‘NICE, NORMAL MIDWIFERY’?

A LONGITUDINAL STUDY OF THE PROFESSIONAL SOCIALISATION OF STUDENT MIDWIVES

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ABSTRACT

This qualitative, longitudinal study explores and compares the experiences of ten student midwives as they progressed through their midwifery training. Five of the students were undertaking the eighteen month course for trained nurses, while the other five were undertaking the three year course for those without a nursing qualification. A grounded theory approach was used, based on in-depth, semi-structured interviews carried out with participants at the beginning, middle and end of their midwifery course. The central finding of the study was that having started the course with a focus on birth as a normal life event, by the end of it their perspective had shifted to one which now focused more on the potential dangers of birth. They worried about `things going wrong'; such as the possibility of death or damage to mother or baby and how they would deal as newly qualified midwives with such situations.

The tension between treating birth as a normal life event yet remaining at the same time alert to what is, in essence, the possibility of death, is one with which every midwife has to deal. Not surprisingly, perhaps, it caused these students considerable anxiety, particularly as they neared the end of their course. The study explores factors that impinged on their changing perceptions and levels of anxiety. These were identified from the data as the following themes: the nature of the support received by students, the relationship between theory and practice, and the characteristics of the culture within which they were learning midwifery. In the conclusion recommendations for changes in midwifery education and possible areas for future research are suggested.

PREFACE

I am employed as a lecturer in a Department of Midwifery within a university. I teach student midwives, qualified midwives and other health care workers. Along with student midwives and midwifery colleagues, I also carry a small caseload of women for whom I provide total midwifery care in the community.

In February 1992 I had a discussion with a colleague who was planning to carry out a research project investigating student nurses' attitudes to death. He intended to undertake a comparison between nurse students who were on traditional courses and those doing the new diploma course (known as Project 2000). He asked me if I would be interested in helping with the study, from a midwifery perspective, researching the attitudes and experiences of student midwives. This seemed to me to be a useful and interesting project, coming at the right time. Through my work as a midwife in hospital and in the community I had on numerous occasions been involved in supporting parents whose baby had died before, during or after birth. I had also happened to be present at the time of the totally unexpected death of the baby of a woman to whom I had become very close during her pregnancy. I had done my best to help the woman and her partner in the painful months afterwards, and later on was able to keep in touch and visit after the birth of their next two, healthy, babies. This experience was of significance to me both personally and in my capacity as a midwife. I was keen to explore how death affects us as midwives, believing that this might help us give better care to all women.

My colleague had a psychology background and was interested in examining the relationship between `death anxiety', personality (measured by questionnaires), experience and attitudes. Not long after the start of the project, my colleague had to leave to take up another post. I also took time off for maternity leave when my second child was born. After these two events the

study changed focus. Interviewing the participants about death, I felt that I needed to explore, not only their experiences of death at birth, but also their fears about the possibility of it happening. There were also other areas that they wished to explore relating to their experiences as student midwives. The participants' fears were often expressed in terms of anxiety about `something going wrong' - a phrase which includes the threat of death or damage to mother and/or baby. These fears were inseparable from their experience of professional socialisation in the context of today's National Health Service (NHS). My research methods allowed me to widen the focus of the study in order to explore these aspects of the students' experience.

An overview of my own background will help the reader to understand the influences and concerns that affected me as I carried out the research. As a direct entrant (that is, someone with no nurse training) midwifery student nineteen years ago at the age of 24, I found my training a culture shock. I had just finished a degree in English and French at a university in the south of England. My interest in midwifery had grown out of feminist politics, an interest in women's health, and particularly from having spent a year in France where I met some feminist independent midwives and found out about their work. I then started midwifery training at a hospital in Manchester. At this time, direct entrant midwifery had been almost phased out; there was only one other centre providing it and the hospital where I trained discontinued the course soon after I qualified. In the 1970s technological intervention in childbirth had mushroomed, and I remember being told by a doctor at the beginning of my first placement on labour ward that the dream for the future was to have each fetal monitor wired to a central point so that the midwife could survey the condition of the fetus without having to enter the woman's room (This in fact happens in some hospitals in the United States, according to Davis-Floyd, 1992).

At the same time, pressure groups, such as the Active Birth Movement, were beginning to speak out against the medicalisation of the birth experience, and against what they saw as the inhumanity of the treatment of pregnant and parturient women. The pressure group now known as the Association for Improvements in Maternity Services (AIMS) when it was founded in 1960 was initially known as the Society for the Prevention of Cruelty to Pregnant Women. The increasing medicalisation of life in general was also coming under scrutiny, by people influenced by writers such as Ivan Illich (1977) and Irving Zola (1972, 1973). Meanwhile on the maternity wards I (and several of my fellow student midwives) found life difficult, and at times traumatic. I was trying to balance my feminism and my wish to protect women from what I perceived as the barbarity of medical (and midwifery) intervention against my need to be accepted by the people with whom I was working, and my desire to get through the course and reach my goal of becoming a midwife.

I qualified as a midwife seventeen years ago, and since then midwifery education has undergone fundamental changes. This study aimed to explore the effects of some of these changes, and also to compare the experiences and attitudes of those who have previously trained as nurses and those who have not, because the difference between the two types of training has been the subject of discussion dating back to the inception of a statutory formal programme of midwifery training in 1902. The study also aimed to explore midwifery training from the student's perspective as there are only a small number of studies that address this aspect of midwifery education. During the course of the research, I felt empathy with the participants as they talked about their fears and hopes, and prepared to take on the role of midwife. They were in the process of learning how to be confident, and confidence-inspiring actors in the drama of birth, which is also necessarily a drama about the possibility of death. This is a demanding role in any epoch, but may be more so in an era

where death is seen in terms of failure (Aries, 1981). This thesis is an exploration of these roles and processes.

PART ONE

BACKGROUND AND REVIEW OF THE LITERATURE

General introduction

The following chapters form a background to the empirical work, reviewing the literature that pertains to key issues that emerged inductively from the data. Data collection and the reviewing of relevant literature both took place over the same period of time, as is customary in grounded theory, so that each informed the other during the course of the research.

The midwife is the only professional specifically trained to deal with normal birth, and at the same time she is also trained to recognise abnormality; she is furthermore the central figure of support to a family when a baby dies. However a health based approach (seeing birth as a healthy rather than a pathological process) remains fundamental to midwifery, and is important in order to reduce the level of unnecessary and potentially harmful interventions in the normal process (Wagner, 1994). The midwife, therefore, has to be able to maintain a health based approach and at the same time be ready to detect and deal with any complications. Managing risk is a defining feature of late modern society (Beck, 1992) and notions of risk and accountability were central concerns expressed by participants.

The literature review aims to locate the themes arising from the data in their social context. Chapter One addresses the social construction of midwifery, focusing first on tensions at the heart of the role of the midwife (in particular between the midwifery model and the medical model) and then on the midwife as a professional and autonomous practitioner. Arising from the concept of professional autonomy

there follows a consideration of professional accountability, which is explored from two angles; preparation for accountability, and the meaning and implications of the concept. In Chapter Two the preparation of midwives is addressed, both in relation to those who have a nursing background and those who do not. It explores the evidence as to whether this may lead to different perspectives on, or attitudes towards, midwifery. There is also an exploration of how midwives are prepared for dealing with stillbirth and perinatal death, because this was an initial focus of the study and because issues relating to death or danger are central to the key concepts of accountabilty and risk. Chapter Three examines the concept of risk both in relation to the midwifery and medical models and in relation to perceptions of death.

In summary, the literature review therefore explores: the midwife's role as a professional who is poised at the borderlines between life and death; preparation for and socialisation into this role, and finally how attitudes to death and wider concepts of risk might relate to midwifery education and practice. The review is organised into three chapters in order to separately examine the professional, the educational and the broader social issues all impinging upon the role of the midwife who is, in the words of one of the participants, 'responsible for two lives'.

This section presents a description and discussion of the research methodology, followed by four chapters in which the data are presented and discussed with reference to the literature. The thesis ends with a discussion of findings, with recommendations for midwifery education, followed by a consideration of the limitations of the research and suggestions regarding possible areas for further research.

CHAPTER ONE

THE SOCIAL CONSTRUCTION OF MIDWIFERY

1.1 Introduction

The midwife plays a significant role when a baby is born. In the United Kingdom every birth, apart from those which are unexpected or concealed, is attended by a trained midwife; the midwife is the senior professional present at 72% of births (DoH, 1997a).

> A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.
>
> She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help...
>
> Definition of a midwife, the World Health Organisation, cited in *The Midwife's Code of Practice*, UKCC (1994a, p4).

The word ‘midwife' comes from the old English ‘mid-wyf' meaning ‘with woman'. The role of the midwife, that of one woman supporting another in childbirth, is an ancient one. Until the 20th century in the United Kingdom (UK), the midwife was most commonly a mature, local woman with little formal midwifery training, and this is still the case in many parts of the world (Kitzinger, 1991). In England it was not until the Midwives Act of 1902 that a national system of formal training and registration for midwives was instigated. Nowadays in the UK all registered midwives are required by law to have undertaken an intensive

academic and practical training leading to registration and, together with doctors, have a monopoly on attendance at birth; legally no-one other than a trained midwife or medical practitioner may arrange to attend a woman in childbirth.

The beliefs and practices surrounding birth are often taken for granted by the members of a society, yet study of them affords a great deal of insight into the values and dominant ideas of the time (see for example, Jordan, 1993; Davis-Floyd, 1992; Kaufert and O'Neill, 1993).

Sociological analysis of the role of medicine in society has explored the processes by which medicine both reflects and reproduces the dominant ideas of the society of its time (Freidson, 1970,1986; Armstrong, 1983). In Britain, birth practices and the role of the midwife, besides being moulded by wider societal changes and influences, have also been profoundly influenced by the dominant role of medicine this century. This chapter explores the forces and circumstances that have shaped the midwife's role as it exists today.

1.2 The 1902 Midwives Act

The 1902 Midwives Act, which for the first time provided a national system for the registration and training of midwives, is widely regarded as a crucial development in the history of midwifery in the UK. Periods of instruction leading to midwifery certification were available prior to the Act in most of the lying-in hospitals, but overall provision was poor compared with that available in other European countries (see Donnison, 1988; Marland, 1993). During the 19th century in Britain a protracted battle was fought for midwives' registration. It began with proposals for the regulation of midwifery in the Associated

Apothecaries' Omnibus Bill of 1813 and culminated in the 1902 Midwives' Act. During the years leading up to the Act the boundaries between medical and midwifery practice were openly contested (Witz, 1992, p108). A small group of educated, middle class women founded the Matrons' Aid Society in 1888 (known later as the Midwives' Institute). This group of women fought to raise the status of midwifery and make it attractive to middle class women, whose choice of respectable employment was extremely limited (Donnison, 1988; Kirkham, 1995; Clarke, 1996). To achieve this the Society worked with leading doctors and members of the upper classes who were supportive of the drive towards registration. The end result of this long story, which has been documented in detail by Donnison (1988) and Towler and Bramhall (1986), was that the price ultimately paid for state registration was a substantial degree of medical control. As Donnison (1988) put it: `midwives have the unenviable distinction of being the only profession controlled by a body on which its members must never be more than a minority' (p179).

Anne Witz (1992) has analysed the course of the professionalisation of midwifery from a feminist perspective. The division of labour between midwives and medical men had been a focus of struggle since the seventeenth century (when doctors first began to involve themselves in `man-midwifery'). During the nineteenth century this struggle, according to Witz, became centred around the division between `normal' and `abnormal' labour, with doctors wanting to ensure that midwives restricted their activities to attending upon and assisting normal labours. The problem, from the doctors' perspective, was that when it was the midwife who initially attended a woman in labour, the decision about whether a labour was, or became, abnormal, was left to the jurisdiction of the

midwife. It was therefore the midwife's decision as to whether, or when, a doctor should be summoned. This meant that the midwife had considerable power, as the `gatekeeper' to childbearing women. Witz (1992), using the concepts of dual and demarcationary closure in professional practice, argues that medical men had two responses to this.

The first approach she terms a demarcationary strategy of incorporation. Supporters of this approach opposed midwifery registration, arguing that because there was no definite dividing line between normal and abnormal labour, medical men would therefore need to superintend the whole process. Thus the midwife's role should disappear and the `obstetric nurse' take her place. These nurses would only act under medical supervision, carrying out tasks delegated by doctors. This approach was pursued in the main by general practitioners.

The second approach Witz refers to as a demarcationary strategy of de-skilling: those who advocated this (the obstetricians) wanted midwifery practice to be regulated through a state-sponsored system, with doctors in control of the system. The midwife's role was to be strictly limited to attendance in normal labour and to nursing the mother and baby after the birth. She was not to use instruments, perform operations or prescribe medicines, and her knowledge base was to be minimal: `What you want to educate midwives for is to know their own ignorance. That is really the one great object in educating midwives'. (HMSO 1892, p 101, quoted in Witz, 1992, p113).

The reasons for the ultimate triumph of the second strategy were, according to Witz, both expedient and economic. If doctors had adopted the incorporationist strategy they would have then had to assume responsibility for providing care

to all women, rich and poor. As Witz points out (p116) this was not possible because there were simply not enough general practitioners to provide attendance for working class women. With the de-skilling strategy, rich women would continue to employ doctors while `properly-educated midwives would continue to relieve medical men of tiresome and unremunerative midwifery practice amongst the poor' (Witz 1992, p116).

Brooke Heagarty (1990, 1997) has examined the history of midwifery in the early part of the twentieth century from a class perspective. Her analysis demonstrates the extent to which the battle over midwifery leading up to and following the 1902 Act was also a class-based one, involving not just a battle between midwives and medical men, but between rank and file midwives and the middle/upper class midwives, whom, she argues had more in common with other members of their class, including doctors, than with the working class midwives who had their roots in the working class communities.

The 1902 Act was, according to Heagarty (1997), a turning point in the history of midwifery, because it:

> provided the legal power to reform the practice of midwifery to alter the relationship between midwife and mother (and thereby the midwife's relationship to the working class community) and to create and sustain a powerful apparatus of enforcement (p70).

The 1902 Act legislated for the establishment of the Central Midwives' Board (CMB) with responsibility for regulating, supervising and limiting practice; admission to and removal from the roll; training and examinations; and the issuing and cancelling of certificates. The Act also set up Local Supervising Authorities (LSAs) whose remit was to regulate midwifery practice and investigate charges of malpractice, negligence or misconduct. Midwifery is the

only profession today which has this local mechanism to enforce the statutory regulation of its activity.

The Act was intended to bring about the replacement of the traditional handywoman or `lay midwife' with trained midwives, although it was recognised that this would not be possible until the training courses were established and functioning. Admission to the Roll would therefore be granted to those who already had a recognised midwifery qualification from the London Obstetrical Society or certain lying-in hospitals or those who could pass the Central Midwives' Board examination of competence following a three-month period of training. It would also be granted to women who could prove they were 'of good character' and who had already been in practice for at least a year (referred to as 'bona-fide' midwives).

In one sense the Act was only a partial victory for the reformers in that it allowed the lay midwives to register and to continue to practise as midwives (Kirkham, 1996, p172). The first roll of 22,308 names published in 1905, was made up of 44% of midwives with a formal qualification and 56% of `bona fide' midwives (Tew, 1990, p51). 'Bona fide' midwives continued to serve the poor well into the 1930s (Little, 1983; Dingwall et al., 1988). Their popularity with working class women, according to Dingwall and colleagues (1988), lay not merely in the fact that they were inexpensive compared to qualified midwives but also because they provided additional domestic services and followed local preferences about childbirth rituals. It was not until 1947 that the roll consisted solely of formally trained midwives (Donnison, 1988).

Jane Lewis (1986) discusses the difficulties associated with any effort to reconstruct women's actual experience, pointing out that there are few

identifiable sources to work with (p12). Two studies have drawn upon oral history and archival material in an attempt to explore the nature of midwifery in the early part of this century (Leap and Hunter, 1993; Little, 1983). From these accounts a rather different picture of the handywoman/midwife emerges than that painted by the standard midwifery textbooks. Little (1983, p89) in a study of handywomen that draws extensively on archive material, does not regard the introduction of State Certification for midwives as an unalloyed improvement in the lives of childbearing women. He argues that for working class women, the handywoman had been seen as a friend and equal while the new professional midwife was seen as `the expert', distanced from her clients. This view is corroborated by an often quoted paragraph from Flora Thompson's *Lark Rise to Candleford,* describing a rural midwife at the end of the nineteenth century:

> She was, of course, not a certified midwife; but she was a decent, intelligent old body, clean in her person and methods and very kind. Complications at birth were rare; but in the two or three cases where they did occur during her practice, old Mrs. Quinton had sufficient skill to recognise the symptoms and send post-haste to the doctor. No mother lost her life in childbirth during the decade[...]
> In these more enlightened days the mere mention of the village midwife raises the vision of some dirty drink sodden old hag without skill or conscience. But not all of them were Sairey Gamps. The great majority were clean knowledgeable old women who took a pride in their office. Nor had any of them been entirely without instruction [...] The trained district nurses, when they came a few years later, were a great blessing in country districts, but the old midwife also had her good points, for which she now receives no credit. She was no superior person coming into the house to strain its resources to the utmost, and shame the patient by forced confessions that she did not possess this or that, but a neighbour, poor like herself, who would make do with what there was, or, if not, would know where to borrow it (pp135-136).

This extract (with the words `superior' and `shame' contrasting strongly with the image of the down-to-earth, approachable old village midwife) gives an

indication of the changes that were set in motion by the 1902 Act. It suggests that this was a move away from lay knowledge and experience (which would henceforth `receive no credit'), towards new, professional values. Leap and Hunter's oral history, however, demonstrates that handywomen varied in their practice and acceptability to women, just as midwives do today. The examples they give of questionable practice, which they term `dodgy looking after' rather than life-threatening malpractice are centred around the handywoman's traditional rituals that were seen as out of date by some women; or else concern the handywoman's poverty and lack of time. One of the mothers they interviewed said of handywomen:

> It all depends on who you get, how well you get looked after. If you were unlucky, then you wouldn't get cooked for, your washing done and all that. If they only came in for an hour or so in between looking after their own family, you never got much.

This quote illustrates how useful a good handywoman could be to the women she cared for. The words `if you were unlucky' suggest that the handywoman was often a great help, cooking and washing, and `all that'. It offers some explanation of why handywomen remained popular for so long following the Act designed to phase them out. The certified midwife saw herself as a professional and it was thus not considered part of her role to carry out domestic chores.[1] Leap and Hunter's examples ultimately lend support to Little's argument that handywomen were an integral part of, and on the whole

[1] There is a lack of evidence as to how often trained midwives continued to carry out domestic chores for women, as anecdotal evidence suggests they still occasionally do today. Jane Lewis (1986, p5ff) described this tension between what is evident in the 'prescriptive literature' and the reality of women's lives and discusses the problems this causes for researchers.

an asset to, the working-class community; a source of ‘social capital’ (Puttnam, 1993).

The dominant school of thought in midwifery has portrayed the handywoman as a Sairey Gamp figure, filthy and gin-soaked, failing to acknowledge any possible value that the working class midwife may have had to the women she served. The caricature has been used to validate the drive towards professionalism in midwifery. For example Anne Bent, who has been a leading member of the RCM, wrote in a recent edition of Myles Textbook for Midwives:

> The majority of midwives in Britain at the beginning of the 20th century were uneducated and responsible for the midwifery care of the lower social classes who frequently could not afford the small fees which they were charged. The picture of Sairey Gamp in Charles Dickens' *Martin Chuzzlewit* was sadly true. Now, towards the end of this century, a very different picture is seen. It is that of the well-educated midwife practising as a member of a profession which is respected both nationally and internationally and responsible for the delivery of midwifery care to women at all levels of society (Bent, 1993, p727).

This unequivocal view of the evils posed by `uneducated' midwives is not borne out by the evidence, and in fact one Inspector of Midwives (midwifery supervisor) commented on her statistics for 1907-1918: `The figures show the lowest death rates amongst mothers attended by the very women the 1902 Act was passed to do away with' (Nursing Notes, May 1931, quoted in Kirkham, 1996, p172).

Writing about the development of a more professional identity Sheila Hunt argues:

> The claim to a professional identity in midwifery is widespread, articulated and accepted by the majority of midwives and each new cohort of midwives is socialised into this identity (Hunt and Symonds, 1995).

It is, therefore, important to examine the concept of professionalism if we are to understand current norms and values in midwifery.

1.3 Professionalism and midwifery

The earliest definitions of professions attempted to define a set of criteria which served as a yardstick against which the occupation could be measured. These criteria were largely based on the characteristics of the established professions such as medicine, law and the church (Carr-Saunders, 1955). Although the social organisation of professions and the nature of professionalism is continually changing, it is widely agreed that there are four core characteristics of a profession (Nettleton, 1996, p196). First, *specialised knowledge and lengthy training.* The long training period the individual undergoes ensures that the professional has specialised knowledge that is not available to the lay person, and thus the lay person becomes reliant on the 'expert'. Second, *altruism*: because of this dependency the professional is obliged to operate in the client's best interests and hold to a notion of public service. Thirdly, *monopoly over practice*: because the occupational tasks of the profession are protected by statute. Fourthly, only the professional can judge who is competent to practice and therefore the profession is *self-policing* and *autonomous.* From a functionalist perspective, sometimes termed 'the trait approach' (Symonds and Hunt, 1995, p183; Hugman, 1993) these attributes are necessary for the smooth functioning of modern society.

Critics of the trait approach have argued that the professions cannot be relied upon always to act in the public interest, and that they serve their own interests as much as, if not more than, those of others. For example Johnson (1972,

1977) described the professionalising project as a strategy geared towards the exercise of control both over other occupations and over the client group. The trait approach also tends to emphasise altruism rather than stressing the economic and social rewards of being a professional (Ben - David, 1963).

Although much attention has been focused on medicine in the discussion of professions, and despite the fact that health care professions are markedly gender-segregated, sociological analyses of professions have, until recently, been 'gender blind' (Nettleton, 1996, p199). This meant that despite the fact that professions were essentially male dominated there was little explicit reference to this in the mainstream literature (Hearn, 1982). Carr-Saunders and Wilson(1933) made a distinction between the 'established professions' that were based on theoretical study and prescribed norms of behaviour, and the 'semi-professions' that were more concerned with the acquisition of technical skill. Jeff Hearn (1982) pointed out that this distinction was really a distinction based on gender; 'established professions' being made up largely of men and 'semi-professions' of women (p185). According to Hearn, it was Simpson and Simpson (1959) who first attempted to raise the question of the relationship between gender and professions, commenting on the tendency of the `semi-professions' to be more bureaucratised and numerically dominated by women. Hearn's analysis refers to midwifery as a semi-profession and describes professionalisation as a variety of patriarchal processes whereby men move into and increase their influence on the semi-professions. The development of professions, he argues, is intimately bound up with the social organisation and control of emotionality. Midwifery is a crucial area for Hearn

because birth ‘is one of the most emotional experiences, if not the most’ (p196). Midwives, according to Hearn’s analysis, monitor these emotions (although not necessarily consciously) translating them from private to public terms, and bringing to the attention of the professions (men) if the emotions become too extreme.

The discussion of gender and power issues in relation to professionalism has been advanced recently by nurses (e.g. Salvage, 1985, 1992; Smith, 1992) and even more recently by midwives (e.g. Hunt and Symonds, 1995; Kirkham 1996; 1997). Celia Davies has explored what she terms ‘the professional predicament’ in nursing in an attempt to analyse the drive within nursing for recognition as an established profession (Davies, 1995). Davies (1995), drawing upon earlier work by Jane Salvage (Salvage, 1985), argues that the term ‘professionalism’ can be subdivided into two broad constructs: professionalism meaning ‘integrity or probity of personal conduct’, and professionalism, or professionalisation, as ‘a route taken collectively by members of an occupational group who refine and guard their knowledge base, set boundaries around who can enter and what the limits of practice should be’ (p135). Davies maintains that while the first construct is one against which few would argue, the second is more problematic for nursing. Salvage’s discussion of the drive for professional recognition in nursing (Salvage, 1985) criticises nursing leaders’ drive for the recognition of nursing as a profession. She points out the potentially damaging effects of this drive towards professionalism, which she maintains, is predicated upon the second construct.

Salvage's criticisms may usefully be applied to midwifery; and Kirkham (1997) has examined the concept of professionalism from a midwifery perspective.

The charges against professionalism, according to Davies (1995), following Salvage (1985) are threefold: professionalism is divisive; it emphasises an individual approach and it denies the needs of its workers. Viewed in this way the concept of professional separateness can damage relationships between health care workers as each tries to define its own exclusive sphere of practice. In the case of midwifery, it has attempted to draw a boundary between itself and nursing through an insistence on the midwife's status as autonomous practitioner in contrast to that of the nurse. Hunt and Symonds (1995, p30) represent this as follows:

Midwifery	*Nursing*
Independent practitioner	Dependent 'handmaiden'
Partnership with doctor	Subservient to doctor
Manager of normal labour	Carer for the sick
Health	Illness

Such a conceptualisation of roles is becoming difficult to sustain in today's NHS, as nurses have increasingly specialised and autonomous roles; yet it still remains an important part of midwives' socialisation.

Michael Eraut, following Johnson's (1972, 1984) approach suggests bypassing the attempt to distinguish the true professions from the others and treating professionalism as an ideology. This then allows a more fruitful discussion of the status of different types of knowledge.

The ideology of professionalism may threaten relationships between the midwife and the woman by portraying the midwife as 'expert' and by implication the woman's knowledge of her body as somehow inferior (Symonds and Hunt,

1995). Ruth Ashton, then General Secretary of the RCM, expressed her view of the professional role as follows:

> Midwives cannot be women's advocates because their professional status, their skills and their knowledge, by definition, set them apart from women in general [...] (Ashton, 1992, p70)

Professionalism may also mean valuing technical skills gained through training more highly than skill gained from experience. Midwifery training, although it was initially only three months long when it was first instigated, was after all sanctioned and controlled by some of the most powerful members of society, the medical profession. The 1902 Act marked a major shift in the midwifery tradition because previously the main criteria for becoming a midwife had been maturity, having oneself experienced childbirth and having credibility amongst women clients (Kirkham, 1995).

Lay and medical knowledge have been described as `different ways of knowing', with lay knowledge having its roots in experience, and medical knowledge claiming abstraction from knowledge into objectivity (Williams and Popay, 1994). The tension between lay and professional knowledge is alluded to by one of the qualified midwives in Leap and Hunter's study who says indignantly:

> Once I was really hurt. A woman I'd known all my life, and she said to someone, 'I can't see how she knows so much. She's no' but a lass!' And I was 25 then and done four years in hospital, besides doing midwifery training! (...) But, you see, they thought that experience meant more than training... (p35).

The `they' being referred to here is presumably women clients, who it seems still placed value upon experience, both in terms of the midwife's own life experiences as a mature woman but also in terms of having attended many

women in childbirth. The hospital is presented by the speaker as the most prestigious place in which to learn.

The ideology of professionalism rests upon an underlying assumption that professionals are either self-employed or partners in small practices (Eraut, 1994). It stresses individual accountability for the delivery of high quality care, and yet many nurses and midwives work in situations where they have little control, for example over hospital policies or levels of staffing (Davies, 1995). Service to clients is held up as the highest priority and as a result there is an unwillingness to recognise that there may be times when nurses/midwives need to assert their own needs. The prevailing ideology of professionalism may underlie the fact that scant attention has been paid to the needs of women working in the health service, even though they predominate; for example flexible working and child care arrangements (see Sandall, 1995).

Some midwives, as individuals or in groups, have certainly managed to overcome the constraints and limitations of the professional role, and work constructively with it. The fact that they have done so illustrates that people rarely completely accept the dominant ideology, but resist and subvert it, sometimes passively and sometimes overtly (Martin, 1989). All the same the history of the move towards the professionalising of midwifery has important implications for mothers and midwives. The notion of professionalism in midwifery has, as we have seen, involved some degree of separation between the perceived values and interests of mother and midwife (Kirkham, 1996). It has also, while clarifying a sphere of professional practice, accepted a circumscribed view of the midwife's role. This role was mapped out, over the last century, by a group of reformers keen to regulate and control the practice

of midwifery, not just for the benefit of childbearing women, but also in the interests of the dominant social class of whom doctors were a significant element (Heagarty, 1997). Kirkham (1996) claims that `the values implicit in professionalisation have led us to take on the values of the dominant profession' (p196). The values of the dominant profession, medicine, have been fundamentally interconnected with those of midwifery in the twentieth century and this interrelationship will be examined in the following sections.

1.4 Medical dominance and midwifery

An analysis of the medical model is important in any discussion of midwifery, not only because the history of midwifery has been so bound up with that of medicine but also because the influence of the medical model permeates society and thus inevitably affects the ways in which both consumers and health professionals view birth. The medical model as it is today has evolved over many centuries; this development has been traced by Vouri and Rimpela (1981) who summarise it as having three main elements: the control of nature by human beings; a mechanistic view of human beings; and an understanding of disease which separates human beings from the environment and social context in which they live. Midwifery practice is still largely underpinned by the medical model (Bryar, 1995) which results in an approach to birth that has been characterised as seeing birth as ‘a crisis waiting to happen’ (Arms, 1998) or as ‘only normal in retrospect’ (Kirkham, 1986, p37). This approach may be contrasted with the social or ‘woman-centred’ model, as illustrated in the following table :

Medical view of pregnancy	**Pregnancy as a normal life event**
Normal in retrospect	Normal in anticipation
The unusual as interesting	Each pregnancy a unique event
Prevention of physical complications	Development of the individual through experience of pregnancy
Doctor in charge	Woman and family major decision makers
Information restricted	Information shared
Outcomes	**Outcomes**
Live healthy mother and baby	Live healthy mother and baby and satisfaction of individual needs

(Bryar, 1995, p114)

The woman-centred model is increasingly being espoused by midwives, other health professionals and policy makers in response to consumer pressure and political changes (House of Commons Health Committee, 1992). It is also the philosophical model that underpinned the curricula followed by the students in this study and I will refer to it as the midwifery model of care in this thesis.

The 20th century has seen a progressive movement towards the institutionalisation of illness, birth and death. The place of birth has overwhelmingly moved from home to hospital. In the 1950s and 60s, many women had their babies at home; it is only relatively recently that people have begun to think of hospital as being the safest place to give birth. Following the inception of the NHS in 1948, larger numbers of obstetric beds became available and women were increasingly encouraged to give birth in hospital (Oakley, 1990). The fall in the perinatal mortality rate (PMR)[2] which occurred at the same time, was generally assumed to be causally related to the increased

rate of hospitalisation for birth (Tew, 1990). From the 1940s onwards successive government reports were published, each advocating increased hospital deliveries on the grounds of increased safety for mothers and babies until finally the Peel Report (Standing Maternity and Midwifery Advisory Committee, 1970) advocated 100% hospital delivery. The assumption that the fall in the PMR was a consequence of increased hospital birth went virtually unchallenged until the 1970s when Marjorie Tew, a medical research statistician, re-examined the available data. She was teaching statistics and epidemiology to students in a medical school and found to her surprise:

> that the relevant routine statistics did not appear to support the widely accepted hypothesis that the increased hospitalisation of birth had caused the decline by then achieved in the mortality of mothers and their new babies (Tew, 1990, p viii)

Campbell and Macfarlane (1995) from the National Perinatal Epidemiology Unit in Oxford also examined the statistical evidence and concluded `there is no evidence to support the claim that the safest policy is for all women to give birth in hospital'. Detailed analyses of the statistical association between the falls over time in both the PMR and the proportion of births at home suggest that the relationship between the increase in hospital births and the decline in the PMR are likely to be coincidental rather than causal (Campbell and Macfarlane, 1995). The most likely explanation for the reduction in perinatal and maternal mortality is the increase in standards of living and nutrition (McKeown, 1989). The history of the institutionalisation of birth demonstrates the dominance of the medical model during that era: in the approach of successive policy makers, in the philosophy of the health professionals and of course in the

[2] The number of stillbirths and deaths in the first week of life per 1000 births

minds of women (particularly middle class women) many of whom were choosing to give birth in hospital (Allison, 1996, p109). This change in the place of birth had a profound effect on the role of the midwife.

