is pushing well."
Doctor: "Well I disagree, I think that these contractions are too 'spaced out' to be doing any good."

Midwife: "I'm sorry to disagree, after all I have been looking after her all day and you have just walked in and haven't even palpated her. I am happy with her progress so far so I want to leave her doing her own thing, I will give you a call if I think Syntocinon is needed later, thank you."

Doctor: "You can do as you please but don't come running to me when you are in trouble, I may be in theatre scrubbed up and you may have great difficulty getting someone to come."

Midwife: "I know who I can call if I need medical assistance, thank you for your concern."

Scene 2:

A midwife was talking to a student midwife in the antenatal ward office:

Midwife: "Mr T (one of the consultants) likes the women on antenatal to fast for at least 8 hours before they have an induction but research shows that this is not necessary."

Student Midwife: "Why doesn't Mr T review his policy if research shows that long periods of fasting are unnecessary?"

Midwife: "I think that these consultants are out-of-date because they don't have any time to read journals or research, but we (meaning the midwives) don't have to do as the consultant or doctors say if we can justify our own
decisions, after all we are here to 'protect' the woman from unnecessary intervention."

Student Midwife: "...but don't you get a lot of hassles if you don't do as you are told?"

Midwife: (laughing) "Oh yes, but I feel we must stand up for the women we are caring for otherwise we are not doing the job; do you know what the word midwife mean."

Student Midwife: "With woman"

Midwife: (nodding) "Exactly."

It would appear that by standing up to the doctors and the institutional rules/policies, these midwives also acquire a better self-concept of themselves which in turn gives them the self confidence to tackle similar situations. For instance one midwife said:

"I know things can be made very difficult for me but at the end of the day I feel good for standing up to these people, and I think you've got to feel good about yourself. In fact by standing up to them and winning the case I feel so confident that it even influences the way I relate to my family and friends."

Another midwife confessed to the researcher:

"When my children were growing up I was just like most of the midwives around here, staying quiet just to avoid hassles. But this time things are different... it is like I have more energy to fight and I do feel more job satisfaction being able to care for my mothers the way I want to. And I also feel good when my student appears to respect me for being a true midwife."
The above demonstrates how the midwife's self concept could develop according to the outcome of the interactions. In return the 'new self' then perpetrates a new attitude towards professional life. As Blumer (1969:4) asserts: "The concept of self leads to meaning and 'self-directed' behaviour." In return this new self with a new set of attitudes could be communicated via interactive episodes to other practitioners, in particular to student midwives who are being socialised into the profession. This is because student midwives are not born into the world of midwifery as functioning cultural professionals. It is through professional socialisation that they acquire the unique attributes of midwives; socialisation involves human interaction, and human interaction is symbolic interaction.

**Professional Socialisation and Value Definitions:**

Since the meaning of any symbol is not an inherent quality of that symbol (Cardwell 1968) the midwives decide what its meaning shall be. Taking on the attributes of a socialized professional midwife requires learning the meaning of the symbols utilised in the midwifery world, that is, learning the connection between the symbol and the thing to which it refers. Symbols are part of our empirical reality. By empirical reality is meant that part of our environment which exists outside of the individual, and is available to at least one of his/her five senses. Symbols acquire their meaning through the process of consensus of the human actors who use them (Cardwell 1968). For instance, the consensus agreement that the wearing of a uniform is significant in gaining respect from the consumers of maternity care led to the use of uniforms in a symbolic way. However the symbolic meaning of wearing a uniform is not static, it can be changed through consensus agreement by individuals (in this case, midwives) attributing new value to the symbol. Value is typically defined as the learned meaning of relative worth of ends, objects, acts, and combinations of these (Cardwell 1968).
Hence while most midwives in the education and service sector hold the belief that wearing a uniform is favourable in gaining respect, presently there is an increasing number of midwives who hold a different belief and have either seen the usage of a uniform in obtaining respect as a useless exercise or that the wearing of a uniform is the professional's way of legitimising their authority. Thus this group of midwives would not see the use of a uniform as symbolically valuable. The result is the growth of a sub-cultural value or belief which may or may not influence change in practice. The important point to note is that a student midwife who enters the midwifery profession would not possess his/her own well organized system of value definitions. The student must learn a system of values through interaction with others. Generally speaking, the individual comes to accept the system of values held by those people most immediately significant to him/her. In this case these significant others are most likely to be the midwifery tutors and mentor midwives. The implication here is that if the cultural beliefs, values and attitudes acquired by the student from the tutors are dissimilar to those they acquire from their mentor midwives, then conflict would occur.

From observing the working environment of midwives, it would appear that the prevailing values are defined by the 'survivor' and 'nurse-midwives.' These midwives form the majority group and are seen as very powerful in maintaining their value definitions which prescribe what is acceptable and unacceptable behaviour of the members of the group in the midwifery world. Failure of any of the members to hold the accepted set of values is frowned upon and differentially sanctioned according to the degree of relative consensus and the intensity with which prevailing values are held. Practitioners who fail to accept and act on the agreed set of values may be seen as acting in a deviant way.
For instance one student midwife was reprimanded for 'allowing a woman to wander about when in labour.' The latter occurred because the mentor midwife working with the student at the time did not believe that women should have the freedom to mobilise when in labour. On the contrary the midwife believed that the woman should be confined to bed until the whole birth process was over. Consequently when her student 'allowed the woman to wander about' the former was seen as being deviant in not accepting the midwife's view.

On another occasion the same student midwife was working with a midwifery tutor on the delivery suite when mobilisation of the 'labouring woman' was advocated by the tutor. In this instance, the student midwife was able to encourage the woman to walk around in early labour because the midwife working with her shared the same belief system. Unfortunately not all the midwives working on the delivery suite that day shared the same belief hence the pair (ie the midwifery tutor and the student) were seen as 'doing their own thing.' This was permissible for a short spell (ie for a day) because the other midwives considered that the tutor had more authority and that therefore they had to put up with her action. The interesting thing is that the other midwives did not change their belief system as a result of the tutor's action nor did they label the tutor's action as being deviant or 'bad' in any way. They just appeared to address the whole issue as a temporary occurrence that would return to normal once the tutor left the delivery suite. In fact this was untrue as the belief propounded by the tutor did not disappear when the tutor left the delivery suite, rather that belief was incorporated into the student's belief system. As the student proclaimed:

"I am glad to have worked with J (the tutor) as I could see what a big difference encouraging the woman to walk about makes; that is, her labour speeded up and we had a lovely delivery." However, such a belief is not an universal one among midwives.
Indeed it is not even a belief held by a majority of the midwives hence the student constantly felt unable to put into practice what she believed in. To do so against the wishes of her other mentor midwife would be seen as deviant.

Durkheim addressed the possible sources of the value definitions which define a given act as 'bad' and therefore an act of social deviance. According to Durkheim (1960:25):

"...we must not say that an action shocks the common conscience because it is criminal, but rather that it is criminal because it shocks the common conscience. We do not reprove it because it is a crime, but it is a crime because we reprove it."

Hence, any act can be defined as a deviant act because it is considered unusual or undesirable by the profession. Consequently deviance is culturally, and therefore symbolically, defined. The idea of labelling certain acts as being deviant is implicitly to draw a parameter in which accepted practices lie. In turn this parameter of accepted practices is then passed on to the next generation of midwives through the process of professional socialisation. However the above example is only one among many that arouse feelings of conflict in the student. On the one hand s/he is taught one set of values, beliefs and attitudes and on the other s/he is exposed to other more prevailing ones. This causes what is termed 'cognitive dissonance.'

Festinger's Theory of Cognitive Dissonance:

Leon Festinger (1956:45) introduced the concept of 'cognitive dissonance' which is based on the notion that an individual tries "to establish internal harmony, consistency, or congruity among his opinions, attitudes, knowledge, and values..." The individual's knowledge, opinions, and values are what Festinger
terms "cognitive elements." According to his theory, pairs of cognitive elements can exist in any of three relationships: 1) irrelevant, 2) consonant, or 3) dissonant. As one might suspect, in the irrelevant relationship the cognitive elements in question bear no significant relationship to one another. In the second type of relationship, or consonance, one cognitive element follows from the other; and in the dissonant relationship, the obverse or opposite of one element follows from another. That is, when a person believes that one event will happen as a result of a belief and the opposite happens, that person will have what Festinger terms a dissonant relationship between cognitive elements. The event, in other words, does not logically follow from the belief. Festinger further propounds the view that people will attempt to maintain consonance among cognitive elements; hence, individuals will need to employ tactics to reduce the cognitive imbalance created by dissonance. According to Festinger, there are three ways in which dissonance may be resolved:

1) by changing one of the dissonant elements, 2) by adding new elements into the cognitive structure, or 3) by redefining the dissonant element as unimportant.

This can be seen in the earlier case: the student midwife acquired a belief system which was not congruent with the predominant midwifery practice and a feeling of dissonance was created. It would appear that the greatest amount of dissonance would occur when students who have been taught one set of beliefs, values and attitudes are subsequently exposed to practice that mirrors a different set of beliefs, values and attitudes. This is in effect a conflict of two cultures ie the 'school' versus the 'ward'. The following is another example of dissonance being felt by the student.

In a study day a student was involved in a discussion of the issue of informed consent. The definition of informed consent is
taken as an understanding of the procedures, goals, benefits, and risks prior to each test (Blatt 1988:39). This means that the client and her obstetrician or midwife enter into a contractual relationship whereby s/he agrees to provide care and the client in turn agrees to let the provider use her/his professional knowledge to guide the former. Hence the professional has a duty to disclose all the information about tests or treatment. Providing all the facts is the basis of 'informed consent'. The discussion centred around the woman's right to know all the facts so that she can make a choice of treatment that is based on as much knowledge as is available. According to the student she was persuaded to incorporate this belief as a fundamental right of every client as a result of the discussion. However subsequently the same student was exposed to a scenario whereby the midwife working with her on the postnatal ward gave an injection of anti-D to a woman with a 'casual explanation' that the latter really required the treatment. The student subsequently had to analyse her feelings about the whole event. The student in her own words described herself as "dismayed that the midwife should give a woman an injection at the same time as telling her that she really required the treatment... she (meaning the midwife) never explained why the client would require the treatment neither did she explain to the client the side effects etc." The student further described the experience as "an assault on the woman" and "degrading as the midwife treated the woman with ambivalence." These are very strong negative feelings that were projected by the student. It could be because the actions initiated by the midwife were not congruent with the student's belief system and hence cognitive dissonance resulted. The researcher was unable to find out how the student resolved (if she indeed managed to resolve) those feelings of dissonance as the student left her training before the researcher had a chance to re-interview her.

Some students articulated how they had been able to reconcile the two sets of beliefs, values and attitudes. Some strategies
devised for coping with the conflict of culture were described as follows:

pretending that the clinical environment is a place whereby 'real care' is given as opposed to the classroom whereby 'ideal care' is talked about.

only practising as the tutor teaches when working with crusader midwives who share the same values, beliefs and attitudes.

making excuses for the clinical midwives as they are seen as being put under pressure by their managers and/or obstetricians.

modifying one's belief system by claiming that what is taught in the classroom is what some midwives describe as 'fashionable' and 'trendy'.

In practice student midwives often find themselves in a position of conflict. This conflict is as a result of the dissonance between two sets of beliefs, values and attitudes. Survival to the end of a span of duty and to the end of the course is the name of the game, hence it assumes uppermost importance for learners. This instinct to cope, in spite of extremely pressurised work situations, has become absorbed from nursing into the midwifery culture as discussed in phase one of this research.

Tutors of course are also individual midwives who have their own belief and value system. However there is an apparent dichotomy in that there is a distinct group of midwifery tutors who share the beliefs and values of the 'crusader' midwives and then there are those who share the beliefs and values of the 'survivor' or nurse-midwife categories. This would in turn influence the
amount of cognitive dissonance experienced by the students. The following example illustrates the above point:

There was a particular tutor who described herself as 'being radical' and wanting to influence her students to think politically about the profession of midwifery and the issue of power and the profession. When challenged by the researcher the tutor denied 'trying to brainwash' her students. She asserted that her students could only be brainwashed if they allowed her to do so as they had minds of their own. However this tutor volunteered the information that her students appeared to 'have the hardest time in the clinical area.' The researcher set out to find out if any truth was apparent in this tutor's assertion. When talking to some midwives about this set of students the following words were used to describe them:

articulate, challenging, switched-on, research-minded, noisy, trying to be too clever, learning to run before they can walk, don't fit into the system, difficult students, hard to mould into our ways.

The latter remark is interesting in that some of the students in this tutor's set appeared to have two socialisation processes going on: that is a belief and value system imposed on them by their tutor in class and a sub-set of beliefs, and a value system imposed on them during their clinical allocations. The result is a conflict situation which equates to the cognitive dissonance described by Festinger (1956). Some students made the following comments:

"It's absurd being taught one thing in the school and being taught another on the wards, one ends up really confused."

"I have come to think that the theory the tutors teach us is not the type of care women want... rather it's the type of care the tutor herself would want. When the researcher
asked why, her reply was: "Because most women don't complain about the care they receive... for instance my tutor makes epidural sound like a torture that is being inflicted on women during birth but I have found most women welcome this form of pain relief."

When the researcher asked the student if it is conceivable that the women did not complain because they feared being reprimanded by the profession the student answer was "I have never thought about that." Other comments were:

"It's good to have another tutor teaching us apart from our own set tutor because we can see that each tutor has a different point of view. But it is still confusing for the students. Like on one occasion we were discussing home versus hospital confinement and both the tutors were using the same set of statistics to back their own point of view, that is one was for home and the other was for hospital births... so at the end of the day who do we believe?"

"I take on board all the comments made by the tutors and midwives, then I sieve through them and make up my own mind about things. Sometimes I come out in favour of the tutor, sometimes the midwives and yet at other times I form my own beliefs. I think that is the best way as students, who will after all be the future midwives could bring new ideas into the profession." "... but having your own idea is difficult at times because it may threaten the tutors or the midwives, as they both try to impose their ideas on students... I suppose that is part of the socialisation process... ie in order to maintain the status quo."

This student would appear to be undergoing a model 2 type learning experience as described in the last section.
Definition of the Situation:

As surmised from the above discussion symbol learning (socialisation) is an inherent process that every profession seeks to perpetuate.

As human beings, we do not make some instinctual connection between symbol and referent. The connection that exists between these phenomena is cultural and, as a result, must be learned through the socialisation process. Moreover social interaction is the process of two or more individuals taking each other into account. Since we learn from other humans (ie we are socialised by other human beings), it follows that at least two individuals are involved in socialisation. Hence it follows that symbol learning must be acquired in a social setting. However no two situations are completely alike; therefore some definition of the situation or social setting must occur. The definition of the situation is a salient factor that needs to be taken into account when analysing a particular interaction sequence.

Of paramount importance in attempting to analyse the process identified as defining the situation is, of course, the individual who is doing the defining. The individual becomes a practitioner through the process of professional socialisation as well as through professional education. As a novice practitioner, the individual becomes aware of the definitions of his/her profession with respect to given situations. As s/he learns the common language from the midwives, s/he also comes to learn that certain moments of disgust, pleasure, and indifference occur repeatedly in similar situations. These facts are then incorporated into the individual’s overall system of language, and s/he comes to bring them to bear in situations where s/he has characteristically observed them in use. The point being made is that the novice practitioner can learn how a significant number
of situations should be defined simply by being present in the familiar context of ongoing interaction. This is where the impact of the hidden curriculum remains the greatest. The following comments serve to illustrate the above point:

"As a student working on the ward, I learn all the time, not just when I'm shown how to do something or some procedure, but even when I see how a midwife talks back at a doctor. ... like I can learn to be more assertive or in some cases less so."

"... there is always something going on all the time, out there (meaning the ward). Sometimes we have nothing to do, you know, no patients say in delivery suite so the staff gather around the nurses' station and that's when I really notice the behaviour of the midwives. Some will be really relaxed and allow you to do the same like allowing the students to call them by their first name while others still maintain their status. You soon learn how to relate to each midwife unless you are new to delivery suite; but then you soon get 'put wise' by the other students."

It is possible that as the student midwife becomes more advanced in her training his/her definition of certain situations will conflict with those of his/her profession. This could then result in a kind of 'generation gap.' However the accuracy of the definition of the situation is related to the concepts available to the person doing the defining. Therefore what the student is capable of defining is relative to the range of concepts which have been learned through past experiences. An excellent example of the way in which concepts available to the individual influence the manner in which the situation is defined is the case of the nursing profession. For example, Corwin and Taves (1963) have suggested that nursing students are interested in meeting people and being of direct service to those who need help. Furthermore evidence based on recruitment campaigns
indicates that most nursing students conceptualise the situation in which a nurse works as one which defines the nurse as 'ministering angel' or 'Florence Nightingale' and these students certainly enter the training with this concept of the nurse. In the classroom situation this concept of 'ministering angel' is further reinforced by the tutors. However, as Corwin and Taves (1963) document, once the student nurse enters the bureaucratic structure of the hospital and must answer to the authority of the senior nurse or manager, the nurse's loyalty shifts from the patient to the hospital. Evidence indicates that the role conception of the student nurse thus changes once she begins to practise in a hospital setting (Cowan and Taves 1963). In Maryo's study (1959) it was demonstrated that one primary area of dissatisfaction identified by practising nurses is the absence of a clear definition of nursing duties; they complained of being asked to perform tasks which conflicted with their conception of their duties. Also Berkowitz and Berkowitz (1960) found that practising nurses were more apt to like best those patients who conformed to their expectations of an 'ideal' patient. Practising nurses evidently alter their definition of the situation in which they work from one which requires a 'ministering angel' to one which defines the nurse as a representative of the bureaucratic structure of the hospital rather than of the patient. Therefore the nurse enters the profession with one set of concepts which may be defining the role appropriately and subsequently acquires new concepts which redefine the situation.

The above discussion is very pertinent to midwifery in which most care is given within a hospital setting which is bureaucratic in nature. Indeed one of the fundamental beliefs, that a midwife is 'a practitioner in her own right' is challenged in practice as 'midwives in some clinics are only used as receptionists or chaperones and to test and weigh women' (Brain 1979). The Robinson et al survey (1983) documents the decreased role and responsibilities of the midwife.
Hence as in the nursing profession the student midwife who enters the profession may be defining the role of the midwife as a practitioner in her/his own right appropriately but subsequently s/he may acquire new concepts (as a result of exposure to the hospital clinical environment) which redefine the role of the midwife as something different, for example, as an assistant to the obstetrician. But while they are still in training they are constantly being referred back to the 'article of faith' espousing that they are practitioners in their own right. Consequently student midwives learn to develop their own strategy for survival during what has been described by one midwife as "the most turbulent period of my professional life." While some of the strategies in resolving their 'cognitive dissonance' have been discussed earlier, another tactic used by students and their midwife mentors is that employed by the street-level bureaucrats.

Michael Lipsky (1980) writes of the aggregated behaviour of individuals employed in public services and develops a theory of street-level bureaucracy to show how the decisions, routines and devices used by individual workers effectively distort 'official' policies to create a system in which it is possible for the street-level bureaucrat to survive.

Midwives in this country are an excellent example of street-level bureaucrats, who make huge adjustments to their way of working in order to accommodate different values, beliefs and attitudes as well as large caseloads and inadequate resources. For instance, philosophical values about individualised client-centred care (as propounded in theory taught in the classroom) become lost in the structural constraints surrounding service provision. Lewis (1990) argues that "it is easier for the street-level bureaucrat midwives to provide care when responses and total conformity are fully predicted and controlled." Lewis (1990) further argues that "it is not too difficult therefore to understand how midwives allow themselves to become coerced into patterns of care
which make little demand upon their specialist knowledge and, even more importantly, upon their time. Hence one consequence of having to learn to work within a bureaucratic environment is that midwives found that they modified their practice so much so that it is quite different from their espoused theory.

Another interesting phenomenon is the way in which midwives and students check each other out before an interaction would take place. Hence the behaviour relative to a situation is typically directed toward those other individuals present, either physically or symbolically, in the situation. When the practitioner midwife enters an interaction situation in which new students are present, the midwife attempts to gain as much information about the students as possible so that s/he may tailor her/his behavior appropriately. Similarly the researcher found that students also try to find out in advance as much information as possible regarding their mentor. As Goffman has aptly stated:

> When an individual enters the presence of others, they commonly seek to acquire information about him or to bring into play information about him already possessed... Information about an individual helps to define the situation, enabling others to know in advance what he will expect of them and what they may expect of him. Informed in these ways, the others will know how best to act in order to call forth a desired response from him.

(Goffman 1971:1)

That behaviour is tailored to others present in the situation, and that these others are important in terms of the definition one has of the situation (Cardwell 1968). For instance the researcher found in this study that as the relationship between a student and her/his midwife mentor changed, there was a corresponding change in the definition of permissible behaviour.
such as allowing the student to have a cup of coffee/tea in the sister's office with the midwives (these were considered to be unofficial breaks). In essence this indicated that as the definition of the student/midwife partnership changed (from newcomer to accepted member of the profession), the level of permissible professional and non-professional activities, and thus the definition of the situation, also changed. In other words, the definition of the situation changes as the definition of the others involved therein changes. It is interesting to note that the status of 'accepted member' is given to the student when the student appears to have learnt the cultural values, beliefs and attitudes of the practice area. These the student would acquire through a process of professional socialisation.

By way of examining the student/mentor relationship the researcher impinges on the professional world which in many aspect resemble the social world. As a result of analysing the two sets of values held by the educational and service sector the researcher also impinges on culture. Sociologists have long been interested in the concept of culture and, as expected, many varied definitions of culture have been set forth. According to Taylor (1972) culture is a 'complex whole'. This complex whole is composed of knowledge, beliefs, art, morals, law, custom, and many other capabilities and habits acquired by man as a member of society and therefore in a social setting. Insofar as the elements of the culture (that is the complex whole) are concerned, it is clear that Taylor (1972) intended his definition to include those aspects of man's world which are symbolically defined. The complex whole implies that these elements are not haphazardly related to one another, but are synthesised into a complex whole which 'makes sense' in terms of human behaviour.

Within the symbolic interactionist frame of reference, culture is a term used to denote the totality of man's symbolic heritage (Cardwell 1968). It thus refers to what any given group of
professionals would define as their 'normal way of doing things'. As previously discussed the novice student midwife is not brought into the midwifery world as a functioning professional human being. Rather, s/he must learn the meanings of symbols and the appropriate referents through the process of professional socialisation. Furthermore, s/he learns the prevalent value definitions and the associated plans of action, as well as how to define the situation. S/he must learn, in other words, the 'normal way of doing things' shared by the group into which s/he enters. The society of which s/he is a member has established a complex set of definitions which provide guides to acceptable and unacceptable behaviour, along with a corresponding set of sanctions to deal with those individuals who violate the cultural norms. Among the normative guides that the society provides for the novice student midwife are stipulations as to the language s/he will use, the kinds of clothes (ie uniforms) s/he will wear, the role that s/he is to assume, the social position s/he to occupy in relation to the hierarchy, the manner in which s/he is to give care and treatment, the level of participation in unofficial activities (like coffee drinking in sister's office) and the amount of study time available during ward allocation.

A subculture is a learned configuration of definitions which broadly parallels the definitions of general culture of which it is a part, but which has distinctive or unique definitions that are different from, or at variance with, the definitions that comprise the general culture. In the midwifery world there are general core values and beliefs that are shared by most of its members such as that of being a 'practitioner in one's own right' and 'being accountable for one's practice.' However, there are also differing values and beliefs held by certain factions of the profession such as the 'crusader' midwives as well as the 'nurse-midwives.' Consequently these midwives promote a subculture. It would appear that the cultural norms or the 'normal ways of doing things' are very important to the nurse-midwives. Perhaps it is the main channel in which they maintain
as much of the status quo as possible. For instance the hierarchical structure is maintained by informal rules about who can sit where (there is usually a designated chair for a senior midwife in the clinical area) and about who can be on first name terms with whom (usually the higher up the hierarchy one is the more one can freely call the senior midwives by their first name).

While there is evidence that students are very much influenced by the values, norms and beliefs of a particular professional culture there is some evidence that students can influence the same culture by their personalities. This point is of great significance as it implies that the profession of midwifery could be changed by the student novice practitioner. The researcher therefore proposes to develop this discussion further. Cardwell (1968:38) argued that "culture is to society as personality is to the individual." In other words, Cardwell saw that the personality of the individual is relative to the general configuration of cultural definitions s/he has been taught. For instance Benedict's classic study (1964) led her to conclude, in part:

...most people are shaped to the form of their culture because of the enormous malleability force of their original endowment. They are plastic to the moulding force of the society into which they are born... In any case the great mass of individuals take quite readily the form that is presented to them.

