

FINAL REPORT

IOLANTHE MIDWIFERY TRUST RESEARCH FELLOWSHIP (1999-2001)

RESEARCH FELLOW: BILLIE HUNTER

I am pleased to provide the Trustees with this final report, detailing the progress of the project and how I have benefited personally from the award. I will also provide an overview of the research findings and consider what implications they may have for midwifery practice.

Progress of the research project:

My research has progressed extremely well over the two years of the Fellowship. Data collection was complete by July 2000, and I then embarked on the daunting task of analysing the large volume of transcribed data and fieldnotes. Data analysis took longer than anticipated (I understand that this is a common experience of qualitative researchers!), but by the end of January 2001 I was ready to commence writing up my thesis. This process has similarly been more time consuming than I expected, but I am currently in the final stages of editing and proof reading, and expect to submit my PhD by Easter 2002. Unfortunately, submission has been somewhat delayed by unexpected circumstances at work which have increased my workload.

Overview of findings:

The aim of the study was to explore how midwives experience and manage emotion at work, with specific research questions as follows:

- Which maternity care situations do midwives experience as emotionally rewarding?
- Which maternity care situations do midwives experience as emotionally difficult?
- How do midwives manage the emotions generated?
- Are there differences between the experiences of student and qualified midwives?
- Are there differences in experience of emotion work related to clinical setting?
- Are there differences in experience of emotion work related to level of responsibility?

Given the lack of previous research into this area, and my desire to explore the issue in depth, a qualitative approach was considered most appropriate. By listening to midwives talk about their work and by observing their practice, I hoped to keep an open mind and avoid assumptions about the nature of emotion in midwifery work. A multi-method qualitative approach was adopted, using focus groups, interviews and semi-participant observation in order to view the issue from different 'angles'. Sixty-seven midwives participated in the study, from a variety of geographical and clinical locations. The sample included student midwives on both eighteen month and three year programmes, and qualified midwives of varying clinical grades.

My findings indicate that midwifery is commonly experienced as highly emotional work. Midwives' experiences appear to vary according to their status and their place

of work. For example, student midwives' experiences differed considerably to those of qualified midwives, being dominated by their experiences of occupational socialisation. Qualified midwives also had differing experiences, which related to their work environment (i.e. hospital or community based) and level of seniority.

Analysis of the data suggested that one way of explaining these varying experiences was the presence of differing ideologies or models of practice, which have contradictory values and perspectives. I have described these as:

- i) a '*with woman model*'. This model emphasises an individualised approach to care informed by a belief in the normal physiology of childbirth. It was more readily identifiable in the data generated by student midwives and those based in the community. This model is widely used in midwifery education.
- ii) a '*with institution model*'. This contrasting model focuses on the provision of universal, equitable care to groups of women, in order to meet institutional demands. It is informed by a medicalised approach to managing childbirth. This model was more discernible in the data generated by hospital-based midwives.

All participants described the 'with woman' model as their ideal. When they were able to work according to this, they experienced their work as highly emotionally rewarding. Conversely, when they were unable to achieve this, as was often the case, they experienced ambiguities and frustrations, which required management of emotions. Student midwives were particularly aware of these conflicting models and the tensions that they created.

Community-based midwives were most likely to be able to provide a 'with woman' approach, as they were relatively removed from the demands of the maternity unit. However, the introduction of an integrated scheme of care (whereby teams of midwives work in both community and hospital settings in order to provide continuity of care) compromised this, as the needs of the institution intruded. Integration also created additional emotional difficulties for midwives as a) midwives' personal and occupational boundaries were encroached on by organisational issues b) there were alterations in the dynamic of the midwife/woman relationship, whereby women had increased (and sometimes unrealistic) expectations of what the midwife could offer.

Hospital-based midwives were less able to work according to a 'with woman' approach, as their work was dominated by the needs of the organisation. The emphasis was on the safe delivery and discharge of large numbers of women and babies within a short space of time. As a result, their work was inevitably task orientated. This was frustrating for many, particularly the more junior midwives, as it did not meet their ideals of a 'with woman' style practice. This mismatch between ideals and reality led to dissonance. It appeared that hospital-based midwives dealt with this by a process of 'intra-occupational boundary maintenance' i.e. they divided themselves into 'us and them' groups within midwifery, according to differing ideologies.

Senior midwives appeared more likely to adopt a 'with institution' approach. They claimed authority based on greater clinical experience and expertise, and maintained

their position via a complex system of unwritten rules and sanctions. In contrast, junior midwives were more likely to aim for a 'with woman' approach. As they had little overt power, they responded to the senior midwives' authority by appearing to comply, whilst using their peer group to express their dissent.