1.5 The midwife's role 1960s - 1990s

Prior to the 1960s, midwives in Britain were relatively autonomous, community based practitioners who attended births at home and in the small maternity units that were run by midwives with general practitioner support. Benoit (1989, 1992) drawing on data from midwives in Newfoundland, argues that midwives working in small cottage hospitals enjoyed substantial autonomy in their practice, free from medical and bureaucratic control. Many British midwives were in a similar situation. In the 1970s and 1980s most of these units were closed down; ostensibly on grounds of safety. The argument put forward by obstetricians and anaesthetists was that these units were too far from emergency facilities, and that all maternity units should have an on-call anaesthetist and obstetrician. The policy of closing down these units also afforded a relatively simple way of making immediate savings for health authorities. The UK perinatal mortality statistics, when examined by Campbell and Macfarlane, showed that isolated GP units had a very good safety record (Campbell and Macfarlane, 1994, p59).

The Local Government Reform Act (1969) together with the Peel Report meant the end of district midwifery as a discrete service offering homebirth with

continuity of carer (Allison, 1996). By the early 1970s the newly formed health authorities organised community midwifery services to undertake two functions: to provide community midwives as part of primary health care teams led by GPs and to give a fragmented antenatal and postnatal service to women booked for hospital delivery (Allison, 1996, p153). As the hospital birth rate rose to nearly 100%, so hospital midwives became involved with the care of almost all women during labour and delivery. Hospital midwives worked as part of an obstetric team, with a consultant obstetrician at its head.

The incidence of obstetrical intervention during labour increased rapidly during the 1970s (Chamberlain et al., 1978) and this resulted in an increase in the proportion of labours in which doctors were involved. `Active management of labour' (O'Driscoll and Meagher, 1980) became the norm in many consultant units, and this meant that increasingly midwives in hospitals were expected to follow protocols for care which had been drawn up by obstetricians, or by teams in which doctors were the dominant group. Such protocols included for example, requirements for the midwife to perform three to four-hourly vaginal examinations on women and to perform amniotomy at a stipulated point of labour (O'Driscoll and Meagher, 1980).

During the late 1970s critical articles appeared in the nursing and midwifery press, describing these developments as reducing the midwife's role to that of an `obstetric nurse' (Walker, 1976) or `doctor's handmaiden' (Rothman, 1983). Concern about the under use of the midwife's skills was expressed by the RCM and the CMB in evidence to the Social Services Committee on Perinatal and Neonatal Mortality (Social Services Committee, 1980). Robinson and colleagues (1983) in their study of the role and responsibilities of the midwife,

funded by the Department of Health and Social Security, concluded that 'the role of the obstetrician and the role of the general practitioner were shown to overlap and in some respects erode the responsibilities of midwives' (p339). Despite recent policy changes with regard to maternity care (discussed below), the organisation of midwifery services, and the ratio of home to hospital births, has remained largely the same since 1967.

The effects of the dominant ideology are felt not only at the level of structure and organisation of the maternity services but also in the ways individual midwives relate to and interact with their clients. Kirkham's study of labour ward communication illustrates how deeply midwifery is permeated by the medical model (Kirkham, 1986). This study demonstrated that midwives working in the consultant unit did not have a language to support midwifery and its skills. They lacked terms to describe or explain the women's experience; instead they used concepts and language drawn from medicine which failed to provide women with the information they needed in labour. More recently Machin and Scamell (1997) have explored the options available to women in labour wishing to have an unmedicalised birth (e.g. being mobile, using non-pharmaceutical methods of pain relief etc). They concluded that the midwives in their small study had little to offer in support of unmedicalised birth and that the care they offered was based largely upon principles drawn from the medical model.

1.6 Accountability and the midwife

The question of professional accountability is central to an understanding of the social construction of midwifery. From the moment of registration, the midwife's practice is defined by a set of rules that have legal force. No other

profession registered with the UKCC, other than nurses registered under part 9 (fever), is in the same position (Dimond, 1994, p40). Rule 40 of the Midwives Rules sets out the duties of the midwife, which is that she is responsible for giving care to mother and baby during the antenatal, intrapartum and postnatal periods, and for notifying a medical practitioner in cases of deviation from the normal[3]. As we have seen, this concept of `the normal' is problematic for midwives because although the onus for detecting abnormality rests with them, the actual definition of normality is presently the province of doctors although currently the issue is being debated in midwifery (see RCM, 1997; Downe, 1996; Davies, 1995). Since the instigation of the UKCC in 1979 the primary duty of the midwife, as for other health professionals, is stated in the UKCC Code of Professional Conduct:

> As a registered nurse midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability must:
>
> Act always in such a manner as to promote and safeguard the interests and well-being of your patients and clients [...]

Acting in the client's best interests may sometimes involve a course of action which may be regarded as exceeding the circumscribed role of the midwife. A case such as this occurred in 1988 when an independent midwife, Jilly Rosser, took a client to hospital in her car rather than wait for medical aid, because in her judgement this was the speediest and safest course of action. The midwife was reported by her supervisor, found guilty of professional misconduct and struck off the register by the UKCC. The evidence for misconduct included criticism of Rosser's record keeping as well as of her using her own car rather

[3] This rule has been recently changed (1998) so that it now reads ‘shall call a registered medical practitioner or such other qualified health professional who may reasonably be expected to have the

than waiting for the emergency services to arrive. The midwife took the case to the High Court, at which point the UKCC withdrew. Rosser was allowed her appeal and the UKCC ordered to reinstate her on the register. The law did not find any aspect of Rosser's practice unsafe; indeed the judge said that he considered the charge against Rosser taking the client to hospital in her own car to be `perverse' (Clarke, 1996, p218). This example illustrates the opprobrium that is likely to be heaped on a midwife who dares to cross the boundaries, and that the UKCC, like the CMB before it, is concerned with keeping those boundaries intact.

The Midwife's Code of Practice does not have legal force, but failure to comply with the Code may be used in proceedings for professional misconduct. The Code states that the midwife is `accountable for her own practice in whatever environment she practises' (UKCC 1994a). The midwife is accountable in four main ways, according to Dimond (1994): firstly to the public through the criminal law; second to the client through the civil law; thirdly to her employer through the contract of employment and finally to her profession through the UKCC professional conduct proceedings (p173).

Besides her accountability to the public, then, the midwife is also accountable to her employer and to her professional body. She is exhorted by her professional body to act as if she were an autonomous professional when in fact she is (unless she is one of the few independent midwives) an NHS employee. Merton's classic (1968) discussion of bureaucracies explored the conflict this produces for employees. Benoit (1989) discusses Merton's work, and the work of critical theorists in relation to professionals:

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requisite skills and experience to assist her': see discussion in Chapter Three.

the tense association between professionalisation and bureaucratisation has resulted in 'organisational dysfunctions' (low productivity, inefficiency) for the bureaucracy and 'psychological dysfunctions' (anxiety, apathy, anomie, alienation) for workers socialised as professionals yet expected to conform to a narrow official role. The frequent way out of this ambiguity is to adopt the role of bureaucrat, thereby discarding professional ideals in favour of the imperatives of the employing organisation (p29).

Researchers examining the role of the midwife in the 1980s and 1990s have shown that midwives may respond to this tension by adhering to medicalised policies and protocols while at the same time professing independence of clinical judgement (Robinson et al., 1983; Henderson, 1984; Garcia et al., 1985; Garcia and Garforth, 1991). The Midwife's Code Of Practice (UKCC, 1994a) states that: `In all circumstances, the safety and welfare of the mother and her baby must be of primary importance' (p3) and `The needs of the mother and baby must be the primary focus of your practice' (p8). At the same time the midwife is accountable to her employer as an employee.

The conflict of accountability this can cause was demonstrated in 1994 when two midwives in east Hertfordshire were suspended following their attendance at a successful waterbirth because although women were 'allowed' to labour in water, it was Trust policy that they leave the water for the birth of the baby. Their client had opted to stay in the pool to deliver and the midwives had respected her choice, in keeping with the Code of Professional Conduct. The midwives in this case were backed by the UKCC but had no right of appeal against their employer's decision after the disciplinary hearing, which they lost. It is possible that the conflict of roles has been accentuated since the recent NHS reforms which have aimed to reduce professional autonomy; this tension

between profession and organisation is now felt throughout the NHS (Holliday, 1995; Kelleher, et al., 1994).

1.7 The current situation

The introduction of general management in 1984 resulted in the old hierarchy of nurse and midwifery managers being dismantled. This reduced the professional autonomy of nurses and midwives; the attacks on medical autonomy, however, were less successful (see Hunter, 1994). In 1990 the National Health Service and Community Care Act introduced the principles of the market economy into the NHS. This constituted a radical reform which has fundamentally altered the shape and character of the NHS, causing it to be increasingly fragmented (Holliday, 1995). The key innovation of the Act was the separation of the purchasing of health care by health authorities from the provision of health care by hospital and community services. While it is not within the scope of this study to analyse its effects, there is no doubt that the 1990 Act effected a huge change in the culture of the NHS (Flynn and Williams, 1997).

During the last decade, Government initiatives that have had a direct impact on maternity care and the work of midwives include *The Patient's Charter* (1991) and *Changing Childbirth* (Department of Health, 1993). The Winterton Report (a House of Commons Select Committee report to which *Changing Childbirth* was the government response) advocated more choice, continuity and control for women in their maternity care, as well as pointing out the need to improve the conditions of the poorest women in society (House of Commons Health

Committee, 1992). This document was underpinned by the social, or 'woman-centred' model of health which is increasingly informing policy initiatives and signals a drive towards reorienting health services into the community and primary health care (Bryar, 1995, p90). The Government response to the Winterton report, *Changing Childbirth* (DoH, 1993) did not address the fundamental issues of poverty and malnutrition that had been emphasised in the Winterton report as crucial to the health status of mothers and babies, stating (p2) that these aspects were not within its remit. It focused instead on aspects which were in harmony with its political aims: i.e. increased consumer choice and control, continuing inroads into the professional power of doctors, and cost reduction (or `value for money' as the report put it). It accepted the principle of 'woman-centred care' advocated by Winterton and outlined ten 'indicators of success' to be achieved within five years (see Appendix B). One of the targets was that 30% of women should have a midwife as their 'lead professional'.

In response to the targets, all Trusts made significant changes to the way maternity care is delivered. Many turned to team midwifery in an attempt to improve continuity of care for women; some adopted a system of group or caseload practice. A small number of innovative projects were funded by central government but in most cases midwives were expected to agree to changes to their working conditions and practices with no improvements in pay and no increase in the number of midwives employed (Lewis, 1996). The incentive perhaps was for midwives to gain some professional autonomy, but there was to be no recognition of the changes in terms of pay and little attempt to address inequalities in maternal and perinatal health. Thus, *Changing*

Childbirth, while appearing on the face of it to support midwifery autonomy, has not in fact presented any significant challenge to the medical status quo (Rothwell, 1996).

The average annual salary of a midwife in 1997 was £16,000 (RCM, 1998). This compared with the average salary of a consultant: £50,000, and of a GP: £44,000. In 1995 a pay award for midwives, nurses and health visitors was announced; it was to be 1% nationally with employing trusts to determine the rest (up to 2%) at local level. The General Secretary of the RCM announced: `Morale in midwifery is at an all time low already and this scandalous pay award will make things even worse' (Allison, 1995, p84). Midwives had been struggling to meet the challenge of providing woman-centred care and the pay offer was seen, by many midwives, as the final insult. In response to widespread anger, the RCM balloted the membership to reconsider its 115-year tradition of opposition to any form of industrial action. This was a momentous event in the history of the RCM, and the result showed midwives to be in more radical mood than perhaps the leadership had envisaged. For one commentator, the result signalled 'a major change in the way midwives see themselves and their place in society' (Tyler, 1995). Of the 53% who took part, 81.8% voted for the College to rescind the policy of opposition to industrial action. 20% said they would themselves be prepared to take strike action. The RCM's response to this expression of dissatisfaction was to negotiate an agreement, (separate from the other health service unions) with the NHS Management Executive (NHSME) that all midwives, in view of their changing responsibilities, be graded at F (NHS Executive, 1995). The recommendation was to be outlined in a letter to every Trust. By early 1998 only a small number

of Trusts had implemented the recommendation, and the Pay Review Body also failed to recommend a minimum F grade for all midwives (Kaufman, 1998). Before it was voted out of office in 1997 the Conservative government announced that it had no plans for further funding of *Changing Childbirth* initiatives and many innovative and successful schemes have since been abandoned as funds have run out. The *Changing Childbirth* Implementation Team was disbanded in March 1998. At the most recent RCM conference it was clear that midwives are very unhappy at the loss of senior grades, and at the long hours and unpaid overtime that midwives are working. Over 1000 G grades have been lost since the early 1990s (Kaufman, 1998). The number of practising midwives is currently 32,803 (a drop of 2,500 since 1995), with 48% of these working part-time (UKCC, 1998a). Currently only 30 Trusts (13%) in the country have implemented the recommended minimum F grade, salary range £16,310 - £19,240 (RCM, 1999).

At the same time, there is to be a major Health Bill in 1999, following the Labour Government's white paper, *The New NHS* (DoH, 1997). The Bill aims to replace the internal market and GP fundholding, creating Primary Care Trusts in order to achieve greater integration between community and primary care services. It is currently too early to judge the ways in which the maternity services will be affected. The focus on community-based patterns of care would seem to offer opportunities for midwifery, proposing 'a return to a more balanced model of midwifery operating seamlessly across community and hospital settings and contributing to the public health agenda' (DoH, 1998a, p3).

1.8 Conclusion

This chapter has outlined some aspects of the social and historical developments which have shaped midwifery.[4] There are obvious parallels with the development of nursing, but in midwifery the midwife's true position has been obscured by the popular ideal of the midwife as autonomous practitioner. The arena of normal midwifery in which the midwife has been proclaimed expert is in fact a limited one, that has been and still is defined by the medical profession. Their professional body, the UKCC, on which midwives are a minority, demands that midwives act as autonomous professionals, within these boundaries. However, there are many instances where the professional autonomy of the midwife clashes with the demands of the employer (see Clarke, 1996: Rosser, 1998). The midwife has a dual identity: autonomous practitioner and NHS employee. She is an expert in the normal, but has little control over the definition of normality. She is the guardian of normal birth in a society, and in institutions which view normal birth, without medical intervention or at home, as a risky business. She sees herself as a professional, and continues to hope that her value will be recognised in pay terms by successive governments, but the reality is that she is more often viewed as a cheaper alternative to medical care. The independent practitioner status that is promoted as part of the professional ideology, and lies `deep in the psyche of midwifery' (Clarke, 1996, p205) is far from the reality of most midwives' daily experience. Clarke's phrase is an apt one because it highlights the fact that these tensions exist in the hearts and minds of midwives, affecting all

[4] See Appendix A for an outline of some key developments in midwifery since the 1902 Act.

midwives, including those in training. The education of midwives will be the subject of the following chapter.

CHAPTER TWO

THE EDUCATION AND PROFESSIONAL SOCIALISATION OF STUDENT MIDWIVES

2.1 Introduction

Midwifery education has undergone major changes in the last few years and is still in a state of upheaval. The principal changes have been those relating to the organisational location, the lines of accountability and to the way in which midwifery education is financed (Silverton, 1996, p75). The introduction of the purchaser-provider division in the 1990 NHS and Community Care Act had a marked impact on the relationship between midwifery education and the maternity services so that now the two are no longer interdependent. Before the mid to late 1980s schools of midwifery were based in maternity units; they tended to be small, and had close links with the service. Midwifery education was financed from the midwifery service budget. Then came the first round of amalgamations, as midwifery schools were incorporated into colleges of nursing and midwifery and some, such as Manchester, became colleges of midwifery. However none of the latter have survived because of Regional Health Authority (RHA) policies which emphasised centralisation and also, according to Silverton (1996) because the RHAs `did not understand the discrete nature of midwifery'. Finally over the last few years most colleges of midwifery and nursing have been incorporated into higher education. This chapter will focus on debates that have been at the forefront of midwifery education in the last few years and will then examine some current issues within midwifery education.

2.2 The direct entry debate

Since 1916 there have been two routes to becoming a midwife. The first, where no prior training as a nurse is undertaken, used to be known as 'direct entry' (DE). The second is a shortened course for trained nurses. In the early part of this century non-nurse midwives were in the majority; but by 1945 they made up 48% of the total number of practising midwives (Radford and Thompson 1988, p37). The strong medical representation on the Central Midwives Board from its inception meant that doctors played a dominant role in the formulation of plans for midwifery training, and direct entry midwives were viewed by them as inferior to nurse trained midwives, because their specialism was too narrow (Heagarty and Franklin, 1994). This view was backed by the members of the Midwives Institute council who were all trained nurses; and nurse training in this era strictly instilled deference to male medical authority (Kirkham, 1995, p2). Radford and Thompson (1988) comment that following the 1902 Act there developed an attitude, not just amongst doctors but within midwifery itself that was hostile to the inclusion of non-nurses. In 1929 a report on the training and employment of midwives, chaired by Sir Robert Bolam was published which suggested that a workforce made up of midwives with dual qualifications was the ideal, if not always practicable. In 1944 a report by the Royal College of Obstetricians and Gynaecologists (RCOG) stated: 'we are of the opinion that every midwife should be a State Registered Nurse' (RCOG, 1944; cited in Radford and Thompson, 1988, p34).

By the seventies there were very few midwifery schools offering DE courses. However the climate was beginning to change. The early seventies saw the start of organised opposition to the increasing levels of medical intervention in normal childbirth. This movement was given impetus by feminism and by writers such as Suzanne Arms (in the US), Sheila Kitzinger, and Ann Oakley (in the UK). Dozens of pressure groups were set up, giving voice to women's

dissatisfaction with a high-tech, conveyor-belt approach to maternity care. The Association of Radical Midwives (ARM) was founded in 1976 by a small group of student midwives alarmed at the apparent trend towards maternity nurse status in their training (ARM, 1979). This group had its foundation in feminism but was made up of midwives of various political persuasions and has always emphasised that the word `radical' in the title is used in its literal sense, relating to roots and origins. One of its stated goals was, and still is `that the true meaning of midwife (with woman) will once more be realised in practice' (ARM, 1996). An ARM working group was set up in the late 1970s to investigate and promote the cause of DE training.

Midwifery education has undergone considerable change since a formal programme was initiated by the 1902 Act. In 1902 midwifery training consisted of three months' instruction by attending a course of lectures, and practical instruction by attending births under the supervision of a midwife (Henderson, 1994, p221). From 1906 to 1916 this three month course was the same for both nurse and non-nurse recruits. In 1916, this was changed to six months' training for direct entrants, while remaining at three months for nurses. The training was lengthened in 1926 (six months for nurses and a year for non-nurses), 1938 (a year and two years respectively) and 1981 (18 months and three years). Radford and Thompson (1988) argued that the increase in length of training, plus various Government reports, plus the increasing hospitalisation of childbirth all acted as a disincentive to direct entrants (p53). By the time the DE training was lengthened to three years in September 1981 only one centre, Derby City Hospital, was still offering the course, but the issue of DE was by then becoming the focus of much discussion amongst midwives. Flint (1986), Downe (1988) and others argued that nurse are geared to a sickness model which they then have to ‘unlearn' if they are to give good psychological support and physical care to healthy women. For example Caroline Flint, a member of

the ARM (and later President of the RCM) asked in an article entitled 'Should midwives train as florists?':

‘might it not be harmful to healthy women to be dealt with by people who have become conditioned to people being ill?’ (Flint, 1986, p7).

Nurse training, it was argued, conditions nurses into the medical hierarchy, where nurses are expected to be subordinate to doctors. It was not, from this perspective, a suitable preparation for someone who was to be an autonomous practitioner accountable for her own practice. It was also argued that direct entrants were more likely to be mature, assertive and have had some life experience, and might as a result be better equipped to act as a woman's advocate, especially in situations of conflict with doctors. There were also demographic and economic elements put forward in favour of the expansion of DE training. It was maintained that DE would reduce wastage, because the midwife would have a single qualification and would be more likely to stay in midwifery rather than use it as a stepping stone to another goal such as health visiting. (This was a problem that had dogged midwifery since training was first instigated.) It would be cheaper to train a midwife by the direct route, rather than fund three years of nurse training prior to her taking up midwifery. There were also concerns about the projected reduction in the number of school leavers. However the `demographic time bomb' never in fact materialised (Symonds and Hunt, 1996, p205).

By 1982 only 7.2% of practising midwives were not nurse trained. At the point when direct entry can be said to have reached its lowest ebb, the tide was already beginning to turn and there were various moves to re-establish midwifery training for non nurses. In May 1985 the English National Board published a consultation paper on nurse education which promoted a health-based common core course for all nurses. This paper favoured a direct entrant

approach to midwifery. In May 1986 the UKCC published *Project 2000* (UKCC, 1986) which proposed fundamental changes to nurse education. The foundation of nursing was to become health-based rather than based on the medical model. At the same time it suggested that midwifery be subsumed as a branch of nursing, one of five options in which a student could specialise following the health based Common Foundation Programme. Midwives rejected the idea that midwifery should become a ‘branch' of nursing. Following consultation the UKCC accepted midwives' objections, and omitted midwifery from the final plans. These events appeared to have the effect of galvanising midwifery into developing alternative projects for midwifery education, including the development of DE courses (Radford and Thompson, 1994). Ultimately a combination of pressure from midwives, concerns regarding predicted midwife shortages, the need to recruit and retain midwives and the cost of training (Henderson, 1994) led to the establishment of DE courses becoming official policy (ENB, 1986; DHSS, 1986). However this policy decision was not supported by empirical evidence and so in 1987 the ENB commissioned a project which aimed to gather information about DE (Radford and Thompson, 1988; 1994).

Radford and Thompson (1988) distributed a questionnaire to all training schools in the country as part of this ENB funded study. They described how midwives were divided into two camps over the DE debate. The first is typified by the following comment by a midwifery tutor:

> My own view is that this type of training (DE) is only second best. As a midwife I have utilised skills and knowledge gained from my nursing experience (Radford and Thompson 1988, p71).

The exact nature of these skills was rarely described, although one Director of Midwifery Services ventured:

> Both nursing and midwifery require many of the same skills - aseptic technique, dealing with people, etc. (p71).

The second view was that midwifery and nursing are two distinct professions and nurse training was not only unnecessary but might even be detrimental to clients and to midwifery as a whole. Radford and Thompson commented that:

there was an underlying feeling in some quarters that the Direct Entrant could be a powerful force for change - largely because she hasn't been conditioned by her ‘general' (p 103).

Interestingly this view was not only held by midwives who had themselves been direct entrants. Although its remit was not to explore differences between midwives who were nurses and those who were not, Radford and Thompson's study clarified issues that had formerly been the subject of speculation. For example, it examined the characteristics of potential DE candidates, and divided them into four subgroups.

1. Older women who had raised a family
2. School leavers who ‘liked babies'
3. Women in their mid- to late-twenties who were frustrated or bored in their present career (these included a significant number of Enrolled nurses and Nursery nurses)
4. A small group of highly qualified articulate women who were interested in women's rights and related issues (Radford and Thompson 1988, p78).

Although the widely-held expectation was that non-nurse midwifery would attract the mature woman, Radford and Thompson (1988) found in their survey that 58% of respondents were under 25 years old. There were marked differences, as might be expected, between the younger and older candidates. They concluded (p103) that the mature woman would be less likely to accept dictatorial or hierarchical management. Henderson (1994, p223) having observed both nurse and non-nurse students and discussed experiences with other midwifery educationalists, commented that the three year course

appeared to be producing `a more questioning and assertive midwife'. To what extent this is due to the changed curriculum, or to the qualities of the recruits to the pre-registration course, or to a changing culture in the health service as a whole has not yet been explored. It is possible that nurses who trained via the health-based Project 2000 curriculum before taking up midwifery might also be found to have a more questioning approach to care than nurses trained under the traditional system.

One of the main conclusions of Radford and Thompson's study was that the profession should clarify the kind of midwife it wished to see produced, since only then could appropriate target groups for recruitment be identified and appropriate courses designed. There are currently over 40 centres offering direct entry midwifery at diploma and degree level (Fraser et al., 1997). However, the number of students in training has drastically reduced (Silverton, 1996).

2.3 The move into higher education

The climate of midwifery education has changed dramatically over recent years. Until the last couple of decades midwifery was a vocational training where the emphasis was on skills, learnt alongside a theory component that was relatively fixed and unchallenged. When the Midwives' Rules set out the standards for midwifery education in 1993, the word `training' was removed. This change is aimed to suggest the academic and affective, rather than just the vocational, aspects of learning midwifery.

Currently the most basic midwifery course is at Diploma level with many centres offering midwifery degree and post graduate courses. The move into higher education (HE) has brought benefits and difficulties. There has been a vast increase in the number of midwifery texts and journals published and the move has also, arguably, brought about access to better library facilities and

increased resources for staff and students (Symonds and Hunt, 1996, p206). Midwifery is now accepted as an academic discipline within HE although in some cases, according to Silverton (1996) midwifery has been marginalised because of its small size. One potential disadvantage is that centralisation of education into Universities and other HE institutions has meant it can be difficult to maintain mutually beneficial links with clinical areas. Furthermore it has not always been easy to fit the complexites of a clinical profession such as midwifery into the modular system currently in place in many HE institutions; in some cases modularisation has led to a segmentation of knowledge (Eraut, et al., 1995). Other difficulties are that students' day-to-day lives now tend to involve a great deal of travelling; and student groups may be less cohesive as they are no longer all based together in one area for their clinical experience. Another important change is that the long course student is no longer a paid employee but dependent upon a bursary. The most common source of stress among student midwives was found in a study by Cavanagh and Snape (1997) to be due to worrying about obtaining a job upon qualification. Students were ‘disenchanted with the profession because of their perception of poor practice, long hours, poor job prospects and low wages’. The researchers also found the everyday experiences of the educational setting, such as cancelled classes and poor resources, to be a source of stress.

The entry requirements for midwifery are five subjects at GCSE, which must include English and a science subject (Midwives' Rules and Code of Practice, UKCC, 1998b). There are other courses approved as appropriate qualifications, such as Access courses, BTEC and National Vocational Qualifications. As regards non-academic skills and attitudes, there is great variation between midwifery educational establishments and between individual midwife teachers as to what constitutes the desired qualities of the potential midwife (Phillips, 1996). There is a lack of consensus as to what

selection criteria should be used in order to try to ensure that the resulting midwife is `fit for purpose' (ENB, 1996).

2.4 The theory/practice gap

The `theory/practice gap' has been the subject of controversy in nursing since the days of Florence Nightingale (Baly, 1980). It has been considered to be `an embarrassing sign of failure' within education and practice (Rafferty et al., 1996). Allmark (1995) outlines three approaches taken by those writers who consider the `gap' to denote a problem. The first is that practice does not live up to theory. The idealised vision of nursing as discussed in the classroom is compared with the practitioner's reality, which is `getting through the work' (Melia, 1987). This conceptualisation leads to questions such as how nurses can be encouraged to be more research minded, and how to reduce ritualistic practice in the clinical area. The second is that the gap denotes a relational problem between the college and the clinical areas so that the perceived solution in this case is the breaking down of these barriers. The third version is that theory is irrelevant to practice, and this is linked to criticisms about, for example, the irrelevance of nursing models. The question that arises from this position is how theory can be made more relevant.

As Rafferty and colleagues (1996) argue, persistence of the gap indicates that it may well be inevitable, and indeed necessary in order for learning to occur. Nursing is not unique, they point out, in being affected by this phenomenon, as medicine, teaching, social work and other disciplines have also had to address the challenge of theorizing their practice. From this perspective, theory and practice are seen as existing in dynamic tension. Theory and practice are not, after all synonymous (Allmark, 1995) and denote different types of `knowing'. Patricia Benner's work (1984), which has been highly influential within nursing, explores the difference between practical and theoretical knowledge. It focuses

on the clinical practitioner, moving the emphasis away from formalisms such as nursing models (Cash, 1995). Sandelands (1991) suggests that practice is characterised by a type of knowledge he calls `understanding', while the type of knowledge underlying theory may be seen as `explanation'. Explanation can be given, while understanding develops, and knowing theory is no guarantee of good practice, so that in practice it is understanding that is paramount. Polanyi's (1958) example of the difference between knowing the theory of bike riding and actually being able to do it illustrates this concept well. However Kolb (1984, p107) quotes Kant: `Thoughts without content are empty, intuitions without concepts are blind'; and he argues that the relationship between theory and practice, or as he terms it, knowledge and comprehension, is a dialectical one, in that they are opposite processes which merge towards a new truth that encompasses and transcends both of them.

2.5 Theory and practice in midwifery

Rosemary Mander (1994) examined the contribution of experience to learning in relation to data she collected during a qualitative study of relinquishing mothers (i.e. bereaved mothers and mothers who were giving their babies up for adoption). She found that experience played a crucial role in midwives' learning. Particularly significant was occupational experience; while personal experience of grief and of childbearing was also involved, although to a lesser extent. She argues that the value of `experience' in learning has been viewed in a somewhat limited way in professional education, and also that the midwives failed to recognise their non-experiential learning as also relevant to their care of the women. She uses Kolb's concept of the experiential learning cycle to illustrate how the term `experience' permits the inclusion of an infinite range of activities, which must include both the practical, clinical aspects and the more theoretical ones, as well as reflective events. There are, she

suggests, two possible reasons for the midwives' attitudes. Either they failed to recognise their non-experiential learning as such because it was limited to only one domain, such as the psychomotor or the cognitive, or else their attitudes resulted from a kind of anti-intellectualism which is sometimes found among those who have achieved a certain level of recognition in their field having received little formal education. Mander concludes:

> The limitation of experience to the work environment, or the exclusion of any aspect or area of experience [from theory] is a disservice to both the learning itself and to those for whom care is being provided (p17).

Thus Mander, like other writers discussed above, concludes that both elements, explanation and understanding, are necessary for practice, and exist in a dynamic tension.

All midwifery curricula emphasise birth as a natural process and the role of the midwife as a reflective practitioner equipped to provide total woman-centred care on her own responsibility (Kent, et al., 1994a; Fraser et al., 1997). There is widespread agreement that in order to be successful, midwifery training depends upon the integration of clinical experience and theoretical knowledge (Robinson, 1996). The theory-practice gap has not been as extensively discussed in midwifery as it has in nursing, but the discrepancy between the role of the midwife as promoted in the classroom and her actual role in clinical practice has been highlighted by several studies of midwifery education (e.g. Davies, 1988; Chamberlain, 1992; McCrea et al, 1994; Kent et al., 1994a; 1994b; Fraser et al., 1997). The difference between `the ideal' and `the reality' has also been referred to in various personal accounts by student midwives discussing their experiences of training (e.g. Hindley, 1991; Walcott, 1996). It also emerged as a key theme in discussions with non-nurse trained pre-registration students (Kent et al., 1994b). Mander's (1983) study of student midwife wastage in training found that those who left were more likely than

those who stayed to perceive birth as a natural, home-based event and that their expectations did not match with the reality of midwifery practice. Kent et al. (1994a) also interviewed students who abandoned their training and found that the `theory practice divide' was cited by some students as a reason for leaving. `Unrealised or unrealistic' expectations were cited as contributing factors for leaving, particularly for the mature student and those with dependent children, although the quantitative data revealed no statistically significant relationship (Kent et al., 1994a, p77).

2.6 Professional socialisation

Professional socialisation has been defined (Cohen, 1981) as

> the complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession. It involves the internalisation of the values and norms of the group into the person's own behaviour and self-conception (p14).

The earliest studies of professional socialisation examined the experiences of medical students. Two classic studies have become reference points in the literature. First is Merton's *The Student-Physician* (Merton et al., 1957) undertaken by members of a sociology research group at Columbia University. The second, *Boys in White,* was carried out at the University of Chicago (Becker et al., 1961). They derive from fundamentally different sociological perspectives, namely functionalism and interactionism. As their titles indicate, the two studies portray student life in very different terms. Merton's study describes the student as a fledgling professional, and focuses on the medical school as the institution which inculcates professional values. This approach is summed up by Oleson and Whitaker (1968) (also cited in Melia, 1987) as follows:

> Once the education system has formally started work on the student, his empty head is filled with values, behaviours and viewpoints of the profession, the knowledge being perfect and complete by the time of graduation. To achieve

this state of grace, the student has moved ever away from the unholy posture of layman, upward to the sanctified status of the professional, being divested of worldly care and attributes along the way. The result: "the true professional", "the finished product", "the outcome of the system." (p5)

The interactionist approach, by contrast, focused on the behaviour of the students as they `learned the ropes'. Becker and colleagues concentrated on the student as an active agent in the process of surviving medical school, uniting with other students to form a student ‘sub-culture' which gave him support in a threatening environment. Paul Atkinson (1981) criticised both approaches for neglecting a crucial area; that of students' firsthand experience of patients or as he calls it, `bedside work'.