(Benedict 1964:254-55)

Other researchers such as Henry (1940); Honigmann (1967) and Hus (1967) also support Benedict's assertion of the importance of culture as the shaping force of personalities of the individuals in society. Lewis (1990) also argues that as most midwives are female and have undergone a socialisation process which is
instilled with patriarchal values this explains why midwives act submissively to obstetricians, who are predominantly male. In the current study one midwifery tutor commented, "I'm sure one reason midwives often act in a subservient way is because midwifery is predominantly a female profession and women are taught right from the beginning to conform and not to rock the boat etc." In the current study the researcher was able to ascertain that the greatest degree of conformity appeared to be evident in the nurse-midwife. It appeared that this was also related to the personality of the midwives ie the group of nurse-midwives seemed to want to remain passive and to conform in order to keep the peace. They saw overruling the organisation and the policies generated by the consultant as an act that was somewhat out of line. This is illustrated by the following discussion that occurred on the Delivery Suite one afternoon:

Midwife D: "I disagree with Mrs K (Head of Midwifery Service) about this team midwifery lark."

Senior Midwife: "It's not for you or anyone of us to disagree, we have to do it whether we like it or not."

Midwife D: "I don't see why, if I disagree I should be able to voice my opinion, it's a free country, isn't it?"

Senior Midwife: I believe that opening one's mouth too often is asking for trouble, especially when powerful people like her (meaning Mrs K) and the consultants are already decided on implementing it" (meaning the team midwifery).

Midwife A: "The consultants only act high and mighty because they think that we women can be pushed around."

Midwife D: "I agree, if we stick together we can be heard."
Senior Midwife: I would agree with D, men do rule the world.

Midwife D: "But we do have a female Prime Minister..."

Senior Midwife: "Ah yes, see what is happening to this country, like the NHS for instance, it's a fine mess; no, our best bet is to follow those who lead otherwise you are not one of us and life is then difficult for all concerned."

Lewis (1990) asserts that as these midwives are socialised into conformity they in turn employ the same tactics in professional socialisation, that is they are preoccupied with the generation of rules both formal and informal, so as to propagate or sustain a given organisational and social order within the profession of midwifery. However, the viewpoint that people are being moulded by society and later by the midwifery profession to fit into the organisation can be challenged. For instance it is clear that the 'crusader' midwives practise differently and this is in part due to the genesis of a different subset of values and beliefs. If indeed researchers such as Henry (1940); Honigmann (1967) and Hus (1967) are totally correct in their assertion that culture is the primary shaping force of personalities of individuals within a specific society then changes within the profession would not be possible. In other words there would not be a subgroup of midwives (ie the crusader midwives) who possess a subset of values and beliefs which consequently affect clinical practice.

The above discussion of culture suggests that the concepts available to individuals for use in their everyday interaction are somewhat relative to the culture setting into which they are born and, subsequently, into which they are socialised. Since perception is relative to the concepts available for use, two individuals might perceive the same situation in greatly different ways. As previously cited human beings are symbolic
animals and their world comes to have meaning for them relative to the consensus as to the meaning of symbols used to represent their world. The way in which an individual midwife perceives a given situation is also dependent on his/her personality as illustrated by the following:

In the College there was a tutor who described herself as an introverted person who spent a considerable amount of time worrying about 'trivial things'. Interestingly she described being a midwife today as 'frustrating' and 'unrewarding' because changes are so slow. She had a rather pessimistic view of midwifery in that she believed that the profession is slowly turning into a branch of nursing.

Another tutor who described herself as an 'outgoing sort' who 'worries about things when they go wrong' appeared to have a totally different outlook on the profession. She saw that while change is slow at least it is happening and nothing is static. She further asserted that "the nurses will have a job to take over our profession."

There was within the maternity unit a senior midwife who described herself as 'being the serious sort' who would not 'tolerate any nonsense.' This senior midwife's personality appeared to be reflected in her perception of midwifery in that she also felt that 'midwives are not serious enough in their work and are letting women get their own way too easily.' She did not support beliefs like choices for the clients or informed consent as these involved midwives in the less serious business of talking and not enough 'getting on with the job.' Moreover she perceived giving choices to women as a silly idea as in her view "midwives and doctors are the experts and should therefore not waste time but tell the patient what is good for them."
Summary:

In this section the researcher sought to illustrate how each of the three types of midwives hold their own professional ideology which could be related to the model of learning that they have been exposed to during training as well as to the professional socialisation process. The difference in the way midwives construct the reality of their world of work and the factors contributing to this difference in perception were explored.

The symbolic interaction theory was used in this section as a theoretical tool to explain why the three types of midwives having been exposed to a technical-rational type training subsequently acquired a different set of beliefs, values and attitudes. For instance, from observing the 'crusader' midwives go about their daily work the researcher sought to understand why this group of midwives felt that they should be advocates for their clients by standing up to the doctors who may intervene in normal childbirth. It would appear that the very act of being assertive towards the doctors caused the midwives to acquire a better self-concept of themselves which in turn gave them the self confidence to tackle similar situations. When a group of such midwives operate in a specific clinical environment (for example in the Delivery Suite) informal rules, routines, protocols and policies are made more flexible and adaptable to meet the clients' needs. The above process is made possible because of group consensus being reached on new definitions of objects, events and situations. Group consensus on definitions also creates shared meaning in the group and communication and a common language for communication provides the mechanisms for the meanings to be shared. Through professional socialisation and a common language, the learning of shared meaning is accomplished. The researcher would assert that the midwifery profession is maintained primarily through the use of a distinct language. This distinct language legitimises the professional status of midwifery. In addition, the language used in practice is both
similar and different from that used in the educational sector. Hence, like the values, beliefs and attitudes there is both a cultural as well as a sub cultural means of communication. The theory of communicative action is explored further in the next section to illustrate the above points.
5.4 The Theory of Communicative Action

Communication is intertwined with all of human life. Hence the study of any human activity and in this case of the actions and behaviour of midwives in their work place must touch on communication processes in one form or another. In a sense this section illustrates a part of the researcher's quest to understand midwives and their construction of reality. Specifically, it is a synthesis of some major contemporary theories of communication and communicative action. The central assumptions of all the theories of communication discussed in this section are that human beings act in the world, that their actions are meaningful, and that interpretation is necessary for the understanding of human action and experience.

The researcher hopes to explain the actions of midwives and the construction of their reality through the means of communication and use of language. The assumption made is that communication itself is a vital vehicle in the social construction of reality (Berger and Luckmann 1966). Language is the fundamental mode of operation of our being-in-the-world and the all-embracing form of the constitution of the world. As according to Gadamer (1976:35) "reality does not happen 'behind the back' of language, it happens rather behind the backs of those who live in the subjective opinion that they understand 'the world'; that is, reality happens precisely within language."

The idea of the social construction of reality was expressed by the philosopher Alfred Schultz (1970) in these words:

"The world of my daily life is by no means my private world but is from the outset an intersubjective one, shared with my fellow men, experienced and interpreted by others: in
brief, it is a world common to all of us. The unique biographical situation in which I find myself within the world at any moment of my existence is only to a very small extent of my own making."

(Schultz 1970:163)

Our meanings and understandings, in short, arise from our communication with others. This notion of reality is deeply embedded in sociological thought. Its most well-known proponents are Peter Berger and Thomas Luckmann in their treatise "The Social Construction of Reality" (1966). According to Gergen (1985) the processes by which individuals account for their world and their experience are based on four assumptions:

1. The world does not present itself objectively to the observer, but is known through human experience, which is largely influenced by language.

2. The linguistic categories through which reality is apprehended are situational in that they emerge from the social interaction within the group of people at a particular time and in a particular place.

3. How reality is understood at a given moment is determined by the conventions of communication in force at the time.

4. Socially constructed understandings of reality shape many other aspects of life. How we think and behave in ordinary life is largely a matter of how we understand our realities.

Hertzler (1965:121) stated, "Language is not merely an incidental means of solving specific problems of communication and reflection; actually, the real world is to a large extent unconsciously built upon the language habits of the group." Each language then represents a particular social reality. Language is
an expression of the culture or sub-culture in which it is used as the means of communication. Hertzler (1965:126) goes on to say:

"A final aspect of language as culture index is that it reflects the essence of the culture of which it is both part and symbol so specifically that another language cannot serve as an adequate substitute. Many words and phrases of language can be understood only by explaining them in their particular cultural setting. Similarly, many aspects of another culture cannot be expressed in a particular language because it does not have the words to do so".

In this study the researcher found that midwives do frequently use a distinct language to maintain their professional status. It was interesting to note that newly arrived students were given a lecture on midwifery terminologies on the first or second day of their course, but the use of slang words such as 'flat baby' and 'the primip' are learnt by the students when they work with their midwife mentors. The use of midwifery terminologies is further enhanced during the period of orientation in the clinical area. It also appeared that the use of this distinct language can be use as a tool to persuade clients to accept certain form of treatment. For instance on one occasion the researcher observed the following interaction: a midwife was trying to persuade a woman in labour to have an epidural for pain relief. When the midwife perceived that the client was resisting to the idea she began to employ technical words such as elderly primigravida with essential hypertension, a small-for-date baby and prolonged second stage. When the researcher tried to ascertain the reason why the midwife concerned should change the mode of language half way through an interaction, the following rationale was offered:

"I felt that the woman was not clear as to why an epidural
could be advantageous to her, so I had to convince her that I know what I am talking about..."

This midwife went on to say that "professionals like doctors and midwives need to be careful in using these words in front of clients as we then run the risk of clients adopting the use of these words, then they are in a position of being expert telling us how to do our job."

It is clear that the use of midwifery terminologies is only meaningful in the world of midwifery or obstetrics. For instance the term 'engagement' has a very different meaning in midwifery/obstetrics from everyday english.

Another interesting point that emerged from this study is that sub-groups like the 'crusader' midwives have developed a form of language which differs from the traditional midwifery terminologies frequently employed by the 'nurse-midwives'. For instance 'crusader' midwives would use terms such as 'client' and 'home/hospital births' while the 'nurse-midwife' would use the more traditional terms of 'patients' and 'home/hospital confinement'. The implication is the difference in the values, beliefs and attitudes which underpin the usage of these terms. For the 'crusader' midwives the belief that they hold is that childbirth is a physiological process and therefore the use of words like 'patient' and 'confinement' is inappropriate. In using words like 'client' they hope to exemplify the active role of childbearing women whereas the use of 'patient' could be argued to have the opposite effect. The communication encompasses the non-verbal, for instance certain gestures are employed by the 'crusader' midwives to make the client more an active partner in the process of planning care. The researcher observed the gestures such as asking a client to write out a care plan, or to test her own urine etc. On the other hand, 'nurse-midwives' would implicitly put their clients in a position whereby the client could be seen as 'passive' or even 'inferior,' for
instance asking the client to lie on a couch and then the midwife talking down at them. Another common example is to ask the client to change into a hospital gown (which often hardly covers the client's body adequately) then sitting the client in a corridor.

These forms of gestures are seen by some, (Oakley 1984, Kitzinger 1988) as designed to make the client feel vulnerable and powerless and are used frequently to help enhance the power of the professional (Oakley 1984). In the course of training, student midwives would pick up these gestures. By picking up these gestures and putting them into practice, again this causes conflict in the student's cognitive system as they are taught by the 'school' to respect the client and to encourage the client to 'feel empowered' to make decisions pertaining to her case.

As the impact of the non-verbal communication on the creation of cognitive dissonance is great, the researcher was disappointed that the debate regarding the use of midwifery terminologies in mystifying the process of childbirth and in enhancing the power of the professional is not included in the midwifery curriculum. As language moulds an individual's reality this is a sad omission for the midwifery profession. Therefore the researcher attempts to provide some stimulation to such a debate in this study by addressing some of the theories of communication and the use of language in structuring one's reality.

In this study the researcher has observed interactions whereby one person was seen to have influence over another and vice versa. For instance, on one occasion the researcher overheard this conversation:

Midwife A:  "I think the midwifery profession is dying."

Midwife B:  "I personally don't think so, look there is Caroline Flint and her team midwifery and direct entry
training; so many exciting things are happening. We want to fight on."

Midwife A: "I suppose you are right, we really cannot give up now."

Midwife B: "Of course we mustn't. Just think about what you did this morning, that is a positive step in helping the training of students."

Midwife A: "Yes, I am proud of myself, I feel better and more optimistic for the profession already."

Like action, the verbal and non-verbal communication expressed by a midwife is based on a set of beliefs, values and attitudes. It would appear to be appropriate at this point to examine Mead's work on communication. He analysed phenomena of consciousness from the standpoint of how it is formed within the structures of linguistically or symbolically mediated interaction. In his view, language has constitutive significance for the sociocultural form of life. Mead's model (1962) does not start from the behaviour of man reacting to stimuli from an environment, but from an interaction in which at least two organisms react to one another and behave in relation to one another. Mead's (1962) basic idea is simple. In gesture-mediated interaction, the gesture of the first organism takes on a meaning for the second organism that responds to it. This response expresses how the latter interprets the gesture of the former. If, now, the first organism 'takes the attitude of the other' and in carrying out its gesture already anticipates the response of the second organism, and thus its interpretation, its own gesture takes on for it a meaning that is like, but not yet the same as, the meaning it has for the other. According to Mead (1962) "When, in a given social act or situation, one individual indicates by gesture to another individual what this other individual is to do, the first individual is conscious of the
meaning of his/her own gesture (or the meaning of his/her gesture appears in his/her own experience) in so far as s/he takes the attitude of the second individual towards that gesture, and tends to respond to it implicitly in the same way that the second individual responds to it explicitly. The above is frequently found in interactions between the doctor and midwives. The doctor does not usually need to explicitly instruct the midwife to prepare the client or equipment but rather by gesture such as studying the client's notes and saying "I will examine you now" or some vague phrase like "well it looks like you need a hand to get this baby out" (the midwife will immediately know that a forcep delivery is indicated).

These types of gestures are very important in clinical practice and students have to assimilate them from the midwife mentors on the ward. It is not something that they can learn in the classroom from the tutors. At the same time as assimilating gestures the students will also be picking up the verbal communication skills. The verbal communication learnt on the ward is not a static process as the students will learn different slang words from 'crusader' midwives and 'nurse-midwives'. The verbal and non-verbal communication used on the ward is sometimes different from the one taught by the tutors, for example slang words like 'a flat baby' and 'she is fully dilated' are not accepted by the educational sector. The tutors would often reprimand and correct student midwives if such words are used in front of them. But the use of slang words is prevalent in the clinical area and most students seem to adopt the usage in order to 'feel part of the team' in spite of the rebuke from the tutors. Moreover the researcher found it interesting that as one student explained - "even if the tutor told me off and I cannot use these words, I would still think in this way." This phenomenon then seems to mimic the practice in that the students and midwife mentors are espousing one theory while practising another.
Mead thinks that he can explain the genesis of meanings that are the same for at least two participants by one organism internalising the relation between its own gesture and the response of the other; the internalisation comes about through one organism taking up the attitude in which the other responds to its gesture.

Each occupational group like midwifery develops its own highly individual form, expressed through characteristic behaviours. In this study the researcher found that midwives have a well developed coded system of verbal, non-verbal and written communications, effectively excluding the lay person from any understanding of what is going on. For instance words like 'engagement of the presenting part', 'the grand multip', 'the elderly primip', 'the Keilland's rotation', 'late and early decelerations' and 'quickening' are used as a means of technicalising the language in such a way as to retain professional autonomy (ie by preventing the lay consumer from understanding). This language mode is one used by doctors as well, although midwives themselves also have a coded form of language that is used among themselves. This coded form of language could be used in verbal or non-verbal expression as illustrated by the following:

1 A woman was near the end of the first stage of labour. The woman felt like pushing but was told by the midwife not to as she was not in the second stage of labour. Phrases such as 'don't bear down yet'; 'keep breathing, that's it' and 'keep going, good girl', were used to encourage the woman to refrain from pushing too early. When the midwife left the room the student took over by using the same phrases.

2 It was interesting to note that one of the most common gestures displayed by midwives when they entered the room of a woman in labour was to go over to the cardiotocograph (CTG) machine and to study the trace of the fetal heart
rate. They then smiled at the woman and said, 'everything seems to be fine', or 'everything seems in order'. Again in imitation student midwives often gestured to the CTG machine as soon as their mentor midwife arrived to take over a shift.

Another gesture frequently used by midwives in consoling women who appeared to be distressed with labour pains was the offering of back-rubs and sips of water. It was also evident that the more anxious the midwife or student midwife was about the need to be seen to be helping the woman to cope with the pain, the more such gestures were displayed. These gestures were often displayed when the researcher first entered the setting or when the student midwife was left alone with the client. It may have been that the student (knowing the researcher is a midwifery tutor) felt the need to be seen to be doing something active to alleviate the distress. On one occasion a woman actually said, "please don't touch my back, I feel as if it's breaking in half..."; yet the student and later the midwife ignored this request and continued with the back rubbing until the woman reiterated the request twice. When the student was prevented from massaging the woman's back, the former then proceeded to change the position of the client's pillows!

Sub-groups develop into impenetrable cliques, sharing both working and social hours (for example coffee or lunch/dinner breaks). Sub-groups like the 'nurse-midwives' constantly call clients 'patients' and midwives 'nurses'. On the other hand such words are considered undesirable by the 'crusader' midwives. On one occasion the researcher was invited to have a cup of tea in the staff room on Delivery Suite. The following conversation took place:
Midwife L: "I cannot believe Miss T (a senior midwife) has gone on holiday; its like a breath of fresh air here, working without her checking on us all the time."

Doctor F: "I kind of miss her".

Midwife H: "I think you are right, we seem to miss having her around; but by the same token I wouldn't mind if she got lost at sea... (laughter by all)."

This group of professionals shared a similar dislike of one of their colleagues which was expressed in the form of tittle-tattling with each other over a break period. This form of conversation is often evident in the work place. Thus it can be said that values, beliefs and attitudes are expressed through verbal and non-verbal communication which becomes internalised as a way of life.

Hence in summary, midwives appear to communicate verbally and by gesture to interpret events and to share those interpretations with other peers. One consequence is that their realities are shaped by the very act of communicating. This reality in turn, hinges on a set of beliefs, values and attitudes. The beliefs, values and attitudes may or may not be congruent to those espoused by the tutors. Indeed in communication just as in practice (ie the actual task of performing a midwifery task) the students are exposed to conflict. The students often find that their way of seeing things is changed as a result of using a different language code on the ward.

Some of the comments made by student midwives may serve to illustrate how they felt their realities were being shaped by the midwives with whom they worked in their everyday professional life:
"When I first started midwifery, it was really difficult. I couldn't understand some of the terminologies used and you feel left out, so I spent a considerable amount of time trying to learn words and terms like engagement', quickening and so on. As soon as I became familiar with the 'language of midwifery' I felt I belonged because I could see what the midwives are on about, that is, I could see things from their point of view."

"I think I learnt very fast especially in how to relate to patients, doctors and other midwives. Then the work became easier as I could communicate on the same wave-length... I felt like I was accepted then."

"Looking back on my training I felt myself changing, it's a really weird process, nothing specific, just felt myself changed in some ways."

Shotter (1984) believes that human experience cannot be separated from communication. Our speech both reflects and creates our experience of reality. Central to this link between communication and experience is the process of making accounts. Shotter's social accountability thesis is as follows:

"...our understanding and our experience of our reality are constructed for us very largely by the ways in which we must talk in our attempts to account for the things and events within it... our ways of accounting for things have a coercive quality to them; only if we make sense of things in certain approved ways can we be accounted by others in our society (profession) as competent, responsible members of it."

(Shotter 1984: 134)
The researcher was intrigued by the number of empowered explanations that were given by midwives. They have been described by Gergen and Gergen (1982) as explanations suggesting that human behaviour and action is determined or brought about by outside forces. These can also be further divided into person-centred, concentrating on factors inside the acting person, and situation-centred involving factors primarily outside the person.

Some of the common phrases used by midwives in person-centred explanations are:

"She was required by the manager to..."
"She was confined by unit policy"
"The midwife is trapped by rules, formal and informal"

Examples of situation-centred explanations are mirrored in statements like:

"It is a habit of midwives to follow routine..."
"It is a natural trait for midwives to shelve responsibilities"
"We are brought up to conform"
"We are socialised into behaving in a subservient manner"
"I believe that it's midwives themselves who fail to change"

The above led the researcher on to question the extent to which midwives are interpreting their own actions. This issue relates to problems of meaning. It appears that some midwives behave in accordance with the stimulus-response principles as propounded by the behaviourist. These midwives then react strictly to pressures from the environment and in so doing they act rather than think. The thought processes do not appear to be present either before or after the action.

One of the observed consequences is that these midwives are readily accepting of whatever pressures are exerted onto them.
This leads to a non-actional situation. As one student midwife asserted: "some midwives are like zombies they just take whatever is thrown at them by the obstetricians and management, I feel sorry for them..."

It appears that in many instances there is a form of double-consciousness which is best described by the researcher as a mismatch between the midwife's own feelings, desires and perception and the restrictions of her/his role throughout the professional career. One manifestation is the inability to sense the self.

In phase one of this study two student midwives asserted that this is a case of female oppression. In their view the zombie state is brought about by a gradual erosion of self confidence, a process which has already begun from the time that women are socialised into society. This arguably is seen as a form of female oppression which continues into their professional life. A student midwife commented:

"I am sure that being primarily a female profession has something to do with it... Having a baby is considered to be women's business and hence there are controls exerted everywhere including how much the midwife is allowed to perform her role."

The role which language plays in the construction, perpetuation and representation of midwifery as a separate profession is significant. One relevant argument is that language is 'man-made', it either denies the existence of the midwife or provides words which have negative connotations. For instance many midwives are being called nurses, this then denies the existence of midwives who claim that they are not nurses. So powerful is language in structuring thought as reality that it can 'blind' its users to the evidence of the physical world... (Spender 1980). Hence, the role of the midwife as a 'practitioner in
her/his own right' can either be 'eclipsed' or 'exposed' by the language used in the midwifery community.

The researcher overheard a discussion between a midwife, a house officer and a male consultant obstetrician, with the latter as saying:

"I think highly of midwives, they do a splendid job, caring for the patients, but I see that as women's work and their domain is really in the teaching of patients to be competent mothers, also to 'perfect' their technique of breastfeeding."

A midwife asserted that her manager's insistence on calling midwives 'nurses' is insulting and serves to erode their confidence to practise as 'practitioners in their own right'.

Some midwives feel strongly that the use of the word 'patients' to describe pregnant women serves to label pregnancy as an illness hence reinforcing the midwives' role as caring for the sick like nurses rather than as 'practitioners in their own right' caring for healthy pregnant clients.

There is a minority group of midwives who appear to be thinking interpreters. In this instance these midwives create meanings and use these meanings to interpret and understand situations in which they find themselves. These midwives then consider the consequences and sometimes appear to make real effort in manipulating their circumstances. They attempt to make real choices based on intentions already mapped out in their mind.

Shotter (1984) sees the self as having the power to act, yet feeling constrained by rules of action. Rules may be followed or
broken. Because of the presence of rules and our personal powers to follow them or to break them, one must think through and plan one's action, and these plans are largely framed in terms of potential accounts. Shotter also believes that people could constantly assign meaning to and make sense of their experiences; they could further attempt to figure out what the event means, what it is the means to, what it indicates, points to, specifies, etc. The meanings assigned to an event are closely tied to the language used to account for the event in communication among participants. In short, Shotter argues that "our understanding and our experience of our reality is constituted for us largely by the ways in which we must talk in our attempts... to account for it" (Shotter 1984:173). However in this study most of the midwives appear not to have the ability to make sense of their circumstances and experience. This inability is illustrated to some extent by statements like "I don't understand why it is so hard to be a midwife in the true sense of the word", "I will never be able to understand how one can avoid imposing policy on women...." and "I get so frustrated, not knowing why the managers want us to do certain things which clearly do not benefit the patients."

The relationship between communication and the experience of reality constitutes a loop: communication determines how reality is experienced, and the experience of reality affects communication.

One interesting aspect of the research is that some students demonstrated immense ability not only to understand themselves but also to attribute meanings to their colleagues lack of understanding of self. This is illustrated by the following statements made by some student midwives:

"I think that my midwife tries hard, but she went through an old style training and they were not encouraged to
think for themselves, so they cannot see what is wrong with the system."

"I think that most midwives cannot use their experience constructively because they are too frightened of the managers and consultants, what these people can do to her, and this fear is very real to them... of course if they think hard enough they will realise that these people are humans like you and I so they don't have the power..."

"Some of the midwives are old fashioned, they were trained to accept rules and these in turn impinge on their right to practise, but they go on accepting it because they cannot see what's wrong with it... after all they feel a day's work is a day's salary"

"I can understand why midwives fail to practise autonomously because of the fear of litigation etc, but the way I see it, you are either a midwife or not. I chose to train as one and no rules and regulations are going to prevent me from fulfilling my role, I can always be an independent midwife or I will practise in some third world country."

"I think power is only there if we allow it to be used, so if midwives refused to be frightened by the powers that be then they can use their skills more. I certainly will try my hardest to fulfil my role as 'a practitioner of normal childbirth' when I qualify, I will not let anyone frighten me with threats of litigation or whatever."