These divisions within hospital midwifery were a notable and unexpected feature of the data. There were many accounts of conflicts between midwives, which at times appeared to border on bullying. It appears that these conflicts may result from these conflicting models of practice.

As well as exploring the differing sources of emotion in midwifery work, I also wanted to explore how midwives managed their emotions. There appeared to be mixed messages regarding this, which could be related to these differing models of midwifery. The 'with woman' model adopted an 'affectively aware' approach, which emphasised the importance of expressing feelings and managing emotions via sharing and support. In contrast, the 'with institution model' emphasised the need for 'affective neutrality' i.e. concealment of personal emotions in order to provide a detached professional image. Student midwives were particularly aware of these mixed messages regarding appropriate management of emotion. They described how they assessed the 'feeling rules' of the environment in which they were working and adapted their emotional responses accordingly.

Implications for practice:

These findings would appear to have important implications for practice. A 'with woman' approach, although currently advocated as the way forward in maternity care, is frequently not achievable in reality, and this creates emotional conflicts and dilemmas for midwives. Participants described feeling disillusioned and emotionally exhausted. As a result, some were considering leaving midwifery; others described using 'distancing' and 'toughening up' strategies in order to cope. It was particularly notable that the new 'integrated' system of maternity care seemed to have increased the emotional demands on midwives, and that they felt ill prepared for this.

It was evident that these dilemmas not only affected midwives personally, but also had wider implications for midwives as an occupational group. There was widespread evidence of inter-collegial conflict and divisions. All these issues are likely to be contributory factors in the current crisis in recruitment and retention within the profession.

There is no simple solution to resolving these problems. The contradictory models of practice that have been identified are rooted in differing approaches to maternity care, which have complex histories and thus cannot be quickly or easily addressed. It appears unlikely, for example, that a 'with woman' approach can be achieved in a hospital based maternity care system, as the needs of the institution will always dominate. A fundamental sea change is necessary if new approaches to maternity care such as integrated practice are to succeed. For example, one possible long-term solution would be to move maternity care into midwifery led birth centres.

In the short term, midwives need preparation and support for managing the 'ideals/reality' gap. It is recommended that these issues be tackled 'head on' in the

education of student and qualified midwives. I intend to develop these ideas further in my work as a midwifery lecturer. I currently take a lead in supporting students with the development of their interpersonal skills and intend to incorporate the findings of the study into these sessions. I am particularly interested in the use of creative and experiential methods, such as role-play and the use of participatory theatre techniques, as a means of exploring these issues.

The findings also have implications for the supervisory process. Support – or the lack of it - was a key concern for participants. It was notable that participants did not identify statutory supervision as a source of support, turning instead to informal collegial networks. The most appropriate methods for providing midwives with support need to be explored by further research.

This is the first piece of research to explore the emotion work of midwives. As such it has been exploratory, and ultimately generates more questions than answers. There is clearly much more that needs to be found out, but it is anticipated that this study will stimulate a much needed and timely debate.

Personal benefits:

I have gained much from being awarded the Fellowship. Being able to take ‘time out’ from my usual work enabled me to become totally engrossed in the study, in a way that would not otherwise have been possible. This was particularly invaluable during the period of data analysis and writing up. I should like to acknowledge the support of my colleagues in the School of Health Science in facilitating this period of study leave.

I have considerably developed my knowledge and understanding of the research process during this time, and this has been of benefit to my teaching, as well developing my skills in the supervision of research projects. This enhanced knowledge is partly the result of reading and formal learning, but most importantly, derived from ‘hands on’ experience of the ‘muckiness’ of doing actual research! I have been extremely well supported throughout the process by my supervisor, Dr Lesley Griffiths, who has provided encouragement and a ‘sociological eye’, which has given me fresh insights into the data.

As a result of my increased research knowledge, I have been successful in being appointed as Senior Lecturer in Midwifery, with particular responsibility for developing the research profile of midwifery within the school. This is an exciting new development for the department, which I hope will provide opportunities to further develop aspects of this study. I have had two papers published (see attached), both based on the literature reviewed for this study. Once my thesis is submitted, I intend to work on further conference papers publications in order to disseminate the findings.

To conclude: I am extremely grateful to the Iolanthe Trust for awarding me the Research Fellowship and giving me this invaluable opportunity. The experience has had a significant impact on both my professional and personal life. My confidence in planning and conducting research has increased considerably, and I have been able to share my new knowledge with students and colleagues. The research has generated

important insights into the emotional aspects of midwifery work, which have implications for education and practice. Finally, I must give especial thanks to the participants: I am very grateful to all the midwives who participated in the study and gave so generously of their time, and to the women and families who allowed me to observe their care.

Billie Hunter

12/02/02