With regard to the professional socialisation of student nurses, Simpson (1979) like Atkinson, argued that the division between the two fundamentally opposed views of socialisation has inhibited research into the subject. Simpson's longitudinal study of student nurses emphasises the multidimensionality of the concept of socialisation and argues that a dynamic and processual view should be adopted. From this perspective, significant questions are:

why and how students incorporate[d] into their behaviour some of the things they learned, and rejected others, so that only a portion of their learnings persisted as enduring patterns.

Melia's (1987) study, although locating itself within the interactionist tradition, addressed these questions. She found that student nurses, despite the fact that they perceived themselves as professionals, were in fact more often treated as a pair of hands on the wards, just `getting through the work’ (pp30-52). Like Becker and his colleagues, Melia found that the experience of being a student had its own distinct characteristics, related to `learning the ropes’. Eraut and colleagues pointed out that it is a psychological priority for students

that they are accepted in the service setting 'as legitimate, and at least partially competent, professionals' (Eraut et al., 1995, p99), and that such acceptance often depends on the student being useful rather than inquisitive.

2.7 Mentorship in midwifery

The concept of 'the mentor' is widely accepted throughout midwifery and nursing. The word first appeared in curriculum preparation documents produced by the ENB in 1988. The ENB insists that provision is made for mentorship of students, and it is a requirement of validation that criteria relating to mentors are met (for example, adequate preparation of mentors, staffing ratios and so on). The ENB regulations for the approval of courses state that a mentor is:

> an individual who has an understanding of the context of the student's learning experience and is selected by the student for the purposes of providing guidance and support (ENB,1996:6.5).

The idea of mentoring and later on, of preceptorship, was taken up by nurses and midwives in the UK following dissemination of North American research into the benefits of mentorship during nurse training. Mentorship was originally adopted from the business world; two writers in the Harvard Business Review (Collins and Scott, cited in Burnard, 1988) wrote an article entitled `Everyone who makes it has a mentor', maintaining that all the most successful people in the business world had had a mentor to guide their progress.

The arguments for adopting the approach were linked with a move towards a more 'process-oriented' and student-centred approach to learning. Studies of nurse training (e.g. Melia, 1987) had been critical of the way that students were being `thrown in at the deep end'. Another concern was that students' learning had been `task oriented' rather than `people oriented' (Smith, 1992). The

institution of a system of mentorship was one way of addressing these difficulties; as Morton-Cooper and Palmer (1993) explain:

> What lies at the heart of the process is the shared, encouraging and supportive elements that are based on mutual attraction and common values [...] A mentoring relationship is one that is both enabling and cultivating; a relationship that assists in empowering an individual within the working environment (p59).

Research into the operation of the mentoring process within midwifery and nursing has identified several difficulties with the process itself. Although the concept is widespread in midwifery and nursing there is little empirical evidence for its efficacy (Shamian and Inhaber, 1985; Foy and Waltho, 1989). There is also considerable confusion over the meaning and objectives of mentorship (Leonard and Jowett, 1990; Kent et al., 1994a; 1994b; Maggs 1994). Julie Kent and colleagues (1994a, 1994b) identified problems with mentorship as a main theme in their evaluation of pre-registration midwifery programmes. Problems highlighted included lack of understanding about the process of assessment; students feeling that mentors had no overview of the course; mentors struggling with heavy workloads and staff shortages.

Until recently mentors have been identified and assigned to student midwives in consultation with midwifery managers (Maggs, 1994). Most mentors have little or no choice as to whether they are appointed mentors (Walker, 1991) although for most it is included in contractual obligations, so the midwives are aware that there is a teaching element in their role. This lack of choice on both sides was a potential problem. Levinson et al (1978) in their classic work on mentoring, based on a study of 40 men in a variety of paid employment suggested that mentoring is best seen as a form of love relationship. Caldwell and Carter (1993, p15) make an analogy between the mentoring partnership and marriage, saying that just as formally arranged marriages may succeed, so

can formally arranged mentor-protege relationships, although they do concede that there is likely to be a higher success rate when there is some element of choice! Walker (1991) suggested as a result of her study of community midwife mentors that a more co-operative contract would increase motivation and creativity; recently ENB guidelines have been altered so that students are now encouraged to select their own mentors. Morton-Cooper and Palmer (1993, p62) describe a relationship based on trust where the `mentoree' moves gradually from dependence to autonomy:

> Testing, taking risks, making mistakes and the freedom to be creative takes place within the mutual understanding that the mentoree is valued and supported [...] The mentoree becomes gradually more self aware, gains in confidence and begins to develop the capacity to `go it alone'.

For this kind of mentoring relationship to develop, there needs to be a degree of continuity as the mentoree is guided through the phase of transition. One of the problems with mentoring in nursing and midwifery is that the placements are short, with students moving frequently from area to area. Such discontinuity is not conducive to the development of trust outlined above.

Davies and Atkinson (1991) discuss the transition from trained nurse to midwifery student. Drawing on data from an ethnographic study by Davies (1988) of student midwives who were nurses before starting midwifery training, they argue that the change in role is threatening to students' self identity. Dingwall (1977) in his study of health visitor training came to a similar conclusion. Davies and Atkinson argue that in response to the stress of suddenly becoming a novice after having been an experienced nurse, students revert to ritualistic behaviour in order to cope: "they may turn to tried and tested routines of nursing in `doing the obs'. [Using] their established recipes of knowledge and action [students] sought refuge in a restricted set of tasks and definitions of clinical work" (Davies and Atkinson, 1991, p120). They talk of this

as a `reversion to nurse behaviour' (p122), and argue that through the bringing of `inappropriate nurse behaviour' into midwifery there is a danger that British midwifery is in danger of losing its `independent practitioner status [that is] so proudly proclaimed throughout the world' (Davies and Atkinson, 1991, p122). The study by Davies (1988) is significant because it is one of only a handful of studies which attempt to explore the experience of midwifery training from the student's perspective. The finding that students may revert to ritualistic behaviour in order to cope has important implications for midwifery educationalists. It is however important to differentiate ritualistic coping behaviour from 'nurse' behaviour: the two are not necessarily synonymous. Isobel Menzies Lyth, a psychoanalyst, identified ritual task performance amongst student nurses as an attempt to eliminate the anxiety attendant upon decision making. She argued that this ritualistic behavior becomes part of a 'social defence system' (Menzies Lyth, 1988):

> A social defence system develops over time as the result of collusive interaction and agreement, often unconscious, between members of the organisation as to what form it shall take. The socially structured defence mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms (p51).

Such anxiety reducing behaviour may be more to do with the effects of the institution than with whether one is a trained nurse or not. Direct entrant students, although their change in role will not be from trained nurse to inexperienced student, will be making another, probably equally stressful transition as they adapt to working within the institution. It would be interesting to replicate this fascinating study with non-nurse trained student midwives to explore the differences in coping strategies adopted.

This issue is important, because underlying the debate about the future of midwifery education has been the assumption (see also p37) that non-nurses will be in a better position to challenge the medical model than recruits who

have already been socialised into nursing. Although this may well be true in some cases, this position focuses too closely upon the qualities of the individual recruit and not enough on the context within which the student is learning. One non nurse student wrote:

> Much as we have not been socialised into the nursing hierarchy it is amazing how, as impressionable students, we have been ready to conform to the rigour of top-down disciplining and it makes me wonder how we will develop the self-confidence and assertiveness to become independent, responsible and accountable practitioners in our own right (Hindley, 1991).

Indeed one small study, conducted in a hospital (Carlisle et al., 1994) which compared stress between nurses and midwives found that the midwives perceived themselves as having less autonomy and less clarity of role than did the nurses questioned.

2.8 Conclusion

Midwifery education is undergoing fundamental change. From a situation where most student midwives were already trained nurses, the position is about to be reversed so that the pre-registration (long) course will become the most common route into midwifery. Many educationalists have worked towards this, and deserve recognition for their efforts. There are currently many exciting developments taking place in midwifery education. At the same time, it is important to remember that underlying many of the recent changes is the question of economics; the non-nurse route into midwifery is the cheapest option. These new midwives, even though they have entered midwifery by a different route, will nevertheless be subject to similar pressures and tensions: they will still, for example, experience conflict between professionalism and bureaucracy, and find that the day to day reality of midwifery practice is far from the ideal to which they aspire. The material conditions in which these students find themselves, I suggest, will play a more decisive role in the future

of midwifery than the question of whether or not the novice midwife has been previously socialised as a nurse. The following chapter examines the concept of risk, because it is a defining feature of today's NHS and therefore central to any exploration of the experiences of midwives and student midwives.

CHAPTER THREE

MIDWIFERY AND RISK

3.1 Introduction

The study of midwifery and of professional socialisation into midwifery leads into a consideration of the nature of the tensions that are an inevitable part of the work of the midwife today. Student midwives, at the same time as undergoing a `status passage' themselves, are in the process of learning to care for women who are undergoing the major life crisis of giving birth and becoming mothers. For the novice student midwife, whether her background be in nursing or elsewhere, coming into midwifery and undertaking midwifery training is a challenging experience (Davies, 1996; Phillips, 1994).

The transition from lay person to professional or from trained nurse to midwife is likely to present a challenge to students' self esteem and sense of self identity (Davis, 1975; Dingwall, 1977; Davies, 1988, 1996; Bradby, 1990a; 1990b; Chamberlain, 1992). The student starting her midwifery training enters an institution which is bureaucratic, elitist, male-dominated and in which she occupies the lowly position of 'junior student'[5] so she is divested of her previous identity and status. For the nurse trained student midwife, she is about to go from competent practitioner to novice, while for the non-nurse student, the knowledge and competence that she has already acquired from other life experiences may not be given due recognition. For those who have previously been nurses, this change in status from `responsible nurse' to `subservient student' causes `student anxiety' (Davies and Atkinson, 1991)

[5] This term, although no longer used, to my knowledge, in midwifery curricula, is still often used by tutors, midwives and students themselves as a way of differentiating between those students early in their training and those further on; but it has a peculiar ring when it is applied for example to a mature woman with considerable life experience and, maybe, children of her own.

while those who have not been nurses may have similar problems in adjusting to the new culture (see Hindley, 1991, personal account).

At the same time student midwives are learning to deal with the intensely powerful and culturally symbolic experience of birth. A fundamental tension for midwives is that birth is usually normal, but occasionally a tragedy happens and a mother or baby dies or suffers some severe trauma. The midwife is poised to watch for any sign of this happening; the risk of death is present in the consciousness of both mother and midwife. Therefore attitudes to death have an important bearing on midwifery practice. The culture in the NHS and in wider society is one which continually emphasises and attempts to assess and manage risk. These two elements - the nature of caring work (especially midwifery with its particular life and death issues) and the present culture in the NHS come together to create specific challenges for student midwives as well as more experienced midwives. This chapter explores how midwives and doctors perceive risk in relation to childbirth: initially attitudes to death are examined, and the ways in which the midwife's relationship with the reality and the threat of death may have changed since the beginning of the century. The chapter concludes with a discussion of the culture of risk in midwifery and in the NHS today.

3.2 The meaning of risk

The process of birth in a modern industrialised society is probably physically safer today than ever before (Enkin, 1994). In the UK 7.2 babies per thousand die at birth (this includes pre-term babies and those with congenital abnormalities) and fewer than one in ten thousand women. Modern obstetrics is, however, dominated by the concept of risk; risk assessment and risk management are common buzz-words in the NHS today. In order to explore the concept of risk in midwifery, it is first necessary to define the meaning of

the word ‘risk'. Carter (1995, p136) says that risk ‘points simultaneously to the presence of and possibility of danger'. Mary Douglas, who has written extensively on the concept of risk, has argued that risk is a social construction, in that ‘groups of people (identify) different types of risk as a result of their particular form of social organisation and the nature of their interaction in the wider political structure' (Gabe, 1995, p6). Ulrich Beck (1992) has also highlighted the political aspects of risk. He challenges the assumption that scientists have a monopoly on rationality in relation to risk assessment, arguing that `at the centre of their work they continue to be reliant on social and thus prescribed expectations and values' (p29).

The analysis of perceptions of risk is important here for a number of reasons. Firstly, the actual risks related to childbirth have changed dramatically over the last few years. Secondly if we accept that people's perceptions of risk are socially conditioned it may be that there are differences between the scientific-rational view of risk as espoused by much of the medical profession, and the perceptions of midwives. There may also be differences between the perceptions of midwives and of the women for whom they are caring (see Annandale, 1988). Childbirth still presents dangers, even though the risk of death for mother or baby is much lower in industrialised countries than it used to be. The most pressing concern that now needs to be addressed is, according to Douglas (1994), the way in which real dangers are being used 'to give automatic self validating legitimacy to established law and order' (p29). Translated into a midwifery context it can be seen that the real dangers associated with birth are used to reinforce the medical model. This is perhaps made easier by women’s vulnerability at the time of birth. The medical model continues to dominate modern childbirth despite the increasing weight of scientific evidence that it confers its own risks and cannot necessarily protect women from danger. For example, the presenter of *Woman's Hour,* Jenni

Murray, was told by a consultant obstetrician: `You want natural childbirth. Well, if this baby dies, or you die, on your own head be it' (Murray, 1996). Although these words were spoken in 1983, I would argue that it is still commonplace for some doctors and midwives to hold the spectre of possible death over women who choose something other than the accepted medical model of care. It is a threat that has been used as a weapon in the battle to control women's choices regarding their maternity care (Beech, 1996). An exploration of attitudes towards death will therefore provide some insight into current birth practices.

3.3 The medicalisation of death

There is now a considerable body of literature examining attitudes to death, past and present. Geoffrey Gorer (1965, pp192 - 199) argued that the subject of death had become a taboo in modern society. (The word `taboo' according to Cline, 1995, comes from Polynesia and means `areas of social life marked off simultaneously as sacred and forbidden') (p1). Gorer contrasted this modern treatment of death as taboo with past societies where, he believed, communal ritual allowed people to make some sense of death and dying. He claimed that if problematic experiences such as bereavement are not handled ritually, psychological difficulty for the individual will ensue. Traditional rituals surrounding death generally included the idea of renewal and regeneration (van Gennep, 1960). Ariès (1981) in his history of Western attitudes to death took a similar position to that taken by Gorer, suggesting that the dominant attitude in society now towards death is one of fear and shame. Death, according to Ariès, has become a medical matter, and medical ideology constructs death as the enemy and as a sign of failure.

Ariès conception of the medicalisation of death has much in common with the work of Ivan Illich (1975), who wrote: `Suffering, healing and dying [...]are

treated as malfunctions from which populations ought to be institutionally relieved' (p138). The medicalisation of death, according to Ariès, has involved firstly the use of `clean talk' about illness in terms of cure, which is opposed to the disgust at the `dirtiness' of death; secondly, the relocation of dying people into hospital away from public view; thirdly the regulation and organisation of death by doctors who see it as failure (Cline, 1995, p28-29). Death remains a hidden subject in the sense that it is 'sequestrated from public space' (Mellor, 1993, p11), and that this takes place because the experience of death in contemporary society has become a privatised, individualised one. Death has been 'routinely removed from view' (Giddens,1990, p161). Norbert Elias (1985) described this in powerful terms:

> (in the past) the sight of decaying human beings was commonplace... Today things are different. Never before in the history of humanity have the dying been removed so hygienically behind the scenes of social life...(p85).

The parallels with birth are clear. There is a paradox, however, within the idea of the sequestration of death and birth in that behind the hygienic screens in the hospital there is a lack of personal privacy. This lack of privacy in relation to modern childbirth has been commented on by Flint (1984) and others. In a personal account of her mother's death a similar lack of privacy is highlighted by Trench (1996) who comments:

> Her death at a weekend in a general ward of a NHS hospital was casual, random - and public. (...) The ward was full of children, running about and stopping to stare at us. A nurse drew the curtains around the bed. Then another nurse arrived, and without a word or glance at me, turned off both the machines.

Trench's account illustrates the isolation that is felt when one is suffering alone and unsupported in a public, unfamiliar place and there is a sense that the nurses have lost touch with their humanity - the second nurse relates only to the machines and not to the woman. This experience leads Trench to wonder whether nurses are trained to deal with death, because the nurses she

encountered appeared to be so scared of it. There have over recent years been concerted attempts to change attitudes to death; for example the seminal work of Kubler-Ross (1975) in the United States and the British Hospice Movement founded by Cicely Saunders. These small groups of health professionals have tried since the 1960s and 1970s to effect change within medical and nursing education and practice in order to break down the taboo surrounding death and reduce the isolation of the dying. Cline (1996) lists other movements which she says have profoundly affected approaches to death and bereavement: the Green Movement, the Women's Movement and the USA-based Death Awareness Movement. The latter group she says made a real challenge to the denial of death, by instigating courses for health professionals, and facilitating humane programmes of care for the dying.

Research by medical sociologists, most notably David Field (1984, 1986) and Field and Howells (1985) indicates that doctors and nurses find dealing with the death of patients very difficult. Doctors, `the high priests of modern society' (Kelleher et al, 1995, pxiii) find themselves helpless in the face of death. The expert knowledge and special skills of the professional cannot reverse it. Studies of the socialisation of nursing students (e.g. Smith, 1992) and of nursing work (Lawler, 1991; Page and Meerabeau, 1996) also suggest that death and dying are particularly stressful aspects of the nurse's work. Nurses' anxiety in the face of death has been interpreted as strongly related to the ‘unknowness' of death and the implications for their own mortality (Hurtig and Stewin, 1990; Kiger, 1994).

Frederic Hafferty, in a study of medical students, says:

> it is in situations involving death and dying that uncertainties, mistakes and failures are highlighted and norms of emotional management and professional decorum are most forcefully challenged (1991, p9).

3.4 Midwives and death

Finch and Wallis (1993) in a study of wills and inheritance found that the people they interviewed demonstrated a strong sense of the normal order of events and of ‘a right time to die.’ Premature deaths, then, such as the death of a baby, or of a woman of childbearing age, may be particularly difficult to deal with. The death of a child before its parents constitutes a sharp threat to this sense of the natural order, and people involved, including the health professionals, are likely to be psychologically unprepared and isolated in their grief (Walter, 1995).

Throughout history, even the most straightforward labour has carried with it the intimation of death. It is, even today, part of the midwife's 'raison d'etre' that she is on guard during a birth; guarding the normal process and at the same time alert to any possibility of danger for mother or baby. Leap and Hunter (1993) in their oral history of midwifery interviewed a ninety-five year old woman (Mrs. G) who had been a handywoman in Bexleyheath for fifty years. In one interview Mrs. G refers to her role as layer out of the dead:

> If they were dead, I laid them out. ‘Course I did. The dead can’t hurt you, I’ve laid out hundreds. I’d get called out all times of the night or day. It was either to get one in or take one out (‘*Get one in’ meaning help at a birth*) (p29).

Mrs. G’s interviews show a kind of jokey familiarity with death and dying:

> It’s nothing to be frightened of. People say ‘ooh it must be difficult’ but it’s not. It’s easy. They used to say ‘How do you wash them?’ and I would say ‘With soap and water, mate’(Leap and Hunter, 1993, p29-30)

Flora Thompson's midwife/handywoman in *Larkrise to Candleford* was described as 'seeing the beginning and end of everybody'. With the 1902 Act and the growth of a salaried profession the traditional connection between birth and death was severed (Cline, 1995, p76). The certified midwife no longer included laying out the dead among her customary duties.

It is hard to estimate how often midwives/handywomen would have had to deal with maternity-related deaths. Although maternal and neonatal death rates were high at the beginning of this century with 3,000 or more women a year dying in England and Wales as a result of pregnancy or complications (Leap and Hunter, 1993), maternal mortality was higher in hospitals than for births conducted at home, and midwives, despite having a higher risk clientele of poor and working class women, had a better safety record than doctors delivering women in hospitals (Arney, 1982). As regards stillbirth, it was still an unusual occurrence. In the day to day work of the midwife, most births were conducted safely (Allison, 1996). The death of a child, and the early deaths of adults were, however, an ever-present reality for most families, at least until the 1920s and 1930s, as the collection of letters published in 1915 by the Women's Co-operative Guild testifies (Davies, 1978).

Esther S., a midwife interviewed in Leap and Hunter's study, recalled only one maternal death in the district and that was when a woman died following a hospital birth. As for stillbirth, she says:

> Of course we got stillborns, but only very rarely fresh stillborns, mine all died from abnormalities (Leap and Hunter 1993, p147).

Mrs. G, the handywoman who had been practising in the early 1900s had seen maternal deaths:

> Of course I've seen some die...sometimes the woman died of exhaustion, you see because they're frightened.. They're frightened to bear down in case it splits something, you can understand it really, but I don't think so many dies in childbirth as what they makes out (p146).

This comment illustrates a lay perspective, one that links the physical and the psychological; the woman may die from both exhaustion and fright, something that this handywoman `understands'. She understands the profound influence that psychology may have on the process of giving birth. However, she doesn't feel that 'so many dies ... as what they makes out'; 'they' are presumably the

medical experts. The professionalisation of midwifery, and increasing medicalisation are important in changing perceptions of risk in relation to childbirth.

Esther S. also experienced the stillbirth of her own first baby:

> Of course I was devastated. I was very shocked about it all (...)
> But I do think with an experience like that, you're better off at home. You haven't got to come back into your home and enter it. You're with people you know. Nowadays of course, they know much more about how to help people through it with the aftercare and counselling. But it's a very traumatic thing (Leap and Hunter, 1993, p147).

The words of this midwife give us an insight into the medicalisation of death. She talks about being better off at home, because 'you're with people you know'. The hospital is an institution where people come and tend to you, but you are not 'with' them. And you are certainly not with people you know, with people who are really sharing the experience, for whom this loss is significant in a similar way. Interestingly, she juxtaposes being at home with 'people you know' against 'they', the experts 'who know much more about how to help' but there is a suggestion that theoretical knowledge cannot compensate for being in unfamiliar surroundings. Death, like birth, has been removed to the sphere of the 'experts', i.e. the hospital. Sally Cline (1995) a feminist writing about women and death says:

> Courses are offered in how to accept the unacceptable that is death. They are timid answers, an attempt to domesticate passion (for grief is passionate), to tame the violence of grief [...] We cannot manage the unmanageable (p75).

Although Cline's argument is a persuasive one, it should also be noted that counselling and support have been shown to be helpful in enabling people to deal with loss if provided in an appropriate manner. Indeed, in the past, ritual practices surrounding death have been aimed, whether consciously or not, to help people cope with death (Gorer, 1965) therefore they are in some senses, attempts to make the experience more manageable.

Today, in hospital, although practices are geared towards abnormality and birth as pathology, the outcome must be the perfect, healthy baby. As one contemporary doctor states:

> It was what we were all trained to always go after - the perfect baby, that's what we were trained to produce (Davis-Floyd, 1992, p227 also cited in Lane, 1995, p65).

One former handywoman stated her understanding of her job at a birth in different terms:

> to make sure that the mother doesn't bleed to death - and that the baby doesn't die you see (Little, 1983, p50)

Put very baldly, these are the clinical tasks of the midwife. But few midwives today would, I believe, make similar statements. For many the dread of 'something going wrong' constantly dwells at the back of the mind, exacerbated by the way in which birth and death are managed in hospitals today.

Cline (1996), a feminist writing about women and death, maintains that:

> for females, both life and death are intimately associated with females' psyches, expectations and their bodies, with the implication that both life and death are something that can be comprehended and delineated as something `inside' them (p200).

She quotes Josephine Speyer, the founder of a `Natural Death Centre':

> Those who have given birth always feel that death is a part of them. Even women who aren't mothers feel death is something inside like the possibility of birth. Those women who have had a natural birth are more likely to feel death is part of a way of life. Everything that applies to childbirth applies to dying. That's why I feel that women have an easier attitude towards death (p332).

It is possible that women through the process of becoming pregnant have a sense `from the inside' of the ever-present possibility of death' as Cline suggests. As one of the women in her study says:

> Once I was pregnant I felt I was introduced to a form of death that men do not experience: it was a fear that my child would die (p165).

Although I am sure most fathers would deny that they are not touched by the same profound fear, the concept of a kind of bodily understanding of death ‘from the inside’ is an interesting one. If there is some sense in which this is so, and it would be a fruitful area for research, the denial of death in modern hospitals also has implications for midwives, as women. It may lead to a psychological repression of this immanent awareness of the possibility of death. Awareness of the possibility of death may be an integral aspect of the labour experience for many women (see Odent, 1991). The awareness of death, as we have seen, also affects carers on a professional level as the possibility of professional `failure'. The possibility of death then becomes all the more difficult to voice; being denied on a psychological and on a professional level; it becomes linked with 'dread'. Giddens, following Kierkegaard, defines dread as:

> the prospect of being overwhelmed by anxieties that reach to the very roots of our coherent sense of 'being-in-the-world' (Giddens, 1991, p137)

3.5 Childbirth and risk

The definition of risk is central to the medical model of childbirth. The medical model assumes that the body is always ready to fail, even in ostensibly low-risk cases (Lane, 1995). Birth is a risky business, this position implies, and therefore women must put themselves in the hands of obstetricians. The tacit bargain is that, if the woman is passive, attends antenatal care, and does what she is supposed to do, the obstetrician will make sure that all turns out well. Unfortunately, nobody can promise this to a woman. As Wendy Savage, an obstetrician well-known for her unorthodox views in obstetrics, said:

'If doctors play God, they shouldn't complain when they are blamed for natural disasters' (Savage, 1986).

Doctors' training takes place in hospitals and their experience of normal labour and birth is usually limited to a small number of cases in the hospital (Savage, 1992). After that, their experience of birth is usually only to be called in to a labour once complications have developed. Then the doctor has to make decisions about the care of someone s/he has never met before, in a stressful, sometimes life or death, situation. It is hardly surprising, therefore, if 'doctors have lost faith in women's ability to give birth naturally' (Savage, 1992). Discussing the attitudes of prospective general practitioners to the care of labouring women, Savage (1992) said that they saw intrapartum care as dangerous and the prevailing attitude was one of anxiety.

The medical view of risk in childbirth may be radically different from the views of women themselves. These differing constructs of risk are illustrated in a study by anthropologists Kaufert and O'Neill (1993). Their study population was a group of Inuit women living on the West coast of Hudson Bay. In the early 1980s there had been a change in official policy which stipulated that all births should occur in hospital. So instead of delivering at the local nursing station, women were sent to a hospital some distance away and two or three weeks before their expected date of delivery. Kaufert and O'Neill analysed a conversation between a woman and a physician and concluded:

> The woman's definition of risk is community based and acquired through experience. She sees the death rates quoted by the physician as theoretical constructs, lacking local validity. The physician dismisses her claims as irrelevant for a definition of risk which is objective, scientific, expressible in numbers. Yet it is the physician who moves the discussion into the emotional sub-culture of the debate....For the woman, risk is the occasional threat in childbirth, accepted as part of a natural process. For him, risk in childbirth is a constant and frightening element in his clinical life (Kaufert and O'Neill, 1993, p51).

Interesting in this account is that, despite all his apparent objectivity and use of statistics, it is his fear, and his view of childbirth as a dangerous event that is the motivating force underlying the arguments of the physician. This study supports the approach taken by Douglas (1994), who argues that risk analysts typically consider the lay person to be weak on probabilistic thinking, whereas in fact the lay person is thinking probabilistically but taking different factors into consideration. She suggests that when assessing risk we should take into consideration the moral and political factors involved rather than merely the technical aspects.

Medicine is not a static phenomenon. It has undergone radical transformations throughout history (Kelleher et al, 1995, Porter, 1996). 'Hospital medicine' is the dominant form of medicine in the modern world, but according to Armstrong (1995) the 20th century has also seen the growth of another model, that of 'surveillance medicine':

> The distinctive feature of surveillance medicine is that unlike hospital medicine, which concerned itself with the ill patient, it targets everyone: surveillance medicine requires the dissolution of the distinct categories of healthy and ill as it attempts to bring everyone within its network of visibility (p 395).

William Arney (1982) examined the ways in which this emerging model impacted upon obstetrics in the United States. According to Arney, instead of searching out and containing pathology as it had previously attempted to do, around the late forties and early fifties obstetrics began to turn its attention towards developing systems for the monitoring and surveillance of all births. This had consequences for concepts of normality:

> Monitoring and surveillance deals with the problem of residual normalcy by ignoring it. Under this new regime no distinction between normality and abnormality exists (p85).

Until the 1960s and 1970s in this country, which, unlike the States, had a recognised and state regulated midwifery profession, midwifery had a distinct sphere - ‘the normal' - and the midwife could (and did) proclaim herself as the

‘expert in the normal'. Midwifery meant assisting/attending the childbirth process, and reaching successful conclusion without the use of instruments. The definition of abnormality revolved around the need to intervene with instruments. It was a gendered concept as it was based on the idea that the natural work for a woman was the passive one of supporting and caring, while the doctor's role was active and interventionist (Witz, 1992, see Chapter 1). The sphere of the normal as we have seen was in fact a concept engineered by doctors with the aim of protecting their own area of practice so that the midwife did not encroach upon the professional sphere of medicine. The ‘problematisation of the normal' (Armstrong, 1995) thus becomes the problematisation of the role of the midwife.

This ‘problematisation of the normal’ has been evident in the midwifery literature over the past five years, as midwives have been coming to the realisation that the definition of normality is crucial to an understanding of the role of the midwife (see Downe, 1996; Davies, 1996; Fawdry, 1995; RCM, 1997b). Much of the debate has focused on what midwives actually do, and how normality may be defined; but perhaps the real issue is to do with midwives’ control over their own practice and their philosophy of care. Interestingly, the sphere of the normal, and therefore the province of the midwife up until fairly recently in fact included situations such as breech births and twins, and very many such births were dealt with successfully by midwives working in the mothers' homes (Allison, 1996). The Midwives' Rules stated until 1998:

> In any case where there is an emergency or where she detects a deviation from the norm, a practising midwife shall call to her assistance a registered medical practitioner... (Rule 40, UKCC, 1993)

Rule 40 has recently been revised so that the decision to summon assistance does not so much depend upon the vexed question of normality but whether

the midwife judges the situation to be 'outside her current sphere of practice'. Moreover it is recognised that she may call upon a doctor or 'other qualified health professional' with the appropriate skills. This change is an important step forward for midwives' autonomy, reflecting recent debate. It puts the midwife in charge of deciding the limits of her expertise, and of deciding upon the appropriate person to summon for help.

Midwifery theorists comment on the opposing models espoused by midwives and by doctors, and juxtapose the birth-as-normal, birth-as-pathological models. These differing philosophies were clearly outlined in the Winterton report, and presented by Lane (1995). The 'woman-centred' or social model was described as follows:

> Becoming a mother is not an illness. It is not an abnormality. It is a normal process which occurs during the lives of the majority of women and can indeed be seen as a manifestation of health. It is physically very demanding and is a time when women are vulnerable in many ways. They require help and support during the process of being pregnant, giving birth, and postnatally and some of this, though not all, needs professional help. In some circumstances the quality of the professional help is literally vital. But it is the mother who gives birth and it is she who will have the lifelong commitment which motherhood brings. She is the most active participant in the birth process. Her interests are intimately bound up with those of her baby.

The obstetric view was laid out by an obstetrician giving evidence to the Winterton Committee:

> There are low risk and high risk pregnancies, but there is not a no-risk group. Because all are at risk, the delivery suite is an intensive care area and should be staffed as such, both to deal with emergencies and to monitor mother and fetus in labour to prevent serious problems.

Note that the obstetrician says `prevent serious problems', indicating a somewhat optimistic view of the power of obstetrics, which is for the most part concerned with trying to manage problems once they have been detected. The medical model is, however, extremely pervasive: amongst midwives themselves (Comaroff, 1977; Bryar, 1995) and in society in general. Ellen

Annandale showed how even women choosing a natural birth at a birth centre with a philosophy that promoted the concept and practice of birth as normal harboured expectations of birth that were ‘never fully independent of obstetrical notions of risk'. Part of the midwives' work was to manage these concerns and expectations (Annandale, 1988, p99). Annandale calls this a ‘double message' about birth that operates at the cultural level. She suggests that fears that something untoward may happen during labour are fuelled by it. The interaction between the midwifery and the medical models, then, is a complex one.