The above accounts relate well to Gadamer's interpretation of self. Gadamer (1976) is a leading proponent of philosophical hermeneutics. He is primarily interested in how understanding is possible in human experience. For Gadamer, interpretation itself is part and parcel of being. The central
tenet of Gadamer's theory is that our tradition gives us a way of understanding things, and we cannot divorce ourselves from that tradition. Observation, reason, and understanding are never objectively pure, they are coloured by history and community. Gadamer asserts that we are simultaneously part of the past, in the present, and anticipating the future. In other words the past operates on us now in the present and affects our conceptions of what is to come. We therefore cannot exist outside an historical tradition. Gadamer believes that experience is inherently linguistic, we cannot separate ourselves from language. The perspectives of tradition, from which we always view the world, are embodied in words. Gadamer says:

"The linguistic is not a 'sign' which one lays hold of; it is also an existing thing that one shapes and endows with a meaning, making a sign to render some other thing visible. Both possibilities are wrong; rather, the ideality of the meaning lies in the word itself. Word is always already meaningful."

(Gadamer 1960:35)

Meaning can be found in the practitioner's action. Interpretation is the process of discovering the meaning in action. Interpretation is a hermeneutic process of studying patterns in the action, determining what overall meanings are suggested by these patterns, then testing these meanings by examining patterns once again and revising the interpretation as necessary. The language of one's culture determines one's experience and creates a bias or way of understanding. Often milieu consists of powerful forces that subvert and oppress individuals. Dominant linguistic forms and communication media may prevent certain groups from full participation in the control of their profession. Hermeneutics can be seen as a sociological reflection process that undertakes to free the individual of outer and inner forces and compulsions simply by making the person aware of
them. Insofar as these are forces and compulsions which tend to legitimate themselves linguistically, Habermas (1987) sees the critique of ideology as the means of unmasking the 'deceptions of language'.

The implication of what Gadamer and Habermas propound is that if midwives could understand how they arrived at their way of seeing the world and how that reality could be influenced by language and symbols then they would be in a stronger position to manipulate their profession. The process of understanding how communication impinges on their action and practice would set midwives free and consequently permit them actively to steer the course for the midwifery profession.

In this study it appears that a midwife may not be able to practise as 'a practitioner in her/his own right' because of organisational constraints in the form of formal and informal rules. Such rules are articulated in a linguistic form that midwives fail to uncover. Kirkham's study (1981) showed that the pressures of the power structure of their setting were reflected in the words and actions of those involved in giving care. For instance who controlled the labour depended on whose territory the client laboured on. Actions carried out by midwives regarding the relief of pain as well as anxiety of their clients showed that these were aimed at maintaining control appropriate to the institutional setting rather than meeting the client's perceived needs. This form of practice which is organisational-centred rather than client-centred. The implication here is that students exposed to such a learning environment would experience cognitive dissonance as there is an explicit conflict in beliefs, values and attitudes taught by the 'school'. This organisational centred care is mirrored in the way in which midwives communicate with their clients. While there has been little research carried out on how midwives communicate with their clients there has been considerable comparative research in the field of nursing. For instance Marikheim (1979:12) observed:
"Patterns of communication between nurses and patients reflect this authority/subordinate role. The care recipient has been a passive, dependent model... The nurse often evades direct questioning from the patient... their communication style indirectly negates the nurse's understanding of the patient's condition from the patient's perspective."

Faulkner (1980) described student nurses acting 'quiet' ie 'saying nothing to be safe' and as a result ignoring patients' needs. Macleod Clark (1981) described the following strategies nurses employ to control conversation: avoiding issues raised by patients, blocking talk and using stereotyped patterns of conversation. In the present study the researcher has seen events which resemble those strategies described by Macleod Clark (1981). For instance, on one occasion a student midwife was looking after a client in the first stage of labour. The student repeatedly resorted to 'small talk' whenever the midwife disappeared in spite of the client's wish to be engaged in 'professional talk'. For instance when the client was experiencing a strong contraction she asked, "why is it so painful?" the student answered "just breathe deeply and it will go away, that's it, keep breathing, go on, good girl, keep going..." As soon as the contraction had gone off the client asked "Would the midwife get me an epidural, is that where she has gone to, to ask the doctor?" The student's response was: "She will be back soon, she may allow you to have an epidural, who is looking after your other child?"

Words and phrases like 'allowed' and 'good girl' serve to put the client in a powerless position. There are other means of reducing the client to a subservient position including the use of gestures such as turning one's back on a client who was asking to mobilise in labour and joking with a student regarding another client who had previously requested an 'internal examination' to see how far on she was in labour. Later, the
student confided in the researcher that she did not find anything funny when the midwife said:

"Oh yea, so she wants an internal, does she? What do I do, do one right in the middle of the corridor? (laughter)"

When probed by the researcher as to why she did laugh with the midwife, the student stated:

"I don't really know really, it just seemed the natural thing to do at the time; now I wished I hadn't."

The significant point is that while the student joined the midwife in carrying out a particular gesture, the former later tried to analyse and understand her behaviour. This form of reflection is important as a means of 'freeing' oneself from the group, otherwise all the values, beliefs and attitudes of the group would be absorbed like a sponge by the student.

It would appear from this study that most of the student midwives were aware that they were constrained by structures such as policy and protocols. While all the students interviewed asserted that policy and protocols should not be used as that is not client centred care, most of them nevertheless rationalised the usage of these as 'being there to protect the midwife against litigation' or 'we cannot change these as we are only students'. Students not only saw themselves as being a powerless group, they also tended to see the midwife as being in the same position as themselves. This is illustrated by the following statements:

"I don't think that midwives can do much about policies etc because the consultant dictates them and he is more powerful in the hierarchy".

"...even after you've qualified you've got to toe the line otherwise you'll soon be thought of as being a deviant."
"I think midwives have the power to change things like policy especially if they are senior midwives, but I don't think that many midwives bother to do so, as it is difficult. It can be such an uphill struggle that at the end one can be really burnt out."

Summary:

The world of midwifery is marked by communication as the reality of midwives is linguistically determined. In this section the researcher used a synthesis of some contemporary theories of communication and communicative action to understand how midwives construct their reality. Such an exercise is in itself hermeneutical in nature.

The work of Mead (1962); Hertzler (1965); Berger and Luckmann (1966); Gadamer (1976); Shotter (1984); Gergen (1985); and Habermas (1987) was discussed in general terms. For midwives to be more proactive in controlling their profession they need to come to a deeper understanding of their thought processes as shaped by language and by communicative action. Overall the present study suggests that the majority of midwives do not have much understanding of how their reality is socially constructed by the prevalent values, beliefs and attitudes of the midwifery culture. Consequently most of the midwives are caught in a spiral pattern of helplessness and despair: practising in a manner that they disagree with; yet unable to change the current pattern of giving care.
5.5 Conclusion to Chapter 5

In this chapter the researcher begins by describing the 3 types of midwives ie the 'crusader' midwives, the 'survivor' midwives and the nurse-midwives. The 'crusader' midwives appeared to espouse a set of beliefs, values and attitudes that is congruent with those taught to students by the educational sector. These midwives also try to base their practice on their espoused theory in spite of constraints from the organisation. Therefore in this situation there does not appear to be a great gap between theory (defined as espoused theory) and practice (defined as theory-in-use). 'Crusader' midwives seem to have an assertive personality and they use this attribute to 'protect' their clients' rights to choose the type of care the clients wish. In addition, the 'crusader' midwives learnt by reflecting on their practice on a day to day basis. By so doing they are in a position to redefine theory. Hence 'crusader' midwives are in a privileged position to help the profession to make progress by a process of emancipating theory and practice.

The 'survivor' midwives do appear to share most of the fundamental beliefs, values and attitudes of the 'crusader' midwives and the educationalists. However, the 'survivor' midwives only espouse this set of beliefs, values and attitudes verbally; for in practice their action (or theory-in-use) does not reflect these beliefs, values and attitudes. This causes difficulty to students who then experience cognitive dissonance as a result of being exposed to practices that are underpinned by a set of beliefs, values and attitudes that are different from those taught by the educationalist. The 'survivor' midwives seem concerned of this issue but nevertheless feel powerless to rectify the situation. The best that they can do is to explain to student midwives that they still hold the same beliefs, values
and attitudes as those that they learnt from the 'school' but they feel unable to put these in action because of the perceived constraints posed by the organisation. These constraints ranged from fear of being ousted by other colleagues to being 'passed over' for promotion.

The 'survivor' midwives do not appear to be engaged in reflective practice as they tend to spend time and energy on getting the work done and to 'survive' the system. Therefore they do not gain from reflecting on their clinical experience as much as the 'crusader' midwives, nor do they play a very active part in re-defining theory from practice. Their practice seems to be based on the body of knowledge gained during their training. This situation causes more of a gap between theory and practice. This group of midwives do attend post basic courses to up-date themselves. Interestingly during these study sessions 'survivor' midwives are really motivated to reflect on their practice and could be very vocal about the changes that they feel ought to be made in order to advance practice. Some would vouch to make positive changes to practice when they get back to the practice area but it appeared that this resolution seldom come to fruition. This is probably due to group pressure to conform to the status quo.

'Nurse-midwives' appeared to have a set of beliefs, values and attitudes that are on the whole different from the 'crusader' and 'survivor' midwives and the educationalists. This causes a very real problem for most of the students who have worked with this group of midwives. This is because of the gap between theory and practice which is considerable. The main common complaint made by students is that they are giving care to clients based on rituals and routine rather than on research findings as espoused by the educational sector. This causes a sense of disharmony for the students and as a result they have devised ways to correct this. The researcher felt a sense of despair when talking to the students as these respondents felt that changes in practice is at
best slow and at worst impossible as most of the key positions in the organisation are held by this group of midwives. While this group of midwives is small in number they are nevertheless very powerful as they determine most of the policies relating to practice. Moreover as they are reluctant to pursue any postgraduate studies the chance to motivate these midwives to reflect on their practice is scarce.

The relationship between theory and practice appears to be highly related to the type of midwives. Paradoxically midwives who have undergone the same type 1 model of basic training and educational programme as described by Argyris and Schon (1974) have ended up with a different way of seeing the midwifery world and subsequently developed a different set of espoused theory and theory-in-use. These differences mirrored the way in which each type of midwife delivers care in the practice setting. The latter is very significant as practice precedes theory. In other words, when something is shown to work in practice, a theory is developed to describe the phenomena. Once validated the theory should then be grounded in practice, but since practice is a dynamic process the theory should be similar in nature. The above discussion serves to illustrate the complexity of the theory/practice relationship.

Using the work of Argyris and Schon (1974) has enabled the researcher to make a bold assertion, that is, the relationship between theory and practice as conceptualised by the nurse researchers (Bendall 1976; Alexander 1980; Fretwell 1980; Orton 1981; Melia 1982 and Ogier 1982) appeared to be based on a wrong premise. The premise is that in an ideal situation the gap between theory and practice should not exist. But as Schon (1983) points out professional practice is essentially individual. Hence as a practitioner works in a practice setting s/he would encounter problems that require the practitioner to reframe in order to find a manageable solution since there are no ready-made theories for every problem that occurs in practice.
Students have to learn to deal with the 'swampy lowlands' type problem as described by Schon (1983) and this they learn from the mentor midwives in practice areas. Indeed in this study students have emphasised the importance of learning from their midwife mentors. Similarly they attribute the learning from the 'school' as being of secondary importance. The students are exposed to three types of knowledge namely normative, empirical and tacit knowledge. The normative and tacit knowledge can only be gained from the midwife mentors. Unlike the tutors who teach students mainly by group discussion and reflection, the mentor midwife teaches by responding to a clinical case verbally as well as non verbally through the use of symbols and gestures.

Like a process of osmosis the students absorb the knowledge and its underlying beliefs, values and attitudes. The internalisation of these could alter the self concept and in return the new self would perpetuate a new attitude towards professional practice, for example, to be submissive to the management hierarchy or to the obstetricians.

As part of the socialisation process midwife mentors appeared to pass on tacit knowledge to students. In a powerful way this form of knowledge serves to highlight the parameter of accepted practice. This parameter of practice is in turn bounded by a set of beliefs, values and attitudes. The researcher would assert that the prevailing beliefs, values and attitudes come from the 'survivor' and 'nurse-midwives'. However, the scenario does change for instance when a group of 'crusader' midwives dominate a specific practice setting. The researcher has seen a process of power confrontations between the 'crusader' and 'nurse-midwives'. The power confrontations would at times develop into a type of cultural battle whereby both groups try to assert a type of practice based on their beliefs, values and attitudes. In such a situation the characteristics of the different group of midwives become more distinct and could be described as almost 'tribalism' in nature. Power confrontations have a 'crack in the
wall' effect as the midwifery profession appears to be disintegrating. One tutor went as far as involving the students in drawing up a 'mini-manifesto' in preparation for 'doing battle' with the service sector. The 'crusader' midwives saw an urgent need to 'reach the unreachables' by evangelising their set of beliefs, values and attitudes. They defined the 'unreachables' as being the 'nurse-midwives' and their message is delivered in words as well as action. Therefore the 'crusader' midwives would consistently act and speak in such a way that illustrates that they are living out their faith to be practitioners in their own right. They would use a language that reflects the essence of their subcultural beliefs, values and attitudes to their client. The language used by the 'crusader' midwives is very similar to the one used by the educationalists and is one considered to be 'professional'. This language code is designed to make the clients feel empowered to make decisions regarding their care. In contrast the language used by most of the 'survivor' and 'nurse-midwives' is implicitly designed to diminish the rights of the clients to be involved in决定 their own care. Instead the language appeared to enhance the power and status of midwifery practitioners. It is important to note that professional experience cannot be separated from communication as speech and gestures both reflects and creates the experience of reality. The implication here is that if midwives realise that language shapes their reality then they can attempt to make sense of their situation and work at ways to change it as appropriate. In other words to engage themselves in a hermeneutical process of freeing themselves of outer forces by just being aware of it. As communication determines how reality is experienced and the experience of reality affects communication, sometimes students find themselves having learnt a language that is unacceptable to the educationalists. For instance phrases like 'a flat baby' and 'she is fully dilated' are often frowned upon by the tutors as they are slang words which are regarded as 'unprofessional'. 
From the above discussion it is evident that the midwifery profession is united by a fundamental belief that 'midwives are different' and are regarded as 'practitioners in their own right'. However there are groups of midwives in both the education and service sector that have differing beliefs, values and attitudes. The bond that unites the profession is very fragile because while almost all midwives espoused that they are 'practitioners in their own right' their practice does not always reflect their espoused theory. The researcher could surmise from the data that the midwifery profession is divided. Although the current legislation in Britain permits midwives to be practitioners of normal childbirth the effort made by the profession to truly accept and exercise this role is very lukewarm. The mission to 'save the profession' is underway and the main participants are the 'crusader' midwives. However the 'crusader midwives' are again not always united in pursuing a cause and the result is that some midwives find themselves involved in a power confrontational situation almost singlehandedly. As one midwife admitted to the researcher that "...having got myself tangled up with management in a hostile way I suddenly found myself 'flying solo' as my colleagues 'chickened out' and left me to face the consequences." One technique that the management hierarchy seem to employ frequently is to divide the midwives who share a certain concern.

This chapter has provided a fairly thorough examination of the problematic nature of autonomy and professionalism for midwives. In concluding this chapter, the researcher feels compelled to ask the question "Is the midwifery profession divided?" The next chapter is devoted to addressing this very important question.
The question posed by the researcher at the conclusion of Chapter 5 was "is the profession divided?" This is a profound question as it challenges one of the fundamental beliefs of midwife practitioners. This fundamental belief is that midwives are 'practitioners in their own right' and therefore they are 'different' from nurses and consequently could lay claim to being a different profession altogether (EAG working group-RCM/221/91). Indeed Lewis (1990) argued that concepts of autonomy, role monopoly and research based practice are the three key elements which provided support to the midwife's assumption of professional status. The above assertion however does not challenge the question of whether midwifery could be considered as a separate profession from nursing or whether midwifery is a branch of nursing.

Of all sociological ideas, one of the most difficult to analyse satisfactorily is the concept of a profession. It is suggested that there are three basic problems which could account for the confusion and uncertainty. Firstly, there is a semantic confusion, arising from broad and general use of the word. Secondly, there are the structural limitations enforced by attempts to devise basic characteristics of a profession, and lastly, there is the adherence to a static model, rather than an appreciation of the dynamic process involved in professionalism (Millerson 1964). According to Wilding (1982:1):

"In all developed societies there are occupational groups enjoying or asserting certain claims to privilege-autonomy,
a monopoly of a particular field of work and a high level of rewards. Because of the size and importance of these groups, defining and characterising has been a major sociological industry.

Searching for a set of characteristics which might effectively define 'professionalism' Greenwood (1965) looked at the occupational classification of the United States Census Bureau and especially at those occupational groups identified within the professional category. Greenwood then attempted to isolate those common attributes displayed by those occupational groups which were not identifiable amongst the so called non-professionals. He found that all professions appear to possess five main attributes:

1 systematic theory
2 authority
3 community sanction
4 ethical codes
5 culture

Greenwood (1965) further elaborated that the acquisition of skills and knowledge of a specialised subject in order to obtain the authority, community sanction and ethical codes are not sufficient to acquire the 'professional status'; it is the superimposed professional culture which effectively confirms true professional status.

Indeed according to Harries Jenkins (1970) among the cohesive factors which ensure the continuance of the occupation as a group collectively, one of the most significant indicators of professionalism will be the group culture.

Harries Jenkins (1970) asserts that there are two forms of culture, ie professional and non-professional. Non-professional culture is formed as a result of behavioural interaction, whereas
the source of professional culture is the ideological values of the occupational group. These values are the basic and fundamental beliefs of the group. The unquestioned beliefs upon which its very existence rests.

It appears that each occupational group needs to go through a process of 'professionalisation' in order to become a profession. This process should facilitate social change within an organisational group and becomes established through a series of steps. Etzioni (1969) asserts that some occupational groups will never make the series of steps to complete professionalism. He concluded that nurses were at the stage of semi-professionalism, when he described the rigid stratification system of hospitals, with doctors at the top of a caste-like system:

"The most important point to note is that the semi professionals, such as nurses and laboratory and X-ray technicians, are located on a continuum with doctors: there is no hierarchical pattern with a gradual approach to, and fusion with, the highest status, that of the physician. Instead, the caste-like system puts an unscaleable wall between the physician and the semi-professionals in the hospital.

(Etzioni 1969:69)

As most midwives today began their careers in nursing it has been argued by some (Drife 1989, Robinson et al 1980) that its traditions and culture are firmly carried forward into midwifery. For instance a very similar stratification system is evident with the obstetricians at the top. Sheila Kitzinger et al, (1990) expresses her perspective of the midwife as one working passively in a master/servant relationship with the medical hierarchy. This view illustrates how one person chooses to classify midwives: as invisible, but supportive to doctors who appear to hold a monopoly over the process of childbirth.
When pressed, midwives themselves firmly assert their fundamental belief that they are different from nurses as they are 'practitioners in their own right' and hence are not the handmaidens of the doctor. Some authors argue that there are fundamental differences in the two allied occupations of nursing and midwifery (Rankin 1980; Boyd and Sellers 1982; Towler and Brammall 1986).

Explaining his reasons why midwives are not yet recognisable as autonomous professionals as intended to be by statute, Drife, an obstetrician, blames the fact that midwifery has become incorporated into the disciplinary structure of the nursing profession. Midwifery and nursing have too much in common in terms of attitudes, values and beliefs to deny that midwifery is not a branch of nursing. It is interesting to note that the set of beliefs, values and attitudes that dominate in the practice setting are ones that resemble those in nursing practice. Some would argue that such similarities in culture are deeply rooted as illustrated by the caste-like position occupied by both nurses and midwives within the hospital hierarchy and the wearing of uniforms and caps by both groups.

"The cap... symbolises modesty and obedience. In other ways, the uniform resembles that of other women workers in low-status service jobs, such as chambermaids and waitresses."

(Salvage 1985:31)

Dingwall and McIntosh provide further affirmation of this view of nurses:

"The traditional dominant-subservient relationship between doctors and nurses remained unchallenged for many decades. Rooted as it is in status differentials, the position of women in society, differences in education and renumeration,
and the tendency of nursing to be an adjunct to medicine, this relationship has become deeply entrenched. (Dingwall and McIntosh 1978:107)

White (1988:163-8) postulates that "nursing recruits have been processed and socialised by general (sickness) nurse training and have been imbued with a way of thinking, values and attitudes to which all student nurses are subjected." Whether these values and attitudes are modified or reinforced during what is purported to be a different process within midwifery training, remains an interesting issue for future research. Certainly in a survey of newly qualified midwives' views of their training, Golden (1980), exhibits evidence that some nurses do not enjoy midwifery, as they preferred to look after sick people who really needed them. At this point Golden (1980) suggests that noticeable differences can be drawn between the two professions.

A recently published report by the UKCC for Nursing, Midwifery and Health Visiting (1986) demonstrates an awareness of role differences amongst the project team members:-

"The role of the midwife can be said to be substantially different from that of the nurse in that a midwife potentially has a greater professional independence as the level of decision making is a different order. The midwife is expected to have diagnostic skills relating to both mother and baby that are at one level similar to the obstetrician and indeed there is an overlap of skills between the two. Midwives also have a limited responsibility to prescribe certain scheduled drugs and the right to referral to, and discharge from, hospital within limitations. All these together with a need for manual dexterity and to develop the confidence to function in this way, point to a potentially special and different preparation for midwifery". (UKCC 1986:6:33)
On the other hand there are those educationalists who believe that the attitudes, beliefs and values of midwifery are arguably seen to be so similar to nurses that there is a call for increasing shared learning between the two professions. Indeed Akinsanya (1987) argues that there are significant aspects of the knowledge and values which are central and common to nurses and midwives. The latter would included nursing theories and models of nursing, informed and safe practice and the application of knowledge derived from other disciplines (Akinsanya 1987). The argument for midwifery education to be part of Project 2000 is getting stronger and more and more midwives seem to be swayed towards this idea. It is a powerful ideological tool to persuade midwifery educationalists to opt for running their courses similar to Project 2000 type courses as the fundamental premise is that there is a common feature which a curriculum planning team could grasp as a unifying focus for a pre-registration course which takes account of the needs of both midwifery and nursing students (McParlane 1976). This further implies that there is a system of knowledge, values, attitudes and beliefs that is common to both the midwifery and nursing profession. For instance Akinsanya (1987) argues that the diagnostic and prescription rights of a midwife are functions sanctioned by medical practitioners and such functions would be sanctioned to nurses as their quest for an increased knowledge base is fulfilled. Nurses will be given the rights to prescribe certain medication (Crown 1989).

Downe (1990a) argued that the whole premise from which the midwifery and nursing professions originate is completely different and she further expresses concern that the application of one philosophy of one profession to another profession would be detrimental to the care given in either case.

In order to analyse if midwives are 'practitioners in their own right' and hence are 'different' from nurses the activities of these individuals needs to be further analysed. Perhaps a good
starting point is to ask the question: what do nurses do? and does this differ from what midwives do?

McFarlane (1976) suggested that caring is the essence of nursing. Akinsanya (1987) argued that care is a common feature of what nurses and midwives do. A dog or cat that is unwell could be provided with care, the person assuming such a caring role is taking on a nursing role but would not necessarily be classified as a nurse or midwife. This appeared to be supported by Akinsanya's next statement "caring is a feature shared by nurses with other professionals and even professionals without professional education..." (Akinsanya 1987:15). Hence to classify midwifery as a branch of nursing based on the notion of 'caring' is not very convincing.

The activities of nurses and midwives are encompassed within their role. Most midwives also believe that their role is that of an advocate and 'being with the woman who is going through childbirth.' Indeed in the Code of Professional Conduct it states that:

"Each registered midwife is accountable for her practice, and in the exercise of professional accountability shall:-

1 Act always in such a way as to promote and safeguard the well-being and interests of clients.

2 Ensure that no action or omission on her part, or within her sphere of influence is detrimental to the condition or safety of clients."

(UKCC Code of Professional Conduct 1992:2)

The above statements emphasise that the interests of the client reign supreme. However, embedded in the statements are key beliefs, values, and attitudes which form the foundation of the
midwifery profession. Midwives need to address the question: does the nursing profession also share this set of beliefs, values and attitudes. The researcher will illustrate this further by examining the difference between the role of the midwife and the nurse as documented in the data of phase two of the research. On a number of occasions the researcher elicited from the actions of the midwifery practitioners and from the subsequent dialogue with them that these midwives saw that their role is to be an advocate for the client. This meant that if the obstetrician issued an order and the midwife using her own clinical judgement decided that the obstetrician's instruction was not in the interest of her client, then s/he could overrule this instruction. Moreover, s/he must be able to explain and justify (that is to be accountable for) any action or omission of action on her part. It would appear that the nurse's role is different in respect that s/he is to aid recovery (that is to give appropriate care) following medically ordered intervention (Downe 1990a).