Midwives themselves are carrying this double message; it remains at the heart of midwifery training and of the system of care within which most midwives work. Most people's expectations of birth are affected by it to some degree. The medical model permeates every aspect of midwifery practice including the relationship between mother and midwife. A move towards understanding risk in childbirth from a cultural perspective, i.e. taking into account and valuing other aspects of birth besides the physical might help to reduce the hegemony of the medical model. We need to explore the meaning of childbirth from different perspectives, and in so doing, we may find that there are aspects of the birth experience that have not yet been voiced. For example recent studies have highlighted the importance of women feeling in control during childbirth (Lundgren and Dahlberg, 1998; Halldorsdottir and Karlsdottir, 1996a). There is evidence that having felt fear and powerlessness during the birth may cause women to have long-term psychological problems. (Menage, 1993; Ballard, 1996). An increasing number of litigation cases hinge upon psychological trauma suffered by women during labour. This may well force consideration of issues other than the purely physical. Even in its own terms, the paramount

importance given to the consideration of the mother and baby's physical safety, the medical model is inadequate, according to research by MacArthur et al (1991) which demonstrates high levels of physical morbidity suffered by women following childbirth in the UK.[6]

3.6 Litigation and blame

The witch-hunt that was traditional at the death of a tribal chief is being modernised. For every premature or clinically unnecessary death, somebody, or something, can be found that irresponsibly delayed or prevented a medical intervention (Illich, 1977).

It is widely believed that medicine, and certain fields in particular, such as obstetrics, is undergoing a 'crisis of litigation'. Litigation rates are cited as having a drastic effect on the number of doctors who wish to enter obstetrics, and of causing doctors to practise defensive obstetrics (e.g. Ranjan, 1993). There is disagreement as to the extent of this crisis (see, for example Dingwall, 1994), and it is hard to assess the true extent as litigation cases take several years to come to light.

What is important for my purpose however is to examine, not the actual levels or rates of litigation, but how the climate of fear regarding litigation affects the midwife and student midwife. Until fairly recently, midwives were for the most part relatively unaffected by worries about litigation. Most midwives (with the exception of the very small number of self-employed midwives) are employed by NHS Trusts and are therefore insured under the vicarious liability of their employer. Doctors, as well as being protected by vicarious liability, have their

[6]This survey highlighted the `scant evidence of any serious attempt to follow up the effects on women of intervention during childbirth (and) found correlations between chronic backache and the use of epidurals; between chronic headache and neckache and general anaesthesia and caesarian section, between tranquillisers given during labour and pain in the legs; (...) and between caesarian section and postnatal depression' (Health Committee 1992:xlix). These were only some of the long term health effects related to modern obstetric practice.

own insurance through the Medical Defence Union. Since the removal of Crown Indemnity in 1990, however, litigation has taken on a higher profile in maternity care. Settlements in cases where medical negligence is found can reach as much as £2 million, and such amounts can severely damage a Trust's finances. The Congenital Disabilities (Civil Liability) Act 1976 established the right of a child to claim compensation if s/he suffers harm as a result of negligent care prior to or during birth. A child may start an action any time up to the 21st birthday; while if a person is deemed of unsound mind within the meaning of the Mental Health Act 1983, and the condition persists, an action may be brought in her/his name at any point during her/his lifetime. This applies to babies born brain damaged, and it is these settlements, when health carers are found to be negligent, that are the most expensive. Cases can drag on for years, and a midwife may be approached for her account of events during a birth in which she was involved many years previously. This is a burden peculiar to those involved in care during childbirth; 'the sense that the future haunts the present' (Annandale, 1996).

At the same time there is a fundamental shift occurring in the social organisation of health care. Dingwall (1988) examines the role of medicine in the Welfare State, and argues that the culture in the NHS was initially one in which the concept of social medicine was dominant. The concept of social medicine was rooted in the bourgeois reformist, or social democratic position that human beings are interdependent; and that it is the duty of the privileged to protect the needy (but without attempting fundamentally to change the existing structures of social relations). Dingwall examines Illich's criticisms of medicalisation, and suggests that:

> the calls for deprofessionalisation ushered in a very different model of human nature and social organisation, where the diffuse bonds of community gave way to the more calculating alliances of autonomous individuals (Dingwall, 1988, p58)

This new model is one where the language of law is employed to stress the values of individualism; and this language, Dingwall says, is the language of modern society. Rather than the traditional ties of mutual obligation and sentiment, the incentives to behave well in modern society are the legal sanctions attendant upon a wrong decision. The risk management approach focuses on the consequential penalties for getting things wrong. This is the climate in today's NHS.

3.7 Conclusion

Elias (1985) in his perceptive and moving discussion of death in the modern world, wrote:

> At present medical knowledge is often equated solely with biological knowledge. But it is possible to conceive that, in the future, knowledge of the human person, of people's relation to each other (...) will likewise, be part of medical knowledge.

This, too, is the aim of the midwifery model of care. Unfortunately, Elias' hopes seem a long way from realisation. Far from enabling those working within it to begin to explore the relations of humans to each other, and to understand the importance of trust and security in order for humans to be able to achieve their potential, the present culture in the NHS seems bound to isolate the individuals who make up its workforce. In this atmosphere, how are we to equip student midwives to approach their task with confidence? Ellis, writing in the British Medical Journal in 1986, and quoted by Savage (1986) commented about being involved with birth:

> The awareness of the paper-thin divide between life and death can be life-enhancing or can shake your confidence completely.

Anthony Giddens, in a discussion of self and self identity in modern society (Giddens, 1991) observes that individuals, to be able to function in everyday

life, need a sense of `ontological security' (p36). Ontological security is a sense that life is meaningful and has purpose; it is a sense of basic trust which is essential in the building up of an 'emotional cocoon' allowing individuals to get on with day-to-day life. There is evidence (Annandale, 1996; Dingwall, 1994) that for many nurses and midwives in the NHS today it is becoming increasingly difficult to maintain the sense of trust and security which is necessary for optimal human functioning. This research study examines the ways in which the experience of training to be a midwife may present a threat to the student's sense of 'ontological security' and thus make it an arduous journey for the student to become the kind of midwife - competent, caring and flexible - who is needed to safeguard the birth experience for women in the future.

CHAPTER FOUR

RESEARCH DESIGN AND METHODOLOGY

4.1 Research design

In this section I aim to provide a `decision trail' of the research (Lincoln and Guba 1985, 1989). Lincoln and Guba advise qualitative researchers to give an account of the research which ensures that the methods and logic of the research are explicit and therefore open to scrutiny. In this way the reader can determine for her/himself whether the interpretations and conclusions of the enquiry are credible ones in the context of the data obtained.

As I explain in the preface, my study had a curious provenance in that its initial purpose was to explore student midwives' anxieties concerning perinatal death, and their experiences as they encountered it during their training, with the ultimate aim of isolating factors which could lead to improved educational preparation. It was intended to form part of a larger study comparing the attitudes towards death of those nurses who had undertaken traditional nurse training with those who had been prepared via the new nurse training, Project 2000. In my section of the research I opted for a comparative element too,

planning to compare the attitudes and experiences of a group of student midwives who had previously trained as nurses with a group who had not had any nurse training, because (as discussed in Chapter Two) there has been much speculation about the differences between midwives prepared by these two routes but as yet little research. The initial research questions were decided primarily by my colleague in the context of his larger study and were as follows:

What are the students' attitudes to death and how do they change during their training?

What are the personality characteristics of the students and what correlates are there with their attitudes to death?

What are the experiences that the students have had with death?

What are the differences in attitude and experiences between student midwives who have a registered nurse qualification and those who have not?

What is the development of their attitudes and experiences over the course of their training?

One of the strengths of the research design is that it was both comparative and longitudinal. This design was chosen in order to provide an insight into any differences between the groups that might either pre-exist or arise as a result of the two processes of professional socialisation, and also to give an indication of how participants' attitudes changed over time. The research instruments initially used were the Cattell PF personality test (see Appendix C) and the Templer Death Anxiety scale (Templer 1970, see Appendix D). This scale has been used in studies carried out in the United States to explore the efficacy of death education (e.g. Durlak, 1978). Most of the data, however, were obtained by interviewing students at intervals during their course, using a semi-structured interview schedule which allowed students to discuss their feelings and experiences (see Appendix E). When my colleague moved to take

up another post, the focus of the study changed, so that the material from the interviews became the primary data, and the last three research questions became the focal point for the interviews. The data from the personality tests have not been used in the analysis, although occasionally they are used for illustration. Participants' death anxiety scores and personality characteristics are included in Appendix F for completeness along with biographical data for the initial participants

4.2 Methodological framework

The methodology used was grounded theory as first described by Glaser and Strauss (1967). This methodology was chosen because it allows the voices of the participants to be heard as they tell their stories (Keddy et al., 1996) and also because it stresses the importance of the context in which people function (Holloway and Wheeler, 1996). The core element of grounded theory is the process of constant comparative analysis. This means that:

> Doing grounded theory, rather than a tidy process, is as messy as preparing a gourmet meal, where all the parts need to come together at the end [...] the collection of data involves both a relatively simultaneous critique of existing literature as well as an exploration of categories (or themes) and then a linking of these categories (Keddy et al., 1996, p450).

Initially I carried out a literature search related to midwives, student midwives and perinatal death. For some proponents of grounded theory, including Glaser and Strauss (1967), an initial literature search is inappropriate because it causes the researcher to enter the field with preconceived ideas, and this is something to be avoided in so far as it is possible. When theory is derived inductively from the data the grounded theory researcher may be keen ‘not to contaminate [his/her] efforts to generate concepts from the data with preconceived concepts that may not really fit’ (Glaser, 1971, p31). Bartlett and Payne, 1997 argue that some form of literature review is desirable, both to

ensure that the researcher is sensitive to the ideas he/she may discover in the data, but also, on a more pragmatic level, to ensure that the intended study has not already been carried out. It is probably particularly difficult to enter the field with no preconceptions when one is an `insider researcher' as I was. It is important, however, that any preconceived ideas are amenable to change as the research progresses. The issue is addressed by Bartlett and Payne (1997):

> The skill of the grounded theorist lies in reading around the project in order to become theoretically sensitive, while at the same time phenomenologically 'bracketing' specific knowledge while actually performing the analysis (p181)

.

As the study progressed it became clear it would be necessary to examine the literature relating to professional socialisaton. It also emerged that some concept of risk was present in the minds of participants and I wished to explore the nature of this concept. The literature review chapters are therefore informed by the thinking that occurred during the process of data collection and analysis. In grounded theory, as well as exploring the literature at the same time as gathering data, the researcher writes `analytical memoranda' recording observations and insights which occur during the process of analysis. The value of this approach to theory generation is the constant interplay between ideas and research experience (Bulmer, 1979). The researcher accepts and explores ambiguity and uncertainty rather than attempting to fit the data into a preconceived framework. New hunches and insights may be followed up, and new cases sampled in order to further explore emergent ideas, or to provide negative case analysis (Denzin, 1989; Henwood and Pidgeon, 1993). This is based on Popper's (1972) theory of falsification and his suggestion that one way of being critical is to seek to refute assumed relations between phenomena. Negative case analysis is important because the researcher may

be tempted to ignore data that do not fit the developing theory, whereas examining these cases in most instances provides fruitful insights and is of course essential to the credibility of the overall analysis. When I became aware of the individual differences in the responses and attitudes of individual participants I decided to include narrative analysis (Reissmann 1993) specifically in order to attempt to uncover some of the reasons for those differences, so providing a form of negative case analysis (see Chapter Nine).

At the first interview we discussed participants' feelings about midwifery and their experiences of death (see Appendix E). Several students had already had significant experience of death, both in their personal and professional lives. Following the initial interviews I created a list of categories (Appendix G). This was achieved by a system of 'open coding' of the interview transcripts (Appendix H). I transcribed the interviews in the recommended way for grounded theory - this involves typing on the left hand side of the page and leaving the right hand free for writing codes on. I then read through each transcript and broke down the data into separate segments - each segment a discrete part relating to a particular concept for example, 'being busy'. Once initial open coding had been carried out, I manually cut out the chunks of data and sorted them into categories. This process has been made considerably less laborious by the development of computer programmes such as the Ethnograph (Seidel et al., 1988).

Creating categories was done by grouping together similar concepts and giving them a name; I then put the chunks of data into named folders. New concepts emerged with each interview, especially because the study was longitudinal, and therefore the issues raised by participants changed as their courses

progressed. In the end the categories I chose for analysis were those which contained the most data, (i.e. the concepts or phrases students had used most). These wider categories later became subsumed into the themes which make up the chapters 5-8. The themes were derived through the use of the constant comparative method. Using theoretical memos, I linked categories to other categories, and explored and described the nature of the relationships between the different categories. Eventually I identified what appeared to me to be the central phenomenon or storyline, and then arranged the remaining categories in relation to this. Some qualitative researchers maintain that to increase rigour, the data should be independently coded by another researcher (a form of triangulation - see Denzin, 1978) and in retrospect this would have been a useful strategy, particularly if that observer was a researcher from a field other than midwifery.

In an attempt to assess inter-rater reliability in qualitative research David Armstrong and others compared the themes identified by six researchers from one focus group transcript. They found that the researchers identified similar themes from the raw data (initial analysis), but that the 'stories' (i.e. interpretation) then constructed by researchers were different; they were 'packaged differently' (Armstrong et al., 1997, p60). There is then, likely to be broad agreement over the themes identified, but consequently each researcher brings to bear their own individual perspective on those themes. In other words, the process of interpretation involves a dialectic between researcher and data in which the researcher's own views have important effects. This study employed grounded theory techniques in order to subject the data to the

closest analysis possible, but the interpretation is also a product of my own particular perspective and concerns.

As an ‘insider researcher’ I am inevitably ‘intimate with and emotionally attached to my area of research’ (Mitchell, 1998, p29). In recognition of this, during data collection I used open questions in an attempt to ensure that as far as possible the discussion represented the participant’s concerns rather than my own. During data analysis, the categories I identified were derived directly from the data and the study relies on the words of participants as the primary data. I consciously attempted to ‘bracket’ out my own preconceptions and prior knowledge when generating and comparing categories. Frequent discussions with my supervisor, who did not have a midwifery background, also helped me in my attempt to treat the familiar as ‘anthropologically strange’ (Hammersley and Atkinson, 1995, p9). The analytical account was grounded in the data, beginning with description and moving on to identify key factors and relationships, searching for themes and patterns. This part of the process was systematic and controlled. The final part of the process of analysis, according to Wolcott (1994) is where the researcher attempts to give his or her interpretation of what is occurring. Interpretation involves seeking explanation and understanding ‘beyond the limits of what can be explained with the degree of certainty usually associated with analysis’ (Wolcott, 1994, p36). This part of the research is where the ideas of the researcher are legitimately brought into play and thus reflects the researcher’s own knowledge, concerns and creativity. Most studies of socialisation, for example Becker's classic study of medical students (Becker, 1970), and Davies' study of the initial experiences of student midwives (Davies, 1988) use ethnographic observation as the main method of data collection but this was impossible for me because of the nature of what I was studying at the outset. I felt it would not be acceptable for me to observe

students as they attended grieving parents; privacy is obviously vital in these situations. As the study progressed it would have been entirely appropriate to have adopted additional methods of data collection. This would have been in keeping with the principles of grounded theory, but I was constrained by time and finances. Other useful sources of data would have been diaries kept by participants (see Davies, 1988); records of critical incidents (Benner, 1984), and observation of, for example, perinatal mortality meetings (where doctors, midwives and other involved health care staff meet to discuss the management of cases when a baby has died). Risk management meetings, which are now becoming a feature of the organisation of most NHS Trusts, would also have provided some useful data.

4.3 The participants

I began the research by constructing a proposal and seeking approval for the project from the principal of my own college. This was given after I had submitted an outline of the project and the initial interview schedule to the college corporate management team. I then approached the head of Midwifery Education in another centre which provided pre-registration training, who very kindly agreed to allow me to speak to the students. At the start of the project, the trained nurses studying midwifery were known as post-registration students while the non-nurses were known as pre-registration students. (Prior to that, as explained in Chapter Two, they had been called ‘direct entry’ students). Today the terminology has changed again; now the 18 month course for nurses is known as pre-registration (short) and the three year course for non-nurses is known as pre-registration (long). These rapid name changes reflect the rate of change within midwifery education. For clarity I refer in the transcripts to the students as either nurse or non-nurse. The students were white, female and all aged between the ages of 18 and 38 at the start of the study. Both the groups

were undertaking courses that had only recently been validated. The non-nurse students were studying at a college which had been incorporated into higher education a year previously, and, as I have said, my own college was in the process of being incorporated. The first centre was located within a maternity hospital; the second in a university. From discussions with the midwife lecturers at the second centre it was clear that although the process of incorporation into a university had not been easy, it was now viewed in a fairly positive light. All the students in the study finished the course with a Diploma in Professional Studies (Midwifery). This course is soon to be replaced by a degree in midwifery, achieved in the same timespan.

4.4 Ethical issues

At the beginning of the study my colleague and I felt that it was not necessary to consult the ethical committee, because the study would not directly involve clients. Having reflected upon this since, I now feel that studies involving staff or students should still be subject to ethical committee approval. As Robinson (1996, p43) points out, NHS staff are increasingly becoming subjects of research. They may feel under pressure to participate, particularly if the researcher is a senior colleague, and some research may cause damage to self-esteem or to relationships at work.

I explained the study to students, so that they could choose whether or not to become involved, and emphasised that they could withdraw at any point if they wished. My colleague and I were aware that discussing death might evoke distressing memories or experiences, therefore an experienced counsellor within the college was contacted and agreed to provide counselling if any student wanted it. This information was given to participants. I recognised that it was likely that the responses of the students in my own college would be influenced by the fact that I was a teacher in their college, and that they might

have felt obliged to take part in the study. To try to ensure that this did not happen, I emphasised that participation was completely voluntary. I arranged not to be directly involved in teaching those participants who were students at my own college, so that they would be less likely to relate to me as students to teacher. I also ended up being away from the college on maternity leave for much of the research period and thus had little contact with them other than for the purposes of the research. All names given in the study are pseudonyms.

4.5 Sampling

The student intakes consisted of 16 non nurses at the first centre and 18 nurse trained students at the second. With each group I introduced myself and outlined the aims and design of the study. I explained that participation was voluntary, and that the first part involved filling in a personality questionnaire and another form relating to anxiety about death.

In both groups all the students agreed to take part. After carrying out the initial personality and death anxiety questionnaires, I selected five students from each group: two with a low death anxiety score, two with a high score and one with an intermediate score. Thus the levels of death anxiety, as measured by the Templer (1970) Death Anxiety Scale formed the basis for initial purposive sampling although later on in the study theoretical sampling was employed. With theoretical sampling, once the research has started and initial data have been analysed and examined, the researcher sets out to sample different situations or individuals specifically chosen in order to further explore the emerging theories (Holloway and Wheeler, 1996, p104). Following this principle I interviewed two newly qualified midwives, and on a single occasion, one group of qualified midwives. One of the midwives (Mary) was a newly-qualified non-nurse midwife who had trained in another study centre and was now based in a nearby hospital; I thought this might give me some idea as to

whether the concerns raised by the initial participants were shared by a midwife who had trained at a different site. The other, Lisa, was a newly qualified midwife who had trained at my college but moved to a different area to work. Both these informants provided data relating to the context of care in other settings. The group of experienced midwives I interviewed were students on a course I was teaching; I selected them because they were easily accessible and agreed to critically discuss my findings with reference to their own experience as mentors.

4.6 Interviews

The majority of the data, then, for this study were obtained by semi-structured interview. I conducted three interviews prior to starting the study in order to practise techniques and also to explore the subject. Following Spradley (1979) the interviewing technique was ethnographic; a `series of friendly conversations' with a specific research agenda. Interviews were carried out three times during the students' course: at the beginning, middle and end. Interviews were audiotaped and I simultaneously made notes, covering key aspects. On average, interviews lasted one to one and a half hours. At the beginning of each interview I reiterated the purpose of the study, or (later on) discussed how it was progressing, and gave participants transcripts of previous interviews. I fed back each participant's score at her first interview, explaining why she had been selected for the study. Interviews were nearly all conducted in a small seminar room in each centre. The study is based on 32 interview transcripts.

Following the initial interviews, the interview schedule was subsequently adapted in order to explore the ideas that were emerging. Thus data collection

and analysis were carried out in parallel. Most of the interviews I transcribed myself although a small number were transcribed by another person. In this case of course the maintenance of confidentiality was crucial and was stressed to the transcriber. It is considered better (see for example Maykut and Morehouse, 1994) for the researcher to transcribe interviews her/himself because this way the researcher becomes `immersed' in the data (p101). It also ensures that important information (for example tone of voice, hesitation, or emphasis) is appreciated by the researcher. As is customary in qualitative research, data are presented in the form of quotes from interviews accompanied by commentary. Sometimes the subject of the interview related directly to their experiences of stillbirth and perinatal death but often it was simply a question of my being prepared to listen to what was causing the participants `anguish' (Keddy, et al., 1996, p451). Participants did not always have direct experience of death, but all wanted to discuss their thoughts and feelings regarding the risk of ‘things going wrong’. This, it became clear, was a fundamentally important issue for these midwives in training and their views underwent significant change as they progressed through the course. One of the advantages of the grounded theory research method is, as I have indicated, that it allows for the following up of new ideas and insights which only become apparent as the study progresses.

In contrast to studies with a positivist framework, where the researcher strives for objectivity in order not to `contaminate' the data, in qualitative research the nature of the relationship between researcher and participant becomes an important element of the research process. The aim is for equality in the relationship so that the research is a product of the interaction between researcher and participants. During the interviews for this study information and ideas were shared and I answered participants' questions. I think this made it easier for participants to be open with me, and that they were less

likely to feel I was judging them. One participant in a letter to me telling me of her experiences following qualification, wrote:

> Talking to you was quite reassuring in that some anxieties related to midwifery practice obviously last, even when you've gained lots of experience and whilst I expect a lot of midwives wouldn't admit to feeling anxious at times, your openness made me feel it's totally acceptable to be able to admit to the odd doubt from time to time.

The interactive approach to qualitative interviewing probably increases the validity of the findings because it undermines, to a certain extent, the power relations between interviewer and interviewee and allows the respondents to talk more freely about attitudes and experiences. Oakley (1986) talks as a feminist social researcher about how interviewing women affected those women in three main ways:

> in leading them to reflect on their experiences more than they would otherwise have done; in reducing the level of their anxiety and /or in reassuring them of their normality; and in giving a valuable outlet for the verbalisation of feelings (p247).

Oakley suggests that in repeated inteviewing over a period of time a relationship is bound to build up. Several students commented that talking with me had given them a chance to explore their feelings. I felt I became friends with most of the students. This brought benefits for the research. For example most of the students (seven out of ten) responded to my letter asking for news of their experiences since qualifying. This supplied a different perspective from the one that would have existed if the last contact had taken place just as the students finished their course (a time when they were particularly worried about the future). It also gave information about whether they were continuing to practice, and their conditions of work. The interactive approach to interviewing is an accepted approach to the collection of qualitative data (Hammersley and Atkinson, 1995) and was appropriate both for the needs of the study and the nature of my relationship with participants. I did ensure, however that I asked

open questions and tried to avoid leading questions. Where I quote from the interviews I include my questions in order that the context of responses may be seen.

4.7Letters

Seven months after I had completed the interviews I sent all participants a Christmas card, and told them how the study was progressing. I also invited them to write to me telling me how they were finding life as a qualified midwife. I received cards and letters from three of the nurse group, three of the non nurse group and both of the qualified midwives and I used this, with participants' permission, as additional data in relation to the climate of practice (Chapter Eight) and in the narrative accounts. I have not been able to trace the non-respondents, who had moved since I had last contacted them.

4.8 Feedback of analysis

Although I returned interview transcripts to participants for validation, and discussed the results of the personality test and their Death Anxiety scores with them, I was not able to feed back the overall analysis, because I was unable to set up a forum in which such feedback could be gathered. Most participants had moved on to new jobs in different areas and I had lost touch with four of them. I was able to obtain participant feedback on the narrative accounts with only two out of three of the participants (see Chapter Nine). Feedback of analysis gives the participants a chance to express their opinions as to whether they feel that the researcher's account is an accurate one; it is regarded by some researchers as a crucial test of validity (Lincoln and Guba, 1985). Participants' responses can then provide new insights and may cause the researcher to modify conclusions (see, for example, Moffat, 1989). Hammersley and Atkinson (1995) argue that respondent feedback can be

problematic, because ‘we cannot assume that anyone is a privileged commentator on his or her own actions in the sense that the truth of their account is guaranteed’ (p229). Such feedback should be seen, therefore, not as a direct validation or refutation of the researcher’s inferences but rather as a valuable source of data.

4.9 Reflexivity

The notion of `reflexivity' (see, for example, Hammersley and Atkinson, 1995) is important for qualitative studies. Reflexivity entails the researcher being reflective about her/his own values and attitudes and appreciating the ways in which these may affect and inform the research process. Researchers are never divorced from the subject under study and therefore must take into consideration their own position as the main research tool (Holloway and Wheeler, 1996, p13). Reflexivity is perhaps particularly important when one is an ‘insider researcher’ (Mitchell, 1998) as I was. Researching a familiar setting engenders benefits and problems. It is easy to gain access to participants, and the researcher may obtain insights that would not be available to someone without insider knowledge of the culture and language; yet at times respondents will assume a shared knowledge which means they may not explain, or even fail to mention, certain ideas that might be important for the research. There is also a risk that the researcher will also miss important concepts through over-familiarity with the culture. In order to maintain reflexivity, researchers are advised (Glaser and Strauss, 1967; Lincoln and Guba, 1985; Taylor and Bogdan, 1984) to maintain a diary throughout the period of the research, noting down analytical insights, feelings and experiences. In a longitudinal study the diary clearly documents the ways in which ideas change and develop with the passage of time. The diary also provides a record of the conduct of the research. ‘Bracketing out’ one’s own

prior knowledge (Bartlett and Payne, 1997) is important, as discussed above, during the analysis of data, but is not always possible or desirable at other points. For example, after the first interviews, I reflected 'I had thought it best at first not to become involved, to stay non-committal - found it impossible, unethical ... Although we have a counsellor they'd have to make a special arrangement to see him... and my reaction at the time is important to the students'. However, despite the checks that I built in to the research in order to minimise the problematic aspects of my 'insider status', there may have been times when because of my involvement and beliefs I have understated some aspects of the data.

4.10 Generalisability

This qualitative study does not aim to conclude with predictions about the behaviour of student midwives, or argue for any direct cause and effect relationship between variables. The participants cannot be considered representative of student midwives at large, partly because of the type and size of the sample and also because of the fact that the courses were relatively newly established in the colleges from which the sample was taken. Moreover midwifery education and practice is currently undergoing such rapid change that there are likely to be quite large differences between curricula and learning environments throughout the country. My aim, therefore, through the identification and interpretation of themes from the data, as well as through the use of participants' verbatim descriptions of events, is to give an insight into these students' experiences during training. Small non-representative studies may be used as the basis for generalisation (Bryman, 1988; Morse, 1994; Yin, 1994; Sharp, 1998) as long as it is recognised that such generalisation is theoretical rather than statistical in nature.

4.11 Conclusion

The study of midwifery education is central to an understanding of the culture and politics of midwifery. The attitudes of birth attendants are likely to have profound and long term effects upon the lives of childbearing women (Oakley, 1992; Halldorsdottir and Karlsdottir 1996a); and these attitudes are fostered, modified and developed to a great extent during the years of training. This longitudinal study was designed to examine the developing attitudes in context, with reference to existing theory, in order that a greater insight might be gained into the socialisation process into midwifery. At the same time I recognise that, as a midwife teacher researching midwifery education, this study reflects both the experiences of the participants and my own, 'insider' perspectives and concerns.

CHAPTER FIVE

PERCEPTIONS OF BIRTH: FROM NORMALITY TO ABNORMALITY

5.1 Healthy mothers and babies

The core theme of the study was that during the process of professional socialisation into midwifery, all participants' perceptions of midwifery and birth underwent fundamental change. This chapter explores and analyses the changes that took place, while the following chapters deal with issues that emerged as having an important bearing on the change in perspective.

All the participants, both nurses and non-nurses, initially talked of midwifery in similar terms, emphasising that they saw it as a normal life event:

Emma (nurse): It's to do with healthy mothers and babies, isn't it?

Carol (nurse): It's more dealing with healthy individuals than the sickness side of it. I prefer the idea that it's as healthy as possible.

Irene (non-nurse): This is a normal thing that healthy people do.

In the early months of both courses the curriculum focused on normal pregnancy and childbirth. This is an attempt to give students a thorough grounding in the normal, in order to allow the student to practise basic skills, but also to try to ensure that they absorb the philosophy that birth is a normal life event. Stressing that pregnancy is a healthy state was also a feature of the curriculum for student nurses interviewed by Ann Seed (1991). One of them said: ‘Well they’re supposed to be healthy and they kept trying to stress that when we had our days in school’ (p260). Stark and Elzubeir (1994) from a preliminary evaluation of a pre-registration course for non-nurses said that the students’ initial perceptions of midwifery were perhaps rather idealistic, adding, `it could be argued that their naivety was compounded by their lack of nursing

experience' (p183). The data from the present study suggest however that the two groups, both nurses and non-nurses, had similar perceptions of midwifery, which could be termed idealistic, but are in fact in keeping with the image of midwifery that is presented in textbooks, in promotional literature regarding midwifery training, and perhaps most importantly, by midwifery educationalists when pointing out the differences between nursing and midwifery (see, for example, Bryar, 1995, p114). Furthermore, an initially `idealistic' approach, which is then modified in process of professional socialisation, is a consistent feature of the literature regarding socialisation into professions generally.

All the participants, apart from one, were based for much of their clinical experience in consultant units. (These units are headed by consultant obstetricians, specialists in dealing with problems in pregnancy and birth, who have their own team of doctors working with them.) Although initially both groups spent time working on the community alongside midwives giving primarily ante-and post-natal care, their experience of birth itself took place for the most part in hospitals. Only two of the participants witnessed a home birth during their training. Evidence from the Clinical Standards Advisory Group Committee on Women in Normal Labour (CSAG, 1995) suggests that a high level of medical intervention in normal labour is commonplace in consultant units (and indeed, the initial data suggest, in midwife-run units too.) So what is ‘normal' in the sense that it is customary practice in a hospital may be ‘abnormal' in terms of the physiological process. Conversely, when a woman gives birth in hospital, without any medical intervention, in a position that is physiologically normal (for example upright or on all fours) this is so uncommon (see data from CSAG, 1995) that the woman may be seen as 'abnormal'.

There is, therefore, an immediate conflict for these students, both nurse and non-nurse, where the thrust of the curriculum is not just at odds with, but the complete opposite of what they experience as soon as they go out into ‘the real world', and ‘nice, normal midwifery' appears to be the exception rather than the rule.

5.3 Contemplating `things going wrong'

For most of the participants, the possibility of ‘things going wrong' was not an immediate worry early on in the course. The following quotes are from participants early on in the course:

SD: Have you thought about things going wrong?
Angela (nurse): Well, maybe at the back of my mind, but with midwifery it's the other end of the scale from the elderly. It's a healthy thing.

`The other end of the scale from the elderly' suggests that midwifery is seen as the furthest it is possible to get from having to deal with loss or death. But as Mander (1994, p16) points out, even normal childbearing triggers, for many women, feelings of grief or loss. There will also be, among the women with normal pregnancies, a substantial number of women who have experienced bereavement in their lives, or have had a previous miscarriage. Besides this, modern antenatal screening methods ensure that most women will have to consider the possibility of loss or fetal abnormality early in their pregnancy.

Frances (non-nurse): It was something I definitely pushed to the background. I was aware that things can go wrong, but obviously the positive side was what influenced me more. I have had no experience of anything going wrong yet so, but I am aware, listening to people, that these things do happen, but again until it happens to me, I am thinking, oh well, OK, let's push it away for now.

Participants were aware that problems occur in childbirth but preferred at this stage not to have to consider what they saw as the negative aspects. There is

a feeling that this is better dealt with later on in their course, when they have more experience. This perspective was reinforced by the organisation of the curriculum as discussed above. In summary, initially participants described birth as a healthy part of life; and although they were aware that problems do occur, in the early stages of the course they preferred not to dwell upon those aspects of childbearing. One exception to this was Deirdre who had previously worked on a gynaecological ward, who had criticisms of the way in which bereaved mothers were treated on that ward:

SD: Did you think about this aspect, say, a baby dying or problems in childbirth?
Deirdre (nurse): I did, because working on gynaecology, you have a lot there, up to twenty weeks , so you've already dealt with.....It is the same to a certain extent, whether it's 6 weeks or 40 weeks, to me it's been their child they've lost. On the ward the staff couldn't cope with it because they didn't see it as a baby, they just saw it as an early pregnancy, 'it doesn't matter, they can have another one'.....

She also commented on how she viewed the midwife's role when a baby dies:

I see it as a big part, and I think it's a very important part, definitely. It's not going to be the easiest thing to do at all, but it's something I'm aware that does need doing and they do need support.

I then asked participants directly about how they would feel if they were involved in giving care to someone whose baby was stillborn. Although both nurses and non-nurses conceptualised midwifery in similar ways, there was a difference between their responses to this question. The nurses talked about how they might `handle' the situation. This indicated that they were aware that as professionals caring for someone, for example, whose baby has died, they would have certain duties and responsibilities besides providing emotional support. Some of the nurse-trained students were worried about this aspect of their role:

Angela (nurse): I'd panic. I think it's not knowing how to handle the situation, because we have not got the experience. I would feel absolutely devastated, I should imagine, but I wouldn't know how it felt, because it wasn't my baby... It's

difficult...I would feel a bit awkward, I imagine. I would hope there was somebody else there. As a student, I haven't got the experience of looking at it from a qualified midwife's point of view, who are experienced and who have been through it before.

The key concept here is how the student feels that experience - having 'been through it before' - will be essential in enabling her to 'handle' the situation. When she is 'qualified', dealing with loss will be different, but at the moment she would 'panic', and feel 'devastated'. It is significant that she uses the word awkward as well as the word devastated. This seems to indicate the two levels on which she might experience the situation: `devastated' is her emotional response. Then there is the surprising word 'awkward' that relates to the professional role, which she hasn't achieved yet in midwifery. The word awkward has been used in this sense by Buckman, who discussed the breaking of bad news as 'this awkward (but important) part of clinical medicine' (Buckman, 1984, p1597).

Some of the anxiety discussed by nurses appeared to be related to expectations of how one should behave as a professional - not showing panic or anger, and behaving calmly, for example. There has been discussion of the meaning of professionalism in this context, and it is now generally agreed that it should not mean being distant or aloof (see for example Davies, 1996). Rosemary Mander (1994) discusses the question of midwives crying with grieving mothers and concludes that there is still ambivalence about this among midwives (p157). This ambivalence was expressed clearly by one of the midwives in her study, who said:

There are really two schools of thought about (crying). First there is the old school which says that you must retain your professional thing quite intact. The second view is that you grieve with the woman. I think that it really depends on the midwife and the woman. I am quite happy to hold her hand or put my arm round her shoulder, but I think that you need to stay a professional.

This concept of professionalism is problematic, not only where grief and bereavement are concerned, but for the practice of midwifery in general,

because caring for women in pregnancy and birth involves emotions. Caring involves reflection and intuition which cannot be separated from awareness of one's own emotions. It was possible to differentiate several different uses of the term `professional'. Sometimes participants used it to mean being altruistic, sometimes it was used to mean doing one's job well, at others it was used to mean hiding one's feelings.

The non-nurses, in the first interviews, talked about ‘things going wrong' from a different perspective, tending to focus on how it might feel for the parents rather than on issues to do with responsibility, or being professional. Three of the non-nurses said that they had considered this aspect of midwifery in depth before starting the course (as did Deirdre who explained that she had a particular interest in counselling).

SD: Had you thought, when you thought about midwifery, had you thought about if something went wrong, how you would cope with it?
Gail (non-nurse): I hoped I could sort of take it on board and still be there for the mum, to care for her as she needed.

Gail had worked as an auxiliary nurse on a maternity unit before starting her training so she had had some experience of helping with birth. She had considered her role in bereavement and seemed to have confidence that she could support parents.

Another non-nurse student, who was only 19 years old, spontaneously mentioned the possibility of maternal death in her first interview:

SD: You say you saw midwifery as normal, did you think about any problems, what would happen if anything went wrong?
Kath (non-nurse) Yes, it did come into my mind before I came onto the course, could I deal with somebody dying. There may be a time when a mum does die on you or a baby does die, but I thought I'd have to deal with that when the time comes. I thought it was a bit morbid, but I thought well... sometimes you read the papers, a mum died in labour or whatever... I thought could I cope with somebody who I'd been looking after for a few hours and got a really good relationship going. I haven't dealt with that personally but I suppose it would be hard.

She was the only participant to speak openly about the possibility of maternal death, and it is perhaps significant that she was not a trained nurse. For the nurses, choosing midwifery is seen as a positive move away from sickness and death and it is possible that some of the nurses who choose midwifery may actively wish to avoid issues to do with death; as Glaser and Strauss (1965) also suggested:

> many nurses frankly admit a preference for [...] fields of nursing where there is little confrontation with death.

For the non-nurses who had never dealt with bereavement before, or experienced death in their own lives, starting midwifery training brought them into closer contact with death than in their lives previously. Kath discussed the possibility of death in terms of a relationship, and considered whether she would be able to cope emotionally rather than seeing it as a challenge to her professional competence. Her language indicates that at this stage in her training she still has a `lay' perspective on maternal death: `sometimes you read the papers'. In summary, then, both groups were similar in their conceptualisation of midwifery, but there was a difference in the way the two groups thought about stillbirth and problems at birth. This difference was related to the fact that the nurses had previously been practising as health professionals and were aware of how they might be expected to act in the situation. It could also be argued that they had moved from holding a primarily `lay' understanding of the situation to a `professional' one.

5.4 Changing attitudes

All the participants' attitudes to childbirth changed during the course. By the end of the course both groups talked about childbirth in very different terms from those that they had used initially. In the final interviews they spoke of birth as fraught with potential dangers. The non-nurses were now more aware of

and concerned about the midwife's professional responsibilities, whilst all participants seemed to be very worried about how they would cope as qualified midwives. I spoke to them all near the end of their course at a time when the transition to qualified midwife was looming so this was probably a particularly stressful time for them, and must be taken into account when considering the findings. All the same, there was no doubt that their view of childbirth had changed.

The literature concerning student socialisation (see Chapter Two) had suggested a different development might take place. I had expected that they would realise that midwifery is not always 'nice and normal', but that with increasing theoretical knowledge and clinical experience their confidence would grow as they prepared to take on the role of midwife. Van Gennep, a French anthropologist (1960), discussing what he called 'rites of passage', identified three subdivisions of transitional states: separation, transition and incorporation. Incorporation is often viewed as occurring at the end of professional training; my data suggest that incorporation tends to take longer than this and also that there is a great deal of individual variation (see narratives in Chapter Nine).

It might also have been inferred from some of the literature (Davies and Atkinson 1991, Flint 1986, Downe 1988) that the non-nurse students, because they had not had as much exposure to the medical model, would perhaps find it easier to retain their perception of birth as a normal physiological event. This position suggests that such students might be likely to have lower anxiety levels regarding their role as a midwife. By the end of their training however, these data indicated that both groups had similar concerns. The anxieties the nurses had had at the back of their minds were now at the forefront, while the non-nurses now had similar worries about responsibility. Both nurse and non-nurse students used similar words when discussing their feelings about

qualifying; they used words like ‘terrified' and ‘frightened' once the time of qualifying drew near.

SD: Can you talk about how you feel about being a midwife now?
Frances (non-nurse): Terrified, that's how I feel, if I'm going to be totally honest. I'm very glad to be qualified, I feel like it's the end of three years of hard work, and I want to get on with things, although part of me thinks 'I could do with another year on the abnormal' I think you've got to get on with it, you've got as much out of being a student as you're going to get and now you've got to get out and do it. But I am very frightened ...

The key concepts here are that once qualified, Frances will be 'getting out and doing it'; ‘getting on with things' i.e. practising as a midwife and gaining real experience which brings together theory and practice. This is a predictable finding; it makes sense that students need experience before they can feel confident. Two participants, Gail (non-nurse) and Carol (nurse), echoed Polanyi's (1958, p59) point and compared qualifying as a midwife with passing a driving test:

Gail: I hope it's like learning to drive! I mean on passing my driving test I thought -`I'm not free to drive, am I? I can't possibly drive' and yet I drive all over the place now - but it didn't come overnight and I don't think being a midwife will come overnight either.

Carol: It's a bit like passing your driving test really, when you've passed, that's when you do a lot of the learning.

All the participants, both nurses and non-nurses, talked of wanting more time to concentrate on ‘the abnormal'. The feeling was that ‘the normal' was unproblematic and taken for granted while the majority of the learning and experience needed to revolve around abnormal cases. However, on further probing it was clear that the normal was not unproblematic either. Few of the students were confident at the prospect of attending a woman with a physiological third stage[7], or in conducting a home birth.

[7] This refers to the woman delivering her placenta and membranes without the use of oxytocic drugs.

Carol (nurse): There were only two midwives on and me - in the end the sister on there said she'd do the delivery with me - we had a physiological third stage but that was frightening as well, because I'd never seen it, it was my 37th delivery but I had to ask `what do I do?' So it was very frightening

The fear of doing something of which she has no experience here intersects with a fear about the shortage of staff on the unit (see Chapter Seven for discussion of staffing). Josie (non-nurse) also had fears about helping with a physiological third stage:

Josie (non-nurse, final interview) I don't know what the policies are ... I'm not so sure I'd want to do it ... I'd be frightened to death of waiting and waiting ...[...]... I've never seen it done ... I think some midwives do it.

Josie is a non-nurse, but at the end of her course her first thought regarding a physiological third stage is to wonder what the `policies' are, reflecting her experience on a consultant unit. `Some midwives' i.e. the radical ones, or possibly the older ones, who feel confident, might also undertake it. When one considers that midwifery is supposed to be primarily concerned with normal childbearing the finding that all students wanted more time on the abnormal is significant. Yet in situations which could truly be classed as normal birth, i.e. home birth and physiological third stage, for example, they did not express confidence either, because they had little experience of these events. This is an indication of the powerful effect of the environment within which they are learning midwifery. Trying to protect the normality of birth, and supporting a woman to try to ensure that she has a physiologically normal birth, is a complex, skilled job but this did not seem to be fully recognised by the participants. There is as yet only a small amount of research related to the art of midwifery in empowering women to have a normal birth (for one example, see Price, 1996) or on the psychology of women in labour.

Students' preoccupation with `the abnormal' may also be primarily an indication of the anxiety caused when things threaten to go wrong. This is a quote from Gail again, in her final interview, but most paticipants voiced the same concern:

I think if you go into a hospital and they don't know you, you go in as `a midwife' - nobody says `Oh, this midwife has just done her training' You're classed as `a midwife' - you know `Go on, get on with it!'....Which is nice if everything's nice and normal, but if it isn't.....(long silence)

5.5 Aloneness

A strong sense of aloneness pervaded the final interviews, as the students contemplated life post-qualification. The feeling was of a huge burden of responsibility carried alone. This idea of aloneness was echoed many times by the informants.

Irene (non-nurse) The responsibility is so tremendous and yet it's not recognised by the lay person, by anybody really..

Frances (non-nurse) At the moment we've always had supervision but (when you're qualified) you know that you're IT. There's nobody to shout to if you have problems.

Carol (nurse) Frightened now, all these cases I've described to you [...] when it's you facing that situation on your own, it's quite daunting really.

This sense of aloneness, coupled with expressions such as `frightening', `nerve-wracking', and `harrowing' was something also found by Bewley (1995) when she interviewed students and newly-qualified midwives in a small qualitative study. The participants in her study had previously trained as nurses, so her findings also contradict the initial conclusions of the evaluation by Stark and Elzubeir (1994), which uses similar quotes from non-nurse students to ask the question: `Does nurse training provide individuals with a more realistic understanding of what being a midwife, or at least being a health care professional, entails?'

The quotes, in this study, Bewley's, and Stark and Elzubeir's indicate that there may be sources of anxiety that are common to both groups, and that they may

be to do with the climate in which the students are learning midwifery. The words they used indicated that participants felt that they would seldom be able to rely on more experienced colleagues for support once they were qualified (this is discussed in Chapter Seven).

The feeling that they had not had enough experience, particularly in abnormal midwifery, was repeated by most of the students. It was not limited to the non-nurses. Deirdre (nurse) said:

> I'm glad I'm at the end of the course, but I still feel as though I'm not ready - very frightened really. I just don't feel I've had enough experience, I feel as if in that time I haven't enough experience.

Maggs and Rapport's pilot study of the immediate post-registration experiences of a group of non-nurse trained midwives suggested that midwives prepared by the pre-registration (long) route felt confident in normal midwifery but not in dealing with abnormal situations. The (unstated) implication is that this is related to their lack of nurse training, but my data suggested that trained nurses also had similar worries, and therefore there may be other factors involved besides the students' previous socialisation as a nurse. Their fears were related to being in charge on their own, and of being `responsible' - then, of course it is the `abnormal' that causes anxiety for any midwife, because the women who are `normal' will survive anyway. The newly qualified midwife fears that she is the one who will be held accountable for whatever goes wrong. This is a realistic appraisal of the situation.

5.5 Normality and abnormality

The following extract is a comment from a non-nurse student about half way through her course, and it shows how her experience in the hospital caused her anxiety about `normality':

SD: I'm interested in this idea of midwifery as a normal thing... I suppose your course helps you with that...?
Frances (non-nurse): I think it does because we haven't got any previous nurse training so we're not medicalised from that sense, but as I say even being on delivery suite here, I think there's an anticipation that things will go wrong almost ... it's anticipated ... In some respects it's reassuring that you've got a team there, if, God forbid, there are problems, but in other respects it takes something away from you ... you're constantly thinking, 'Oh should I go and say this?'... 'Should I go and say that this is normal?' ...It makes you nervous, but maybe that's just lack of confidence...

The non-nurses saw themselves as not medicalised; it was part of their self-image. The fact that they were not nurses was important to them but involved a stereotyped and misguided view of the nurse's role. For example, Josie (non-nurse) commented

A lot of the midwives say that the difference between nursing and midwifery, well, there's no comparison really, because the doctors always give the nurses instructions, whereas in midwifery you use your own initiative, and you're responsible, and it's only when things are slightly abnormal that you refer them to a doctor, but the rest of the time you make your own decisions.

This was something `a lot of the midwives say' - i.e. it is a common conception among midwives. Although there are important differences between nursing and midwifery work, it seemed that midwives needed to conceptualise this in terms of the subservience of nurses (`the doctors always give the nurses instructions') as opposed to the independence of midwives. In practice, however, when midwives work in hospitals their autonomy is often compromised. Nurses are seen as somehow `not responsible' and not making their own decisions. It was clear that the culture in which the non-nurses were training did not automatically mean that being `non-medicalised' would be an asset, something that was also suggested by Stark and Elzubeir (1994). Learning to be a midwife in such an environment, as Frances said, `takes something away from you', making it difficult to develop confidence. Although it has been observed that nurses resort to nursing ritual in order to cope (Davies, 1988), non-nurse students needed to find their own survival strategies too (for example offering to make tea for the staff). In her final interview, Frances said:

I must admit - normal - you'd feel mega-confident there because you've dealt with so much that isn't normal. If they're normal when they come in, then they're not, normally, by the time they've gone home. Something's normally happened - you've normally made them abnormal.

Normal in the sense of customary, or usual, is here juxtaposed against the concept of normal in the physiological sense. The participants' lived experience, therefore, was in conflict with the midwifery philosophy of birth as a normal physiological event and this causes a tension at the heart of the role of the midwife. The following extract illustrates just how profoundly some student midwives might be affected:

Angela (nurse): You're worried about your exams, your responsibilities, and whether you're going to get a job at the end of it, and how you're going to cope if not...
SD: Because if you knew you were getting a job at the end, it would be easier...?
Angela: It's just that when I had my little girl - I didn't have a nursing background - you just think everything's going to be great and you're going to have this baby at the end of it. I think if I have any more I'm going to feel really stressed (...) not just the delivery, but all the things that could go wrong...

Angela suddenly shifts from talking about exams, responsibilities and jobs to a very personal view of the risks of childbirth. This sudden shift seems to indicate a deep level of unease, a feeling of `ontological insecurity' (Giddens, 1991). Perhaps this is connected with the feelings of isolation experienced by participants. Angela is now aware of `all the things that could go wrong' and this sets her apart from other women, who don't `have a nursing background'.

Similar feelings were described by Kath in her final interview. Kath had not previously trained as a nurse, but the following quote illustrates how Kath has been socialised into a role where she now considers her own perceptions to be very different from those of other women:

SD: Have your views of midwifery changed at all?
Kath (non-nurse): Yes because in the hospital they've had every obstetric emergency (...) I just stand back and I think, God, they think pregnancy's normal, these women think it's all hunky dory and then...
SD: So you've got a very different perception...

Kath: Oh yes now I have because I've seen... I'm thinking to myself I never want children, I know too much, because I'm a worrier, and if I got pregnant I'd be a nervous wreck for nine months, I know I would... It has put me off having children. When you're just starting you think, oh, it's all going to be nice normal deliveries, forceps, maybe a section (laughing) you know, we've dealt with eclamptic fits, haemorrhaging...!

It seemed that to be successfully socialised into midwifery involved this change in perspective, from the idealistic to the cynical. The same has been found in studies of nurses (e.g. Smith 1992).

Lisa (nurse and qualified midwife):

It's so funny to talk to midwives, and you talk about home deliveries, and they say 'Well, working here for any longer, you'll soon realise!' They say 'Oh I could never have a home delivery now that I've seen too many things that have gone wrong.'

This is a description of an attitude commonly found in hospitals, both among doctors and midwives, which is at odds with the evidence that home birth is at least as safe if not safer than birth in hospital (Campbell and Macfarlane, 1995). But hospital may be a place of safety for the staff who work there in that it is familiar and predictable to them.

5.6 Responsibility and accountability

The new role after qualification for some of the students was symbolised by the prospect of a different uniform. One newly qualified (nurse-trained) midwife, worried about a forthcoming stint on labour ward, plucked at her dress, saying: `Once you've got THIS on - it's all different.'

Gail (non-nurse) said

(...) as a student your lilac dress means that, you know, there's always the support there , but as a trained midwife you've got to take the responsibility for it all, and it fills me with... apprehension, should I say?

The participants emphasised the transition from student to midwife in terms of responsibility. They indicated that they all felt they hadn't had enough time to manage cases on their own. There was no ‘easing in' to the new role:

Irene (non-nurse): I think you need more time, you need to be pushed more to manage cases on your own , when you're on the clinical area. (...) I suppose it's this question of not being - I think until you're actually registered, you're not legally responsible for your actions - I think that the midwife is responsible, and that makes a big difference.

Brenda (nurse): It's frightening to think that in such a short time you are going to be responsible for two lives (...)

‘Being responsible for two lives': again, this participant is considering the responsibilities of the role. It could be argued that her perspective is one based on a medical model that has been learned during her previous training as a nurse, because a midwifery model would stress the woman's autonomy and responsibility as well. However, these exact words, `responsible for two lives' were used by a non-nurse student in Stark and Elzubeir's (1994) evaluation. Both students are expressing an anxiety about the deep significance of the midwife's role as a person who stands at the boundaries of life and death.

Lisa (a newly-qualified midwife, quoted above) talked about having a different view of childbirth since starting midwifery:

Lisa: You think, ‘God! So much could go wrong!
SD: Did you think that when you first came into midwifery?
Lisa: Um... I knew that it was... I had a feeling that there was a dangerous side to it but not really, no, I didn't think... You don't really know when you're not a midwife... I think I've definitely changed since becoming a midwife.

This talk of a ‘dangerous side' has a certain ambiguity. It is, she suggests, dangerous for the women, but perhaps also for the midwife in that it exposes her to anxiety. Both groups, nurse and non-nurse, juxtaposed this new awareness with their earlier view of midwifery, implying that it had been a rather naive view, one that ordinary women held but that now they knew otherwise.

Gail (non-nurse) described the effects of this awareness:

I think you become aware of what can go wrong - this idea of nice, normal midwifery...I mean it is true to an extent but when you get these things that do go wrong, and you become aware of what can go wrong, um, I think when you're doing a delivery, instead of thinking 'this is a nice straightforward one' I'm thinking 'I hope this doesn't happen' or 'I hope I do this right' so it doesn't always... in my mind it's not going smoothly because I'm always aware of what could go wrong and what I'm looking for...

She went on to say:

We're now getting towards the end, but I think everyone is aware of the responsibility that goes with 'the end' ... you're responsible then. We've had quite a bit on accountability, and this person suing that person and all the rest of it ... it's frightening ...it makes you feel like getting up and saying 'I think I'll give this midwifery lark a miss!

Ellen Annandale's study of legal accountability in nursing and midwifery found that nurse and midwives felt vulnerable and that risk constantly surrounded practice: `it is in the background, there is an atmosphere: it is always there' (Annandale, 1996, p280). As one respondent in her study said:

you hear of others 'being held accountable' and begin to fear that whatever you say or do may not be right. And you begin to feel more alone (p280).

Giddens (1991) discusses the experience of basic trust, linking it with a `faith' in the coherence of everyday life:

'Trust is directly linked to achieving an early sense of ontological security. Trust established between an infant and its caretakers provides an inoculation which screens off potential threats and dangers that even the most mundane activities of day-to-day life contain. Trust in this sense is basic to a 'protective cocoon' which stands guard over the self in its dealings with everyday reality. It 'brackets out' potential occurrences, which, were the individual to contemplate them, would produce a paralysis of the will, or feelings of engulfment [...] trust here generates that 'leap into faith' that practical engagement demands.'(p3)

This is reminiscent of Savage's (1992) words: `doctors have lost faith in the ability of women to give birth naturally'. Where birth is concerned, faith in this sense is necessary in order to inspire the woman's confidence and to assist

her to achieve a normal birth. It means the attendant has to be able to `bracket out' distant and unlikely risks, while simultaneously appraising potential risks in order to give safe care. It means recognising and understanding the normal processes of birth, in order to carry out the 'practical engagement' of helping women give birth.

5.7 Conclusion

It can be seen from the evidence here that a `faith in women's ability to give birth naturally' is difficult to create and sustain in the current climate, not just for doctors, but for midwives and probably birthing women too. As well as the medicalisation of birth, which students experience on a daily basis, there are also the effects of the increasing emhasis on risk and individual accountability in the health service. Added to this are the effects of living in the `risk society' which ensures that even distant disasters are brought to immediate consciousness (Beck, 1992).

`Nice, normal midwifery' was a recurring phrase used by all participants. The rather cosy word `nice' implies safety and security, a little midwifery haven safely encompassed within the bounds of normality. The definition of normality, however, as we have seen in Chapter One, is far from straightforward, and is instead the focus of a long-standing power struggle between midwives and medical men, while ordinary women have had little say in the debate. Furthermore the occupation of midwifery concerns culturally taboo subjects such as sexuality, death, and messy bodily fluids (Douglas, 1994) ; and the word 'nice' is a strange epithet to apply. It will be necessary for midwifery educators to explore ways of helping future midwives, in this era of change and

uncertainty, to gain a basic trust in women's bodies and in their ability to give birth. The next chapter explores the ways in which students in this study were prepared, and prepared themselves to deal with loss and death. An acceptance of death and loss in midwifery and childbirth, I will argue, is crucial to a perception of birth as a normal part of life. Unless we can accept that birth does at times end with loss, or that birth causes the most frightening and unmanageable emotions sometimes, we will be unable to fully embrace the full implications of the experience of birth, and midwives will be doomed to chasing a chimera of 'nice, normal midwifery.'

CHAPTER SIX

IT'S NOT SOMETHING THEY CAN TEACH YOU: PREPARATION FOR DEALING WITH DEATH

6.1 Introduction

When students are confronted with a challenging situation such as an emergency, or the death of a mother or baby, psychological preparation for such an event is important. There was evidence that in some cases the approach to dealing with such situations was of the 'sink or swim' variety described in other studies of student nurses (e.g. Melia, 1987; Smith, 1992). Because the initial aim of the study was to explore students' attitudes to death,

some of the initial data related to students' perceptions of their preparation for dealing with perinatal death and bereavement. This chapter explores the relationship between theory and practice as seen from the perspective of the participants.

6.2 Learning in school and in practice

Discussing their initial nurse training, the nurses said that they had to deal with death on the wards long before there was any discussion of it in the classroom. For example:

Brenda (nurse): I can remember that they put [teaching about death] right at the end of the first year and by then many of us had already experienced death. It just seemed that they put things in totally the wrong order and you could have done with that at the beginning before you had set foot in a ward really.

The non-nurses' comments about the timing of the discussion of death and loss in the midwifery curriculum were similar to those of the trained nurses discussing their nurse training:

Frances (non-nurse) (....) It might be mentioned in lectures - stillbirths, neonatal deaths, but because we're still heavily into 'normal', we haven't really had any serious grounding.

Very early in her training one of the non-nurse participants was involved with a mother whose baby had died. She discussed her experience with the other students in her group, who were therefore aware that something similar might happen to them. Participants from this group said that they felt the subject should be discussed earlier on in the course rather than left to the second part of the training which dealt with the complications of childbirth.

Kath (non-nurse): I think there should be some input about - I don't know - some support about what is going to happen if you are faced with a stillbirth or an abnormality. It has happened to a colleague and they were devastated because they had had no input whatsoever about how to deal with it. They wanted to see the normal - the normal birth can turn into an abnormal.

The aim is for the student midwife to experience normal birth, but of course this is not always possible to arrange. As Kath rightly points out ‘the normal birth can turn into an abnormal’. If the organisation of midwifery care changes as recommended in *Changing Childbirth* (DoH,1993), students will be providing continuity of care alongside their mentor and will stay with the woman whether or not complications develop.

As Chapter Five describes, the students' attitudes towards childbirth changed during the course from initially seeing birth as normal to coming to see it as pathological. Therefore it appears that the attempt to impart the philosophy of birth as ‘a normal life event' does not succeed, despite the focus of the curriculum. The reality of midwifery care is not so easily partitioned, and the perception, for those students who experience perinatal death early on in their course, that this is somehow not supposed to happen to them yet, might make it more difficult to deal with. (For further insight into how this particular student dealt with her experiences, see Frances’ narrative account in Chapter Nine).

At their initial interviews the participants were positive about the classroom input, and it is clear from the above quotes that they saw theory as potentially useful preparation for practice. Later on in their course their views on the value of preparation appeared to change, and most of the participants in each group did not speak of classroom input as having been particularly useful. They also did not seem able to envisage cases where it might be helpful. The recurring theme was ‘it's [i.e. dealing with perinatal death] not something they can teach you':

SD: Do you feel that the course has helped you prepare for dealing with a stillbirth?
Josie (nurse): Not in itself, no [...] We'd done the counselling course and that's what we felt we needed, how do you cope with this sort of thing... we got notes but basically it's how do you cope yourself, you've just got to get on with it and do it really - no pointers there.

Josie here seems to equate 'the course' with the classroom input and 'getting notes'. There is a feeling that theory can be of no use when it comes to 'coping'. Theory is seen as 'notes'; perhaps more linked with the passing of exams than with personal growth and development. There is a suggestion here, too, that she had expected the counselling input to help prepare her but that it had not done so (`we'd done the counselling and that's what we thought we needed'). It seemed she might be unable to voice what she did in fact need in order to prepare herself because she wasn't really aware of what kinds of teaching and learning methods could potentially be used. This approach may have grown out of their experiences in the classroom, i.e. maybe they were `just getting notes', or may have been part of the socialisation process where clinical midwives emphasise the primacy of experience (see discussion in Chapter Two). Both groups talked of theory in this way. These are extracts from interviews half way through the course:

Josie (non-nurse) I think you only learn through experience, no matter how...you have to be in the situation

Carol (nurse) we haven't really had a lot of input on counselling - but I don't think it's something they can teach you - I don't think we should have done any more (...) I think it's something you develop... you can be taught it but... I suppose on reflection it helped to understand the problem...

This hesitant reply indicates that Carol feels that theory is of limited value; although there wasn't much counselling input, she didn't feel there should have been more. Yet again there are indications of ambivalence when she says `I suppose on reflection it helped to understand the problem'. She portrays learning as a rather passive process: ‘they' teach you, ‘you can be taught'. She indicates that understanding 'the problem' is separate from knowing how to act. This ambivalence was frequently expressed. Participants felt they should be better prepared for dealing with difficult experiences but that the only way to learn was once you were actually in the situation:

SD: Has the course helped you feel prepared for dealing with stillbirth?
Brenda (nurse): Yes and no. I don't think it prepares you for when you're there and you're facing the situation - it's just knowing, when you're actually involved, how you're going to deal with it. I was on the ward when we had a lady come down for monitoring and the baby died. I wasn't actually involved in the care, but the atmosphere takes over everybody. I don't think you're prepared enough for that... but I don't think you can be until you're in that situation

Kath (non-nurse): (...) Obviously, no one can prepare you what to say, but...how to deal with the situation, but the actual counselling session we had was just general counselling (...)
SD: Do you think role-play is useful ?
Kath: We thought we'd be doing role-play because the previous group said, 'Oh, videos...they video you talking to each other', so we went in and said to her 'We don't want videos, **we do not want** videos, anyone recording, so she said, 'Fair enough'. We don't mind role-play - but we didn't get around to role-play or anything

The non-nurse group seemed to have a fear of using videos for experiential learning and Kath thought it was `obvious' that no-one could 'prepare you what to say'.

The idea 'I don't think it's something they can teach you' was repeated by both groups of students. Like the student nurses in Smith's (1992) study these students

'preferred to see learning about feelings and emotions to do with death and dying as experiential; going through the experiences themselves and observing what other people did' (Smith, 1992, p110-111).

You might have 'notes' but this, they felt, would make little difference when it came to the real-life situation. From the words these students used, it was as though learning through 'experience' and learning in the classroom were seen as totally separate. Both the elements that Mander (1994) suggested as a result of her study are also revealed in these data (see discussion on pages 53-54). Firstly the classroom teaching might not have been seen as helpful because it was limited to the cognitive domain and was failing to address emotional or ethical aspects. Given the current emphasis in the curriculum on reflection as a way of learning from experience this is a significant finding. In reflection, a critical analysis of various aspects of an experience is intended to

bring together theory and practice and bring greater depth of knowledge, to further inform practice. From informal discussions with other teachers, and from the literature on reflection (e.g. Rich and Parker, 1995) it is clear that many teachers and lecturers feel they are lacking the necessary skills to manage the complex emotions brought up by reflection and by experiential learning. Secondly as the students were socialised into midwifery, they were acquiring the prevailing attitude that regards theory as having little relevance to practice. One student, not part of the study sample, said that on her first placement to labour ward she asked a midwife a question related to some research findings, and the midwife retorted: `Don't you use the R-word around here!' [8]

Since the incorporation of midwifery and nursing into higher education there has been an increasing emphasis on academic credibility. Midwife and nurse teachers have been occupied with managing the transfer into higher education, which traditionally accords less prestige to the `practical know-how' which is an essential aspect of midwifery and other professions such as nursing and teaching (Eraut et al., 1995). As health professionals become further integrated into higher education, it is to be hoped that the importance of this kind of knowledge will be increasingly recognised and suitable methods of teaching further explored and developed. There are signs that this process is under way; for example the growing interest in hermeneutic phenomenology as a basis for nursing research (Annells, 1996; Reed, 1994) and the use of `problem based learning' in midwifery pre- and post-registration courses.

Learning how to deal with stillbirth or birth complications indicates a particular need for `reflection prior to action' (Boud and Walker, 1993) in order that a

[8] The student also pointed out, however, that when she returned to the labour ward this particular midwife was undertaking some continuing education, and her attitude had changed dramatically. She even began to ask the student for information and to discuss issues with her, relating research (footnote 8 cont'd) to practice. This example, for me, illustrates the transformative power of continuing professional education.

woman experiencing a difficult birth is attended by someone who has had some opportunity to explore her own feelings and anxieties prior to the event. There was evidence from Frances' case that despite the widely expressed belief `you only learn once you're in the situation' it was possible to prepare, to `reflect prior to action' and to have some prior idea of how one might react. Frances was `thrown in at the deep end' by a midwife with the words `she's got to learn about it sooner or later'. This might have been disastrous, either for the mother, for Frances or for both. Frances felt that she had been helped by having watched a television programme about stillbirth a few years previously (Langden Films, 1986). This, she said, had made a great impact on her. The film had shown parents and siblings holding their stillborn baby, with staff supporting the family but not controlling or dictating what should happen.

SD: You feel if you'd not seen that...
Frances: Yes, I don't know how I'd have reacted and I don't know how I'd have been expected to react, because really my mentor didn't discuss it before I went into the room at all. (...) There wasn't really any preparation at all. I think if I hadn't seen that....I must admit that I hadn't really considered it, but, thinking about it, I think that provided the role model as to how I acted. Because (the programme) was a very normalising sort of - everybody (in the programme) was very easy to speak about the death, which I think there's - quite a lot of staff don't feel that comfortable. It somehow took away the embarrassment side that I expect a lot of staff still feel going into that situation, the inadequacies.