Midwives further assert that they have a greater knowledge base in order that they can allow the consequences of alternative action to be assessed. For instance midwives have told the researcher:

"When I did nursing we spent 3 years studying all systems of the body. In midwifery we spent 18 months just studying the reproductive system and related subjects. I think that say how in depth our knowledge is in order to be accountable for our actions in practice."

"I think it is difficult to get a balance of the theory, a midwife need to know all about the normal in order to practise autonomously, yet she needs to also be informed about the abnormal in order to give appropriate referrals to the obstetrician."
The nurses may well argue that they too are trying to achieve a level of knowledge which would encourage the doctors to give them the same degree of accountability. The loophole is that the degree of accountability that midwives exercise does not appear to be a medically sanctioned exercise but as several midwives argued, is enshrined in statute (Nurses, Midwives and Health Visitors Act 1979). As one midwife asserted:

"While as a nurse I was given the opportunity to extend my clinical skills to encompass tasks such as suturing and siting of an intravenous infusion, but I was still never in a position to overrule an instruction or course of treatment ordered by a doctor."

It appears that midwifery has an infrastructure built around government statute, which should facilitate the midwives' role as autonomous practitioners in their own right. However in reality most of the midwives that the researcher has spoken to in the course of this study suggest that these midwives share a common concern: that midwives are currently not using their skills to be advocates for their clients. Many are also asking if the devaluation of midwifery skills would mean that there will not be a midwifery profession in the future, as midwives are to all intents and purpose 'obstetric nurses' whose task is to assist the obstetrician in carrying out his instructions. The researcher would like to point out the obvious reluctance by the profession in accepting that currently there is a large section of midwifery practitioners who are already 'assisting the doctors' by carrying out the doctors' instructions.

Warning that midwifery could be engulfed by nursing is given by a consultant obstetrician (Drife 1989). This fear is endorsed by a group of midwives who are calling for a new midwives act (Nursing Times 1989/90). Then there are those midwives like Lewis (1990) who argue that a new midwives act is not required, as professional status is thought to be achievable through a more
radical use of current legislation, which already provides the legal framework for the further development of midwifery as a profession. So it appears that the profession is again divided in their beliefs over what should be done to re-affirm the role of the midwife. The present situation appears to be that there is already legislation that describes quite clearly the parameter of midwifery practice. It is this parameter of practice that gives midwifery the status of being an autonomous profession. However, while the newcomers to the profession are taught in 'school' the role of the midwifery practitioner and his/her sphere of practice as laid down by legislation, they are often exposed to practices which undermine this belief. One reason why this is happening is because midwives feel that the constraints on their practice are so great that they have to submerge their beliefs and values most of the time, as illustrated by the following excerpts:

"I think that we had it as a profession, standards of care and ultimately our status, values and beliefs are being challenged. How can I give the care I want to give to my patients when they (meaning managers and obstetricians) impose on me policies that I have no part in deciding."

"We need to break free of control of other bodies, like the doctors, nurses and lately the 'general managers' whose real concern is to save money. I am so disillusioned with midwifery as I have to compromise my ideals, it is impossible to teach students 'wonderful care' when we have insufficient staff and rigid routines."

"Ten years ago I was a practitioner in my own right but since birth has become a medical event, I am no more than a doctors's assistant. I hate being there just to chaperone the doctors especially when some of them are more inexperienced than I am, but when I laboured this point I am
told by my manager that I am 'not moving with the times' and that I am old-fashioned."

During the course of observing midwives working on the wards it became clear that the degree of autonomy and accountability is wide ranging as illustrated by the following examples:

Scene 1 - Antenatal clinic

A midwife of 3 years experience is checking a woman who is about 32 weeks pregnant.

Midwife: "Are you well?"

Client: "I feel great, just can't wait for the day to arrive!"

Midwife: "Enjoy the time that you have to yourselves while you can, before you know it the baby will be here and you will have your hands full. Now, let me examine your tummy.
(midwife conducted her examination)

Midwife: "I think that everything seems to be fine, are you taking your iron tablets?"

Client: "No, I have stopped taking them because they gave me a lot of constipation."

Midwife: "You must take the tablets, otherwise when you see Mr E (the obstetrician) he will tell you off for being a bad girl" (laughter).

Client: "But what about the constipation?"
Midwife: "Well, you should eat more fibre and drink plenty of fluids, but whatever you do, don't stop your iron or else all hell will break loose!

The midwife in the above excerpts appeared to dismiss the client's complaints and was concentrating on the wishes of the consultant obstetrician. Hence it is difficult to see how she could be seen as making decisions and being accountable for them. The second examination conducted by the same midwife again displayed her need to seek approval from the doctor:

Midwife to student: "Please could you take her blood pressure for me."

Student: "It's 120 over 90, do you want to check it?"

Midwife: "I'd better do that (checked the client's blood pressure). It's about 120 over 95, I think we will check it again later."

Midwife examined client with student and was engaged in a conversation for about 10 minutes, then midwife rechecked the blood pressure.

Midwife: "It is still a bit up, 120 over 85. I think while you are here I might as well get the registrar to have a look at you.

Midwife sent student to get doctor. Midwife wrote out her findings in notes.

Doctor arrived, checked client's blood pressure.

Doctor: "It seems to be a bit up, maybe we should get you in for observation and rest."
Client: "I can rest at home. Last time my blood pressure was a bit borderline and my community midwife kept an eye on me while I rested at home."

Midwife: "Lovey, this time is different, you've got a little one at home, you can't rest properly so we should admit you to antenatal ward."

Client: "I would prefer to rest at home, my mother can help to look after Daniel. If I am in hospital I won't be able to rest as I will be worried about him."

Doctor: "That sounds fine (turning to midwife) can you arrange for the community midwife to check her B/P daily and I will see her again in a weeks time, okay."

Midwife: I'll do that for you, and we'll see you next Monday."

Scene 2 Midwife looking after a client in labour:

Midwife: "I think that we will do an examination to see how far on you are, okay?"

Client: "How long do you think it will be?"

Midwife: "I can't tell without examining you. So if it's all right with you I'll get the trolley ready and do a quick examination."

Client: "yea, alright" (breathing through her contractions)

Midwife did the internal examination and said to the student and client:
Midwife: "Good, you seem to be doing nicely, I would say you are about 6 cms (the cervix needs to be 10 cms dilated before the client is ready to have the baby)."

Midwife to student: "The cervix is soft, central and about 6 cms. I think she should not be too long."

(Midwife completed her examination, checked the fetal heart rate and wrote up her notes)

Midwife: "I think I will give Doctor M a ring as she wanted to know how you were getting on. She (meaning the doctor) wanted to give you an injection to speed things up because your waters have gone for a long time, but she might decide to leave things alone now that you seem to be getting on."

Client: "How long will it be before I'll have the baby?"

Midwife: "It's difficult to tell, it could be an hour, or it could be four. Generally we say that it's about 1 cm an hour but then it is your third baby, so it could be quicker. Anyway I'll have a word with Doctor M and see what she wants me to do."

(Midwife went off to phone the doctor and returned ten minutes later)

Midwife: "Doctor M is coming to see you, okay. Are you comfortable lying on your back, do you want to try lying on your side?"

(Moved client with the help of the student)

Doctor M arrived, said 'hello' to the client and looked at her notes.
Doctor to midwife: "I think we can leave her alone" (meaning not to give client the injection)

Midwife: "I think so, she seems to be getting on by herself."

Doctor: "Right then, I'll leave you all to it (waved to client and went out of room)."

Midwife: "Thank you, Doctor M."

The midwife in this case had already decided that the client was probably getting on well in labour yet she felt the need to consult the doctor for confirmation. In the case of normal labour it is expected that the midwife being a 'practitioner in her own right' would make all the decisions pertaining to her care and would only refer if the woman's labour deviated from the normal (Midwives Rules 1991). When the midwife was asked later by the researcher why she felt the need to consult Doctor M she stated:

Midwife: "I always play safe and seek advice. If anything goes wrong like if later she got an infection I am covered because I sought medical advice."

The irony is that the accountability ultimately rests with the midwife herself and seeking advice from a doctor would not exempt her if her management of the case is questioned. This is because whether the midwife chose to be accountable or not in her/his practice, current legislation still assigns the accountability to the individual practitioner.

In everyday practice midwives appear to be comforted by the thought that if they follow the doctor's advice, guidelines and policy they would not be held accountable for their action. Yet there have been instances whereby the very reverse has happened.
as illustrated by the following story told to the researcher by a midwife manager:

Manager:

"I was asked to appear in court as a witness in a case whereby the baby born was severely brain damaged. The midwife who delivered the baby sensed that there was something wrong with the fetal heart rate when the patient was near the end of her labour. When the midwife went to put a monitor on she found that the fetal heart rate was about 80 most of the time, even in between a contraction. She went to call a doctor and then proceeded to examine the patient. She found that the patient was 8 cms dilated and informed the doctor accordingly. The doctor examined the patient and instructed the midwife to carry on as normal as he thought it was too early to do anything else, he thought that the baby would be born soon. After about half an hour or so, the patient was ready to push. She was moved to the delivery room and commenced pushing. Forty five minutes passed and there was little progress. The fetal heart varied between 85 to 110. The midwife called the doctor again who came to see the patient. He asked the midwife to put her in a lithotomy position and to increase the Syntocinon. The midwife did exactly as asked and the patient was encouraged to push. Another 35 minutes later the head was visible and the midwife scrubbed to deliver the baby. The fetal heart rate was at about 80 all the time. The midwife infiltrated the perineum in order to do an episiotomy. But the doctor said that there was no need as the head was descending well and the perineum was stretching. The baby was delivered after a ten minutes delay and was very asphyxiated. He also suffered from fits for a week. When cross-examined the midwife stated that she was anxious about the heart rate
throughout the labour but felt she had done her duty by reporting it to the doctor. She did say that she disagreed with the doctor when the latter asked her not to do the episiotomy but the midwife stated that she did not wish to have an argument with the doctor in front of the patient, also she was worried that the doctor would not do the suturing for the patient. This midwife was found to be negligent."

There were many incidences observed in the clinical area particularly in the delivery suite whereby the midwife appeared to have decided to take one course of action but subsequently changed her mind because of the doctor's instruction. This the researcher presumes is the reason why students make comments such as: "midwives are not really practitioners in their own right because they don't make decisions", "midwives are always talking about being different from nurses but I can't see it" and "midwives may believe that they are accountable for their actions but in practice they kow-tow to the doctors most of the time."

The area in which midwives appear to be making most of the decisions is on the postnatal ward. Like one midwife said, "I feel like the Queen here, without the doctors telling us what to do, although things are changing a bit as recently we are beginning to get some interference from the paediatrician on issues like feeding..."

The researcher was able to spend some time on two of the three postnatal wards observing the actions of midwives. While the midwives do appear to have more autonomy in this area of practice the system of care is fragmented with the midwife assuming the traditional ward management role, allocating tasks to students and other ancillary workers. It is also in this area that the traditions and customs are very prevalent. According to one student she attributed this to the fact that there are many part-time as well as older midwives and they are the group that
usually fail to update. This statement is contradicted by what the midwives told the researcher. For instance most part-time midwives asserted that they are keen to keep up to date with research etc, but feel that 'management' largely ignored their needs. There was an undercurrent of anxiousness that they are 'missing out' on study days, courses etc. The older midwives articulated that they see themselves being updated a lot by the student midwives but would take any opportunity to go on any study days and courses that management sent them on. When asked if they themselves would go on courses or the odd study days, four out of six of these midwives stated: that they would "if it was not so far away", or if it helped them "to do the job better" or "if these study days are free".

One area of practice that is largely disputed is the issue of breastfeeding - that is the how, when and why issue. The way in which midwives helped mothers to breastfeed ranged from the use of research based practice to "methods that have been tried and tested." The students are very critical of the latter practice as they are taught research based practice in the classroom. Most students also believe that to be a 'true professional' midwives need to be able to substantiate their practice by quoting pieces of research. This belief is also evident in some midwives who assert that "we should strive to be a research-based profession" and "the reason why we fail to promote breastfeeding is because of our old fashioned approach." However, there are also midwives who hold a different belief which is reflected in their practice. These midwives believe that:

"research can be used to a certain extent, but it has to be further tested in practice, to blindly implement research is not the answer."

"theory that was taught to me in class is not borne out by my clinical experience; I think the tutors go on too much about research and forget that mothers are individuals, also
there are constraints in practice. For instance we were taught to encourage mothers to demand feed and the greatest sin is to complement feeds but I have found that mothers get tired with demand feeding and eventually give up because they find it too time consuming so now I advise my mothers to demand feed up to a degree but if she is too tired and wants a rest it is no harm giving the baby a bottle."

Yet it is interesting to note that the degree of autonomy exercised by the midwives depended to a large degree on the kind of relationship between the doctor and the midwife and the prevalence of medical control. There is surprisingly little research on doctor-midwife relations, with the notable exceptions of Walker (1976) and Kirkham (1981). Existing research on inter-professional relations in other health care professions suggests that they can have important effects not only on job satisfaction, but on the quality of care that clients/patients receive (Revans 1964). According to Donnison (1977) the relations between doctors and midwives are highly charged and traditionally antagonistic. The relationship between the two is not rigidly structured, and medical and midwifery staff at all levels often have conflicting views of each other's legitimate spheres of practice. Many such disputes crystallize around the disputed territory of 'normal' versus 'abnormal' birth, 'midwifery' versus 'doctors' cases. There is no question that "the midwife is the person who is... trained to conduct normal labours on her own responsibility. She must be able to recognise the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor..." (World Health Organisation 1966:9).

However the problem is that the definition of 'normal labour' is political. The medical ideology that all births are normal only in retrospect has meant that doctors have legitimised the total control of all births. According to this model all births are under the direction of the doctors and midwives only act as the
consultant's deputies and in accordance to his/her policy. Hence there is no room for the midwife as an independent practitioner for normal labour, since a 'normal labour' can only be recognised in retrospect. Even the midwives are divided over what could be defined as 'normal' or 'abnormal' childbirth.

Another problem is the use of the words 'obstetrics' and 'midwifery'. Obstetrics is a term used to cover the application of scientific knowledge to ensure as far as possible the physical wellbeing of the woman before and immediately after birth and the emphasis is on the bio-physiology. The obstetrician therefore 'stands by' just in case something happens, or something goes wrong. This led onto the ideology of birth being potentially dangerous. 'Midwifery' is used to refer to the more socio-psychological aspects of childbirth and the work of the midwife is seen to be more of a supportive role. Indeed the word 'midwife' means to be with woman during childbirth. Walker (1976) argues that the claim that midwives are 'practitioners in their own right' is rarely recognized in practice as the perception of the midwives' role by doctors is that of a 'specialised nurse' or 'a nurse who has been delegated more responsibilities by the doctors.'

The senior house officer (SHO) and midwives are the members of the medical and midwifery staff who work most closely together especially on the delivery suite; it is here that some of the general issues of conflict are brought sharply into focus. In the study by Kitzinger et al (1990) they found that midwives make far more of a decision-making contribution than is formally acknowledged. Senior house officers may be officially responsible for many decisions, but, as one midwife stated in this study "you're usually putting it into their hands to do what you want them to do." Indeed the researcher found during her observation on the delivery suite tactics used by some midwives to get what they wanted such as:
Midwife rang doctor and said:

"Oh, Doctor M I am ringing you about Mrs T who is not really getting on. You wouldn't be so kind as to come and write up some Syntocinon for me, I'll make sure that the kettle is on for a cup of tea for you."

The midwives' low status inhibits them from openly expressing opinions, a situation that is exacerbated by some SHOs who argue that they, as doctors are the only competent decision-makers (Kitzinger 1990). This type of attitude has led midwives to develop ploys to deal with the doctors in order to ensure that their decisions are implemented. These 'survival strategies' are passed on to the student midwives during their exposure to the clinical environment. For instance the researcher overheard a midwife saying to a student:

"Get that trolley ready because I want Doctor H to examine the patient. I know he said he will come back at four pm but I want him to do it now, it's unfair on the patient. How I get the doctor to do it earlier is to say to Doctor H that as I know he is the only one on call this evening I think he should do the examination before his colleagues have all disappeared in case he is needed on gynae ward or in theatre, I find this trick always works."

Most of the midwives the researcher spoke to have got some tactics to get SHO to do what they want, it was as if they had all read the same manual on 'gaining SHOs compliance'. Statements such as "you have to be devious", "all you have to do is to boost their ego a bit" and "I just humour or bribe them" are all tactics used by midwives to 'get their own way'. It is a strategy to enable them to practise as independent practitioners to a certain degree in that they have made the decisions that they think are the correct clinical management and they are trying to implement the latter by working around the SHOs. This
form of tactics was also employed by midwives in the study conducted by Kitzinger et al (1990) in that the midwives were found to be involved in what the authors chose to call 'hierarchy maintenance work' which is elaborate games etc, aimed at getting the decisions made by the midwives implemented by SHOs.

Working with the consultant obstetrician is another obstacle that midwives feel they have to overcome. The post of consultant represents the highest point of the medical hierarchy, and the incumbent of this position has most control over the way in which she or he wishes to work. The consultant's path crosses that of the midwife in mainly two ways - as policy maker and through direct contact in clinical practice. While the consultant does not spend much time on the delivery suite, nevertheless his or her presence is very dominant by the fact that the management of labouring women is very much centred around the policy laid down by the consultant/s. It is here that the standard issues of normal midwifery versus abnormal medical cases come to the fore. It is here that the consultant determines when a doctor should take over from a midwife, when drugs (and how much) should be administered and procedures carried out. Some of the consultant's policies are very general and are then left to the midwife's interpretation while others were found to be rigid, hence restricting the midwives' freedom to make decisions. The interesting thing noted by the researcher was that while these policies are usually in written form, there seems to be also a set of unwritten policies around which govern practice. These unwritten policies are prevalent in the case where the consultant is very flexible with his policy hence allowing each midwife to interpret these differently. It appears that in such cases a dominant group of midwives (usually occupying the post of sister which represents the highest in the midwifery hierarchy) do the interpretations and pass on their beliefs to more junior midwives. In this way the fundamental belief that midwives are practitioners in their own right is challenged. For instance a student commented:
"We were always taught that a midwife is a practitioner in her own right but on the wards the sisters will tell the staff midwives what to do. This is wrong and the way I see it unless we do away with the hierarchy which we inherited from our nursing days, midwives can never be practitioners in their own right.

Another student's comment was:

"I always was led to believe that the sisters assumed a more managerial role but in clinical practice they cannot interfere with the decisions of the staff midwives however junior or newly qualified they are. Yet in practice I find that staff midwives are usually directly or indirectly supervised, indeed this was a live debate at the time of the clinical grading. Managers stated that newly qualified midwives like nurses can only be awarded a 'D' grade because they still have to be supervised. Yet according to the midwives rules a midwife is responsible and accountable for her action as soon as she qualifies and is registered to practise. For instance I am hoping to be doing midwifery on an independent basis as soon as I qualify so who is going to supervise me? When I mentioned this to some of my colleagues they were horrified, and some said 'but you can't do that.' I asked them why not, there is no law that says I cannot, indeed the statutory rules permit me to do just that."

The practice of having a set of unwritten policies which is passed on to midwives who newly arrive is not only confined to the delivery suite but is found in every clinical area. For instance in an antenatal clinic, there seemed to be very little evidence of decision-making by the midwives. Most procedures were carried out because consultant so and so liked it that way or because the sister said the consultant liked it that way. In the absence of sister her deputy would carry on with this chore
of passing on the set of unwritten policies. It was interesting to find that sometimes this set of unwritten consultant policies was contaminated by those beliefs which seemed to have come from the midwives at the top of the hierarchy as illustrated by the following:

Researcher to consultant at one of his clinic sessions:

Researcher: "I believe that you like all the women to come back at thirty two weeks.

Consultant: "Yes and no, I like to have some patients back at thirty two weeks so that I can check the presentation and order a scan if need be. But half the women I don't honestly need to see. If there is a midwife clinic I'd rather they see the patients, it will cut down my work load."

Researcher: "Why do you think that there is no midwife clinic set up locally?"

Consultant: "I really don't honestly know, it's a question that you need to ask the midwives, I would have thought."

Researcher speaking to midwife in charge of clinic

Researcher: "...I was generally speaking to Mr E and he gave me the impression that he would like some of his clients to be seen by a midwife as it would lessen his work load and he also believes that he does not necessarily need to see all of them unless there is an abnormality."

Midwife: "We have been through this time and time again, it would appear that the consultants can't make up
their minds what they want. Anyway, its a matter of shortage of staff, we like to do our own clinics but we haven't got sufficient staff. I get part timers who are here for a few hours. Like this morning the wards are busy so they took away half my staff so if we had organised a midwife clinic it wouldn't have been workable. I am not having patients sitting around waiting for an hour or more."

The 'waiting for an hour or more' was an interesting remark as on three occasions the researcher had witnessed several women waiting for a period of at least an hour and a half to see the doctor. This is also a complaint that is borne out by the audit report in phase one of the study, hence the 'waiting' does not appear to be a legitimate reason for not having a midwife clinic. As far as the 'shortage of staff' is concerned it has always been a problem according to a manager. She further stated that "when we want to extend a service like having a midwives' clinic we would need to put in a case of need to the general managers and if we get what we want we can go ahead with the plans, otherwise we will have to do it with the existing staff that we have got."

It was difficult to ascertain whether the practicalities of organising a midwife's clinic are really impeded by shortage of staff or whether this is used as an excuse. It does appear that there are midwives who are really enthusiastic over any opportunity to assume more responsibility for their role. For instance when the midwife in charge of the antenatal clinic was changed to a younger midwife, the latter did try to implement a midwife's couch. This scheme involved a midwife being totally responsible for seeing women during a consultant clinic session. This midwife gave the following explanation:

"The way I see it having a midwife's couch is the next best thing to a midwife's clinic because if there are
that morning or afternoon. It is a flexible system but it
does offer midwives and students the chance to use their
full skill and so far every midwife who has participated in
this scheme has felt a lot of job satisfaction."

When the usual midwife in charge returned to clinic after having
recently worked on delivery suite (all midwives generally have
to rotate to all clinical areas to update their skills) she
stopped this scheme in spite of some protest from the staff
midwives. The midwife in charge gave the following reason for
stopping the idea of having a midwife's couch during a consultant
session:

"I don't see the point of having a midwife's couch, after
all women come to a hospital clinic to see a doctor.
Otherwise they can go to their GP's (general
practitioner) surgery and be seen by the community
midwife there, it's usually a shorter wait there."

In returning to the official definition of a midwife which states
that:-

"a midwife is a person who, having been regularly admitted
to a midwifery educational programme, duly recognised in the
country in which it is located, has successfully completed
the prescribed course of studies in midwifery and has
acquired the requisite qualifications to be registered
and/or legally licensed to practise midwifery."

(UKCC Code of Practice 1991:2)

Her/His sphere of Practice will comprise the following:

"S/he must be able to give the necessary supervision, care
and advice to women during pregnancy, labour and the
postpartum period, to conduct deliveries on her own
responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help."

(UKCC Code of Practice 1991:2)

While the autonomous role of the midwife appears to be clearly defined by statute the manifestation of such autonomy is not clearly visible in practice. One of the obvious reasons is the 'taking over' of childbirth by obstetricians. Having established what Arney has called "the optimal birthing trajectory" (Arney and Bergen 1984), obstetricians were able prospectively to assess the course of labour. Obstetricians viewed themselves as heroes, rushing in with their surgical armamentarium when things went wrong (Schwartz 1990). Obstetrics has pushed therapy back from the curative into the preventative field. Instead of being mechanics responsible for the repairing of faults when nature goes wrong, they became engineers in charge of the smooth running of 'all systems' so that faults did not occur. The obstetric engineer has to master and control normal physiology in order to prevent the abnormal from happening. In so doing the obstetrician tended to encroach into the territory of the midwives and resulted in the redistribution of intraprofessional responsibilities. As in her 'Textbook for Midwives' Myles (1981:2) says: "The basic role of the British midwife... (as) a 'delivery woman' who practised independently... has been superseded. It would now be considered a retrograde step for a midwife to take sole charge of an expectant mother, thereby depriving her of the scientific expert care only the obstetric team can provide." It appeared that one of the tasks assigned to the midwife in her new role as subcontractor to the engineering programme is to explain and to make mothers feel at ease with novel technologies. The researcher found that one of the primary roles of the midwives is to assist the doctor and demonstrate a
'caring attitude' towards the clients. For instance when a client is referred to the doctor for an instrumental delivery the midwife then assumes duties such as preparing the delivery trolley and assisting in the opening of equipment such as forceps for the doctors, in addition to holding the woman's hand and comforting the woman and her partner. This role places the midwife in a subservient position of being a doctor's aid. Most of the midwives in this study felt that they often are asked to be a doctor's assistant and this role causes conflict when they try to practise as 'practitioners in their own right' for the sake of their student midwives. This role conflict which is prevalent in the clinical area also serves to pass on a set of values, beliefs and attitudes that is different from those taught by the tutors.