Frances was already aware of the ‘embarrassment side’ and the inadequacies that staff feel. Her comments show how, as she says, the people on the programme provided a role model. Without this, Frances felt she would have had little idea about how to cope either on a personal or on a professional level. The model presented was not the usual professional role model, it was `normalising'. It was a model where the death was spoken of openly and easily. The programme showed the family grieving and adjusting to their loss. Interestingly, in my experience of showing this to midwives and students, many find it difficult to deal with, calling it 'morbid' because the family have total

access to the baby's body for several days, and the other children hold and talk to the baby. The reaction of those midwives who find it `morbid' is evidence of the taboo still surrounding death. The fact that parents often need to explore their dead baby's body, repeatedly touching it, in the same way as they do with a live baby, may be very hard for health professionals to cope with. Perhaps this is because it blatantly confronts them with the fact of the death.

One student in the nurse trained group spoke positively about the classroom input.

Deirdre (nurse): I think it's been very good - the theory and watching the videos and talking about it and the practical procedures as well as the counselling - I've found it good.

Deirdre had had prior experience of counselling in her work as a gynaecology nurse. She was also the only nurse student to spontaneously discuss articles and books she had read, relating ideas from her reading to clinical practice.

These data confirm that dealing with loss is a very difficult, yet crucial part of the curriculum. Participants' comments showed that although they were often critical of the teaching they had received, there was resistance on their part sometimes when teachers suggested using different learning methods, or in some cases, resistance to discussing loss in the classroom. Further research on how to prepare students for this aspect of midwifery would be very useful. Perhaps, the more openly loss is discussed, the lesser will be the fear of death. In Frances' words, death will be more 'normalised' because it will be discussed and overt provision made for it. Perhaps then midwives will be less haunted by the possibility of something going wrong.

6.3 Experiences of stillbirth

In both centres it was commonplace for students to be steered away from having to be involved with women experiencing a stillbirth. Several

explanations for this were offered. The reason most commonly put forward was that the woman needed care from an experienced midwife and needed as much continuity as possible, with as few people as possible involved in her care. As Mary, a non-nurse midwife qualified for a year, said:

It's very hard to take a student with you into that environment - it's often the close relationship that you have with her - but to have another person in, almost as an observer... unless they can actually take part in it, it's quite hard...the dynamics change so much, don't they?

In two instances, however, students who had already been providing care for a woman were removed from caring for her once it became clear that all was not well.

Carol (nurse): I'd met her the night before and then they didn't really like the students to go in....they just wanted to try to keep the continuity with the midwife....there was a hell of a lot of people going in and out and she was labouring, so it was upsetting.

This quote indicates that despite the expressed aim of preserving continuity with one experienced midwife, in this case at least the woman was subjected to ‘a hell of a lot of people going in and out'. It suggests that at times there may be other elements at play in decisions not to involve students as the following extracts indicate:

Carol (nurse): (discussing a different occasion) I had actually palpated her (....) they tend to shield ladies like that from the students; they don't want you to get involved with it really. They tend to get the qualified staff - there were just two sisters who went in and I just saw the baby afterwards.
SD: Is that to protect you, or the woman, or what ...?
Carol: A mixture of both, because they don't know how to deal with us dealing with the situation ... or whether they felt that they didn't want to get too many people involved...

Emma (nurse): Well, there have been a couple of occasions where maybe the lady will turn up on the labour ward and you will have been sent round to do baseline observations and start admitting her and then things like - if there's a problem with the fetal heart, it's taken away from you, but you've actually been involved with her (....) I know it's completely different from general nursing but in general nursing you were never protected that much from it - never taken away from a patient who was dying and a qualified member of staff put in if

you'd been caring for them. I know it's different because it's more of a....but a lot of the time that's the way you come to terms with it - by actually doing it and not being protected from it.

Deirdre (nurse): When we were on the labour ward we were very much kept out of it - it's sort of 'you don't have to cope with that' and then, all of a sudden, you're a staff midwife looking after this person and you're on your own then, aren't you ?

The non-nurses also had the experience of being `shielded'. Josie (non-nurse) described being partially involved in caring for a bereaved mother. It was her only experience during the course of dealing with perinatal loss. It was not clear why she had been so much on the periphery as she was a senior student almost at the end of her course and would, perhaps, have had a lot to offer. Short staffing played a part but was not the whole reason:

Josie (non-nurse): I was working with my mentor but it was very very busy. I was only partially working with her and then being whisked away to do admissions and things like that, so I wasn't with her all the time. And she was looking after a lady who'd had a termination for fetal abnormality so really I didn't get the full picture of things. I was just in and out of the room helping [my mentor] to sort things out, but that's my only experience. [...] They didn't want to talk about it at all and, of course, [my mentor] was having to sort things out like the post-mortem - that sort of thing - and they did agree to a PM [post mortem] although because I went off the labour ward I didn't know the outcome... so I wasn't totally involved. I was just basically helping out....it's a bit of a shame really I didn't get more of an opportunity to speak to them.

[...]You see they wouldn't put a student in with a lady who was, say, having a termination for fetal abnormality, they'd put a more experienced midwife in, or they tend to. When I've been on Delivery Suite they've tended to put a more experienced midwife - someone who's dealt with the situation before... but some midwives end up never having contact...

The experienced midwives I discussed this with confirmed that it was usual for certain midwives to be the ones informally recognised as able to cope with caring for bereaved women, and for those midwives to be asked to do so. They were often the ones who were seen as a bit more involved and a bit more `alternative' than the others. They also pointed out that the changeover to

`team' midwifery would mean that midwives who had never been called on to give such care would now be expected to as part of their continuity of care for their own client, and that this might be extremely difficult for some:

Gail (non-nurse): It was one midwife who dealt with her, nobody else went in - just one midwife - so we tend to be steered clear of some of these things purely by our status [...] as students we know what's happening but we're not actually involved, for the mum's sake more than ours, because they don't want to load more and more people in and out, do they ?

Gail seemed to accept that it was better for mothers that students were not involved and were ‘steered clear'. The words ‘purely by our status’ suggest that it is not normal practice for students to be involved; that this is something that is almost automatic, rather than something decided with reference to the family's wishes and to the individual student.

With regard to stillbirth, the worry most often mentioned concerned communication:

Kath (non-nurse) I'm not scared of dealing with the child, the dead baby or anything, it's just 'what do you say'? You think 'If I say this, I'm going to put my foot in it and she's going to say - 'Get lost!'

Participants' principal worry was about what they would say in the situation. Yet there is in fact a sizeable body of literature regarding communication with parents whose baby has died, e.g. (Kohner and Henley, 1991; SANDS, 1991; 1995).

It is quite possible that a student might in the whole of her course never be closely involved with parents whose baby has died, purely because the situation did not happen to arise. It would also be perfectly possible for a student who was anxious about dealing with death to avoid it altogether, and she would be able to avoid it for a large part of her time once qualified.

Several students made comments that indicated to me that any experience a student missed during her training might well become a focus for anxiety, as she felt that once qualified she ought to be able to carry out the whole range of midwifery skills (see also Buckman, 1984, who makes the same observation in relation to medical students). This view was shared by most participants although Mary, a qualified (non-nurse) midwife saw it rather differently:

I think the same midwifery skills are transferable, you don't have to be in that exact environment to deal with it, and there are various ways you can talk about it...there's role-play and so on... But if the [student midwife] learns to listen anyway, it's the same skill!...Little basic things about empathy, like knowing when to touch and when not to touch...

This perspective was echoed by Josie (non-nurse):

I wouldn't say we'd had a great input on stillbirth - we've had several lectures, SANDS[9] was very good - we had the videos which were quite... sad. But what I found most useful was going out with the `psyche' nurses. I listened to them and listened to the interviews... just with the eye contact and with listening helped.

It appeared that a chance to learn the affective elements of providing midwifery care were what was lacking from the classroom sessions. As Mary suggests, there are various ways to talk about these things. One technique that is becoming more common is `story telling' to discuss practice situations. ‘Story telling' is becoming increasingly recognised as an alternative to what one writer (Bowles, 1995, p365) sees as the `academically generated and rhetoric laden notion of reflective practice'. It has been written about with particular reference to the discussion of ethical issues (Bowles, 1995).

6.4 Mentors and perinatal death

Although in Frances' case she had not been prepared for her first experience of stillbirth, subsequently she had the highest praise for her mentors:

[9]The Stillbirth and Neonatal Death Society is a support group for parents, made up of those who have experienced the death of a baby themselves, and they had been invited into the classroom to talk to students, giving them an insight into the experience of parents.

Frances (non-nurse): [my mentor is] very compassionate and extremely supportive - even if you make a total balls-up of something...(...)she's there but she'll give you the space to do your own thing.

The other student who had a positive experience of helping when a stillbirth had occurred made the following comments about her mentor:

Irene (non-nurse): She was brilliant, she really made sure I was in the thick of things.

and

She's marvellous, she gets so involved and makes you, `forces' is the wrong word, but really encourages you to do things.
SD: It was interesting you said `forced, oh, that isn't the right word'... perhaps sometimes we have to be pushed towards things we would rather avoid...
Irene: That's what she's good at - the mentor, she's absolutely fantastic at doing that, because in other situations, I'll say, `Oh, I'd rather not' - she pushes me and makes me do it and afterwards I'm glad.

Again, although Irene focused on her mentor, she herself had positively made a choice to be involved:

SD: Can you go over again how you got involved ?
Irene: The first thing I heard was that there was a baby that was ‘arresting' so I went down and asked if there was anything I could do to help

Irene further described her mentor and role model:

She's got a lot of imagination and just seems to know exactly what....I think she susses you out as a person when she first meets you and she susses out the sort of person you are and she's very perceptive at recognising areas you need to be pushed into.

This particular mentor, it appears, recognised that her student would be able to cope and gave her the necessary support. However it would probably not be helpful to a bereaved woman to have an unprepared, anxious student caring for her: this is a crucial event in the woman's life and she should have the best possible care. This is possibly why some midwives do not encourage students to involve themselves, because the midwives are protecting their clients. Perhaps they realise the students' lack of preparedness and are not in a

position to give the necessary support to help them deal with the situation. The mentor may be worried about the student's possible reaction, particularly if she has not spent any length of time working with her. The data revealed other factors involved in the process of 'shielding', connected with the material conditions of a midwife's work on a modern labour ward; such things as short staffing, lack of time, not knowing the woman beforehand, and not knowing the student.

6.5 Conclusion

The most important finding is related to the participants' changing perspective. As described in Chapter Five, they move from a view of birth which fits with the midwifery model to one that is closer to the medical model, but it appears that the training or supported experience that they receive in many cases does not enable them to feel confident about dealing with complications related to childbirth. The midwifery curriculum still has as its primary focus and philosophy a health-based concept of birth as a normal part of life. This as we have seen gives rise to a tension surrounding `the abnormal', and it may be for this reason that the students feel inadequately prepared on the whole.

There was also a widely held belief that theory could not possibly prepare one for the real experience. This belief has an element of truth to it, as Page and Meerabeau (1996) show in their study of nurses' accounts of cardio-pulmonary resuscitation. They say:

> The theory does little to prepare one for the sheer physicality and intimate proximity of the body work that may be involved (p319).

But there is also another, more fundamental factor:

> The absence of discussion of these issues within preparation for practice echoes their absence in social discussion since the `civilising' of the body began in the sixteenth century. Since this work is not openly discussed it is not

publicly displayed and as such becomes invisible, which poses problems for articulating the breadth of the nurse's role and its knowledge base (p319).

Page and Meerabeau are here pointing out the wider reasons for the lack of discussion of death. There is an inarticulateness about death in our culture, and particularly within conventional medicine and medical training. It is still a taboo subject. Yet if we accept that women, when they give birth, gain some understanding about death ‘from the inside’ as Cline (1993) suggests, this means that the potential of midwives and midwifery to truly ‘be with’ bereaved women is at present, to a great extent, being denied. A key aspect of the work of a midwife is not articulated. Midwives have had a long history of connection with dealing with death, and their role places them at the boundaries of life and death, yet we have not yet begun to explore the meaning of this, partly because of our history of medicalisation and the fear of death that goes with it. To begin some discussion of these issues would, I believe, be liberating but also very difficult to sustain in the context of obstetric practice today. The context in which these future midwives were working is the subject of the following chapter.

CHAPTER SEVEN

'I'VE NEVER, EVER WORKED IN SUCH A DIFFICULT ENVIRONMENT': THE CONTEXT OF CARE

7.1 Introduction

This chapter examines the students' experiences in the context of the organisations within which they were students and caregivers. The organisation and ethos of both the clinical setting and of the college inevitably played a part in the development of participants' attitudes. Some of the quotations in this section are longer than is customary in research reports but when presented in this way give a fuller picture of the overall environment and the many influences operating within it.

The nurse students were mainly based for their clinical practice in consultant units or with community midwives. Their college was a school of nursing and midwifery which had recently undergone three amalgamations and was shortly to be incorporated into a university. Some of the non-nurse students were initially based in a small, `low-tech' maternity unit which was closed during the early part of their training and incorporated into a larger consultant unit. One of the students remained in an outlying unit that dealt mainly with normal births. The midwifery education department had merged with a newly created

university shortly before their course began. During the period of the study hospital Trusts were in the process of reorganising services in an attempt to achieve the targets outlined in the document *Changing Childbirth* (DoH, 1993; Appendix B). So both these groups of students trained during a time of great upheaval both in the academic sphere and in practice. The issues most often raised by students when discussing their clinical experiences were problems to do with: short staffing, relationships with mentors, and situations related to fetal monitoring.

7.2 Not enough staff

Worries about having to cope alone with a difficult situation loomed very large in the minds of all students as they neared qualification. This fear of aloneness has been discussed in Chapter Five. In fact their fears were not unjustified according to the letters I received from students after they had been practising as midwives for several months. One woman, Lisa (nurse), who had qualified and moved to a different area wrote:

> Unfortunately you'll be sad to know I'm leaving midwifery. I've thought about it for a long time and decided to hand my notice in (...) I felt I needed a lot of support to make me stay. Unfortunately in this unit I've not had support. It's difficult with team [midwifery] to support 'E' grades because everyone who is on labour ward is there because they have a woman, and can't be nipping in and out of your room to look at traces etc. The co-ordinator very often is only 18 months to 2 years more qualified than me and looking after someone in labour now scares the hell out of me. When I'm on the ward, I'm more often than not on my own - especially on nights. I'm no longer prepared to run between two women in early labour, 4 women with feeding problems, a 28% section rate, the 'phones, the buzzers and the other psychological and physical care of up to 28 women and babies. It upsets me when I think that I'm not leaving because I don't care but because I care too much.

The key issues here are: firstly that she felt unsupported, and that she saw this lack of support as related to the new organisation of maternity care - team midwifery. Each midwife is responsible for her own individual client and thus couldn't be `nipping in and out to look at [fetal monitoring] traces etc.' It is

significant that she highlights `looking at traces' as something she needs help with; fetal monitoring traces were a constant source of anxiety to participants as discussed below. More often than not she is working on her own - and the staffing level renders it impossible to carry out adequate care. The picture she paints, with the phones and buzzers and breastfeeding women needing support is familiar to every midwife who works in a hospital.

When participants wrote to tell me how they had fared since qualifying, their workload was identified as the most stressful aspect of midwifery practice. This was a particular problem when midwives were caring for bereaved families. Emma (nurse) wrote:

> The main problem I have when looking after couples that have lost a baby is the time factor. I feel that we should have someone to take over the responsibilities of the midwife caring for the grieving couple, as this does not happen on the ward although it does happen on delivery suite.

Emma was now working in a different hospital from the one where she had trained. She had commented during an interview half way through her course:

> I don't think [dealing with stillbirth] would bother me if I had the time ... that is what I'd worry about, not having enough time, that's the one thing that would really bother me. If it's really busy on the ward I've seen them give a midwife who's looking after someone who's had an IUD [intra-uterine death], then they might give them someone who's in a first stage room, say for induction. So there may be readings and ... just the fact of having another case on your mind, when you'd rather just be with that mother. How can you go from someone who's just lost her baby to someone who's expecting a happy birth? [...] and that's all that would bother me if I was qualified, that there wouldn't be time.

So, sadly, Emma's fears about not having enough time, once she was qualified, to support bereaved parents were proving to be justified. Another qualified midwife, Mary, discussed helping a bereaved woman in labour, and continuing to care for her the next day:

> ...But what was almost doubly difficult was the next day ... we put her in the Rainbow room, which is for women who've been bereaved - which is lovely -

and [..] she felt much better in there [...] and then the next day all of the family came up, and I dressed the baby, took them in - and again I find that part of the job very satisfying - it feels a good part to do in a funny kind of a way - but at the same time I'd got a normal delivery, and I delivered the normal delivery within minutes of going backwards and forwards to grieving relatives and a dead baby who I'd just dressed - and I'm sure lots of other midwives have had to do the same thing - I'm not special - but the shift in emotions is just ... far too ... extreme ... if you're going to be able to do either of them competently. To share in the joy, and be with that woman and ... you're literally walking out of that room, going to the fridge, collecting the baby, taking that in, going back and within ten minutes or so ...

Mary indicates that although it is possible to manage emotions, this extreme case makes it impossible for the midwife to give adequate care to either woman. The data indicated that this was not a rare occurrence. Frances (non-nurse) while training also talked of the difficulties of caring for another client while also trying to support a bereaved couple. She and her mentor had cared for a woman experiencing a stillbirth, and left her to sleep until her husband returned:

And then a lady wanting a waterbirth came in and my mentor was the only one experienced in waterbirths and I'd done a few with her and we ended up in the opposite room with the radio on, trying to block out any noises because we couldn't move the [bereaved] woman really and the pool was obviously stationary ... and we couldn't ... and we felt really guilty because we were trying to be really happy for this woman and make that a good experience and then nip back across and see if [the bereaved woman] was all right. And then the Dad came back and the baby's head was visible in the pool and though I'd done a few with my mentor, I didn't want to be there on my own. So that was fine, and I went back and showed the Dad the baby. It was a good three quarters of an hour really [..] so I went back over the way and she still hadn't delivered, this girl, and then she delivered about ten minutes after, but we were on a late shift (normally ends at 9 p.m.) and we didn't get off until about 20 to 1 that night because we hadn't done any notes [...] and it was difficult ... nipping from one to the other really. You're trying to put on the right face and deal with your own emotions ... but... never mind.

This long quote describes the pressures on the midwives involved and shows how necessary it was for them to do `emotional work' (Hochschild, 1983, p132) in order to be able to care for these two women. The midwives were `trying to put on the right face and deal with [their] own emotions' i.e. give both women good care and also deal with the personal consequences of the experience.

There is no question of the `stiff upper lip' of professionalism here; it just would be impossible for these two midwives to express their grief and sadness at the stillbirth without this impinging on the experience of the woman with the healthy baby. She says `we felt really guilty' - implying that the tendency is for them to internalise the problems which have in fact been caused by the material conditions within which they are having to work. Also the telling pause at the end of this quote where she says '... but... never mind' seems to indicate that one is just expected to get on and cope with it. The narrative gives a suggestion of the amount of unpaid overtime carried out by committed midwives. It is likely to be mainly because of the calibre of the midwife mentor that she has ended up in that situation; that she was the only one experienced in waterbirths tells us about her attitude and expertise. Her approach to the student is conveyed beautifully in this quote too, as throughout it there is a feeling of mutuality and support. Frances says '**we** felt really guilty': not only were they doing the practical work together but also experiencing, and presumably discussing at some stage, similar emotions. As Frances later said 'she's compassionate and really supportive'. The relationship with the mentor has a crucial mediating effect in these emotionally challenging situations.

Not having enough time for psychological care was a common theme in the data and was also identified by Mander (1994). For example Mary continued, discussing the situation where she had been caring for another woman as well as the bereaved mother:

> But I think it's the whole aspect of time with women who've been bereaved as well ... They talk about dealing with women holistically, but psychological support often takes time, you know you have to be prepared to not talk and listen or give them time to talk as well ... and well, you know [you're told] 'you can have three women or 'you can have another woman, because she's not doing anything'... 'well, actually, she's grieving, you know, that takes time'... and plus the fact there's 6 million amounts of paperwork to do.

Mary's comment ‘they talk about dealing with women holistically’ suggests that one element of the theory-practice gap may be caused by the constraints of the environment within which practitioners are working. Porter and Ryan (1996) argue that:

> The gap is not the result of clinicians' ignorance of nor antipathy to theory, but is largely generated by the lack of resources enjoyed by nurses.

Being busy' and `being seen to be busy' have been discussed as integral to the culture of nursing (Melia 1987); and Menzies Lyth (1988) has argued persuasively that the routinised nature of nursing is a means whereby nurses protect themselves from anxiety. There were instances in my data, and from discussions with practising midwives, where midwives felt forced, in situations where they were the only practitioner available on a busy ward, to make choices about where to concentrate their energies. Ensuring someone's physical safety had to take priority on these occasions. While no doubt there are individuals who shelter behind the performance of routine tasks as a means of reducing their anxiety, the impression I received was that these newly qualified midwives were keen to give 'holistic' care, and found it more satisfying when they were able to do so, but that they were often frustrated because their workload meant that it was impossible for them to devote the necessary time to women. Some of the students' fears about qualifying were related to this heavy workload. Lovell et al. (1986) in a study of fifteen bereaved mothers found that one frequently voiced criticism was that they sensed the limited time staff were able or willing to spend with them. Rosemary Mander (1994, p67) who interviewed qualified midwives about supporting bereaved women states that the difficulty of making time to listen emerged from the interviews:

> The midwives told me of the strategies they used to ensure that they were not disturbed with a grieving mother. They were aware that although they might

make time to be with the mother for an hour, say between 14.00 and 15.00, that might not be the time when the mother felt like ‘opening-up'.

So their lack of time was here forcing them into an approach that could not be considered a holistic one. This question of whether the difficulty of ‘making time' is due to psychological factors or to constraints within the working environment, or rather to what extent the two elements interact in different individuals, is an area which would repay further study. Moreover, if midwives are already anxious because of not having enough time for any of their clients, this anxiety will lead to still greater defensive behaviour. The overall conclusion from the data in this study, and from discussions with clinical midwives, is that staffing in the units concerned was insufficient to allow midwives to function as they would wish, or as women would wish them to. The holistic care advocated in *Changing Childbirth* (DoH, 1993) was still a long way from realisation.

7.3 Continuous electronic fetal monitoring

I include a discussion of electronic fetal monitoring here because it is a topic that occurred in the interviews many times despite the fact that I never questioned participants about it. The use of electronic fetal monitoring was associated with anxiety for participants:

Brenda (nurse): It's that difficult when you're monitoring the fetal heart and it's audible and you hear it decelerate and you think, how long do I stand here like this and will it pick up? and then it's not knowing whether it's just because it's gone into second stage and that's why, or whether there's something up and it's ..... that's what frightens me about being qualified....at the moment there's always somebody I can look across to and say ‘is this all right?'

Brenda hints at the extreme anxiety she faces, and will face once she is qualified; not feeling able to tell whether things are normal or whether 'there's something up' - i.e. that the fetus is hypoxic, and therefore in danger of dying or being damaged during birth. She pauses without naming that fear and then goes on, ‘that's what frightens me about being qualified' and again there is a sense that she feels there will be no-one to turn to, and she will be responsible

before she feels ready to take on the responsibility of making these clinical judgements.

There were differences between individual qualified midwives and doctors in the way that tracings were interpreted. This difficulty with interpreting fetal heart traces has been one of its fundamental problems. Fetal monitoring provides information about the fetal heart rate. However, tracings are not only interpreted differently by different obstetricians, but also by the same obstetrician at a later time (Enkin et al., 1992). If this is the situation for experienced practitioners, then, how much greater will be the anxiety for the novice. Brenda continued:

I find the monitoring really difficult - I've had tracings where I've gone out and said to the midwife ‘Look at this, it looks a bit flat' and they've said ‘Oh no, it's fine, look at this, this and this' and then I've had a tracing that I've thought ‘well, it's similar to that other one and they said that was fine and I still show it to them and they say ‘oh, no, that's not right'

Whereas Brenda was seeing her difficulty with cardiotocograph traces as largely due to her inexperience, Lisa described the same phenomenon, illustrating how the use of technology, and clinical decision making are social phenomena too, and how difficult this can be for students and new midwives:

Lisa (nurse, newly qualified midwife):I had a case the other day - the woman was on a monitor and the fetal heart started 'dipping' quite badly - late decelerations, they were, so I got the registrar in [...] and she said ‘If it doesn't improve in about 15 minutes, just give me a ring again.' There were three G grades in the office and I said ‘I'm not very happy - it's not got any worse but it's not got any better' but each and every one of them came in and said ‘It's fine, don't worry about it' but I know now. I've learned my lesson. I just felt I couldn't go to the 'phone and ring the registrar because I felt that I'd be undermining what they'd just said. I could kick myself now, because I just think, next time just go over their heads, but it was very difficult.[...] The next morning the midwife who'd taken over said ‘really, you should have got the doctor in a lot earlier to see that trace'. [...] I just felt I wasn't supported very well, they all knew about the trace ...

Her account portrays graphically how nerve-wracking it can be for newly qualified midwives, and students when they feel unsupported. These are

crucial decisions and midwives are called to account for them. Fetal monitoring traces are often used in cases of litigation, and the most common complaint is when abnormal traces have not been acted upon quickly enough. It is not surprising that this is a source of anxiety, and that it may be hard for students to gain confidence in their clinical skills in an environment where monitoring is a dominant feature of care. This problem is reminiscent of Ball's (1987) research into postnatal care which found that one of the aspects of care that caused new mothers anxiety and impaired their confidence was conflicting advice from midwives. The same process can be seen as occurring here with students and fetal monitoring. Lisa (nurse, qualified midwife) said:

> Sometimes my eyes are glued to the monitor, because I'm worried about the trace, but sometimes I just think God, just forget the trace! ... and the woman's looking at the trace and ... you know I'm really worried, I just think, all I've seen - don't get me wrong, I've had some lovely normal deliveries, but if all I've seen is 'hi-tech', what am I going to do [...] you do become dependent, that's what happens to the midwives there - they've become dependent on all this technology, and I'm just worried in case I've become dependent on it, which I don't think I have at the moment, but ...

Monitoring fetal and maternal well-being using one's own observational skills is fundamental to midwifery but these participants were worried that they were not able to learn these skills and that they were becoming dependent upon technology. In surveys of women's views about fetal monitoring, some find it reassuring, particularly those women whose labours have been deemed high risk. However surveys have also found that it causes anxiety in a number of ways. Some women find that it is uncomfortable. It restricts a woman's freedom to move around and may give rise to justified concerns that the electrode will damage the baby's scalp. Women reported that the monitor was a distraction that interfered with the relationship between the mother and her caregivers or companion (Garcia et al., 1985) and being electronically monitored appeared to increase a woman's chances of being left alone in labour. Enkin et al. (1992)

in a review of randomised comparisons of different methods of fetal heart rate monitoring, conclude the evidence suggests that:

> intrapartum death is equally effectively prevented by either intermittent auscultation or continuous fetal heart rate monitoring, provided that importance is attached to the prompt recognition of fetal heart rate abnormalities [...] the current evidence suggests that more intensive monitoring increases the risk of intervention with no clear benefit for the fetus [...] Regular auscultation, by a personal attendant[...] therefore appears to be the policy of choice.

They point out that it may be difficult to achieve this in hospitals where universal fetal monitoring is the norm, firstly because individualised care is seen as not possible to achieve, and secondly, because of midwives having lost confidence in their ability to monitor labour by intermittent auscultation. The evidence from my study indicates that electronic monitoring hinders students from developing confidence in their midwifery skills. It has been known for some time, since the large randomised trial performed in Dublin (MacDonald et al., 1985) that electronic fetal monitoring increases the morbidity of mothers without improving long term outcome for the baby, but it still remains common practice in many units. The reasons for the persistence of this practice, therefore, must be social rather than `scientific', and an exploration of the reasons suggest that it may be connected to a fear of death. Sullivan (1996) suggests that fetal monitoring is used in an attempt to ward off fear of death. The assumption seems to be that if we can only have more information from inside the uterus, we can predict whether everything is going to be all right. But paradoxically this talisman used to reduce anxiety merely creates further anxiety because there is a lack of agreement upon how to act on the information it provides, and ‘the trace’ may be used as evidence against practitioners in court cases. It also distances midwives from women because of the use of technology rather than touch. It is possible to speculate that dependence on technology, because it reduces the ease with which carers can pick up subtle, bodily cues from women, makes it more difficult for midwives to

tune into what are often referred to as intuitive feelings about women, so that they lose a sense of connectedness, and feel more alone.

7.4 The micropolitics of the maternity unit

Whilst the conflicts between doctors and midwives appear often in the literature, usually when difference in philosophy is being discussed, inter-midwife difficulties are written about far more rarely; although they are often discussed informally among midwives. Although occasionally participants had clashes with doctors, more often it was other midwives who made their lives difficult. In one way this is self-evident because as the students are supervised, they have far more to do with other midwives so are more likely to discuss problems relating to them. However it was also clear that many of the midwives did not hold what is widely accepted to be the `midwifery philosophy' of birth as a normal event and the midwife as autonomous practitioner. One non-nurse student (Josie) described a clash with her mentor which was related to the boundaries between midwifery and medical work:

> The doctors expect you to clear their trolleys for them...the midwife I told you about, the dragon, said "Will you clear that trolley?" and I said "Well, why couldn't the doctor do it?" and she said " The doctors are busy and that's what we're here for". I said "What if I got a needlestick injury, touching his sharps?" And she said "Well, you've got to make sure that you don't. They're busy people, they haven't got time. That's what we're here for - to look after them." She didn't like me for that afterwards!

Midwives, and nurses are working in an environment where women are still subordinate; the work they do is seen as `women's work', their pay is in most cases less than a third of the average doctor. One of the ways in which midwives seem to shore themselves up in the hospital is to ally themselves with the mores of the institution and with the other staff rather than with the women. This was clear from Hunt's (1995) study, where she examines the rituals on a labour ward, including the cultural significance of the tea break.

Thus one of the participants in this study was told by her mentor, "you spend too much time with the women": the norm was to spend time in the office with the other midwives. There is an accepted way of doing things and if a midwife or student doesn't `fit in' her life may be made difficult. Students or midwives forging bonds with women was perceived at times as threatening. Deirdre (nurse) described a situation where she and her mentor had built up a good relationship with a young, scared sixteen year old woman in labour:

> And then we went for tea and when we came back from tea another sister had gone in, who didn't even know this girl, and the sister said "she doesn't want me, she wants you two back", gone in and said to this girl "well, you're still 8 centimetres, you're going to have an ARM[10], your contractions aren't good enough." And I thought how dare she - it's not even her patient and to go in on someone's teabreak and do that! So then we went into the office and the midwives said "Why didn't you do an ARM on her?" There was an office full of midwives and all of them said to her "Why didn't you ARM her at the last (vaginal examination)" - because they do that here, as soon as they can get in, they do it, it's terrible.[...] So this midwife said "There was no indication whatsoever" so one of the midwives said "Doctor P said when he came up here she had to have an ARM". So she said "If Doctor P comes, look at the partogram, how's that for progress, you can't get any better progress than that, if he comes and starts argy-bargying" she said "What's the point - can anyone else give me a reason why I should have done it?" And the sister in charge of the unit said "To see the colour of the liquor" so she said "I've been listening in, there's no sign of fetal distress, what are you talking about?" In the end, all the midwives said she should have ARM'd her and to go in and do an ARM ... We came out and she said "See what you're up against?".....I felt so sorry for her [...] If your colleagues aren't backing you up it's so hard ... I do feel sorry for her, because she got no support whatsoever.

At the beginning of this quote, the sister's action of going in and overriding the initial management is also linked with some resentment of the bonds the three had already forged because she says of the young woman "she doesn't want me, she wants you two back." Performing an amniotomy (ARM) in this case was clinically unwarranted and would probably have caused the woman to experience more painful contractions, but the doctor had said it should be done

[10] ARM - artificial rupture of the membranes, or amniotomy. Employed by midwives to acccelerate labour in cases of slow progress but often carried out as a routine intervention in hospitals where active management of labour is normal policy

and only one midwife was prepared to stand out. Standing out makes her vulnerable, and she knows that if a problem does then develop, in this instance she will get little support from her colleagues. The midwifery model is nominally espoused by individual midwives but is still not part of the culture of this particular unit, so therefore most of the midwives feel safer allying themselves with the dominant model, that of the doctors. Perhaps too, this is another reason underlying participants' talk of feeling alone - because they are exposed and unprotected when they adopt a woman-centred approach in such a climate. One participant at the end of her course wondered about what sort of midwife she wanted to be:

> Carol (nurse) I have worked with a midwife... I know there was a baby that died recently and she got really involved with the family [...] she's so lovely with the ladies and she got so involved - this couple got married and she was invited to the wedding. She does get quite involved with the people, where some of the midwives, some of the other midwives think she gets too involved really, she doesn't know where to draw the line ... I'd like to see myself doing similar things, but I don't know whether I'd go as far as (B) does, to see them out in the community ...I'd like to think I could support the women, but I don't know whether I'd go as far as be friendly with them to that extent - I don't know whether it's right or wrong [...] she's really professional about everything, does her job really thoroughly, I know she really lives for midwifery [...] a lot of the midwives ... really don't want to be involved - they go to work, do their job, go home and that's it...