From the above discussion it is evident that most midwives still believe that they are 'practitioners in their own right' as defined by statute. But this belief is not always reflected in their practice.

To the researcher there appears to be evidence which suggests that while the midwifery profession is on the whole united in espousing that they are 'practitioners in their own right', their clinical practice often falls short of this belief. The researcher would assert that a key question that midwives must ask themselves is "has the role of the midwife been changed by midwives defaulting in their responsibility of being practitioners of normal childbirth?"

Since the data in this study suggests that the majority of midwives are practising by referring decisions to the obstetricians or to more senior midwives, perhaps the profession needs to redefine what is midwifery. One solution as proposed by Downe (1990b) may well be to accept the division of the profession and have obstetric nurses who wish to hand over the autonomy and accountability of managing consumers of maternity
care to doctors and a smaller group of midwives who wish to reclaim the accountability and autonomy.

Whatever course of action the midwifery profession contemplates taking will have serious implications. Indeed this study itself also has great implications for the profession which the researcher aims to discuss in the next chapter.
CHAPTER 7

IMPLICATIONS

Midwifery is at an important crossroads in its developmental history. Past ties to a medical orientation employing the disease model of illness are weakening as the limitations of this model are identified. Consequently there is a change in perspective with the primary emphasis on using a facilitative rather than an interventionist approach. Intervention presumes abnormality or dysfunction and the role of the midwife in intervening is to correct this abnormality. Facilitation on the other hand presumes that pregnancy and birth are physiological processes and the role of the midwife is to aid the unfolding of these natural processes.

However, one of the findings of this research is that while midwives may on the whole believe that birth is essentially a physiological process they do not necessarily match their actions to this belief. They seem to lack the confidence and knowledge base to make decisions and be accountable for the decisions made. Most of the midwives observed in action appeared not to want to enter the obstetrician's domain of diagnosis and treatment. Moreover midwives were very tentative in their findings. A common occurrence was that a midwife would be reluctant to commit herself, as illustrated by the following:

"I'm not sure it's an OP position as I cannot feel the suture lines, there is a lot of moulding, you know."

"The contractions do seem far apart, but then things may be happening, it's one of those things that one cannot tell..."
"I think that Mr H (the obstetrician) may well be right... it could be facing the right way round this time. I certainly can't say definitely one way or another as your 'tummy' is very tight."

Hence the actions of the practitioners of midwifery suggest that they find it difficult to overrule the doctors' findings; the consequence is that the midwives also keep to a medical model when giving care. The care given to clients is attuned to problems rather than needs. Midwives also simplify matters by typically casting clients into certain moulds and acting towards them accordingly. In so doing they adopt a language system that separates them from their clients but pulls them closer to the obstetricians. The obstetrician/midwife relationship is cemented together by interactions and interdependence. This interdependence is two-way: the obstetrician requires the assistance of the midwife and vice versa.

It has been documented in this study that midwives tended to practise according to routine rather than research as the 'school' propounded. Routines inhibit inquiry and change so that the profession of midwifery emerged with a traditional rather than an objective approach to a problem. Rules and regulations are seen as an inherent part of ward routine which provides a disciplined framework for ward control but by their very nature they deny an environment of inquiry hence the predominant attitude 'you are here to work (care, nurse) not to think.' Merton (1957:184) argues that "people tend to respond to such a situation which appears to be threatening and excites distrust by clinging to established routines and institutional norms, this adherence to rules and routines further reduces stress for the individual." One interesting result was that Merton (1957:253) found that "individuals displace their goals and the result is that an instrumental value becomes a terminal value hence the routine becomes an end in itself, that is a ritual."
Yet student midwives in this study appeared to be actively interpreting the professional world of which they have to be a part during training, and also which they choose to take part. Hence resolution of the learner/worker dichotomy would constitute a vitally-needed step forward in midwifery education. There is some evidence that students wish to be seen and treated more as students by the mentors. This suggests that a process of re-education of the mentor midwives is essential in order that they appreciate the needs of the students.

Again another aspect is that currently wards are still generally being organised on the basis of a work ethos that gives primacy to maintaining routines in order that tasks may be accomplished. On such wards, students' learning may not be accorded high priority. Changes in attitude can be discerned in the trend towards abandoning task allocation in favour of individualised client care. In this study it was found that while 'management' has started to promote client care based on a nursing process the philosophy behind using such a tool was not clear to practitioners and hence they were just undertaking the paper work involved. Continuing education may resolve some of these problems.

The Code of Professional Conduct (UKCC 1992) points out that:

"Each registered midwife is accountable for her practice, and, in the exercise of professional accountability shall:

1. Act always in such a way as to promote and safeguard the well-being and interests of clients.

2. Ensure that no action or omission on her part, or within her sphere of influence is detrimental to the condition or safety of clients."
The above clauses are the first two from the UKCC Code. At first glance they appear unequivocal, reasonable and accurate. Every midwife who sees her/himself as a professional should be happy to accept them. The clauses emphasise the primacy of the interests of the client which should hold sway above all else. Yet these two statements impinge on hidden issues (such as the values, beliefs and the knowledge base of midwifery) and they also make several key assumptions. The first clause assumes that midwives are in a position to assess the best interests of their clients; the second assumes that midwives know and can define their sphere of practice. These assumptions do not have an empirical basis (but is the professional ideology) and the reality is shown to be a minefield.

For instance, in order to assess the best interests of clients, midwives must have time to develop an empathic interpersonal relationship. This proves to be difficult as most midwives find themselves working in an organisation which may have other goals than fostering effective interpersonal relationships. Midwives, like other National Health Service employees, are often rewarded for bureaucratic efficiency by treating all clients/patients alike in order to save time. Hence the quality maxim which suggests that each person has to be treated as an individual is seen as an ideal that can be impossible to achieve in the clinical situation. Such a dichotomy creates conflict. Other conflicts that arise which put the midwife in a difficult if not impossible working situation were described by a student midwife (Anderson 1990) as follows:

"Client as Individual versus Institutionalised Care: Midwives want to give care based on assessment of the client's individual needs and yet the former work within a bureaucratic structure which promotes fragmented care.

Teamwork versus Independent Practitioner: Midwives are independent practitioners in their own right and yet they work
within multi-disciplinary teams where disputed areas of work overlap with those of other professionals.

Hierarchy versus Autonomy: Midwives are theoretically autonomous and accountable for their decisions and yet they work within a rigid hierarchy in which they must defer to those above them or risk censure."

Hospital policy versus Autonomy: Midwives try to give care based on the philosophy that birth is a physiological event and is unique to the individual, and yet they work within a hospital framework which promotes the ideology that childbirth is an illness with unpredictable complications. This ideology promotes policies which aim to standardise and thus control that event.

The above are just some examples of conflicts confronting the midwife but the list is much longer. It does appear to be an impossible working position for the midwife. Indeed, as one student argued in her essay:

"For a midwife to survive in this environment and to retain her accountability, integrity and sanity, she must combine the deviousness of Machiavelli with the diplomacy of Disraeli!"

(Anderson 1990)

In addition, the midwife would need to have the following attributes to be 'a true practitioner of normal childbirth: 'knowledge, autonomy, confidence and self awareness. S/he requires knowledge so that the relative consequences of alternative courses of action can be assessed, and in order to be accountable s/he requires autonomy. It is of little value if the midwife knows what type of 'best' care to give to the client if there are constraints (internal or external) which prevent her/him from delivering that care. A midwife practising as a
practitioner in her/his own right would need to be confident in her/his own abilities and judgement. Lastly, s/he would require to have self-awareness to understand one's values, competence, personal limitations and vulnerabilities.

From the above it could be deduced that the aim of midwifery training and education should encompass the attainment of attributes that will produce the kind of midwives who can be 'practitioners in their own right' and be accountable for their practice. This aim may be made explicit in the official curriculum but as the study showed, the impact of the hidden curriculum needs to be considered otherwise there will always be a dissonance in the beliefs, values and attitudes between the education and service sectors.

As technological, social and environmental changes and the advancement of midwifery occur, it is important for midwives to be able to learn from their everyday work and to use knowledge from midwifery practice in that work (UKCC 1990). Many of the midwives in this study appeared unable to learn from their work.

Reflection in learning is not a new idea, indeed it is akin to Aristotle's concept of deliberation (Elliot 1983:227-245). Dewey also discussed the problems in 'Forming Habits of Reflective Thoughts' (Dewey 1933:56) and he later defined reflective thought as:

"Active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, it includes a conscious and voluntary effort to establish belief upon a firm basis of evidence and rationality."

(Dewey 1933:9)
The basis for midwifery activity would appear, from this sample, to be mixed, primarily consisting of midwives who practise routinised care based mainly on personal idiosyncrasy and common sense rather than scientific principles. The present study further shows that students value learning in the clinical area especially if they feel that their midwife-mentor is a practitioner who can, through a process of reflection, give rational explanations for her/his actions. It seems that student midwives do not object to the traditional style of apprenticeship training - i.e. 'sitting by Nellie' if the trainer is a midwife who can account for what s/he is doing. As one student midwife declared:

"I think I learnt more from my midwife than all those weeks in school... after all things are real on the wards and in the community; I mean you meet 'real' mothers and babies... not supposed ones in the classroom. I love being with my community midwife who talks me through most tasks telling me why certain things should be done one way rather than another. She has a lot of experience and that's important, you should learn from those experiences, which you don't get in school."

Indeed what students are saying is that their primary learning experiences are those learning experiences which occur in the clinical area. This has tremendous implications for midwifery training as the statutory bodies governing midwifery education in England and Wales are advocating a form of training that in effect encourages the students to spend more time in the classroom.

An Ideal form of Training:

In England the English National Board controls the training of midwives and through its policies sets out the ideal for ward training of student midwives. These ideas are translated into
official curricula which make explicit the aims and objectives of the course, the educational approach that is to be used, the assessment and evaluation processes. The current trend is to base health professional courses at Institutes of Higher Education and to encourage the development of undergraduate diploma and degree courses. These courses have a greater emphasis on theoretical content than traditional courses; hence, in effect more time is spent in the classroom. Based on the findings of this research it would appear that this trend is not in harmony with what students find to be their primary learning experiences. This is illustrated by the following statements made by some DipHE student midwives:

"I do feel that all this time spent in the classroom is not necessary. I know we need some theory but I could get this from my midwife if she is one of those up-to-date ones. The difference is that she teaches me the theory as we go along but surely that's more relevant, I can put it in the context of practice."

"I don't like going to school much. The other day we spent 2 hours on a psychology lesson which we cannot put into use in midwifery. Then we had a lecturer teaching us the role of the health professional in a changing society, all she did was talk about her own pregnancy and how she coped with the morning sickness and so on, I think I would benefit more from working with a midwife."

The conflicts and realities of midwifery education in the ward situation were described many years ago by an English surgeon, Balme (1937:77) who wrote:

"She is not there as a student, to learn what is the matter with each individual patient and how to nurse each one. She is there as a piece of ward machinery to carry out certain duties which have got to be done."
The rationale behind the statutory body's policy to make health professional training into a more educational programme is that the issue of students being used as 'a pair of hands' has to be addressed.

This latest policy appears to have increased the gap between theory and practice. In the espoused theory the educationalists teach research based, planned individualised care. Moreover they emphasise reflection in practice as often the basis for conferring the academic award is the student's ability to be critical. However in the theory-in-use it was found that most of the care was routinised and based on rituals.

Nursing research has highlighted the problem of the gap between theory and practice; the tutors tend to withdraw to the school, and consequently become the 'purveyor of ideal nurses' (in this instance ideal midwives) remote from what goes on in the wards (Bendall 1976:10). For instance, Bendall found that what nurses wrote in their examinations was not practised in the ward and skills learnt in the school were not performed in the same way in the ward.

However the way in which the performance of tasks on the ward differs from the way such tasks were learnt from the 'school' is only one aspect that nursing research has illuminated. This research has also shown that there is a difference in the values, beliefs, attitudes and the knowledge base (which underpin the practice) between those propounded by the tutors and those that are circulating on the wards. As students move from ward to ward they interact with different staff members in each environment and in so doing they undergo a social process, whereby they are influenced by the attitude and values of those around them. Hence if students work with the 'crusader' midwives they will build on the beliefs, values and attitudes that have been handed down by the 'school', but if a student works with 'survivor' or 'nurse-midwives' they often experience conflict as
the set of beliefs, values and attitudes could be vastly different from the 'school.'

Learners confessed that they are too weak to alter the system, hence many get disillusioned and some leave as they feel unable to tolerate the situation, therefore leaving behind a workforce that may be more prepared to accept the situation. The training of midwives in this case is seen to have one consequence, that is, it sustains the contemporary structure of the profession and provides an obedient workforce.

Although this is one perspective that has emerged from the data in this study, there is also another perspective which is more optimistic for the profession. In the latter case both students and midwives feel that there are already signs of change in the profession as the following statements illustrate:

"I disagree that we are stuck, it depends who you work with. Some midwives are 'superb', they are with the client all the way, they respond to their needs, giving care just like we are taught in school, and these midwives are always working at changing the way we give care. It seems to me that the major block to change are the rules and policies imposed by the hospital, doctors etc but even those are not static, like Miss T (who is really old fashioned) is thinking of retiring and if we get a midwife who is research-minded etc then there will be change, even in hospital rules and policy because that position allows the individual to have a say about which policy to introduce..."

"...if we adopt a defeatist attitude then we are doomed, we've got to keep fighting, the system, the midwives who practise based on rituals and the doctors who try to confine our practice... that is the only way we can survive..."
"...it really depends on the prevailing values as I have said before if the midwife that I have as a mentor is well-informed about her practice, then she can make such a difference. The problem for students is not knowing what kind of midwife you are going to get next, in some ways if we can be attached to one 'good' midwife for the whole of our training it will be great, not so stressful."

Hence the view taken that students move from ward to ward and in the process of interacting with different staff members are socialised to conform to the institutional rules and norms (Bendall 1976, Alexander 1980) can be open to criticism. Whilst students are undoubtedly influenced by the attitudes, beliefs and values of those around them in the clinical environment, this is not a one way process, for students are social actors capable of bringing their own individual characteristics to bear on situations in which they are involved. Theoretically if the situation is social in nature, then there is a two way process in which change is possible. Indeed it would appear that the 'crusader' midwives tended to adopt the existentialist philosophy that individual midwives could be a powerful change agent. Characteristically, these midwives have not adopted the notion of 'safe practice' by abandoning their professional judgement in favour of blindly following ward policies, rather they use their reflective skill to help them to practise safely. The 'crusader' midwives would seem to fit in to the image of the authentic person who is constantly striving for change. These midwives assert that they do not wish to be seen as powerful or high in status. Consequently, they are highly critical of the hierarchy system adopted by midwives in the hospital. Paradoxically, they are given a high status position by students and by the 'survivor' midwives who see them as 'courageous' and 'virtuous'. Some students feel that the survival of the midwifery profession may well rest on these few 'change-agents'. 
Midwifery - A Dying Species?

In a speech addressed to midwives the President of the Royal College of Midwives, Margaret Brain, asked the following questions (1986):

"Why do midwives feel that they cannot fulfil their full role?"
"Have we trained midwives who do not want this role?"
"Are we at the cross-roads in midwifery practice and education or is it a T-junction where a decision must be made to go one way or the other?"
"Are we going to continue to train midwives to practise midwifery with all that that means or are we going to become maternity nurses?" (Brain 1986).

While these questions are not easy to answer, this piece of research has aimed to shed some light on these concerns. The students who participated in this study asserted that they have found their midwife mentors were generally not supporting what the school taught hence the gap between theory and practice, was too simplistic. According to the midwives interviewed many actually had the same values, beliefs and attitudes as the tutors and the profession at large. Such values and beliefs include those described in the Royal College of Midwives' document 'A Philosophy for Midwifery' (RCM/221/91 - refer to appendix 5). However the actions of midwifery practitioners as observed by the researcher are not always congruent with their beliefs. Therefore their espoused theory and their theory-in-use are different. One reason, as pointed out earlier, is that the espoused theory is not always practical for every client and therefore the midwife has to adapt her actions to the client's needs and to those particular circumstances. In the course of doing this the practitioner may well be redefining theory. However the more common reason why practitioners cannot match their espoused theory to their theory-in-use is because of constraints exerted upon the individual midwife.
While the 'crusader' midwives are more eager to overcome these constraints in order to give the care that matches their belief system, the major group of midwives, that is the 'survivors' generally 'jolly along' with their work. Consequently they have to develop strategies to cope with conflicts; such strategies include rationalisation and re-construction of their reality otherwise one of the effects is that they experience cognitive dissonance. Therefore it appeared that a large majority of midwives have defaulted on making decisions and being accountable professionally. At this junction the midwifery profession does appear to be divided. Whilst there is a small number of midwives crusading for the preservation of midwifery as an autonomous profession, many midwives have already adopted a role of being the obstetricians's assistant.

One interesting question that has emerged is: why are there some midwives who press for change in promoting the right to practise autonomously while others are left to accept the status quo unchallenged? The researcher would postulate that Durkheim's theory of moral forces in social life is relevant here. Durkheim (1952) identified four contradictory forms of moral force being present in society. These are altruism, egoism, fatalism and anomie.

In this context one could assert that the 'crusader' midwives are being altruistic in sticking to the principle of giving good care to their clients. Their belief in autonomy and individuality could be classed as egoism. The 'survivor' midwives on the other hand accept fatalism in the sense that while they share the same altruistic beliefs as the 'crusader' midwives they feel that the constraints imposed on them by the bureaucratic structures will inevitably inhibit the materialisation of their beliefs. This in turn leads to a sense of anomie. Durkheim (1952) further asserted that it is the relative strength of and balance between these forces that determine the nature of any particular collective consciousness. These meaning structures which Durkheim saw as
the essence of social reality, are not static but change generally and consistently over time. Durkheim argued that psychological health, a sense of well-being and alleviation of stress, is generated by those social orders in which there is a balance between egoism (individualism) and anomie and altruism and fatalism (collectivism). Consequently while the relationship of the individual midwife to the group changes form, there is nevertheless the need to bind that individual to the group. Hence the degree of altruism and egoism expressed by the crusader midwives is dependent on group consensus. This may partly explain why there are seemingly changes within the profession at the same time sustaining the stability of the social order. Durkheim expresses this as follows:

"All internal life draws its primary form from without... Therefore, if it individualises beyond a certain point, if it separates itself too radically from other beings, men or things, it finds itself unable to communicate with the very sources of its normal nourishment and no longer has anything to which it can apply itself."

(Durkheim 1952:279)

Hall (1973) sees power as a central issue, that is whether the organisation controls the individual or the individual the organisation. He suggests that a decision has to be made on the extent to which the social structure of the ward is a metaphor for the collective actions of the individual members of the structure and other participants or refers to an independent and constraining hierarchy of positions or set of rules. A model in which everyone conforms does not allow for internally-generated changes. In his argument Hall (1973) suggests that if one accepts that individuals do not receive and respond to stimuli and cultural values in exactly the same way as those who precede and follow, one is able to account for changes (but not for that which remains unchanged). Therefore one must take into account
the power which various groups possess, for people do not need power to conform, but they do need power not to conform.

The implication here is that change within the profession is possible but only as a gradual process. Furthermore in order to effect change these individuals require a degree of power. That power may emanate from unity of group values or arise by virtue of the individual's position in the hierarchy.

It is difficult to establish to what extent midwifery educationalists and 'crusader midwives' could achieve their aim of restoring the 'true role' of the profession. When questioned, both students and midwives articulated that they saw midwifery as being different from other health professions specifically from nursing, but in practice there is very little evidence to document this difference. This is because the impact of the learning experiences in the clinical area (which is the hidden curriculum) is so great on the students. While there were occasional instances when students found their midwives to be practitioners in their own right, generally most commented that their midwife mentors would not make decisions of their own accord but instead would refer to another more senior colleague or to a doctor.

In this study there is evidence that the anomie expressed by the 'survivors' and 'nurse-midwives' slows down the crusader midwives in their mission to promote midwifery as a separate autonomous profession. As Downe (1990b) suggests "one answer may be to leave behind those midwives who wish to practise like obstetric nurses and just gather those who wish to be 'true' midwives and re-establish the profession again through a new Midwives' Act. The implication is that the profession will be divided not only in beliefs, values and attitudes, but also in terms of the sphere of practice, autonomy and accountability."
Another solution might be to increase the opportunities for midwives to continue their education. The traditional 5 yearly refresher course does not appear to have sufficient effect in encouraging practitioners to reflect on their practice. It would appear that what is needed is an on-going staff development programme tailored to the needs of the individual midwife. The new initiatives proposed by the statutory bodies ie the Framework for Higher Awards by the English National Board (ENB 1990) and PREP (UKCC 1990) by the United Kingdom Central Council may be the first positive steps in helping health professionals to learn from reflecting on their clinical experience so that they can redefine theory. The effect of the implementation of the Higher Award and PREP on clinical practice and consequently on pre-registration midwifery educational programmes is not within the scope of this research but is nevertheless a much needed research issue.

Another pressing need is to reflect on the philosophy of midwifery education and the educational approaches used. So many curricula consist of philosophies that are mainly words or jargon taken from educational texts that are difficult to comprehend hence making the task of putting it into action almost impossible. All educationalists need as a starting point to address the question: what kind of midwives do we want in the future?

It was nearly 30 years ago that Revans wrote:

"Learning occurs most effectively when doubts in the mind of learners can be voiced spontaneously when they are to him most insistent. If the learner cannot ask questions or seek clarification when he stands in need of it, his learning process will be retarded, since new knowledge is most easily absorbed when there is eagerness to use it."

(Revans 1964:54)
Educationalists need to ask themselves if the official curriculum adopts an educational approach that allows this student-centred learning to occur. Are students encouraged to ask 'awkward' questions and to speak their mind freely? In this study students identified that this is what they need most to help them to 'survive' their training. They need to be able to voice their concern regarding the 'real' care that they witness happening in the ward area in a protected environment such as in the classroom. By reflecting and sharing ideas they can help each other to resolve their inner conflicts or cognitive dissonance and find a way forward to put into practice their ideas of the type of care they truly wish for their clients.
CHAPTER 8

FINAL CONCLUSIONS

The researcher became interested in carrying out this research as she experienced first hand some of the problems associated with the education of midwives in the classroom and the ward situation. Hence this thesis is concerned with exploring the student midwives' view of the practices of the mentor midwives based mainly on the students' learning experience. In addition, an analysis of the values, beliefs and attitudes which underpin practice was carried out.

Phase one of the research was carried out by conducting 'informal chats' with student midwives regarding their training and educational programme. This was followed by a more formal process of evaluating all courses at post-registration level and a content analysis of audit reports of the learning environment. As this phase of the research was primarily carried out in the College of Midwifery and the maternity units where the researcher is a senior manager the issue of validity was raised. Consequently a sample of ten interviews of student midwives from another College of Midwifery was also conducted. The general findings supported those from the College where the researcher works.

The main finding from phase one of the research is that there appears to be a set of values, beliefs, and attitudes and a knowledge base promoted in the clinical area which differs from those taught in the College of Midwifery. For instance, student midwives will recite the 'articles of faith' that midwives are practitioners in their own right but in reality they found their mentor midwives deferring decisions to more senior midwives or to
doctors. Hence while many midwives espouse the belief that birth is essentially a physiological process they do not necessarily match this belief with their practice. Most midwives appear reluctant to enter the obstetrician's domain of diagnosis and treatment even when the case is still within the confines of normality. Consequently the care given to clients becomes more attuned to a medical rather than a midwifery model. Another consequence is that midwives tend to base their practice on routine rather than research-based care as propounded by most of the educationalists.

The student midwives interviewed, strongly asserted that there is a gap between theory and practice. Basically what they were saying is that the beliefs, values and attitudes propounded by the educational sector are not congruent with those from the service sector. This is a very simplistic model as is revealed by phase two of the research which gave the researcher a chance to talk at length with midwives. Indeed contrary to the students' general assumptions, not all midwives are different from the tutors. The researcher was able to categorise the midwives into three basic types. While these categories are not exhaustive they nevertheless have distinct characteristics. The three types of midwives are as follows: The Crusaders, The Survivors and The Nurse-Midwives. The interesting point is that while all these midwives have generally had the same form of training ie a traditional programme which is teacher-centred and didactic, there are nevertheless differences in their practice. This led the researcher to question why there are such differences and how these different types of midwives could reconstruct the reality of their world of work. The researcher eventually employed Argyris and Schon's theory of reflection in practice and the theory of symbolic interaction to explain some of these phenomena. Lastly the theory of communicative action has also been discussed to illuminate the role language plays in the perpetuation of some of the beliefs, values and attitudes held by different sub-groups of midwives. This is a significant
point as midwives were found to practise on the basis of the meanings they have for words like 'midwifery', 'obstetrics', 'patients' and 'clients'.