Midwives who are really `involved' pose something of a threat to those who see midwifery as a job and are more detached from their clients. Carol didn't think this midwife's involvement was unprofessional, but she wasn't sure whether she personally would get so involved. Perhaps she felt being accepted by her colleagues was more important. She would like to see herself supporting women, but she's not sure if it's right or wrong to actually be friends with the women - this is phrased as a moral decision about what sort of midwife she will ultimately be. With woman, or with the institution?

Another (nurse) student in her last interview before qualifying, grappled with a similar question, wondering whether she did in fact want to practice autonomously:

Brenda (nurse): This has been going through my head recently... as a newly qualified midwife, is it going to be more stressful having all that power and would I be better off working in a unit where there's a lot of intervention and midwives haven't got much power to start off with - until I get confident in doing certain things, but I mean, half the battle is staying where you know the policies and procedures and the paperwork.

Power and autonomy brings the uncertainty of choice and responsibility; it seems safer for this new midwife, perhaps, to retreat into the ostensible security of procedures and paperwork. Midwives respond differently to the tension between the midwifery and the medical model. Some choose, whether consciously or unconsciously, to operate as 'obstetric nurses', following policy and procedures and allying themselves mainly with the bureaucracy. Others see themselves as autonomous practitioners, their main allegiance to the women; and very often they are ostracised by their colleagues (Robinson, 1998). One qualified midwife, Mary, a non-nurse, expressed the paradoxical nature of the environment in which midwives are supposed to be helping women to give birth to their babies:

I've never, ever worked in such a difficult environment - it's a women-only environment, yet it's the least woman-friendly...[...] But I sometimes wonder ... and think ... how do you think you're going to get confidence if you're surrounded by fear the whole time? The people who should be giving you confidence, the senior midwives, are saying 'Why haven't you put her on the trace? The doctors won't like that!' and 'Don't forget to do your documentation, you know, litigation and all that!' I mean, documentation **is** important, but it's that whole thing all the time - 'don't forget to watch your back' and ... 'have you washed her down properly?' (*laughing*)

This last line is a beautiful exposition of the way in which the 'watch your back' mentality' (also discussed by Annandale, 1996) may foster a rigid, task oriented approach to care - 'washing her down properly' sounds like hosing down a car, or a dirty animal. The litigious environment cuts these women off

from their own abilities truly to care for mothers: there is an atmosphere of tension, even fear, which stifles creativity and produces `the frightened employee' talked of by Merton (1968). The frightened employee plays safe by rigidly sticking to policies and procedures.

An essential element of good professional care, however, from the perspective of recipients, is genuine concern for the individual as a person (Halldorsdottir and Karlsdottir, 1996b) and this means having the freedom and the ability to be flexible in responding to clients' needs and wishes. One woman in Halldorsdottir and Karlsdottir's phenomenological study, who during her labour experienced a 'severely uncaring encounter' (p146) said:

'I was hurt and bitter, both because she had been so harsh, brusque and inconsiderate and not being able to bend a rule when it is very important for you' (p146).

The authors conclude that:

'the nurse/midwife perceived as uncaring is perceived as being thoughtless, strict on routine and rules [...] , not taking notice of woman (and husband) and being non-co-operative' (p146).

7.5 Conclusion

If such rigidity of approach is damaging to women, we can see that it is of the utmost importance for women that as midwifery educators we explore how best we may foster a flexible attitude to caring, so that the prospective midwife may ultimately become a midwife who has the strength and courage to to 'bend the rules' when she judges it to be necessary in her client's best interest. Some of this is organisational, relating to issues of power and the question of who makes the rules in the first place. Some of it is to do with the way learners are treated, and of course these two elements intersect. Kirkham (1997) has

referred to ‘parallel processes’ whereby as we are treated, so do we treat others. The following chapter examines the experiences of participants in terms of the support they felt they received during their training.

CHAPTER EIGHT

YOU REALISED IT WASN'T JUST YOU: SOURCES OF SUPPORT FOR STUDENT MIDWIVES

8.1 Introduction

If becoming a midwife is a `rite de passage' (Van Gennep 1960), and if, as I have argued, the transition for student midwives is particularly demanding, the question of support becomes important. Students interviewed discussed various forms of support upon which they drew through the course: support from home - partners, family and friends; peer support - from other students; support from clinical staff - auxiliaries; and support from `mentors'. Interestingly, academic staff (personal tutors) were rarely mentioned by these particular students when discussing support networks. This chapter focuses on the support available to students vis-à-vis their training, because although relationships outside the course inevitably have an important bearing on students' overall experience of midwifery education, this was not an area that was explored in depth with participants in the interviews.

8.2 Peer support

Some participants, it was clear, drew a great deal of support from friends and family at home, but of course this was not true for all. Most of the students mentioned the value of peer support. Several said how they felt that some things could only be understood by others going through similar experiences:

Angela (nurse):You realised it wasn't just you, everybody was the same. (...) During my training I lived in the nurses' residence so I was with all the girls from my set there.(...) I don't know if it would be quite the same if I'd lived at home or lived with people who weren't nurses. I think that they can feel more empathy ...they've been through it themselves. I know if I tried to explain to my husband I don't think he would fully understand.

Peer support seemed to be especially important for the non-nurses, all of whom talked enthusiastically about the support they received from the rest of the group. The sharing of experiences added to their learning too:

SD: Who are the people you would talk to?
Kath: Colleagues in the group. That is the most crucial. We learn a lot from each other. We say, 'I did this delivery and this happened.' We learn a lot from each other.

One of the non-nurse students was a single parent, with no living parents. She said that she got support from work:

I really haven't got support at home to turn to. [My children] are quite young, I don't think they would appreciate...! But yes, definitely work colleagues, I have been very lucky with mentors... anything I have addressed with the mentor has been addressed, I've never had to come into college and look for tutors to discuss things, I've been very lucky in that respect, but we are a good group and we do discuss a lot of things together.

Firstly, she says she has been ‘very lucky ' with mentors: the implication of this is that possibly others aren't so lucky, or that it is a bit of a lottery. Secondly, tutors are seen as a last port of call for support. Seeing a tutor about a problem involves having to ‘come into college'. The impression the students gave, if they mentioned tutors at all, was that mainly they tried their best to sort things out in the clinical areas without involving the academic teaching staff. Thirdly, she says ‘we are a good group'. The non-nurse group tended to speak of themselves in this way. The nurses did not. They did not appear to have the same cohesion, and the value of support from their group wasn't mentioned to the same extent. The nurses tended to discuss the value of group support when speaking of their initial training as nurses but not when speaking of midwifery training. This possibly relates to the need students have to stick together during their first episode of socialisation as a health professionals, or it may be due to other factors such as the dynamics of the particular group. One nurse said that her group `wasn't very outspoken.'

8.3 Auxiliary nurses

Both groups of students spontaneously mentioned auxiliary nurses as being particularly helpful. This has been discussed in the literature with regard to talking to patients and fits with Melia's (1987) and Smith's (1992) findings that talking was perceived by trained nurses as ‘not real work'. The structure of the hierarchy means that auxiliary nurses are seen as more approachable, and as Melia discussed, less ‘busy':

Brenda (nurse): Auxiliaries on the ward tended to be a lot better than the qualified staff. In fact all the way through my (nurse) training I learnt more from the auxiliaries than from the general...
SD: I wonder why that is...?
Brenda: I know from qualifying now that the qualified staff are very busy and they have a lot of pressure on them, and the auxiliaries tend to have a bit more time and are able to show you things and they seem more approachable on the whole. So if you have a problem you tend to go to them.

Brenda appears to accept that qualified staff are ‘very busy' and that this is a factor in their lack of availability but she also says of auxiliaries ‘they seem more approachable', suggesting that it is also linked with their position in the hierarchy. One of the non-nurses was rather more forthright on this question:

SD: You said if a mother or baby died there would be plenty of people you could talk to...?
Kath: (...) I think the auxiliaries are best. I think they are looked down on by trained staff and I think... when a member of staff is giving you a lot of hassle on the wards it's the auxiliaries who say 'keep your chin up' or whatever (...) a lot of midwives , nurses or whatever, they could have, say, 20 years of experience and they just treat everybody like a dogsbody.

It is clear that this non-nurse participant identifies with the untrained staff, and so probably did the previous student during her nurse training. But the previous participant, having qualified, now knows that ‘the qualified staff are very busy' and feels that this is some justification for the fact that they spend so little time with students. The non-nurse student gives a graphic illustration of the hierarchy, and the power that, for some, having 20 years' experience brings.

The words ‘keep your chin up' suggest empathy and solidarity amongst those at the ‘bottom of the dirt pile' (Smith, 1992, p120)

8.4 Mentors

The mentor had a tremendous influence on the lives of the participants in this study. The mentors singled out for praise by the students were described as confident, assertive women:

Frances (non-nurse): She's very, very strong - she has a strong personality, very experienced, very confident and very alternative (...) A lot of people don't like her ... she says exactly what she thinks. She is very assertive.

The comment 'a lot of people don't like her' is illuminating and tells us a great deal about the context in which these women are learning to be midwives. It brings to mind the study conducted over two decades ago by Broverman et al (1970) and discussed by Oakley (1986, p25). In this famous study a group of mental health clinicians gave identical descriptions of ‘normal healthy men' and ‘normal healthy adults' while ‘normal healthy women' were described as submissive, easily influenced, excitable and emotional and not independent or aggressive. This, argues Oakley, is the image of women ‘extant in the medical model'. The image of the confident autonomous midwife does not readily fit with the medical model and there are many examples of conflict whenever midwives attempt to act autonomously (see Robinson, 1998).

Kath (non-nurse) talked about her mentor. Her comments give an insight into the role of the mentor:

She's great. I've learned so much. I've worked with her for three years. She's not one of these midwives who don't let you do anything. She [says] 'you haven't done this, you're going to do it... and I'd love to be a midwife like she is, to stand up to the consultants, and say 'No, you're not doing that'.

This quote neatly encapsulates the different aspects of a good mentoring relationship: attraction, teaching and learning, continuity, risk-taking and role-modelling (Darling, 1985). Kath continues, giving an idea of the extent of this

mentor's influence on her learning, but more than that, on her life and self image:

I might have been a totally different person now...I do feel extremely lucky. She's been great. She's put up with a lot! She was my first mentor...I'd never been on a ward before. On the first week I said 'what are your feelings on pre-reg?' and she said 'I've got no feelings at all, a post-reg student or a pre-reg... Fair enough, you don't know how to do BP's and so on but you can learn that. You're both the same midwifery-wise'.... I'll never forget her for that.

The acceptance that this midwife showed to her made a crucial difference at that first exposure to midwifery, when she had never before set foot on a ward. Although the curriculum was not designed to allow for self-selection of mentors, in the non-nurse group it was informally arranged by some of the students. I checked this with one of the tutors who told me that the more confident assertive students tended to do this. This may have been evidence of a process sometimes known as the `Matthew effect':

This is the name given to the circumstance in which gifted students find mentors more easily than less gifted students or disadvantaged minority students, which increases the existing gap between the groups. The Matthew effect comes from St. Matthew's gospel: `For to every one that hath shall be given, and he shall abound; but, from him that hath not, that also which he seemeth to have shall be taken away' (Caldwell and Carter 1993, p19)

Another participant, Mary, a non-nurse midwife, spontaneously referred to an example of this process:

Interestingly, I saw a woman I trained with the other day - she's slightly older than me, and she had very very low confidence levels - much lower than mine, and was very seriously thinking of giving it up at one stage [...].. and she had very poor mentoring as well. It was almost ironical, the ones who needed it the least got it the most - the ones who fitted into the system - they came across as quite confident. Whereas (the midwife student I trained with) wouldn't have come across as confident in any way, and at one point she had to change her mentor because she got on so badly....

This suggests that if a student `fits into the system' and is unthreatening she is likely to be popular, and find mentors easily. This in turn will increase her confidence. The criticism of `lacking confidence' seemed to be a difficult one to deal with, and once lack of confidence had been highlighted it seemed hard to

throw off. It suggests, again, the importance of the mentor in helping students develop confidence. Confidence among newly qualified midwives was identified by interviewees in an ENB-funded study of the effectiveness of pre-registration education as being, most importantly, the ability to admit to not knowing something and being able to ask for help from a more experienced practitioner (Fraser et al., 1997). Thus trust plays a crucial role in the development of confidence.

Kath and her mentor (see narrative in Chapter Nine) may have found the mentoring relationship came relatively easily because she was still very young (18) and the power balance in the relationship was not problematic in the way that it might be for other mentoring pairs. Perhaps it was no coincidence that the student who had most problems with mentors was the oldest in the non-nurse group (38). Another 37 year old in that group left the course fairly early on. Pre-registration courses in midwifery aim to attract mature women (see Chapter Two): perhaps research is needed to examine in greater detail the experiences of mature students in midwifery, as it is possible that there are specific problems for older women in the hospital hierarchy.

The negative effects of an unhappy mentoring relationship were evident from the interviews. It seemed that in some instances this could have a lasting effect on the student's confidence. There were examples of what Darling (1985) referred to as ‘toxic mentoring'. The most commonly reported form of problem mentor seemed to fit a particular type of person described by Heirs and Farrell (1986) as 'the rigid mind'. This is one of the psychological responses to bureaucracy described by Merton (1968, p204). He called it 'overconformity', the perspective of the frightened employee, saying that fear produces 'routinised action'.

Heirs and Farrell (1986) categorised those operating with 'rigid minds' as concrete thinkers, dealing only with black and white concepts and having

preconceived ideas that are not amenable to change. They argued that such people lack imagination or creativity, feeling safest in bureaucratic surroundings. Because the rigid mind is suspicious, and resistant to new ideas, when placed in positions of authority such people attempt to stifle the ideas and innovations of others.

Emma (nurse) said of her mentors:

> They never praise you when you do something right ... or if you use your own initiative it's not 'Well done!' it's … 'that's not according to policy'. It's very 'you do it and you don't question it'

Pam Smith (1992) examined students' experiences during their training:

> Students describe trajectories where they begin fresh and enthusiastic with an `uncanny way' of getting to know their patients, but arrive at the end of three years' training `cynical and disillusioned' (p141)

Smith speculated that this was due to fragmented relationships and lack of consistent support and concluded that

> if students' individuality and caring commitment is repressed too often and for too long then it is likely that they will choose hierarchical relations, stereotyping and labelling as preferred forms of emotional labour (p141-2)

Certainly, it seems from the participants' accounts, that many midwives end up abandoning the goal of remaining 'women-centred' in the medical hierarchy. One newly qualified midwife (Greenall, 1996) described the effects of working in this climate, on herself and on a fellow midwife:

> I understand why morale is low. I know I can't work for long periods meeting sometimes ten women a day, forming a new relationship with each... working like a cog in a machine... repeating the same words and phrases... repeating the same actions as if I were a robot.... When a woman requested a bath before being given syntocinon, I found myself checking with a doctor and writing down his response. I was grateful to be covered by a medical opinion; that someone else had made the decision. Of course I knew that there was no reason whatsoever why she could not have a bath!...(...) Recently I was reported to the manager by a sister (...) I had given a woman a piece of toast - not a cracker, ice cream or other item listed on the protocol. (p7)

Emma (nurse) talked of her experiences:

I don't find the staff very helpful anyway. But unless you actually ask the midwife you're working with how they'd deal with that or could I have done that differently, they don't usually come back to you unless you've made a mistake. They never tell you 'Yes, that was good' or ‘I would have dealt with it this way’.

Giddens (1991) makes some retreat into routine understandable, not just as a reaction to bureaucratic structures but as a human tendency in day-to-day life:

the chaos that threatens on the other side of the ordinariness of everyday conventions can be seen psychologically as 'dread' in Kierkegaard's sense: the prospect of being overwhelmed by anxieties that reach to the very roots of our 'being in the world.' Practical consciousness, together with the day to day routines reproduced by it, helps bracket such anxieties (p37)

Although Giddens is discussing ordinary daily routines here, his approach may make us a little more sympathetic towards the 'rigid mind', in that rather than berate individuals for their shortcomings we may examine the conditions, both material and psychological, that lead to the development of such attitudes, and then set about trying to change those conditions.

The relationship between mentor and `mentee' had some similarities to a parent- child relationship, in that when it was successful, it provided a secure base from which the student grew and developed, ultimately gaining enough self-confidence to become independent. Caldwell and Carter (1993) made the same analogy when discussing the study by Levinson and colleagues (1978). They had talked of 'good enough' mentors, who are less than ideal, but adequate in a practical sense. It was Winnicott (1988) who first used the term 'good enough', and used it in the context of parenting: he spoke of 'the good enough mother'. Although it would be useful to research what constitutes 'good enough' in midwifery mentors, it is an interesting analogy in that it links with psychological research concerning the development of basic trust.

Students interviewed in a study of mentorship by Earnshaw (1995, p276) identified the role of supporter as a key role. He says:

‘many of the students seemed to view the mentor as a matriarchal figure whose purpose was to smooth their passage through training rather than to provoke, challenge and present them with the unfamiliar.’

Many of the students in his study saw the mentor as reducing stress, helping with orientation, ‘settling in'; and giving them a 'sense of belonging'. Earnshaw is somewhat disparaging of this wish of the students to have a `matriarchal figure' smoothing their passage but given the information from this and other studies of professional socialisation in the health service it is an understandable need. This aspect of the mentoring role may indeed be the most necessary one if students are to gain any degree of confidence.

Some participants said that they felt that acceptance by the mentor, and developing a sense of belonging, was dependent upon them adopting their mentor's standards so there is evidence that the development of confidence was dependent upon their `fitting in' with the mentor and the mores of the institution.

8.5 Conclusion

It is argued here that midwifery training, because at its heart it concerns matters of life and of death is a particularly challenging experience. The development of confidence is a crucial issue and needs to be further investigated. If we wish to produce midwives who are safe, competent practitioners we must ensure that they are adequately supported as they go through their training. Students undertaking pre-registration midwifery training come into midwifery from very different backgrounds and there is a need, both in the classroom and in practice, to develop systems of support which

recognise and value the different life experiences and philosophies of students.

Where midwives themselves are feeling vulnerable and under threat, they may resort to practices and develop attitudes which are not conducive to student learning and self development. Increasing the autonomy of midwives, and their control over their own practice, and perhaps most importantly, creating a climate of trust and co-operation, will improve the learning experience for students. The next chapter, through referring to the narrative accounts of three participants, demonstrates the central role of the mentor and explores other factors which sustained students on their journey to qualification.

CHAPTER NINE

PROFESSIONAL SOCIALISATION INTO MIDWIFERY: NARRATIVE ACCOUNTS

9.1 Introduction

During the analysis of emergent themes using the coding and categorising that is characteristic of grounded theory, it became clear to me that the method needed to be complemented by a more holistic, less fragmented approach in order to do justice to the development of individuals over time. A key feature of the narrative is that it has temporal qualities; like all good stories it has a beginning, a middle and an end (Coffey and Atkinson, 1996). As the study progressed and differences between students emerged, particularly differences in their levels of confidence and the way in which they conceptualised birth, it seemed that these differences could be more fully exemplified and explored by giving individuals a more coherent voice. Participants' stories were often vivid and moving, providing a window into the socialisation process. Kirkham (1997) describes the significance of stories as follows:

'A story tells more than its tale. It speaks of context and values. Listeners absorb the story through their own view of the world and by links with their own stories. The tellers reinforce different aspects of their own values in each unique story-telling' (p183).

Storytelling is, therefore, a shared or dialogic activity. Narrative analysis has been described as an especially valuable approach to the analysis of qualitative data (see Reissmann, 1993) because it can provide a critical way of examining, not only key actors and events but also cultural conventions and norms (Coffey and Atkinson, 1996). It is also a technique which can give weight to the voices of oppressed groups that might not otherwise be heard (Plummer, 1995). The narrative accounts that follow are the stories told by three of the participants, constructed by me from the interview data and checked for validity with two of the participants concerned.[11]

Although it is useful to fragment the accounts of participants in order to examine themes that emerge from the data, at times it is appropriate to

[11] I sent a copy of my analysis to all three participants but did not receive a response from Kath.

examine them individually as narratives. The participants are individuals with their own history and personality, and although there are many common themes in their experiences, the differences between them are also important. At the end of the study there were marked differences in the prospective midwives' levels of confidence and enthusiasm, and these persisted after qualification. Case study analysis is a useful method for examining key factors in the development of individuals. The following narrative accounts outline the experiences of three of the participants. Each of them is a non-nurse, so the accounts will not be used in order to make comparisons with the nurses but to explore the process of socialisation into midwifery as it affected three women. The cases have been picked because each shows a different process taking place, and also because of the vividness of the descriptions.

9.2 Gail

I interviewed Gail four times during her three-year course (unlike the other students, whom I interviewed three times, and Kath, whom I saw twice). I then spoke to her on the telephone when she had been qualified for six months. A few months later she wrote me a letter about her experiences since qualifying. Gail was a mature student of 38, who had three children, and had previously worked as an auxiliary nurse on an obstetric unit for three years. At the first interview she was quietly positive about the course and her reasons for undertaking it. At this stage, early on in her training, she appeared to have an empathic approach to the women and related to them as equals. Her language tended to be non-medicalised:

I delivered one the other day and so the next day I went down to the ward to see her and I walked in and she said "oh give us a hug" and I thought "oh!" She said "I couldn't have done it without you" and it made it worthwhile.

Replying to the question on how she might cope if something went wrong, she replied:

I hoped that I could sort of take it on board and still be there for the mum, to care for her as she needed.

She said that she had considered problems such as stillbirth prior to starting the course because of her experience as an auxiliary nurse. She had seen a stillborn baby. She said: ‘I knew that coming into midwifery that this is going to happen’.

This response was in marked difference to all the other students, both nurses and non-nurses, who tended early on in the course to say that they hadn't given much thought to this aspect of midwifery. Unlike the others, too, Gail then spontaneously began discussing issues relating to stillbirth and loss:

I couldn't imagine how terrible it must be for the parents. I've been given three live babies and to think that one of them could be dead, it doesn't bear thinking about. From a personal point of view it must be terrible. (...) I think in some ways if a baby dies, it's final. It's when a baby is either critically ill or going to be handicapped for life, I think that must be worse, because you look to the future and think how am I going to deal with this living being whose quality of life is so poor.(...) In many ways it's like a death, because you expect a healthy baby and if you're not given a healthy baby it's a death of your expectations.

Gail was showing a great deal of insight for a student at this stage of her course, when there had been no classroom input about loss. She then went on to tell me about a recent bereavement she had experienced.

A year on into her course, at her second interview, Gail had suffered another bereavement of a close relative. She had also seen two deaths on her clinical placement on a medical ward. She witnessed a resuscitation where the woman subsequently died, and also a failed attempt to resuscitate an elderly man:

there they were fighting for his life and I thought `thank goodness, let him go' because I'd seen it [with my relative] so I was glad with this man I just thought `oh, leave him alone', you know. So I stood with him for about half an hour, while everyone was rushing to tell his family and I held his hand - I didn't want to leave him on his own at that point. (...) I think if you've seen death close to with family you can take it on board, when it's people that you don't know.

She discussed her own experience of the death of her close relative as something which helped her to deal with the deaths of patients.

SD: Was there anything more you wanted to say about those deaths?
Gail: Well, they were both relatively elderly, at least they'd been given a chance of life, because when you have a stillbirth, it doesn't seem fair, they've not been given any chance of life, have they?

Gail had had a high death anxiety score which we discussed, thinking it might be related to the fact that her relative had so recently died. A high score on the Templer and other death anxiety scales is commonly presented in the literature (e.g. Durlak, 1978) as a negative attribute. A high score is considered to be indicative of an inability to deal effectively with the issues raised by an awareness of death. In contrast, Gail discussed death thoughtfully and openly. This was not the case with most of the other participants. Perhaps her death anxiety score merely reflected the fact that she was thinking and reflecting more about death than the others.

When questioned in her second interview about the theoretical aspects of learning about helping bereaved parents, Gail replied:

Gail: I think until you're actually in the situation - if it's born alive and then - dead - you would be feeling `is there something I could have done,' that sort of thing (...)You're going to be shocked as well as have to counsel and look after your lady (...) You have to put your own feelings and shock aside to deal with the lady and see to her.

Her language is already changing. The `mum' she talked of before has become `your lady', with its overtones of professional responsibility. The feeling she describes of `is there something I could have done' is a familiar one to professionals. She is beginning to move from a lay perspective of identifying with the woman, to that of the professional, having to deal with her own emotions while at the same time continuing to care for the woman - `you have to put your own feelings and shock aside.'

Despite this shift in perspective as she was becoming socialised into the midwife's role Gail seemed to be maintaining a down-to-earth approach to dealing with death. Discussing a stillborn baby, she said in the second interview: `OK the baby was dead, but you can still give it a hug!' She felt that the staff on the medical ward had been supportive and given her the option of not being involved when the two patients died:

I was really aware that on the ward if I'd said OK and run away they'd have been fine... but I'm not that way. I mean death is part of life, it's going to happen to us all sometime.(...) I think a lot of it is fear of death isn't it? We all fear death because it's an unknown - something unknown to us - but when you see it- I think if you've never seen it happen, it is something to be frightened of...

Gail was here demonstrating `existential awareness of non-being' (Tillich, 1977) and stood out as the student most able to discuss death. She identified this as related to her own personal experience of bereavement. Nine months later, replying to a question about whether or not she felt she had changed during the course, she said:

I don't like to think I've gone harder but I think I've gone a little bit harder to get through... I hope I haven't, but I feel I probably have done, a little bit.

At this (third) interview she showed none of the calm confidence that had been evident at the first two interviews. She appeared much more anxious. Although she didn't complain about her mentors, it seemed to me that she had not had a safe place anywhere to help her gain in confidence as she went through her course. The group had undoubtedly been an important source of support for her but it didn't seem to have been enough. She recounted an incident related to electronic fetal monitoring, which shows the anxieties that may arise from the use of technology. It is an example of how technology may affect human relationships.

SD: When do you feel most anxious?
Gail: I think when the monitor's on and I think now there's been a `dip' but (...) I've literally looked away from the monitor for a couple of minutes, there was

another student and I was just talking to her and the midwife came back in and said `why didn't you tell me about this?' and it must have happened in a split second - it (the fetal heart) came back up again straight afterwards but she really laid into me.

Then she describes a similar situation where this time she rushed to get a midwife:

She was a different midwife and she said `well that's all right, it's been doing that for ages but it's coming back up again' and I thought well, I don't understand! One minute you get shouted at ...

In the last interview before qualifying Gail's anxiety was very evident. All the students said they were worried at this stage about how they would deal with their new role but Gail's anxiety was more marked than most. There was also a clear contrast between the tone of her earlier interviews and this one. She talked about being frightened of coping on her own with problems and said that she couldn't envisage herself working as a midwife:

I just can't believe, I can't see that far ahead to actually... I can't believe that it would ever happen - that's really it ...
SD: and what is it, is it the responsibility, is it...?
Gail: Probably (laughing) yes, probably... A fear of the unknown, isn't it really, because you don't know where you'll be, or should I say where I'll be, who I'll be with, um... or...

This silence is what Van Maanen (1990) called `an epistemological silence [...] the silence we are confronted with when we face the unspeakable'. Compare this with her comment at the beginning of her training about why she enjoyed her experience on a gynaecological ward:

I liked being with people and helping them. A feeling of being needed. I enjoyed helping them and if it gives somebody help or happiness then it's worthwhile.

Later on in the last interview she said:

I always have a fear of looking stupid, and feeling stupid because there's nothing worse than knocking any confidence that you've got then...
SD: and what sort of situations make you feel like that...?
Gail: All sorts! (laughing) I think will I be able to see the abnormal and act in the correct fashion in an abnormal situation? or am I just going to go along willy-nilly and think `oh, this is something nice and normal' and... I find that hard and

yet as a qualified midwife you have to be able to take that on board and say `of course I know what's abnormal' and `of course I know what to do'

The qualified midwife is seen as someone for whom there are no doubts and fears, who is secure in her judgements, and `acts in the correct fashion'. When I last spoke to Gail she had been working in a postnatal area for some time and had enjoyed that but was 'dreading' going on to labour ward. Six months after that, she wrote: ‘As time goes on the dread of delivery suite becomes more and more nightmarish.’

Her use of the word 'dread' is significant (see p73 for a discussion of the meaning of the word). She had spent a week on labour ward since qualifying, and found it 'awful'. She described an incident where she had thought from examining a woman in her care that the woman was in the second stage of labour but was not certain, so asked a qualified midwife if she would check her findings. The midwife was not particularly helpful, didn't re-examine the woman, and the woman ended up having a traumatic delivery. Gail felt this was her fault, because she may have mis-diagnosed the onset of the second stage, and this bothered her for some time. Indeed she was still worrying about it when I spoke to her. What is important here is not to blame the midwife for her lack of support (she may well have not wished to repeat the vaginal examination because she did not want to cause the woman extra discomfort) but to take note of the extreme anxiety faced by Gail and many other students and qualified midwives. Gail finished by saying:

all of a sudden I'd be quite happy to do this (i.e. work on a postnatal ward) until I retire and if they could just leave me alone... I could do without hassles and responsibilities.

Her words `all of a sudden' imply that this change has happened recently and that this was not what she intended when she set out on her midwifery training. It is also interesting that she sees this current job, working on a postnatal ward

with many high-risk cases, as not bringing so many `hassles and responsibilities.' Yet that work is also highly responsible work. However most of the time it does not entail the life-and-death drama of the labour ward.

It is of course true that some people are likely not to be suited to working with women in labour because of the emotional pressures involved. This could be claimed in Gail's case and in the case of all the other participants who talked similarly. Gail's story, however, provides a poignant insight into the problems inherent in the work of all midwives, and also into the difficulties faced by students. This case study emphasises the importance of the mentor. In her letter to me, written about a year after qualifying, Gail wrote:

> Looking back I think I had a lot of mentors that found me difficult, if this was my fault I am sorry, as I don't think it gave me a particularly encouraging or good experience whilst training. I made myself a list of all the mentors I had whilst training and put down alongside each what qualities and experiences I thought they were able to give and bring out in me (...) In all I counted fourteen, there may have been more, but I have forgotten them. This seems to me, a lot really in order to build up a working relationship with in only three years (...) Looking back I can understand that some mentors may feel a little bit intimidated by having an older woman as a student. This may be due to the student's experiences, perhaps with her own children, that the midwife may not have, or just with life in general, and they may feel they have to prove their ability.

Of particular interest in Gail's account is the question of confidence and how it may be inhibited by unsatisfactory relationships with mentors.

A qualified midwife, Mary, who studied direct entry midwifery as a mature student, said:

> the ones who fitted into the system, they came across as quite confident ... I probably came across as confident in one sense, but I wasn't confident within the system ... I desperately needed it.

Mary was confident `in one sense' because of what she had learned through her life experience. Gail talked with confidence at the first interview but this confidence was rapidly whittled away as she progressed through her course. In the climate in which she trained, technical skills are valued above interpersonal skills and being a professional means not having common cause with women.

It means seeing yourself as someone different, with expert knowledge, and believing this knowledge to be somehow superior to knowledge gained through life experience. However, when confronted with the lay or experiential knowledge of a mature woman, some midwives perhaps feel uneasy and `feel they have to prove their ability' - i.e. show that they are at home in the medicalised system and that the medical view of birth is the appropriate one. Gail was not, at the end of her course, successfully socialised into midwifery. A year after qualification she still had the same fear of working on the labour ward, and wished to avoid it. The narrative account gives many indications of why this might be. Firstly, to experience one bereavement just prior to, and another during training must have taken its emotional toll, although she expressed the feeling that the experience helped her empathise with clients. Secondly, she had to abandon her lay knowledge gained through life experience, exchanging it for the stresses and uncertainties of modern midwifery practice. The two could not be integrated. Finally her experiences with mentors made it difficult for her to develop confidence. The difficulties in the mentoring relationships may have been related to the fact that she was a mature woman.