One of the major findings from this research is that because most midwives' espoused theory and theory-in-use are not congruent this inevitably causes the theory/practice gap which was raised by the students. The most significant point to note is that while students spend time in the classroom with the educationalists learning how to be a midwife (based on a specific set of values, beliefs and attitudes) they are often exposed to a learning experience on the ward which is different (because the values, beliefs and attitudes are different). As students felt that the learning experiences on the ward formed their primary experience as they had the greatest impact, this has tremendous implications for midwifery educational programmes.

The reasons why students tended to conform to the prevailing values, beliefs and attitudes in the ward area were discussed at length in phase one of the research. It is a 'game of survival' which has been described by some students as being 'instinctive'. This creates one school of thought that there is the status quo which is here to stay at all costs. A more optimistic perspective is that while the status quo is generally maintained, there is nevertheless a gradual process of change within the profession. Yet to generate change, power needs to be acquired by the change agent. This may be in the form of acquired power through promotion to a position of higher order in the hierarchy or through collective unity in group values, beliefs and attitudes.

A way forward may well be through continuing education. Fortunately at present midwifery education staff are also responsible for in-service and continuing education, hence there is an opportunity to affect the values, beliefs and attitudes of midwives working in the service sector to bring them in line with
those propounded by the educationalists. Moreover, the apparent close links between educationalists and midwifery practitioners permits the former to influence the practice area to a certain extent. It is imperative for educationalists to exploit this opportunity.

This research has had some profound effects on the researcher as a midwifery educationalist. In some ways it has answered many questions but at the same time many are left unanswered. For instance, it is paradoxical that midwives constantly re-iterate that they are practitioners of normal childbirth when the distinction between normal and abnormal childbirth is an absolute blur. Then there are those midwives who really believe that the true professional role could be restored by having more educational rather than training programmes for midwives when the meaning of education and training are unclear to them. It may be that like nursing the midwifery profession decide to locate their professional training in higher education to gain credibility as a separate profession, but some have suggested this move away from the 'grassroots' that results from professionalisation as being a disadvantage to the profession and its clients (Taylor and Pellegron 1972). The evaluation of midwifery educational programmes which are more academic in nature (ie the diploma and degree type courses) urgently needs to be carried out to assess its validity in claiming to produce 'better midwives.'

It is argued that the philosophy of midwifery care is different from that of nursing (Morrin 1992). Briefly, women are considered to be healthy people undergoing a physiological process and able to be in charge of their own lives and health. Care is hence directed towards surveillance of the woman's pregnancy, incorporating health and parenthood education. The emphasis is on normality, health, independence and self-reliance, whereas in nursing the emphasis is more on illness, dependence and reliance on the carer/nurse. Hence one argument is that those who have undergone a nurse training programme prior to
undertaking a post-registration midwifery course would have been 'conditioned' to an illness model of care and may find it difficult to adjust to being a partner in care with a healthy pregnant woman. The researcher would however argue that since this research has demonstrated that the impact of the learning experiences on the ward is so great then the above premise is probably untrue as pre-registration student midwives who have not undertaken any nurse training could still be picking up nursing type behaviours from their midwife mentors who have themselves been exposed to a nursing socialisation process prior to midwifery training. This suggests another interesting research issue ie are pre-registration midwives more likely to practise as practitioners in their own right, making autonomous decisions and being accountable for these, when they complete their initial training or educational programme?

The purpose of a midwifery education programme is to produce a knowledgeable person who is competent to provide care for a client in normal pregnancy, labour and the postnatal period. The role of the midwife is firmly embodied in statute and this is what gives the midwife this autonomous status. The extent to which in reality midwives actually practise as permitted by statute has been explored and discussed in depth in this thesis. Yet this piece of research does not produce finite answers; the ongoing search for the answer to this important question must not cease.

To conclude, the study was an attempt to formulate the core of an emergent theory that would account for the conflict between theory and practice. The core of the theory that developed is the potential conflict between the cultural values and beliefs that pervade the educational and practice sector. While the researcher has attempted to expose the degree of this conflict the task has only just touched the tip of the iceberg. Consequently the researcher has in this chapter started to produce an agenda for future research. The researcher feels that
the midwifery profession can no longer just pay lip service to concepts such as 'practitioners in their own right,' 'supernumerary status' and 'educationally led programmes.' Instead for these concepts to be effective in real terms, educationalists need to design evaluation tools that are reliable and valid in exposing any conflict in the values and beliefs of the two sectors; i.e., in the service and education. Moreover, a strategy needs to be formulated to handle the conflict that emerged so that the integration of theory and practice can be realised. Such a strategy would need to take into account the very real difficulties associated with practice and its perceived value. In this study it has been revealed that while official statements and documents may appear to demonstrate the importance of practice they do not appear to reflect the real experience of midwives who feel that their skills are being undervalued.

To conclude this research, consideration will be given to how the information collected in the study described can be used for practical guidelines to help closer integration of theory and practice. The main possibilities for action are in the provision of structured feedback to students as well as to mentor midwives to assist with change in attitudes, and in curricula revision. The latter has to do with both the official and the hidden curriculum. Moreover, the profession as a whole needs to examine the validity of their beliefs, values, and attitudes in the light of current practice. Whichever set of beliefs, values, and attitudes is adopted, there needs to be unity among members of the profession in order that these beliefs, values, and attitudes are put into practice.

Another important task is for the profession at large to try to find answers to these questions posed by the president of The Royal College of Midwives:

(Brain 1986) "Why do midwives feel they cannot fulfil their role?" "Have we trained midwives who do not want this role?"
"Are we at a crossroads in midwifery practice and education or is it at a T-junction where a decision has to be made to go one way or another?" and lastly the most profound question of all; "Are we going to train midwives to practice midwifery with all that it means or are we going to become maternity nurses?"

Urgent calls for change are constantly made by midwives at all levels within the profession but unless research findings can be translated into action there is every likelihood that the status quo will continue. The value of research lies not so much in the data as in the application to professional practice in order to bring about change. Hence the midwifery profession needs to look back in its history as well as to look forward in order to gain a clear vision of the pathway in which educationalists as well as midwife mentors need to work together to re-capture the true meaning of midwifery ie to be 'with woman', and in so doing the profession needs to be constantly reminded that "practice without theory is uninformed action, and theory without practice is mere verbalism" (Dyson 1992:46).
METHODOLOGY

1.1 Hunting of the Paradigm

There will inevitably be more than one way of approaching most research problems, and the present study is not immune to the qualitative-quantitative debate. The decision to use a qualitative approach was taken because the researcher felt that there was a need to encourage the midwives to express their ideas about midwifery in a spontaneous, natural, essentially non-directed way. Qualitative methods are particularly useful when describing a phenomenon from the emic perspective, that is, the perspective of the problem from the 'native's point of view' (Field and Morse 1985). Such a perspective suggests that the social world is not objective but involves subjective meanings and experiences that are constructed by participants in social situations. Accordingly, it is the task of the social scientist to interpret the meanings and experiences of social actors, a task that can only be achieved through participation with the individuals involved.

It should be axiomatic that the choice of research methodology is dictated by the aims of the study. However, this simple approach to the choice has been cluttered by the desire of researchers to acquire 'respectability' by using the 'scientific' model in their research design. The availability of sophisticated computer software statistical packages has made the move towards quantitative methods an even more attractive one. Filstead (1970:5) went as far as to say that:
"Most sociologists do not deny the immense heuristic value of qualitative data; to do so would indicate poor professional judgement. However, very few recognise qualitative methodology as a legitimate source of either data collection or theory construction."

There is a tendency to consider a qualitative method to be of use only in the exploratory phases of a study, to open up substantive areas which must be investigated to obtain the 'facts' by a 'respectable' quantitative method. It could be argued that the qualitative method not only has a place in the exploratory phases of a research project, but can also yield useful data in its own right (Melia 1982).

Filstead (1970:4) refers to the 'understanding' approach as qualitative methodology and describes it as:

"Those research strategies, such as participant observations, in-depth interviewing etc, which allow the researcher to 'get closer to the data' thereby developing the analytical, conceptual and categorical components of explanation from the data itself rather than from preconceived, rigidly structured and highly quantified techniques that pigeon-hole the empirical social world into the operational definitions that the researcher has constructed."

Filstead could be seen as fiercely attacking the quantitative methodology in order to advance his case for qualitative work. Nevertheless, the point being stressed above is that the qualitative method has something to offer in the collection of viable data and the formulation of theory.

Given the state of midwifery theory, it would be legitimate to argue that the generation of theory is more critical than theory testing to the development of midwifery knowledge. Theory
construction must begin with the perceptions and perspectives of members instead of with pre-existing abstract assumptions. The ultimate goal is to develop a body of knowledge unique to midwifery that will guide further research and provide a basis for practice. The goal of the researcher is to identify patterns or commonalities by inference from examination of specific instances or events. The reflective process may move from specific ideas to more generalised ideas that result in the identification of concepts and potential relationships (Glaser and Strauss 1967). The aim of the research is to understand the setting or the events, and the processes involved in identifying variables in order to generate theory (Denzin 1970). Theory is thus generated by a process of induction, in which analytical categories emerge from the data and are elaborated as the work progresses (Field and Morse 1985). In a professional discipline, research must eventually produce theories that can be used to improve the practice of that profession. Answers to research questions form the basis of theory and of midwifery knowledge insofar as critical concepts and constructs are identified and demonstrated. These may be descriptive, prescriptive or predictive in nature. Different kinds of theory are used for different purposes but all theory has an intrinsic purpose (Kaplan 1964, Glaser and Strauss 1967).

What is it that one means by a 'theory'? In broad terms, a theory is a hunch, a guess, a speculation or an idea that may begin to explain reality. Theory is the researcher's perception of reality in which constructs and concepts are identified and relationships are proposed or predictions made (Field and Morse 1985). It is a systematic explanation of an event. Hence all theories by nature are symbolic constructions of reality. As Kaplan notes:

"Theoretical concepts are contrasted with observational ones, and theoretical laws with empirical generalisations. Though all conception involves the use of symbols and is
thereby distinguished from perception, in some cases the symbols relate directly to the perceptual material while in other cases the relation is mediated by still further symbolic processes" (Kaplan 1964:296).

Theory can be developed by inductive or deductive modes of thinking or it may be arrived at through a combination of inductive and deductive thinking, as proposed by Glaser and Strauss in their discussion of grounded theory (Glaser and Strauss 1967). The most important point is that theory, whether obtained deductively or inductively, remains conjecture, but as it is tested becomes better confirmed. According to Field and Morse (1985:120) "as theory is derived from the researcher's present knowledge base and personal reality, theories are culturally tied to present paradigms, that is the prevailing thought in a specific discipline."

The discussion of theory is relevant here as Bulmer (1977) asserted that the starting point of research should be 'the interplay of problems, theories and methods in sociological research.' His main thesis is that methods should be viewed in the context of the problems and theories which they are used to illuminate. This is particularly useful when confronted with the qualitative versus quantitative debate. Researchers need not pursue methodological hegemony but derive their methodological approach from a consideration of both the problem in hand and the theory pertinent to it.

Naturalistic Research

Qualitative research is often conducted in a naturalistic setting, so that the context in which it occurs is considered to be part of the phenomenon itself. The emerging naturalistic research paradigm (Fosters and Nixon 1975) is the theoretical stance from which the research issue will be examined. There is
no systematic definition of what naturalistic research is. However, Guba and Lincoln (1982:233) go some way towards explaining the concept:

"Naturalistic inquiry is a paradigm of inquiry... It is frequently asserted that its distinguishing features are that it relies heavily on qualitative rather than quantitative methods..."

Naturalistic research, has also been defined as "...studying behaviour as it would have occurred in the ordinary way and in the circumstances that would have spontaneously given rise to it" (Kidder 1981:264).

In naturalistic research the context in which the phenomenon occurs is an important part of the phenomenon itself. Thus, no attempt is made by the researcher to place experimental controls upon the phenomenon being studied, or to control the "extraneous" variables.

Discussion of the relative merits and usefulness of naturalistic research methods, as against explicitly arranged, controlled, manipulated laboratory methods, have a peculiar tendency to deteriorate into polemics and debates. It is common to hear discussion about issues like "rigour" versus "sloppiness", "control of variance" versus "meaningfulness", and "sterile" versus "true-to-life." However, it is not the intent of the researcher to spend large amounts of time and energy justifying using a naturalistic approach nor will the researcher be pointing out the deficiencies of the experimental approach. What the researcher aims to do in this paper is to address the strengths and unique contribution that naturalistic research might have in explaining the underlying values, beliefs, attitudes and knowledge base in midwifery.
The researcher believes that the use of naturalistic research is justified in order to explore in depth the values, beliefs, attitudes and knowledge base of midwives. Moreover, it has been argued that naturalistic research should be used when there is little known about a phenomenon to be studied (Field and Morse 1985). In pursuing the discussion of naturalistic research further, Denzin (1970) offers a view of naturalistic research that takes as its point of departure the social behaviourism of Mead (1962) and the symbolic interactionism of Blumer (1969). Denzin calls this naturalistic behaviourism. By this term he means the "studied commitment to actively enter the world, understandable from the standpoint of a theory that is grounded in the behaviour, language, definitions, attitudes and feelings of those studied." This interpretation of naturalistic research is pertinent in a situation where the researcher is attempting to turn a set of biographically troubling issues into a research question which culminates in an attempt to offer public answers to questions which were initially personal and private to the informants.

There are several advantages to using naturalistic observation in the study of the values, beliefs, attitudes and knowledge base of midwives. First, and most obviously, naturalistic observation keeps the description as close as possible to the ordinary interaction patterns of the student/midwife and the midwife/client. Secondly, due to the unobtrusive aspect of naturalistic research and the preservation of ordinary interaction the research findings can be generalised to a greater extent (Duffy 1984). Lastly, the detailed information gained may help in the discovery of important empirical relationships.

Midwifery as a scientific discipline is a neophyte. Among the diffusion of foci and goals within the factions of the midwifery profession, researchers struggle to generate and verify the theory base of midwifery. In the pursuit of scientific attainment of midwifery knowledge the researcher has to face
various philosophical ideologies. Each philosophy espouses a specific methodology to gain knowledge. In this age of technology and objectivism, the paradigm of the natural sciences (quantification of data) has been enhanced as the truly scientific methodology. Qualitative methodologies are reserved for generating theory from facts obtained within the natural setting of the phenomenon. Discussed above are some issues and concerns that led the researcher to choose a qualitative (naturalistic) research method. The fundamental assumption of qualitative research is that knowledge of social facts is best attained when the researcher goes inside the natural setting and attempts to see and understand the phenomenon as the subjects do. Since the main purpose of this research is to describe the values, beliefs and attitudes of a midwifery community in which the researcher had already been part of the setting, the use of a qualitative research methodology would appear to be appropriate.
1.2 Research Technique

The naturalistic research methodology employed will include informal interviews and participant observation. Both of these methods will aid the researcher's understanding of the midwives' perception of meanings attributed to their actions.

Interview research is an important method for examining the way midwives develop their understanding of the world. Interviewing is the backbone of participant observation (Chenitz and Swanson 1985). As a participant observer, the researcher never assumes that meaning is shared by all participants. The researcher follows and records events and these events may raise questions that can be actively pursued in interviews. The use of two methods: observation followed by interviews is based on the premise that midwives' actions should not be taken at face value. There are other social and contextual factors involved which might affect what a midwife does, so that the researcher cannot just observe and draw inferences merely from observation. Using follow-up informal interviews enhances the observational data and both methods serve to allow insights into the activities of the midwives and their construction of midwifery.

The informal interview, which is like an everyday conversation, is a valuable method of data collection. While all research interviews are 'conversations with a purpose' (Bingham and Moore 1959), the informal interview epitomises this statement. This method is characterised by natural speech and interaction between the researcher and the respondent. Like everyday conversations, informal interviews have no particular meeting time, length, or place. They are surrounded by no formalities such as the use of an interview schedule. There is also no ceremony that highlights the interview such as the signing of a consent form (Chenitz and
The major characteristics of the informal interview are its social nature and the basic rules that apply to all ordinary conversations, such as turn-taking. As Becker and Geer (1978:323) note:

"In this kind of interview, the interviewer explores many facets of his interviewee's concerns, creating subjects as they come up in conversation, pursuing interesting leads, allowing his imagination and ingenuity full run as he tries to develop new hypotheses and test them in the course of the interview."

To use a more structured approach the researcher may focus too early on the analysis. This could lead to more organised questioning in the field but could also lead to a theory that lacks depth and credibility (Chenitz and Swanson 1986). An informal interview may last minutes or it may go on for an hour or more when the researcher and respondent are in 'deep talk' and neither wants to end it. An informal interview can be conducted anywhere: along the corridors, in a client's room, in offices and so forth. The researcher has to keep practising informal interviewing techniques in order to be comfortable starting a conversation on the spur of the moment, putting the respondent at ease quickly and disengaging with grace. The lack of formality or ceremony surrounding the informal interview means the researcher also needs a tolerance for ambiguity and flexibility. The depth, theme, and questions of the interview are mainly determined by a number of factors such as stage of the research, questions arising from data analysis, as well as the researcher-respondent relationship. While most questions are usually framed at the time of listening to responses, nevertheless Schatzman and Strauss (1973) indicate that informal interviews should be sufficiently flexible to accommodate new themes. There should also be an aim in the researcher's mind at the outset. In view of this, the researcher defined her goals and had the list visible during each interview. The subjects which the researcher
wished the informant to address usually began around the question of what was the respondent's notion of 'midwife' as well as reasons for entering midwifery training and expectations of the course/profession.

The interview is an emerging process and the researcher constantly assesses the respondent for signs of fatigue and lack of interest. The spontaneity of the informal interview provides data that leads the researcher to formulate new ideas (Burgess 1984). In this way, the respondents guide the researcher into their world, the world that the researcher needs to enter and examine. The flexibility of this approach permits the researcher to focus on particular topics or to keep the focus broad. The natural style of this type of interview allows the researcher to get to know the subjects as people, understand them and how they see their world, and finally, perceive the events as they do.

Throughout each interview, the researcher did the following:

1. considered what was being meant in what was said;
2. considered how best to phrase the next question;
3. observed the general pattern of events being discussed;
4. assessed the respondent for signs of tiredness, discomfort or conversely for interest, excitement etc.

The researcher found the task of focussing on the above issue impossible while taking notes, hence a micro cassette tape recorder was used. Indeed this method of recording is advocated by most researchers (Schatzman and Strauss 1973, Gorden 1980). The tape was later transcribed by the researcher and this provided an opportunity to reflect on the data. The researcher always sought permission to tape the interview before proceeding to do so and there were no objections from respondents especially when they were assured that only the researcher would be transcribing the data. Since informal interviews are spur of the moment conversations, consent forms agreeing to the interview are
not used. However the principle of informed consent was applied. The researcher's presence and the purpose of the study were made known to subjects involved in any interaction that formed the data.

Through informal interviews, the researcher seeks to establish truth via those people's understanding. It could be argued that both participant observation and interviews are appropriate tools for research of this type as they seek to investigate situations involving people's inner consciousness (Hosie 1986).

Direct observation is useful in that respondents are not called upon to recall events. As Burgess (1984:124) asserts: "The value of being a participant observer lies in the opportunity that is available to collect rich detailed data based on observations in the natural setting." Participant observation was especially useful in this study where the researcher was seeking to verify the congruity between the respondent's proposed action as elicited during the interview and with the actual action that occurred in the setting. Participant observation also permitted the examination of behaviours that were not included in the informant's verbal description of a situation. For instance the researcher was able to observe the process by which a midwife empowers the 'labouring' woman to take control of her birth process and subsequently make decisions. Furthermore, the researcher could obtain accounts of situations in the informants' own language which gave access to the concepts that are used in their everyday life. The researcher can, therefore, construct an account of a social situation on the basis of the various accounts that are obtained from informants. In such circumstances, there is an opportunity to collect the different versions of events that are available. The result is that the researcher can utilise these observations together with the theoretical insights to make seemingly irrational or paradoxical behaviour comprehensible.
There are four types of participant observation. These are complete participation, participant-as-observer, observer-as-participant and complete observer (Field and Morse 1985), classified according to the amount of involvement that the researcher has in the research setting (Pearshall 1965). The researcher experimented with participant-as-observer. In this method the participants in the setting were aware of the researcher's purpose and dual roles. When entering the setting, the researcher negotiated to take a student midwife and a client group. The choice of this type of observation was based on the researcher's wish to reduce the reactivity. However, the conflict of the two roles when the researcher tried to work as a researcher and a midwifery tutor made it difficult to pursue this course of observation. The next strategy was to assume an observer-as-participant role. In this situation, the researcher spent the greater part of the time observing and engaging in informal interviews with minimal participation in the work role. This method provided more freedom for the researcher to carry out the research. However, research roles are constantly negotiated and renegotiated with different informants throughout the research project (Schatzmann and Strauss 1973). In this study the researcher found that although for much of the time the researcher took an observer-as-participant role there were instances where the researcher had to participate fully as a midwife.

Hence in reality the researcher moves between the role of participant-as-observer and observer-as-participant in what Hughes (1960:57) describes as "the unending dialectic between the role of members (participants) and strangers (reporters)."

Being a midwife observing midwives the researcher was often tempted to intervene. The researcher decided upon entering the field that she would not initiate action as a midwife but if asked would continue a course of action already started by the person requesting it, for example, mopping a client's face whilst
the midwife who had started this course of action relinquished the task to do something else. But there were occasions when the researcher could not observe this rule. For instance on one occasion the researcher had to take over the supervision of the student's delivery of the placenta when the supervising midwife had to help the doctor to resuscitate the newborn baby. In such instances the researcher had no choice but to initiate midwifery action. Not to have done so would have been inexcusable.

One issue to address was 'what should the researcher be observing?'. The aim was to focus on descriptive observation and the researcher found it helpful to use the following dimensions of a social situation on which data was to be collected:

i) Who were the actors?
ii) What was the event?
iii) What were the activities?
iv) What was the goal of the activities?
v) What was the pace?
vii) What were the feelings?
vii) Were there any mitigating circumstances?

With the descriptive dimensions in view it is possible to build up a detailed portrait of a social situation which may lead onto more focused questions in particular situations. For example, using the above dimensions to observe a midwife giving care to a woman in labour, the researcher was able to raise further questions regarding the client/midwife/doctor's relationship and the issues of accountability and autonomy. The researcher began by observing routine events, that is activities that are part of the daily round of 'ward life' such as report-giving sessions, organisation of work teams and interactions between midwife/client/doctor. Then the researcher moved on to observing the way in which care was delivered and the actions of the midwife in order to elicit the underlying intentions and philosophy of care. The researcher also focused upon untoward
events which included emergencies, dramatic situations, and crises which are not anticipated.

Most of the time the researcher was able to observe for periods of two hours or more. The researcher retained the freedom to enter and leave the setting and no appointment system was used as it was felt that the scene might be 'set' for the arrival of the researcher. During the two hour observational periods the researcher only wrote brief field notes or points which served as memory 'joggers'. The notes were kept brief so that the researcher could concentrate on what was happening in order to absorb the atmosphere of the situation as well as the verbal exchange. Whenever possible the researcher would seek a quiet place to write up the comprehensive set of notes immediately following the observational period to minimise loss of data. The goal is to capture the lived experience/action of the participants and to describe the midwifery community setting. The field notes obtained were varied. Some encompassed for example, descriptions of care, or styles of speech, or reconstructions of dialogue. The researcher also noted any behaviours which may have affected the observation such as actions and conversations, which may have changed the interaction/care. The influence of the researcher on the setting was kept to a minimum but there were times when the impact was apparent and this was again recorded to help in the assessment of untoward influences.

One of the main reasons for using participant observation was that participant observation does not seek to control what it studies. But yet the presence of the observer must have some effect on what is being observed. Schwartz and Schwartz (1955:235) state the problem:

"The observer is in a face to face relationship with the observed and by participating with them in their natural life setting, he gathers data. Thus, the observer is part
of the context being observed and he both modifies and is influenced by this context."

Hammersley and Atkinson (1984:111) in their chapter on 'Insider Accounts: Listening and Asking Questions' assert:

"Even in the case of unsolicited accounts one can never be sure that the presence of the researcher was not an important influence. Even where the researcher is not party to the interaction but simply within earshot, knowledge of his or her presence may have a significant effect."

Hence the major obstacle to validity in participant observation is the change in behaviour in the setting when the observer is present (Field and Morse 1985). Undoubtedly midwives will act somewhat differently when they are being observed by a researcher. If researchers are to capture the 'ordinary way' of doing things, then, any research will only approximate this ideal and it can never be fully attained.

In reflecting on this, Fox (1969:321) argued:

"My own experience with direct observation has convinced me that, while distortion is unquestionably introduced, it does not persist for long periods of time... if direct observation begins with a period of time for acclimatisation and orientation during which no data is collected, in most instances the research situation returns to normal."

The researcher must begin by analysing the perspectives of the participants in order to elicit the social meaning of their actions (Melia 1982). To a large extent, the assumption of the participants' perspective depends upon the researcher's knowledge of the social setting. In this instance, the researcher was already familiar with the social setting.
However being part of the social setting and in post as Head of the Training School also posed problems.

As Pearshall (1965:134) observed of nursing research:

"...a nurse is more likely to overlook much that is relevant because she no longer perceives it..."

The researcher did experience difficulty in separating professional judgement from research work throughout the process. The main problem was that the researcher had her own definition of 'good practice' and initially only saw those aspects of care that failed to reach her own standards. It was difficult to observe in such a way so as to be 'anthropologically strange.' Yet this strangeness is essential according to Hammersley and Atkinson (1981:153) "in order to make explicit the assumptions that he or she takes for granted as a culture member."

When the researcher entered the research setting, she carried with her the values and beliefs of 'good midwifery practice' and this resulted in her finding many aspects of care and practice that she considered inappropriate or falling below acceptable standards. This initially clouded judgement and objectivity. However, once the above weakness was recognised, the researcher was able to deal with the problem by constantly bringing into view the purpose of her presence in the research setting. There were other dilemmas that arose 'in the field'.

For instance, midwives appeared to be telling the researcher what they thought the researcher would like to hear. The validity of the research therefore needs to be addressed. Moreover as midwives converse frequently with the researcher regarding midwifery training, as they perceive that her role as Head of the School is to ensure standards of training, the ethics of using this data as part of the research needed to be addressed. Therefore, in naturalistic research whereby the methodological
tool consists of participant observation and informal interviews, the issues of validity, reliability and ethics clearly need some special consideration.

**Validity**

At this point it would be pertinent to address these three issues further. The classic definition of the validity of a measure is that a valid measure is one that taps the construct that is intended to be measured (Diers 1979). Validity assures that the causal relationship verified (or falsified) or the theory generated is not negated by rival hypotheses. The topic of validity has been divided into three main types: content validity, criterion validity and construct validity. Most researchers believe that construct validity is the most important of these three (Kerlinger 1964). Construct validity most directly confronts the relation between the measure and the construct it is intended to measure. Kerlinger (1964) developed a criterion for assessing construct validity. He asserted that there must be a convergence of evidence from diverse groups that would support the claim and that a measure must be capable of discriminating between the construct it intends to measure and other alternative constructs. For instance, in the first stage of this study it was thought to be a worthwhile exercise for the researcher to gain access to another training institution as a researcher without identifying herself as a midwife teacher, to gather additional data as a cross check on validity. Then if the researcher found that students from another training institution said that midwives taught them techniques/procedures that differed from those taught by tutors then the original data obtained from the researcher's own training institution may be more valid.

The limits on validity in naturalistic research are the peculiarities of each type of data collection strategy, for
example, interviewing or participant observation. With the exception of unobtrusive methods, the researcher must be alert to the reactive effects when present in the setting. Duffy (1984) outlines other cautions to be considered by the researcher such as:

1) biases and distortions from selective perceptions and interpretations
2) limitations on observable data or access to interviewees
3) 'going native'
4) knowledge of the subjects
5) researcher-subject rapport
6) reactive effects of the study, setting, or other conditions which tamper with the behaviour or responses of the interviewee or those being observed.

It is possible to increase the validity of the research by triangulation (multifaceted data collection). Using the term triangulation Denzin (1970:26) argues that multiple methods must be used in every investigation, since no method is free of rival causal factors. No method can ever completely satisfy the demands of interacting theory, or can ever completely reveal all of the relevant features of empirical reality necessary for a theory's test or development. Indeed Webb et al (1966:90) argued that "the most persuasive evidence and the strongest influence comes from a triangulation of measurement processes." Triangulation provides many slices of data; a strategy designed to minimise distortions from a single data source or from a biased researcher (Duffy 1984). In this study triangulation consisted of the use of documentary analysis and interviewing in the first stage of the research, followed by participant observation and interviewing in the second stage of the research.
Reliability

The reliability of naturalistic (qualitative) research methodology is difficult to assess. Indeed the impression the researcher received was that the literature attempts to deflate concerns of reliability in this type of research by not addressing the issue. The following is a consideration by the researcher of the issue of reliability connected with the naturalistic methodology (that is informal interviews and participant observation) employed in this study.

Retrospectively, the specific strategies: interview, participant observation, and so forth, can be described but in reality, the methodology is context-determined for the study. In this study observations and interviews were all carried out by the researcher alone, thus rendering unnecessary the reliability correlations that could be made for two raters/observers. Moreover data analysis of naturalistic research is done by means of constant comparative analysis (as opposed to standardised statistical tests in experimental research) and relies upon the insights and abilities of the researcher. This process can be made more reliable by employing other researchers with the necessary expertise to participate in the data analysis in order to identify missing data, incongruence and misconceptions (Duffy 1984).

Ethical considerations

The ethical problems which confront the researcher doing naturalistic observation are somewhat different from those confronting the researcher doing survey research by means of questionnaires. The major difference lies in the goal of naturalistic observation. Since naturalistic observation seeks to observe natural behaviours with a minimum of observer effect, these unobtrusive techniques may mean that people being observed
may not be aware of the observation. Even if they are aware of being observed, they may not be aware of how detailed the observations could be or the implications of those observations. Each research strategy (interview, participant observation, and so forth) has its own potential violations. In general the researcher would be guided by principles of informed consent and the right of subjects to withdraw from the study at any time without penalty. Those respondents who consent to participate in the research need to be assured of confidentiality and anonymity. Fichter and Kolb (1954:23) alert the researcher to the need to be sensitive "to the rights, feelings, and needs of the people he/she studies" and to "treat them with justice, understanding, compassion, and, in the last analysis, love."

Another dilemma that the researcher had to confront was the question of whether to interfere or not in clinical care where there was a lack of expertise. For instance, in one case the midwife was unsuccessful in giving an intravenous injection of ergometrine (a drug given to stop haemorrhaging from the uterus). Certainly the researcher found the temptation to advise and participate overwhelming in the first two months of the research. Field and Morse (1985:47) state:

"Field work introduces special moral and ethical problems that are not usually encountered by other researchers. In becoming a part of the setting, the researcher is exposed to all aspects of the environment. Even if those aspects from which moral and ethical dilemmas arise are part of this study, the researcher, by virtue of being present and being a witness, has a responsibility to the participants."

Estroff and Churchill (1984) point out that, in the clinical setting, both the clients and staff are the research subjects regardless of the focus of the research question. They assert that refusal to become involved in such a situation, in order to maintain access to the research setting, is indefensible as it
places the value of the research per se above the quality of life of the client.

In the above case the researcher decided without delay to intervene and administered the injection of ergometrine as it was an emergency situation. By not intervening the researcher would not only have faced ethical considerations but might also have been guilty of professional misconduct. However not all situations were so clear cut. There were situations where the decision to intervene or not to was a difficult one, for instance in a case where the midwife had an offensive argument with one of the doctors in front of a client who was in advanced labour. Later when the researcher visited the woman and her newborn baby on the postnatal ward the client sought the researcher's advice regarding lodging a complaint against the midwife and the doctor. The researcher in this instance decided not to intervene and suggested to the client that she seek further information from the midwife-in-charge of the postnatal ward.

There was no attempt to adopt a fly-on-the wall role as used by Lelean (1973). Co-operation and a good rapport were certainly needed for a successful outcome to the research. The learners and midwives were involved in a constant dialogue with the researcher.

In 1971, the Council of the American Anthropological Association adopted principles to guide researchers in the field. These Principles of Professional Responsibility state:

"When research involves the acquisition of material and information transferred on the assumption of trusts between persons, it is the sensitivities of those studied which must be safeguarded."

1.3 Embarking on the Research Journey

1.3.1 Selection of Research Site

To begin a field study a research site needs to be selected. Because the researcher was focusing on social processes, there was no need to be concerned with whether a site was 'typical' or 'representative.' As a result a site was chosen which was readily accessible and where the researcher already had established contacts. Other criteria included: that the site permitted the researcher to move from studying simple to complex situations and that the site allowed the researcher to take an unobtrusive role. In this study the research site was a local consultant obstetric unit.

1.3.2 Gaining Access to the Study Group

In order to gain access to the group to be studied the researcher first obtained access to the School of Midwifery and maternity unit via the principal of the school, midwife managers and consultant obstetricians. Informal contacts were made and an explanation given in person to these key people. This was followed up by a formal letter requesting access (appendix 4).

In using a qualitative methodology, which involves the researcher as data gatherer, entry to the field was not assumed once consent for the study had been given by the above key people. The researcher had to establish credibility and rapport with the study group. There is a debate in the literature as to whether accurate information on the perceptions of the members of this setting (in this case, midwives) is given if the researcher is seen to be a part of the fraternity (Pearshall 1965, Field and
Morse 1984). Therefore the way the researcher presented herself to the study group was crucial to subsequent acceptance. The researcher felt that honesty was essential and the aim was to explain the purpose of the research to the study group as fully as possible. The researcher was unable to indicate the type of information that would be used in the final document during the research process because the researcher felt that making respondents aware of early findings might result in self-consciousness and behavioural change which could jeopardise the findings. Nevertheless, it was felt necessary to tell respondents that the content would evolve as the study progressed. Confidentiality was assured and respondents were told that they would have access to the penultimate draft of the thesis. This laid the foundation for establishing trust which was the first step in gaining entry to the group.

In any study involving informal interviews the relationship between the researcher and those who are researched is crucial (Burgess 1984). Before each interview began the researcher explained that there was an 'agenda' of topics that the researcher would like to cover. However, the researcher indicated that there was no requirement for either party to cover all topics and themes in one session nor to cover these topics in a specific order. Having explained something of the aims of the interview and the manner in which she wanted to proceed, the researcher indicated that respondents would be free to seek clarification of any points that had been made and to decide whether they wished to participate.

1.3.3 Selecting Key Informants

The key informants for this research were midwives, student midwives and tutors. In this study informants were those who volunteered to talk to the researcher and to be observed practising in the clinical areas. The researcher found that once
a relationship was established with an informant, the data acquisition frequently snowballed. The first informant introduced the researcher to the next person. However, the researcher was careful not to confine the sample only to those people acquired in this way for fear of bias. In fact, informants were also selected according to their role and knowledge or insights into the setting, and the type of relationship they had with others in the setting. For instance, as the study progressed a number of midwives emphasised the out-dated, inflexible and ritualistic way in which care was delivered by a senior midwife on the delivery suite. The researcher felt that it would be interesting to observe this senior midwife giving care and to follow up with informal interviews. Initially the senior midwife was reluctant to participate in this research. The researcher took time to build up trust and a rapport because it was felt that if the senior midwife was a reluctant respondent she might withhold information and not disclose her true feelings. The lengthy explanation was worth the effort because the result was that this senior midwife had much to say about today's midwifery practice and training of student midwives. Hence in naturalistic research informants are not selected randomly. Selecting informants by statistical chance may severely affect the quality of the data because the informant selected by chance may not be co-operative or best informed on the topic (Field and Morse 1985).
1.4 Data Analysis

In the final stage of the research, the researcher was faced with the challenging task of analysing the data. The process was divided into different stages. Initially a list of research problems, concepts and indices were listed into socio-demographic characteristics, events and conceptual categories. Categories were constructed from statements and events with the result that comparisons could be made between the categories. Furthermore, new categories could be devised on the basis of new concepts and themes that arose from the data. At the beginning, the researcher elicited 65 categories. These were trimmed down to 35 in the final analysis, most of which were pertinent to the conceptual categories or themes such as 'client versus professional power', 'dorminant versus non-dorminant professional values', 'survival strategies in the clinical area', and ectera.

These emerging key ideas were discussed with the researcher's supervisor and interested colleagues. In addition as the researcher described events and phenomena she was guided by her supervisor to appropriate literature. Therefore the researcher was able to impose meaning not only from her subjective viewpoint but also from established theories obtainable from the literature. The process of discussion and explanation helped to clarify the researcher's own thinking.

When a set of key questions was formulated the researcher re-entered the setting to obtain further data for another three months. During this stage the researcher's comprehension,
effectiveness and objectivity were at a maximum. At the end of the three month period, the researcher again withdrew from the setting to re-enact the process of analysis. The analytical process was embedded in the process of recording and analysing field notes and interview transcripts. The researcher also kept a diary of the process of conducting the research and reflections on the dynamics of the setting.

The first purpose of data analysis was to code the transcribed data so that the categories could be recognised, and analysed and behaviours noted. The second purpose was to develop a system of filing which permitted instant retrieval of the data. Hence persistent words, phrases, themes or concepts within data were highlighted in the text by a coloured pen and emerging concepts marked as researcher's notations along the margin of the text. The researcher also extracted the verbatim passages from typed transcript and from handwritten notes which were highlighted and photocopied. The categorised data was then 'cut and pasted' to form cards using staples for fear of loss. These major categories written onto cards were cross-referenced to places in the text where there were supporting quotes and other material. Hence the technique of progressive focussing was adopted.

In making notations, the researcher noted the following:

1) the kind of things that were going on in the context being studied;
2) the forms a phenomenon took; and
3) any variations within a phenomenon

The purpose of this analysis was to delineate the form, kinds, and types of social phenomena and to document their existence. During the second stage of the research, the emerging theory 'fell into place.' The researcher would describe this as 'having located the main stem' of a plant.
Next the researcher re-entered the setting for the final time. This time the task was to locate the branches and examine their connection to the main stem of the plant. The theory then was developed sufficiently for the researcher to focus on obtaining missing information to fill in gaps in the developing theory. The time-consuming activity finally began to bring its own rewards and the chapter headings for the thesis were emerging.

Spradley (1980) describes the progression from descriptive observations to focused observations, to selective observation and he describes the process from observation and field notes to data analysis. The researcher found, as Spradley (1980) had warned, that data analysis led on to more new questions, more data collection, more field notes and more analysis. This cyclical process could have continued as the researcher found that the more she probed the more branches seemed to emerge from the stem of the plant. However, the parameter of this study was guided by the time allowed for the research.

As the researcher is a midwifery tutor, the length of time that the researcher took to comprehend the setting and to obtain the required data was relatively short, nine months. However the disadvantage was the constant danger of the researcher being too close to the informants and losing the objectivity. Whyte, in his study 'Street Corner Society' (1955) dealt with this problem by distancing himself from his subjects at regular intervals and discussing his data with university colleagues. This tactic was employed by the researcher and was successful to the extent that it has helped the latter to retain an objective perspective. As researchers tend to interpret their findings in the light of their own values, the researcher attempted to eliminate biases by first identifying her own values, hence the researcher was able to recognise and declare any assumptions made about the setting being studied.
Lastly the researcher would like to point out the strengths and weaknesses of this study. As a practising midwife the researcher had an intrinsic need to find answers to a significant problem, ie the relationship of theory and practice. While the relationship of theory and practice has been well explained by nurse researchers, in this study the researcher has tackled this differently. The researcher felt that nurse researchers had successfully described what happens to students when they learn on the wards, nevertheless the issue of why things happen the way they do was not explained sufficiently. By using social science theories to impose meaning on the data, the researcher was able to examine the relationship between theory and practice and came out with findings that are original and profound.

The rationale for using social science theories to interpret the data was that the researcher needed to employ the 'sociological imagination' as described by Mills (  ) so that she could see in a new light the very professional world of which she was a member. The researcher felt by using a sociological interpretation framework, the research task was made much easier. Another rationale for using social science theories to interpret the data, was to fulfil the researcher's ambition to make explicit assumptions that underlie midwifery education and practice. In this way the researcher was able to examine the relationship of theory and practice innovatively and provide some answers to a problem which in Jarvis' (1992) view is inadequately formulated.

However, like the other side of a coin the strength of this study is also the weakness. The researcher has taken a tremendous risk in using a sociological interpretative framework. This is because such an approach has enabled the researcher to make some very bold statements about what is happening to midwifery education and practice and why.
Location Details

Hospital  ......................

Ward/Department  ......................

Establishment Details

<table>
<thead>
<tr>
<th>STAFF</th>
<th>Estab. Day Night</th>
<th>In Post Day Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursery Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auxiliaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward Clerk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do trained staff or student midwives carry out any of the following duties:

<table>
<thead>
<tr>
<th>Duties Performed</th>
<th>Regularly</th>
<th>Sometimes</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Messenger</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Audit Form - Learning Environment

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>MET</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask Midwife/Observe</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 The physical structure meets health and safety requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 The ward is clean and hygienic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Heating and lighting are adequate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Bathrooms and toilets permit privacy for patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 The standard and type of decoration is acceptable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Emergency equipment is accessible, clean and ready for use.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Ask mothers/Observe** | | |
| 1 Mothers' privacy is safeguarded when treatment/procedures are carried out. | | |
| 2 Mothers have access to television, radio, telephone. | | |
### AUDIT FORM - MIDWIFERY PRACTICE

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>MET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask Midwife/Observe</strong></td>
<td>YES</td>
</tr>
<tr>
<td>1 There is a statement of beliefs regarding midwifery practice for the ward/dept.</td>
<td></td>
</tr>
<tr>
<td>2 Midwifery Procedures are accessible to all staff.</td>
<td></td>
</tr>
<tr>
<td>3 District Policy and Procedure books are available and accessible to all staff.</td>
<td></td>
</tr>
<tr>
<td>4 A systematic approach to midwifery care is implemented.</td>
<td></td>
</tr>
<tr>
<td>5 Individualised care is prescribed.</td>
<td></td>
</tr>
<tr>
<td>6 Care is evaluated regularly.</td>
<td></td>
</tr>
<tr>
<td>7 Care plans are clear and up-to-date.</td>
<td></td>
</tr>
<tr>
<td>8 Midwives are good role model, i.e. practising midwifery.</td>
<td></td>
</tr>
<tr>
<td>9 Up-to-date and well informed practice.</td>
<td></td>
</tr>
<tr>
<td>10 A system of staff appraisal and performance review is in operation.</td>
<td></td>
</tr>
<tr>
<td>11 Regular ward/dept. meetings are held for all staff.</td>
<td></td>
</tr>
</tbody>
</table>
## AUDIT FORM - STUDENT MIDWIVES' CONTINUOUS ASSESSMENT

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>MET</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask Students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 There is a planned student teaching/learning programme.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Learning objectives are readily available.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 What is taught in class is supported by actual experience in clinical area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Each student has a named mentor for the duration of their allocation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Each student works with his/her mentor for at least one shift each week.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Students are encouraged to evaluate their clinical experience with their mentors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Students work is planned with objectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Most tasks are demonstrated before being carried out.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 A lot of teaching while carrying out tasks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Students are encouraged to participate in all stages of midwifery in individualised midwifery care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## AUDIT FORM - STUDENT MIDWIVES' CONTINUOUS ASSESSMENT

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>MET</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask Students continued</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Students are encouraged to participate in ward rounds/care conferences.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Students accompany mothers for special procedures when such opportunities occur.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Students participate in handover of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 High level of contact time between trained staff and students.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Interaction between midwives and tutors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Specified standards of care are adhered to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 A warm, friendly atmosphere in ward/department.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Students are valued by trained staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Up-to-date reference books and journal articles are available and accessible.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Ask Midwives

Midwives have a clear understanding of the nature and demands of the student curriculum.
AUDIT SUMMARY

The auditor is requested to discuss with the Senior Midwives/Managers the summary of the audit and recommendations.

An action plan will be drawn up and implemented.

Signature of Auditor ...................... Date ..................

Senior Midwife Teacher

Reference:

EVALUATION OF YEAR I (Weeks 1 - 52)

Name ........................................
Hospital for ..............................
practical placement
Date commenced ..............................
Date Completed ..............................

Please indicate your response to the following statement by placing a tick in the appropriate box.

1. Administration and Organisation

1.1 Pre-course information

The information I received before commencing the course was sufficient for me to know what was expected of me

Comments ..................................
...........................................

1.2 Arrangements (if applicable) for the course were satisfactory:

(a) accommodation - residential

(b) transport facilities

2. Introduction to Year I

The introductory period told me all I needed to know about the course programme and the hospital/community especially relating to:

2.1 Layout, facilities and staff of unit

2.2 Special hospital procedures and unit policies

2.3 Library facilities and recommended reading list

2.4 Community experience

2.5 The teaching programme, ie dates of holiday periods, allocation to clinical areas, objectives and content of the course, individual study and project work
2.6 Types and timing of assessments

Any comments and clarification of above

................................................
................................................
................................................

3: Theoretical Instruction

3.1 The course covered the theoretical objectives listed at the beginning

3.2 Time allocated to private study on study days/blocks was in the right proportion

3.3 Tutors' lectures met the objectives

Comments ..................................
...........................................
................................................
................................................

3.4 The group activities/discussions were helpful

3.5 I was able to obtain personal help in my studies when required

3.7 More time might be allowed for .........................

................................................
................................................
Less time might be allowed for .........................

................................................
................................................
Any other comments or suggestions for improving theoretical instruction? ....................

................................................
................................................

4. Clinical Experience

4.1 The course provided experience in all the practical skills require for the third year

4.2 The skills taught - did they relate theory to practice?
4.3 During this period of training were you adequately:    
(a) supported               
(b) supervised

4.4 Are you satisfied with your own contribution towards achieving the required clinical objectives

Comments ..................................


4.5 I would like to have more practice/experience in the following:

.........................................................
.........................................................
.........................................................

Any other comments or suggestions for the clinical component of the course?

.........................................................
.........................................................
.........................................................

5. Assessments

5.1 The written tests/assignments seemed to me to be appropriate and fair

5.2 The continuous practical assessments seemed to me to be appropriate and fair and helpful to my progress

5.3 The course tutor discussed my progress and guided me where necessary during the course to date

Comments on the tests and assessment

.........................................................
.........................................................
.........................................................
.........................................................
.........................................................
6. General Evaluation of Year I

6.1 Please comment on the overall experience and its contribution to your progress and development.
EVALUATION OF YEAR II

Name ........................................
2nd Hospital for ............................
practical placement
Date Commenced ............................
Date Completed ............................

Please indicate your response to the following statement by placing a tick in the appropriate box.

1. Administration and Organisation

1.1 Pre-course information

The information I received before commencing Year 2 was sufficient for me to know what was expected of me

Yes No

Comments ..................................
...........................................

1.2 Arrangements (if applicable) for the course were satisfactory:

(a) accommodation - residential

(b) transport facilities

2. Year II - second hospital allocation

The introductory period told me all I needed to know about the course programme and the hospital/community especially relating to:

2.1 Layout, facilities and staff of unit

2.2 Special hospital procedures and unit policies

2.3 Library facilities and recommended reading list

2.4 Community experience

2.5 The teaching programme, ie dates of night duty, holiday periods, allocation to clinical areas, objectives and content of the course, individual study and project work
2.6 Types and timing of assessments

Any comments and clarification of above

................................................

................................................

................................................

3. Theoretical Instruction

3.1 The course covered theoretical objectives listed at the beginning of Year 2

3.2 Time allocated to private study on study days/blocks was in the right proportion

3.3 Tutors' lectures met the objectives

Comments ..................................

...........................................

3.4 The group activities/discussions were helpful

3.5 I was able to obtain personal help in my studies when required

3.6 Doctors'/outside speakers' lectures were helpful

Comments ......................

........................................

3.7 More time might be allowed for ........................................

........................................................

Less time might be allowed for ..........................

........................................................

Any other comments or suggestions for improving theoretical instruction? ......................

........................................................

4. Clinical Experience - second hospital allocation

4.1 The course provided experience in all the practical skills required.
4.2 The skills taught - did they relate theory to practice?
[Blank]

4.3 During this period of training were you adequately:

(a) supported
[Blank]

(b) supervised
[Blank]

4.4 Are you satisfied with your own contribution towards achieving the required clinical objectives
Comments ..................................
...........................................

4.5 I would like to have more practice/experience in the following:

.........................................................
.........................................................
.........................................................

Any other comments or suggestions for the clinical component of the course?
.........................................................
.........................................................
.........................................................

5. Assessments

5.1 The written tests seemed to me to be appropriate and fair
[Blank]

5.2 The continuous practical assessments seemed to me to be appropriate and fair and helpful to my progress
[Blank]

5.3 The course tutor discussed my progress and guided me where necessary during the 2nd year.
[Blank]

Comments on the tests and assessment
.........................................................
.........................................................
.........................................................
6. General Evaluation of Year II

6.1 Please comment on the overall experience and its contribution to your progress and development.
EVALUATION OF YEAR III (Weeks 114 - 155)

Name ........................................
Hospital for .............................. practical placement
Date Commenced ..............................
Date Completed ..............................

Please indicate your response to the following statement by placing a tick in the appropriate box.

1. Administration and Organisation

1.1 Pre-course information

The information I received before commencing this part of the course was sufficient for me to know what was expected of me

Yes No

Comments ..................................

...........................................

1.2 Arrangements (if applicable) for the course were satisfactory:

(a) accommodation - residential

Yes No

(b) transport facilities

2. Introduction to Year III

The introductory period told me all I needed to know about the course programme and the hospital/community especially relating to:

2.1 Layout, facilities and staff of unit

Yes No

2.2 Special hospital procedures and unit policies

Yes No

2.3 Library facilities and recommended reading list

Yes No

2.4 Community experience

Yes No

2.5 The teaching programme, ie dates of night duty and holiday periods, allocation to clinical areas, objectives and content of the course, individual study and project work

Yes No
2.6 Types and timing of assessments

Any comments and clarification of above

3. Theoretical Instruction

3.1 The course covered theoretical objectives listed at the beginning of Year 3

3.2 Time allocated to private study on study days/blocks was in the right proportion

3.3 Tutors' lectures met the objectives

Comments

3.4 The group activities/discussions were helpful

3.5 I was able to obtain personal help in my studies when required

3.6 Doctors'/outside speakers' lectures were helpful

Comments

3.7 More time might be allowed for

Less time might be allowed for

Any other comments or suggestions for improving theoretical instruction?

4. Clinical Experience

4.1 The course provided experience in all the practical skills required for the second year
4.2 The skills taught - did they relate theory to practice?

Yes No

4.3 During this period of training were you adequately:

(a) supported

(b) supervised

4.4 Are you satisfied with your own contribution towards achieving the required clinical objectives

Comments ..................................
...........................................

4.5 I would like to have more practice/experience in the following:

.........................................................
.........................................................
.........................................................

Any other comments or suggestions for the clinical component of the course?

.........................................................
.........................................................
.........................................................

5. Assessments

5.1 The written tests seemed to me to be appropriate and fair

Yes No

5.2 The continuous practical assessments seemed to me to be appropriate and fair and helpful to my progress

.........................................................
.........................................................
.........................................................

5.3 The course tutor discussed my progress and guided me where necessary during the course to date

Comments on the tests and assessment

.........................................................
.........................................................
.........................................................
6. General Evaluation of the Course

6.1 I feel competent to practice in this speciality and to pass on the skills learnt to others

Comments or reservations ..........................................................
..........................................................................................
..........................................................................................
..........................................................................................

Yes   No

6.2 The course fulfilled my own expectations and my own objectives

Were there any disappointments?

Comments ..........................................................
..........................................................................
..........................................................................

7. If you have any suggestions for improving the course please state below.
4.1 Letter of Consent

7 Wentworth Avenue
Southbourne
Dorset BH5 2EQ

Dear

I am a student registered for a Doctorate Degree with the University of Surrey.

The topic of my research is the analysis of the culture of midwifery education and practice. As part of the research involves observing how midwives conduct their work in the clinical area I would be most grateful if you could participate in this study. In addition I would also need an informal interview with you, the time and venue would be arranged to suit you.

I will, of course, ensure confidentiality of all information given to me.

Thank you for your help.

Yours sincerely,

Elaine Emmons
4.2 Letter of consent

7 Wentworth Avenue
Southbourne
Dorset BH5 2EQ

Dear

I am a student registered for a Doctorate Degree with the University of Surrey.

The topic of my research is the analysis of the culture of midwifery education and practice. As part of the research involves talking to student midwives about their training I would be most grateful if you could participate in this study. In addition I would also need an informal interview with you, the time and venue would be arranged to suit you.

I will, of course, ensure confidentiality of all information given to me.

Thank you for your help.

Yours sincerely,

Elaine Emmons
4.3 Letter of consent

7 Wentworth Avenue
Southbourne
Dorset BH5 2EQ

Dear

I am a student registered for a Doctorate Degree with the University of Surrey.

The topic of my research is the analysis of the culture of midwifery education and practice. As part of the research involves observing how midwives conduct their work in the clinical area I would be most grateful if I could be permitted to have access to the clinical wards for this purpose.

I will, of course, ensure confidentiality of all information given to me.

Thank you for your help.

Yours sincerely,

Elaine Emmons
4.4 Letter of consent

Dear Miss Rigden

I am a student registered for a Doctorate Degree with the University of Surrey.

The topic of my research is the analysis of the culture of midwifery education and practice. As part of the research involves analysing the audit reports and evaluation forms pertaining to midwifery educational programmes conducted in the Dorset College of Midwifery I would be most grateful if I could be permitted to have access to them.

I will, of course, ensure confidentiality of all information I have access to.

Thank you for your help.

Yours sincerely,

Elaine Emmons
A PHILOSOPHY FOR MIDWIFERY

AIMS

The aim of the midwifery profession is to provide a service which facilitates the safe and satisfying transition of women to motherhood. This is achieved principally by the processes of supporting, guiding, monitoring and educating. The unique and personal needs of women in their childbearing years are central to this service.

Implicit within this is the intention to:

- Empower women during their childbearing experience.
- Provide holistic care.
- Maintain professional credibility.
- Be proactive and sensitive to social change and changing patterns of health relevant to the profession.

FUNCTIONS

The function of the profession is to provide a framework for midwifery practice which is underpinned by statute; the EC regulations, the 1979 Nurses, Midwives and Health Visitors Act and the Midwives Rules. This framework enables:

1. The midwife to fulfill her role as an autonomous, accountable practitioner from the point of registration.
2. The setting, maintenance, promotion and regulation of standards.
3. The development of a research-based body of knowledge and practice.
4. The provision of an ethical framework for practice and client advocacy where appropriate.
5. The provision of education to equip the midwife to give care in a variety of situations and settings.
6. Professional representation in public debate to promote and support a high quality maternity service.

....-/cont'
The primary need of the midwifery profession is:

To maintain professional identity and autonomy in order to deliver quality care

Secondary needs emerging from this are:

- To build upon its own body of knowledge through research-based and reflective practice.
- For midwifery clinicians, managers and educationalists to be unified, assertive and mutually supportive.
- To have a strong sense of self-worth.
- To maintain respect and recognition from:
  - women
  - other professionals and society.
- To control and deliver its own initial and advanced education.

Values

The values that underpin the profession are:

- Respect for individuals and for life.
- Altruism which focuses upon the childbearing woman.
- Integrity - which is reflected in honesty and moral principles.
- Justice and equity.
- Democratic principles and processes.
- Self development derived from life experiences and educational processes.
- Midwifery education firmly rooted in midwifery practice.
BELIEFS

The midwifery profession holds the following beliefs:-

- Each mother is an individual with her own rights, needs, hopes and expectations.

- The midwifery profession has the power to influence both the nature and delivery of services to the childbearing woman and her family.

- The future health of a nation depends on the quality of care given to mothers, potential parents and babies by midwives.

- Mothers’ and babies’ needs matter and are to be valued above market forces.

ASSUMPTIONS

The assumptions of the midwifery profession are that:-

- Having a baby is a major life event during which women both need and want the services of midwives.

- Midwifery is the only profession whose prime function is to ensure the wellbeing of the childbearing woman and her baby.

- While midwives are autonomous practitioners they work in collaboration with other members of the health care team.

References

ENB (1987) Course leading to admission to Part 10 of the Professional Register, English National Board.

European Economic Community Midwives Directives 80/154/EEC & 80/155/EEC.

Nurses, Midwives and Health Visitors Act 1979, HMSO.

ED/AT/AM
22 May 1991
APPENDIX 6

Interview Schedule for Student Midwives

When did you commence your midwifery course?

What motivates you to undertake the midwifery course?

Can you briefly describe the way you are taught in class during your midwifery course.

Do you think that the midwifery training you are having will prepare you to take on the role of the midwife?

Do you think that generally midwives prefer students who are questioning about practice?

What do you think about midwifery training/education today?

Do you feel that midwives of today can fulfill their responsibility as role models and teachers in the clinical area?

Do you think that practices are governed by policies?

What effect do you think this has on student's training?

What do you think about the relationship between theory and practice?

Do you believe that positive change in midwifery practice is needed, if so is this possible?

How do you see the future of the midwifery profession?

Are there any other comments that you wish to make in relation
1) to your training?
2) or to midwifery in general?
Observation of work practice

7-2-92 Maternity Unit P011
Delivery Suite

Midwife: S.S. P.S. F.G.

Mother: Mrs Z. P011 36 yrs old UTI in pregnancy 41/2 by Consultant S 3 times

Observation

Mother - already in bed; hospital nightgown
Rm 9 (near midwives station) Bed, locker, 
bedtable, monitor CTG, IVAC and IV stand
Husband coming later

10am

Mother had been admitted, urine tested

Palpation

Midwife SS: Just putting you on the monitor, have you been on it before?
[attached CTG machine]

Client: Yes

Midwife SS: We will have a bit of a trace to see how things go, see if baby is happy. You don't have to stay on it the whole time, so that you can walk around.

Midwife SS: How long have you been contracting?

Client: Since 6 this morning

Midwife: They are coming every 4-5 mins, quite good.

Client: He has just kicked me, this baby
[feels hard on abdomen]
It has been an active baby
midwife ss: Have you any plans for your labour?
client: I would like to play it by ear, see how it goes. I want pain relief if it goes to be a long time.

midwife ss: I can probably give you something.
(client's husband comes in)

midwife ss: I will take your blood pressure now.
client: Alright.

midwife ss: It is not a nice day.
(client's husband: I was up at 3:15 am with a leak in the roof.
client: I could hear dripping, I think it 'set me off.'
It midwife took blood pressure)

midwife ss: Just write down what I have done. You can start breathing exercises.

client: If I can remember them.

midwife ss: Keep practising.

midwife ss: How it gone? I pour a glass of water for client. I the contractions started at 6:30 am? Have you had a 'show'?

client: Yes at 7:30 am.

midwife ss: Have your contractions been regular since?

client: Yes.

midwife ss: Thats when you called us.

client: Called at 7:30 am.
midwife ss: not leaking?
client: No, unless they 'went' when I went to the toilet.
midwife ss: Have you been well?
client: Yes.
midwife: Any problems before the miscarriage in 1989?
Drugs, did you have any?
client: Bromocriptine, that's all.
midwife ss: That's all.
I midwife writes up notes on bedcard at the end of the bed, observes client.
midwife ss: Are you on any medication - take iron?
client: Yes.
midwife: any allergies?
client: no.
midwife ss: Varicose veins?
client: no.
midwife ss: Haemorrhoids?
client: yes. I think so. It's sore on my bottom.
midwife ss: are your bowels regular?
client: yes.
midwife ss: Have you got a co-op cord?
client: yes, in my handbag.
midwife: In the black one?
husband finds it.
midwife reads card and writes.
husband holds client hand through contractions.
husband: Good one?
midwife ss: no food, you can have water. Can't offer you anything else. If you want to go to the loo & can help you, otherwise you can use a bedpan.
I leave room to inform Consultant because client became husband is
I discuss with midwife why
we ask client occupation
I consultant phones back, gives
'go ahead' for examination.

10.35 am Back in client's room.

Midwife 55: He (nearest consultant)
got through and told us
to carry on. Are you happy
to have a VE done? He will
see you at noon.

Husband: Am I in the way?

Midwife 55: No, I will just get
myself ready. I prepared trolley.

To husband: So I give you this. You can
come round here.

Husband: Have husband a stool
on opposite side of beds.

Husband moves, midwife pumps
bed, lays down sheet.

Midwife 55: Are you comfortable?
'Wont be long, I will sit
you up as soon as I'm
finished.

Client: Alright.

Midwife washes hands, wait for
coin. Wears on gloves while
wearing.

Midwife 55: Jeez, just pull this
back, if you would like
to bring your knees up.
Oh I forgot about that.

(Pants stay on)

Midwife 55: These together, have got some
warm savon to wash your down.

Gsuggs, her dawn.

Midwife 55: Right, if you have a
contraction and want me to
stop, I'll tell me. I will gently
examine you.
Midwife 33: Goodness you are 4-5 cm dilated, your membrane are bulging, shall we leave them alone? or shall I rupture them as that will move things faster, after all you don't want to hang around now things are moving well.

Client: Alright, do what you like.

Midwife 33: Mr Scott (her consultant) said to rupture them.

Client: Alright.

Midwife 33: I'll wait for the contraction you don't have to have this done, but usually we help to speed labour up.

Client: Go for it.

Midwife 33: You may feel the contraction more. Your husband hands midwife an amnibook does arms, would you like some gas and air, if you don't want pethidine? Deep breath, not too much or you will get tingling in your nose and mouth.

Midwife 33: When you're ready lift up to husband I shall do it well.

Midwife 33: Put your hands on my shoulders, we will lift you up now. (to client) You're doing ever so well brave girl.

Client: Help client to sit up. Pour her a glass of water.

Midwife 33: Do you know much about gas and air?

Client: waits for contraction to ease.

Client: Alright I don't worry about your hicups.

Husband: How's the pain?
client: I can cope.

midwife SS: gas and air set 50% oxygen
and 50% nitrous oxide for you baby, does no harm to
the baby. Makes you feel woozy, not sick, mouth gets dry. You
can help yourself, doesn’t take away
all the pain.

client: alright.

midwife SS: things are wonderful at the
moment. Everything is fine, don’t
worry. Ill phone Mr. Scott now.
Frustrated takes out trolley
make phone call. I went
in suite to clear away
trolley. Spoke to midwife F.G.
who is in charge of clients progress.

Midwife SS: to F.G

Doing well. 4.5cm dilated
stretchy cervix. Don’t think she
will be long. I’ve called
Mr. Scott.

I went back to room and
write up notes. When finished
stood by clients bed.

midwife SS: blow out, that’s better.

ten minutes later asked
Do you want some pethidine?
It may help to take the edge
of the pain. If you want if you
can have it now, otherwise it
will be too late and I won’t be
able to help you.

client: how long do you think it will be?

midwife SS: difficult to say. May be the
next hour or it can go on like
this for some time.

client: Ill try it if you think it goes
on.

midwife SS: well, I think it will relaxes
you. Also you don’t have to
worry over the baby’s heart rate.
or breathing, we have got an antidote
to reverse the depressive action of
Pethidine.

Client: Yes, I will have some pethidine.

Midwife S5: Good girl.

I went out of room, asked midwife
PS to check pethidine.

Midwife PS to
S5: Do you think she should
have pethidine or an epidural?
have you checked it with
F6 (midwife F G who is in charge)

midwife S5: no

midwife PS: you have better, before we
check the pethidine.

(midwife S5 went to speak to F G)
came back 5 min later.
to midwife PS: F6 says okay - with
pethidine.

I checked pethidine, took injection
way to client's room.

Midwife S5: I will look in here, looks at
client, padly
not getting pressure in back
passage?

No

Midwife S5: shall we give you the injection
in this side. Coming now I give
injection. I wiggie your toe.

Midwife S5: well done. If the light is
in your eyes we can turn it

Client: 8/6 okay at this moment.

11am

Midwife S5: warm enough?

Husband: How long does pethidine take to
work?

Midwife S5: A few minutes.
I went out to sign
drug book.
I came back into client's room,
put her hand on client's abdomen.

Midwife: Alright, are we doing alright?
Would you like your face washed?

Client: Yes, can I also have some water?

Husband: Yes, is it okay?

Midwife: Of course, it's hard work, isn't it?
Husband: I don't think she will bother again.

Midwife: Can I leave you alone for a few minutes so that you can try to get some rest. Here is the bell, ring if you need me.

Midwife: I went room to ask F.G. if she can have a 'quickie' coffee break.

I took coffee to doctor's office, here I discussed with midwife 33. The next of early ARM. Also peridural vs. epidural.

I finished coffee, researcher felt scene to write up notes.
APPENDIX 8

Example of an Interview Transcript

Candidate 1 - Midwife qualified in 1979 practise 7 years in a consultant unit locally

What do you think about midwifery education today?

What do I think about education... well... I think things have improved a lot. When I did mine we did as we were told - never asked any questions. Now students are more questioning and seem to know much more. I think they are more confident as well. Even the doctors seem to relate differently to them. They read more as well - don't know where they find the money to buy all those books (laugh).

Would you feel happier about practising if you did your training today?

I think so, I remember that when I qualified in '79 I was very anxious about things like making decisions regarding the amount of Pethidine to give. In those days midwives had a lot of responsibilities too.

Do midwives have less responsibilities now?

Oh yes, we are practising based on ward policies and what the consultant likes or dislikes or what your manager allows us to do... keep being reminded about litigation. Only the other day I was a witness to a case involving a baby that was born brain damaged 5 years ago.

Were you implicated?

No, it was a registrar’s delivery - difficult forceps, but I was the midwife giving the care at the time.

So you were a witness?

Yes, I was there to give evidence.

Since you were not implicated, why should you not use your clinical judgement in your practice?

That is the stupid thing... half the time midwives are not being sued, its the doctors but our managers still try to frighten us.
If you feel that midwives have less responsibilities now and also their practices are governed by policies, what effect do you think this has on student's training?

I feel defensive all the time... you know... having to justify why I am doing or not doing something, but I think students are very understanding - at least the ones I had were. Sometimes I do wish they would stop asking so many questions - it does put me on the defensive.

Why do you think students are so understanding?

I don't think they have much choice, they either have to accept what happens on the ward or else they may have to give up like so many midwives have.

Can you enlarge on this point?

Well, I think a midwife who constantly tries to change things either gets tired of banging her head against the wall or she leaves the profession. You only get a bad name which may affect promotion prospects. Also most of us have got another life outside so we do the best when we are at work but we cannot waste a lot of energy when things never change.

Do you know of anyone who has acquired a 'bad' name by constantly trying to change things?

Not one person, many midwives and students have been labelled 'aggressive' or 'difficult' in the past. I did know a staff midwife who was told by management not to bother to reapply for a sister's post after she failed for the 3rd time because she was "not sister's material." We were so appalled at the way she was treated, she was a really nice girl and a 'good' midwife.

What happened to her?

She requested to see the senior midwife who gave her a set of objectives to achieve. Last year she got promoted to be a sister. She is still quite articulate but appeared to be less 'aggressive'.
GLOSSARY

**Acceleration of labour** - 'speeding up' the labour

**Active Management of Labour** - method of controlling labour by intervention in order to keep it short

**Antenatal or Prenatal** - pertains to period before birth

**Anti D** - an injection that is used to remove any fetal blood cells which may have entered the mother's blood stream, hence preventing the condition of rhesus incompatibility

**Artificial rupture of membranes (ARM)** - the procedure of rupturing the membranes that surround the fetus in-utero

**Association of Improvements of Maternity Services (AIMS)** - an organisation that is devoted to improving maternity services

**Association of Radical Midwives (ARM)** - an organisation that is devoted to restoring the midwifery role

**Breech delivery** - a delivery where the baby comes out feet or buttocks first

**Cardiotocograph (CTGs)** - a tracing of the fetal heartbeat and contractions

**Central Midwives Board (CMB)** - the old statutory body which regulated midwifery practice and education. This function is now taken over by the English National Board (ENB) in England

**Cervix** - the neck of the uterus

**Client** - consumer of maternity care

**Contractions** - the pain experienced by women during birth when the uterus contracts to expel the baby

**Delivery rooms** - rooms where the woman gives birth

'Doing the obs' - the task of taking temperature, pulse and blood pressure

**Elderly primigravida** (sometimes abbreviated to elderly primip) - this is a term used to describe women who first become pregnant at the age of 30 or 35 (the age criteria is set by the doctors)
Engagement of presenting part - the presenting part (usually this is the fetal head) has passed the brim of the pelvis

Episiotomy - a cut in the perineum to enlarge the birth outlet to allow delivery of the baby's head (or other presenting part)

Essential Hypertension - high blood pressure with no obvious pathological causes.

Fetus - a term used to describe the unborn child

First stage rooms - rooms where the woman in early labour resides

'Flat baby' - refers to an asphyxiated baby at birth

Grand multiparas (abbreviated to grand-multip) - refers to women who are having their fifth baby

Gravida - refers to pregnancy

Hartmann's solution - an infusion used frequently during labour to prevent dehydration

Higher Awards - refers to the higher awards presented to candidates who have achieved the standard of post registration education and practice as defined by the ENB

Keillands rotation - the use of keillands forceps to rotate the fetus during birth

Labour - refers to the process of giving birth

First stage of labour - from the onset of regular painful contractions to the full dilation of the cervix

Second stage of labour - from full dilatation of the cervix to the birth of the baby

Third stage of labour - from the birth of the baby to the complete expulsion of the placenta and membranes

Late and early decelerations - refers to the drop in heart rate in the fetus

Midwife - means 'with woman' during the pregnancy and the process of birth. The role of a midwife is to look after a woman in normal pregnancy, labour and postnatally

Midwives Couch - an antenatal session carried out by a midwife during a consultant obstetrician's clinic

Multigravida - a pregnant woman who has previously had more than one pregnancy
Multipara - a woman who has borne more than one viable infant

National Childbirth Trust - an organisation set up to promote the interest of the consumers of maternity care

'NCT type' - a term used to describe a woman who is articulate about what she expects from the health professionals whose duty it is to look after her during pregnancy and birth

Neonatal resuscitation - a technique used to help a baby who fails to breathe at birth

Obstetrician - a doctor who specialises in looking after women with problematic pregnancies or birth

Obstetric flying squad - a team consisting of doctors and midwives who go out into the community to deal with emergencies during pregnancy, birth or postnatally

Occipito Posterior position (OP position) - crown of fetal head lying towards the mother's back, so that the baby is facing towards the pubis

Palpation - examination of the pregnant abdomen.

Para - having borne one or more offspring

'Partners-in-care' - a term used to describe a concept whereby the consumers of maternity care have an active part to play in deciding the type of care that they wish to have

Pethidine - a drug used to relieve pain in labour

Postnatal - the period after birth, up to 10 days

Puerperium - the period after birth up to six weeks

PREP - Post-registration Education and Practice, a project set up by the statutory bodies which looks at the education of qualified professionals

'Quickening' - the first time a woman feels her baby move

"She is fully dilated" - a phrase used by some midwives to describe a woman who is in the second stage of labour when the cervical os is fully dilated (ie 10 cms).

SPD - small for date baby.

Stillbirth - a baby that has died in-utero and subsequently expelled from the mother without having exhibit any sign of life

Supplement feeds - to 'top up' with artificial (eg cow's) milk after breastfeeding
**Syntocinon** - a drug that causes the uterus to contract

**Transition** - a period in labour when the cervical os is about 8–9 cm dilated.

**UKCC** - The United Kingdom Central Council, a statutory body which regulates the education and practice of nurses, midwives and health visitors

**White Paper** - a government document which proposes radical changes to the Health Service
REFERENCES


CENTRAL MIDWIVES' BOARD, Annual Reports for 1916


DEWEY J (1933) How we Think, D C Heath Boston.

Diers D (1979) Research in Nursing Practice, J B Lippincott, Philadelphia.


Downe S (1990b) Accountability and Autonomy, Conference at Royal Bournemouth Hospital, Dorset.


GOLDEN J (1980) 'Midwifery Training; The views of newly qualified midwives', Midwives Chronicle and Nursing Notes June pp 190-94.


HENDERSON C (1984) 'Influence and interactions surrounding the midwife's decision to rupture the membrane', Research and the Midwives' Conference Proceedings, Royal College of Midwives, pp 67-84.


HO E (1990) 'Midwifery and Nursing: in search of commonalities', Midwifery Matters No 52 Spring, Association of Radical Midwives


HUNT S C (1987) Take a Deep Breath - an ethnography of a hospital labour ward, Msc in Economy, University of Wales, Cardiff


MESTRONIC S and Glassner B (1983) 'A Durkheim hypothesis of stress' Social Science and Medicine, 17, pp 315-327.

MELIA K M (1982) 'Tell it as it is - a qualitative methodology and nursing research: understanding the student nurse's world', Journal of Advanced Nursing 7: pp 327-35.


PEARSHALL M (1965) 'Participant Observation as a Role and a Method' in Behavioural Research, Nursing Research, 14(1): pp 37-42


BIBLIOGRAPHY

Bailliere Tindall, London

ADAMS R N and Preiss J J (1960) (eds), Human Organization
Research: Field Relations and Techniques, Homewood, Ill Dorsey
Press.

ALLEN P and Jolly M (1982) Nursing, Midwifery and Health
Visiting Since 1900, Faber and Faber, London.

APPLE M (1979) Ideology and Curriculum, London Routledge and
Kegan Paul.

services, ARM, Ormskirk

avelin J H (1967) English Midwives: their history and prospects,
Hugh K Elliot, London.

Press.


Barnett Z (1979) The Changing Pattern of Maternity Care and The
Future Role of the Midwife, Midwives Chronicle and Nursing Notes,
Vol 2, No 1120, pp 381-4

BECKER H S (1954) 'A Note on Interviewing Tactics', Human
Organization, Vol 12, No 4, pp 31-2.

BECKER H S (1958) 'Problems of Inference and Proof in Participant
Observation', American Sociological Review, Vol 23, No 6, pp 652-
60.

BECKER H S and Geer B (1957) 'Participant Observation and
Interviewing: a comparison', Human Organization, Vol 16, No 3, pp
28-32.

BECKER H S and Geer B (1958) 'Participant Observation and
Interviewing: a rejoinder', Human Organization, Vol 17, No 2, pp
39-40.

BECKER H S and Geer B (1960) 'Participant Observation: the
analysis of qualitative field data', in R N Adams and J J Preiss
(eds), Human Organization Research: Field Relations and


ROYAL COLLEGE OF MIDWIVES (1977) Evidence to the Royal Commission on the National Health Service, London, Royal College of Midwives.