9.3 Kath

Kath was 18 years old when she started her course and still lived at home with her parents. It was only possible to interview her twice, once near the beginning and once near the end of the course but she was very forthcoming, talking at length about her experiences. At the first interview she very quickly began discussing the hospital hierarchy and how she felt that auxiliary nurses were the most supportive and most approachable:

When a member of staff is giving you a lot of hassle on the wards it's the auxiliaries who say "Keep your chin up" or whatever. I think to myself

sometimes, they have had so many years experience and you think why didn't they go on to be a nurse or midwife ...

Kath was indignant about the hierarchical nature of the hospital, and obviously valued the knowledge that the auxiliaries had acquired through experience. (It is interesting that Gail, the subject of the previous case study, was one of those auxiliaries who did go on to train as a midwife, but as we have seen, the transition was a difficult one).

Most of this first interview was taken up with a discussion about the hospital hierarchy. Kath was finding the attitudes of doctors difficult:

...Some of them treat you like something they have scraped off their shoes. [...] I think it's the women registrars who get on my nerves. They just walk in and totally blank you - they don't even give you the time of day... even to the women, some of them. They are really rough - you'd think with them being women they would be nice and gentle. My theory went out of the window [...] Sometimes you think, I'm going to say something here - "you cheeky so-and-so, don't talk to me like that" - but then you've got to be professional. So you've got to do the professional thing and bite your tongue. Sometimes I find it very difficult.

At this first interview Kath had already absorbed the knowledge that being professional involved `biting one's tongue'. It wasn't just the doctors, however, who treated students and women badly; she commented that midwives behaved in that way too. These were the impressions of a student very early in her training before being assimilated into the culture and they illustrate its elitist nature. Her experiences appeared not to have affected her confidence or self esteem, as she continued:

It's not affecting me personally. It's not affecting my judgement. I think they're the ones with the problem, not me.

This self confidence was evident in the next interview:

SD: Do you feel you've changed during the course?
Kath: Yes. I've become more confident and more mature - because I'm the youngest in the group, I'm the baby. Even my family notice it. They say `you're so - your age...' I've had to deal with life and death - bringing new life into the world and then... someone who's died ... you know.

Unlike most of the other students, Kath seemed to have few fears about how things would be once she qualified. When asked if she worried about things going unexpectedly wrong, she said "No, it doesn't even cross my mind". Asked about taking on the responsibilities of being a midwife, however, she replied

Yes, I was going to say ... A few months ago, I did find I was going to throw it all in ... Oh, yes! I thought, I'm not going to be able to cope with this ... obstetric emergencies and stuff like that.

By the second (final) interview she no longer expressed such anxieties. She seemed to have the greatest confidence of all the participants. However her image of childbirth was now utterly different. She had moved along the trajectory or `rite de passage' described in Chapter Five. In the first interview she said:

SD: You didn't want to do nursing ...?
Kath: No, it was midwifery [...] It's more dealing with healthy individuals, more than the sickness side of it. Of course, that can come into it, but I prefer the idea that it's as normal as possible.

However in the second interview, the following exchange took place:

SD: Has your vision of midwifery changed at all?
Kath: Yes, because at [this hospital] they've had every obstetric emergency [...] and I just stand back and I think, ...God ..... think pregnancy's normal - these women think it's all hunky-dory and then.....

Then she went on to add that her experience had put her off having children:

`I never want children - you know too much.'

`Knowing too much' is the classic view and one that is often heard in midwifery circles, along with the idea that midwives are likely to have more difficult labours because of their knowledge. Kath's perceptions of what midwifery is all about were straightforward. She did not seem to yearn for her previous philosophy of birth despite the fact that it was what had initially attracted her to midwifery. Moreover, she did not seem to have any ambivalence, or worries about not `fitting in'. Significantly, running throughout the anecdotes she gave

me of her experiences was a feeling of being totally supported and accepted, and she talks of `us' (i.e. she and her mentor) rather than `I'. In every incident she recounted, there was a feeling that it was shared. For example, she described an incident that was very traumatic for her, when a doctor inadvisedly intervened in a situation with which she and her mentor were dealing:

It was strange, 34 weeks, PIH, *[pregnancy induced hypertension)* she was being induced for PIH and her BP[*blood pressure]* wasn't that high. She was contracting 1 in 1 and so her BP - her MAP [*mean arterial pressure]* reading - was going up and up. I think the trace was rubbish ... they got the doctor in, he saw the MAP reading so he ran out and had the de-fib [*de-fibrillator*] outside the door and twenty people ran into the room - this is no exaggeration - well, about eight! And I was with a very experienced midwife who could deal with it, and we were railroaded - putting lines in, etc. And this woman was looking at us as if to say "What the hell is going on?" And this baby shot out because she was in the second stage - she went from four centimetres to fully [*full dilatation of the cervix-ready to give birth*] in about an hour. They did a V.E.[*vaginal examination*] on her and she was fully ... and she just pushed this child out, but the child was flat because it had just shot through the pelvis. It was shocked, poor thing. They had the de-fib outside the door! ..... thinking that she was fitting! I was nearly in tears, because I was in the corner just observing. I was shocked, and when it had all quietened down, I went "What the hell was that?" and the midwife actually went to the door and put a complaint in, saying, "How dare you override me on my case? All I asked you to do was come and look at the trace. As a responsibility of the midwife, I've got to show you that trace. If you had stopped and asked me, I would have said she was contracting one in two and we couldn't even get a blood pressure reading!" And he apologised and said, "Well I thought she was going to fit." He's experienced but he does tend to flap, you know. All the sisters came in and they were going, "Get me this, get me that!" It was awful - and I was the runaround - and I was going "What the hell's going on?" And I was leaving - I was leaving that day! And I said to the midwife "If she was going to fit, I didn't see the signs. I'm going to throw the towel in right now because I couldn't see the signs of someone going into an eclamptic fit." And she said "She was not about to fit"... They just came and railroaded us and that was it. I went home and cried the leg off me. It was awful.

Note the technical language she uses, interspersed with colloquialisms; her language is a mixture of medical, midwifery and lay terminology. There is an expressed tension here also between the medical model and the midwifery one which links the physical and the psychological as it recognises that the anxiety

the woman was experiencing caused the baby to `shoot out.' `The trace' plays a pivotal part in this dispute with the doctor. (The role of electronic monitoring is discussed in Chapter Seven). Kath then went on to talk about her mentor in glowing terms. She worked with her over the three years of the course and it was clear that the relationship had been crucial for Kath's socialisation as a midwife, and for her self-esteem as she progressed through the course. Kath's experiences illustrate the mediating effect of the mentor. Even a very distressing incident such as the one she describes above was a useful learning experience because of the support she received afterwards and because her mentor was a role model for her too.

Gail was the oldest of the non-nurse intake while Kath was the youngest, and Kath's experiences of mentorship were utterly different. Kath was 21 when she qualified, so she entered midwifery at a young age. This may have made it easier for her mentor to give her the kind of `matriarchal support' described by Earnshaw (1995). She experienced an uncommon degree of continuity with her mentor, who clearly provided a role model for her. Kath wasn't socialised into a passive `obstetric nurse' role. It was one in which the midwife's strength `to stand up to doctors' was valued. Nevertheless the medical view of childbirth was internalised - she now knows all the things that can `go wrong', and expresses this unequivocally and without irony. Kath had been socialised as a `professional', having specialised esoteric knowledge which she believes sets her apart, even at her young age, from other women.

9.4 Frances

Frances' case demonstrates another socialisation process, where she managed to maintain a belief in the normality of birth. I interviewed Frances three times during her course. She was 35, married, with two young children. Ironically, in view of the fact that she was one of the few to retain a sense of

birth as normal life event, she was the first of the non-nurse students to encounter death. On her second allocation to Delivery Suite she was involved with a mother whose baby had died:

My mentor said `You shouldn't be allocated to this' and I did mention it to my shift leader and she said `Oh, she's got to learn some time.' and at the time I thought `that's really insensitive'. Now I've been there and had this experience I'm quite glad because I don't think I'd.....It was obviously distressing and when I got home I cried a little bit more, but I'd coped with it and I'd got through it. I'd professionalised it and I was OK.

She says she `professionalised' it, meaning that she had somehow managed to distance it a little so that it ceased to upset her so much. She focused on the fact that she was unprepared for the experience, because of the division in the curriculum between `normal' and `abnormal'. She said that it was more difficult to cope with because at that stage in the training `we're still heavily into the normal'.

I think because I'd felt so unprepared - I thought I really don't want to be in that situation again.

By chance she had seen a television programme about stillbirth (discussed on page 124) which had made a tremendous impact on her and guided her actions in this situation. Although she had indeed found the experience traumatic she said at this first interview that she was glad she'd had the chance to go through it and felt stronger because she now knew she could survive it and cope with it. In the second interview with Frances she reflected back on her first experience:

I suppose [my mentor] did try to shield me... It was another midwife who said `oh, she's got to see it sooner or later' - so in some respects I'm probably grateful now... At the time I thought `uh-uh', but I think it's got me over a mental block situation. I think once I'd been exposed and had the tears and all the rest of it, then I thought OK, OK, and there have been cases where I haven't been involved but the baby has arrived in a little moses basket ready to show to Mum and I think had I not had that exposure I'd have thought `Uh-uh, let's get out' but now I tend to look and look at the baby and the details and things so I think it's getting through that initial exposure, from a personal point of view.

She repeats the words `exposed' and `exposure' which interestingly are the opposite to the words `shielded' and `shielding', words used several times by participants. `Exposed' gives the impression of a person deprived of the `protective cocoon' (see page 117) and therefore vulnerable. Frances also conveys the idea - `getting through that initial exposure, from a personal point of view' - that it's an important landmark in her development, as if it has to be dealt with on a personal level before going on to deal with it professionally.

Since this first 'exposure' she had supported another bereaved mother:

I think I feel fairly comfortable [dealing with a stillbirth]. There was an occasion a couple of days ago - there was a recent stillbirth here and I had been involved with her antenatally and she'd been in and I went to see her and it was upsetting and she was obviously distraught, but I did feel able to go in and be with her and talk to her about it, and she had the baby there, dressing it and I met her mum and her little sister, I'd had the little sister listen to the baby's heartbeat with the Sonicaid antenatally, so it was distressing from that point of view, thinking it was only a few days ago (...) I thought about avoiding it and then I thought, that's not really, I don't suppose it's me, but, you know - there's still a danger, I tend to think, do they really want to see you, are you going to be obtrusive, in the way, and then I think `well am I just avoiding it because I don't particularly want to go in.'

The dilemma is a familiar one, that of not wanting to intrude; but as Frances suggests this can also be used as an excuse to avoid a difficult situation.

By the last interview, Frances had had another experience of helping at a stillbirth:

We had a stillbirth, a termination for fetal abnormality, on Saturday (...) and it sounds a bit sick, but it was nice in a way, to do it like that, having been talked through it, and then the delivery and then all the follow-up, and showing them the baby and getting the chaplain and although as I say it sounds a bit sick, it was nice as a student to have done it from start to finish, and now, if I have to deal with one on my own, I'll know what to do. It's a good experience to have.

The two participants who had had supported experience of helping a bereaved mother felt awkward about saying it was a `good experience' and recognising that they now had skills which would be very helpful to parents. Unfortunately this supported experience was rare:

SD: It doesn't sound as though many students get that kind of experience...
Frances: No. I seem to attract them! (laughing) I was speaking to some of the students from last year who were saying 'Oh no, we never saw any, we were never involved with any' - even some of the trained midwives, as a student they were never allowed to go in...but I think it's been beneficial as a student because I would hate, as a qualified midwife, meant to know what I'm doing, and to have to go in and be landed in it...what to say?...what to do?
SD: If you hadn't had that experience it would still be a bit of an unknown?
Frances: I don't know how many people wouldn't have come into contact with death at my age... Yes, I would have built it up, certainly, had I not had the experience, I'd have been an `avoider' on Delivery, yes, on Delivery `any volunteers?' I would have been (*she cringes away)* an avoider. Undoubtedly. I wouldn't now, I'd feel quite happy, and I'd feel that I would give as good support as anybody could give I think, not being cocky, I just feel that.

Although Frances claimed categorically that she would have been 'an avoider' if her experiences during training had been different, I found this a little hard to believe, given the way she talked about women and caring for them. However it does indicate that there are likely to be midwives who try to avoid dealing with stillbirth. Frances felt that not being exposed to stillbirth as a student could lead to the formation of a 'mental block' about coping with it:

SD: So if you'd not been exposed to it you would be feeling quite worried at this stage?
Frances: I think so, because I think you would always have in the back of your mind that you were going to have to deal with it at some stage in midwifery... I think, if I'd had no exposure, I think I'd have opted out if I could.

Frances, of all the participants, had the most experience of dealing with perinatal death and bereavement. Yet despite this, she, unlike most of the others, managed to hold on to a perspective of birth as normal. This is an extract from the second interview:

SD: I wondered how you feel at this stage of the course... Do you still see birth as a normal healthy part of life?
Frances: Deep down I do ... I think it's just very difficult keeping it in perspective here [...] There's an abnormal surrounding here. I think it's because it's a regional referral unit, they're expecting a lot of problems - I think that's part of it. But, personally, I have to keep reminding myself that it's not normal, what you see here, and I have to keep going back and reading things that carry on the thought that it can be normal...

She says `personally,' indicating that on an individual level she somehow has to draw support for her belief in birth as a normal life event. She reads in order to sustain that belief. Frances' case study, and the evidence from the other participants, suggest that to be able to sustain, in the current climate, a `faith in women's ability to give birth naturally', one may have to have had a prior conviction about it on entering midwifery. Frances' belief had roots in her own experience, and went back to hearing her mother talking about birth:

(first interview) I think even when I was in my late teens I always thought of the idea of pregnancy being a healthy issue. (final interview) I think my Mum, talking to my Mum...we were both born at home and I was a breech, born at home. Mum made it sound all dead easy ... and she breastfed. I suppose you do pick up things - what you expect it to be like. [...]

Her own experience of childbirth had then confirmed this deep belief

(first interview)[...] I had really normal deliveries and I think that made me even more determined. I thought this is a very normal thing that healthy people do.

(final interview) And I think when you've got children of your own ... I'm not saying, if you've never had children, you can't be a midwife. I don't go along with that idea. But I think you can remember it yourself.

She also saw herself as assertive as a result of her previous work experience:

SD: you come across as quite confident...
Frances: I think I'm just bolshie. I am quite opinionated! It's how you see yourself. I was a supervisor at [a large chain store] for about seven years so I think I got some of my bolshieness from that! Not from ordering people about because that wasn't my style. I think that helped me develop...

So Frances had had work experience where she had had a degree of power and control, and she had a self image of herself as a strong person, as well as emotionally expressive:

I still cry at deliveries[...] I think that's just the way I am, I'm just emotional, you know. I don't particularly want to harden up.
SD: Do people tell you to harden up?
Frances: [...] Yes, other qualified midwives. They say if I hardened up I might get less emotional about it. I can't. I just find it an emotional experience.

`Getting emotional' was seen as a problem by these midwives and they were suggesting that Frances protect herself by `hardening up'. This is discussed by Menzies (1988) as a defensive mechanism against anxiety commonly adopted by trained nurses. Due to a combination of her own character and her experiences during the course, Frances did not reach the stage where she felt she had `hardened up'. In the last interview she discussed her mentors:

> There have been some where I've felt very inhibited because they've been there and I know they are very anti- moving around etc. [...] I find that inhibiting, if you're not really on the same wavelength as your mentor [but] by and large, my mentors have been brilliant. They've been really good and probably shared some of the philosophy about midwifery that I do.

The other thing that helped her keep hold of her philosophy, she said, was being a member of the Association of Radical Midwives and attending their meetings. Frances' case study is useful because it gives an idea of the factors that can sustain students through midwifery training. It also shows that students need to be supported in preparing for dealing with difficult situations prior to experiencing them, both for the student's and for the mother's sake.

9.5 Conclusion

These three narrative accounts give pictures of three different midwives and, perhaps, some indication of what their styles will be. The first, Gail, does not feel she will ever be confident in the labour ward situation and is searching for a role within midwifery that avoids having to care for women in labour. The second, Kath, is successfully socialised into hospital midwifery with supportive relationships around her, seeing hospital as the safest place to give birth. The third, Frances, has managed to keep hold of her faith in normal birth. These accounts are necessarily a simplification, but they provide concrete examples of the challenges of midwifery training, and point to some ways of improving the educational experience so that it poses less of a threat to students' self

identity. The fuller picture provided by the narratives, where we have some sense of the participants as individuals, moves beyond an approach which only addresses the question of how we might select individuals with the right characteristics to enable them to sustain the course. It suggests that the current state of midwifery training and practice means that individuals with potential in midwifery may be being lost and/ or subjected to unnecessary hardship and that, in some cases, attitudes are being nurtured which are not conducive to better care for women.

CHAPTER TEN

DISCUSSION AND RECOMMENDATIONS

10.1 Discussion

This study has explored some of the tensions that accompany birth today and the unique role of the midwife as one who stands at the boundaries of life and death. The participants in the study began their course with the attitude that birth is a normal life event; this philosophy is overtly encouraged by the curriculum, and is part of the history and culture of midwifery. Once they began their clinical experience they were exposed to a different set of concepts, those embodied in the medical model, which was dominant in their places of work. My analysis suggests that the resulting tension gave rise to uncertainty for students and newly qualified midwives as they went through the process of trying to define their own philosophy and attitude to care. The study has illuminated difficulties experienced by all participants during midwifery training. These difficulties may be relevant to the issue of retention of midwives; there is evidence that some of the tensions reported here and in other studies (Robinson and Owen, 1994; Kent et al., 1994a; 1994b) may be factors in midwives' decisions to leave midwifery practice.

It cannot be assumed that merely because they are singly qualified, non-nurse midwives will remain in midwifery. The environment in which midwives work,

and the material conditions they experience while working are also important determining factors in decisions to continue in midwifery practice. Dissatisfactions with conditions of service and combining work with family life were cited as the two main reasons for midwives leaving their jobs in the study by Robinson and Owen (1994).

The assumption that students who have been nurses have been `contaminated' by their involvement with the sickness model needs to be re-examined; it may be that given the way in which maternity care is currently organised in most parts of this country, these nurse-trained students have an advantage, at least in the sense that the training may be less of a threat to their self identity, because they are already socialised into the hospital system. The re-establishment of 'direct entry' (or pre-registration long) courses must be welcomed as a progressive move in midwifery education, but it should not be seen as an automatic solution to current problems. The assumption that older, non-nurse trained students may be more assertive has as its downside the possibility that these students, because they may not immediately `fit in' to the culture, have particular needs that midwifery educators must address. If we feel that mature, non-nurse students have the potential to be an asset to midwifery we need to find effective ways of educating and supporting them.

The study indicated that in both groups preparation for dealing with loss was not adequate, either in terms of the classroom work or in clinical experience. In the classroom, students needed some preparation very early in the curriculum because the nature of their clinical experience meant that they might well encounter bereavement as soon as they started working alongside their mentor. The effects of the relatively recent move into higher education were evident in that

classroom theory was seen as fragmented and not always relevant to practice. The findings from this study support Michael Eraut's contention that the subject-based approach favoured by higher education institutions can be problematic for professions such as nursing and teaching:

> [the] segmentation and packaging of knowledge for credit-based systems seems inappropriate preparation for professional work which involves using several different types of knowledge in an integrated way (Eraut, 1994, p10)

In terms of their clinical experience, the data indicated that at times students were removed from caring for a woman whose baby had died and the students involved were unhappy about this. There may perhaps be advantages to the family of having a student involved, because she may be in a position to give her undivided attention. Sometimes the qualified midwife might be caring for other women in labour at the same time due to shortage of staff but the student could stay throughout if needed. (This idea was endorsed by the group of experienced midwives with whom I discussed the findings of this study.) Some women might find it helpful to think that their experience would enable future midwives to learn how best to help others in this situation. If the student has no supported experience of dealing with stillbirth during her training, she may be more likely to have anxieties regarding this once she is qualified and so may endeavour to avoid such situations (see Buckman, 1984).

Midwifery educators need now to focus on methods of teaching and learning that prepare students for dealing with fear and uncertainty. Students approaching qualification used words like `terrified', `frightened' and `dread'. Although it is likely that those feelings of anxiety reduce with further experience once qualified, it is necessary to have some exploration and discussion of the causes of such feelings. Ulrich Beck (1992) says:

In the risk society [...] handling fear and insecurity becomes an essential cultural qualification and the cultivation of the abilities demanded for it become an essential mission of pedagogical institutions (p76).

Kiger (1994) following her research into student nurses' experiences of death says that educators need to have clear goals in this area, and asks:

Should nurses be socialised into developing hardened emotional postures? Or should they learn to cover a hardened core with a veneer of caring? Or should they be genuine participants in the emotional care associated with death and dying? (p684).

If we want midwives to be `genuine participants' in birth, supporting and empowering women, they, and those learning midwifery, need to be valued for the important work they do. Support cannot simply be provided by other individuals within the system, although this study has shown many examples of individual midwives' altruism, commitment and creativity. As a matter of urgency, midwifery educators and managers must formulate ways of creating support networks for midwives and students. The solution to current problems does not lie in casting blame upon those individuals whose response to the stresses of midwifery education and practice is to develop a protective shell and ‘a veneer of caring’. Neither is it merely a question of attempting to select only those individuals who appear to be psychologically best suited to withstanding the rigours of midwifery education. We have to create opportunities for students and midwives to experience the benefits of providing truly woman-centred care, within a woman-centred service that also addresses the needs and strengths of those providing midwifery care. If this does not come about, there is a danger that many midwives become (to use Weber's

phrase) `specialists without spirit' (1958, p152); going through the routine physical care of women without being able truly to engage with women.

Birth can be more than ‘nice and normal’; for many women and midwives, given the right circumstances, it can be a joyful and life enriching experience. In order to be able to embrace such a philosophy, however, we need to face, and help students to face issues such as dealing with loss, fear and uncertainty. It is essential that we devise ways of preparing students and midwives for these difficult tasks; because midwifery care can have a profound and long term effect upon women.

Currently the majority of institutions where student midwives gain their experience have a medicalised culture, which is geared towards seeing birth as potentially pathological, and also as a potential source of litigation. This culture with its ever-present preoccupation with risk is not, I believe, conducive to the development of confidence in birth attendants. The challenge for midwifery educators is to devise programmes which afford students experience of normal birth and at the same time prepare them for the realities of current practice.

Events and changes taking place in midwifery training inevitably reflect wider societal processes. Conflicting paradigms are currently evident amongst policy makers. Despite a general shift in acute services into the community since 1990, birth continues for the most part to take place in institutions. The latest government White Paper, *The New NHS* (DoH, 1997) promotes a social model of health that seeks to develop primary health care in the community, while the Green consultation paper on public health explicitly recognises the role of social conditions in determining health (DoH, 1998b). This would seem to be the ideal time for midwives to expand their role in the community as a key resource for

maternal and child health. One DoH recruiting advertisement for midwifery, however, suggests a different agenda (see Appendix I) along the lines of a U.S. type system. As the development of occupational standards continues, an alternative model to emerge might be that small numbers of trained midwives are employed in hospitals to deal with acute emergencies while the less dramatic, but ultimately further-reaching aspects of care such as breastfeeding and postnatal support are delegated to other, less expensive workers.

Midwifery and midwifery education may therefore be at a crossroads, with a variety of competing approaches to care in evidence. The tensions experienced by student midwives are to some extent a reflection of the wider upheaval that is taking place. During the course of this research, participants expressed concerns that are relevant to any discussion about the future of midwifery. A health based approach is a defining characteristic of midwifery, which is why in this thesis it has been termed 'the midwifery model'. Midwifery care has been demonstrated to be superior to a hospital based medicalised approach for the majority of mothers and babies (Wagner, 1994) yet participants' experiences during their midwifery education led them to move away from the midwifery model towards one which focused more on the potential risks of birth, and led them to have more fears about birth than they had on entering midwifery. While some of this is likely to arise from inexperience, I have argued that the shift may also be attributed to their experiences of medicalised birth, and the current climate in the NHS. The challenge for midwifery today is how the midwifery model, which holds out unequivocal benefits for childbearing women and their families, may be preserved, adapted and strengthened in the face of current perceptions of risk and accountability. There are some changes that might be implemented to

improve the experience of midwifery training for students and help to better prepare students for life after qualification. These are outlined below.

10.3 Recommendations for education and practice

10.3.1 As the midwife mentor is central to the learning of student midwives, her role needs to be reviewed so that there is greater continuity and to ensure that the student midwife has a secure place in which to learn, to challenge and to ask questions. One possible model could be that the student midwife take on the role of `apprentice', attached to a small team or group practice so that she has involvement with a small number of teaching midwives, and her learning experiences may be arranged flexibly.

10.3.2 Open discussion of perinatal loss should take place from early in the midwifery curriculum, not only because some students will inevitably encounter loss early in their clinical experience, but also because the possibility of death is inextricably connected with the experience of birth. Early discussion may help to improve the current situation where, despite a good deal of progress in this regard, the trauma of perinatal loss may still be underrecognised and badly handled by staff (Lovell, 1997). Students will then have the chance to learn about and reflect upon loss before they are placed in the situation of giving clinical care to a bereaved family. Students' own previous experience of death needs to be taken into account when planning such preparation (Durlak, 1978).

10.3.3 The relationship between 'normality' and 'abnormality' needs to be addressed early in the curriculum and students encouraged to explore and formulate their own perspective and philosophy. The curriculum should not be divided into 'normal' and 'abnormal' sections. It may be more useful, rather

than presenting the midwifery and medical models as separate and competing, to accept the presence of the latter in the minds of both mothers and midwives, and attempt to examine the tensions engendered as a result of this.

10.3.4 An integrative approach to learning (Kolb, 1984; Eraut, 1994; Mander, 1992, 1994) should be pursued in order that the meanings of all aspects of students' experience may be explored. Experiential learning is necessary to enable students to explore the complexities of modern midwifery practice. Experienced clinical midwives with particular skills, and women themselves should be involved more consistently as learning resources for the students.

10.3.5 Concern has been expressed that student midwives are not sufficiently prepared for dealing with abnormal cases (see Maggs and Rapport, 1996; Fraser, et al., 1997) and similar concern was expressed by participants in this study. Use could be made of simulated abnormal and emergency situations (critical incident scenarios) so that students will feel more confident when having to deal with them in the clinical situation.

10.3.6 Participants also indicated that they had little experience of births occurring without some form of medical intervention and that they lacked confidence in dealing with, for example, home birth or a physiological third stage. In the same way that experience of abnormal cases is laid down in the curriculum, it could also be stipulated that each student be involved in several physiologically normal births as well as home births. In this way the potential midwife can fully understand, through her lived experience, that unassisted, physiologically normal birth is possible.

10.3.7 The findings from this research support those of the ENB study by Fraser and colleagues (1997) which suggests that senior students should be afforded increasing levels of responsibility towards the end of the programme, allowing the student to have the experience of `being a midwife' before the end of the programme. It is suggested that this will ease the transition from student to accountable practitioner (p112).

10.3.8 Electronic fetal monitoring, because its routine use causes anxiety and hinders the student midwife from gaining confidence in midwifery skills, should be abandoned apart from in carefully selected situations, as recommended by the World Health Organisation in 1984 and research reports since (Chalmers, Enkin and Kierse, 1989; Wagner, 1994).

10.3.9 Because of the demanding nature of midwifery practice, there should be formal mechanisms in place for the support of all midwives and students. For those who are involved in the birth of a stillborn baby there should be extra support offered (such as paid leave, and counselling). The death of a baby can be an extremely traumatic event for the carers involved and in the centres where this study was conducted, there were no formal structures of support for the midwives.

10.3.10 The present government should take heed of the recommendations of the Second Report of the House of Commons Select Committee (1992), and in particular paragraph 339, pxcviii, which states: `We recommend that the department vigorously pursue the establishment of best practice models of team midwifery care. We believe that as well as research this will require the allocation of pump priming money to fund the additional costs of moving to a new pattern of service.' Throughout this study participants talked of staff

shortages, and qualified midwives talked of not having enough time to care adequately for women. `Best practice' will only be achieved with adequate resources.

Limitations of the research

Before addressing recommendations for future research, it is important to recognise the limitations of the present study. In a study of students' reactions to their courses, it is inevitable that some of their worries and complaints about courses are short-lived, and that the nature of their worries changes as they progress through their courses. Simpson (1979, p15) in her US-based study of the socialisation of student nurses makes this point and goes on to say

> [students' complaints] are personal reactions and are not reliable indicators of acquisition of knowledge, occupational orientations or personal relatedness to the occupational role.

This longitudinal, comparative study has focused on those changing reactions and, I hope, given some insight into the experiences and changing outlook of two different groups of women learning the art of midwifery. `Personal reactions' are the focus of the study because it is an attempt to understand more about the motivations and experience of the participants, both in order to humanise the service for mothers and families but also to try to improve the conditions under which midwives practice, and students learn. To what extent their orientations towards practice persist would be a focus for further study, but the data suggest that these orientations may be longer-lasting than Simpson suggests. In some of the midwives studied they lasted at least until

they left midwifery practice, and were a factor in their decision to leave. Other writers believe that early experiences are crucial in professional socialisation:

> Early in training most doctors develop relationships with patients that become models on which they will base their responses to sickness and death for the rest of their careers (Nuland, 1994).

Early experiences are undoubtedly important in professional training and this is why researching the experiences of student midwives is important. During their training and once they are qualified, students' actions and attitudes will have a fundamental and far-reaching impact on the health of families (Oakley, 1992).

On the whole, the data from the interviews with the non-nurses were richer. It is for this reason that I have included three case studies from the non-nurses and none from the nurses, because the data from the nurse participants were not comprehensive enough for me to construct a narrative of their experiences as they progressed through their midwifery training. This can be seen from examination of the transcripts where there are more questions and prompts from me in the interviews with the nurses than with the non-nurses. The non nurses told me long stories about their experiences, while the nurses tended to answer my questions, but not elaborate as fully. This was, I think, due to a number of factors.

There was no doubt that my interviewing skills improved as the study progressed. Initially I found I was worrying about the tape-recorder, and whether or not it was going to work properly, and did not feel wholly at ease in the role of interviewer. I am sure that my responses and my questioning technique were more effective in the later interviews than in the first few interviews. Unfortunately the first five interviews were all with the trained nurses. Furthermore, although I ensured that I was not involved in teaching the

non-nurse students, they knew me as one of the midwife teachers and this may have affected their responses, making them more careful about what they revealed to me. For the non-nurse students I was an outsider, and although they knew that I was a midwife teacher, their only contact with me was in relation to the study. Finally my relationship with the non-nurses, during the main part of the study, lasted twice as long as my relationship with the nurses. Even though I interviewed the students three times, at the start, middle and end of their course, my contact with the non-nurse students continued over a three year period as opposed to the 18 months of the course for trained nurses. Perhaps those participants who had known me for longer were inclined to be more expansive in their responses.

Another limitation of this study, discussed in more detail in Chapter Four, has been my status as an insider researcher. I recognise that there are inevitably limitations to any attempt to bracket out one's own preconceptions during the course of the research process. However, the use of direct quotation from participants helps to make their own views and perspectives apparent.

The discontinuities in the research process have also affected the finished product, with the result that despite the original aims of the research the issues surrounding perinatal death have been touched upon, but not explored in depth in this thesis. The study however does demonstrate that this is a crucial area for further research.

Because of the the small numbers involved in the study, and the limitations discussed above, it was never an aim of the research to make generalisations about the differences between the two groups, or to suggest that the experiences of the participants are typical of those of other midwifery students

in other areas. The study has identified important themes, however, which may be compared with the findings of other studies, and the consideration of which will add to our understanding of the student's experience of midwifery education.

10.4 Recommendations for future research

10.4.1 The midwife mentor is fundamental to student learning, and individual role models have a powerful influence on learning and professional socialisation. It was the more challenging, assertive mentors who were likely to be cited as supportive and inspiring by participants in this study. This is significant, particularly in light of the findings from other studies that acceptance by the mentor may involve `fitting in' with the mentor's approach and standards. Mentoring in midwifery is an important area for further research (also suggested by Maggs and Rapport, 1996).

10.4.2 This study suggests that a good experience of mentoring will lead to increased confidence at the point of qualification. Research is necessary to explore what kinds of support give most benefit to students (also suggested by Eraut et al, 1994).

10.4.3 Pre-registration (long) courses aim to attract the mature entrant as well as school leavers. It is likely that these two types of entrant will have very different needs and strengths. There was evidence in the present study that older students

faced specific problems with mentoring relationships. Research in this area would be invaluable in designing appropriate learning experiences and curricula.

10.4.4 Students when discussing life post qualification talked of being ‘alone’, and ‘on my own’, something that was also noted by Bewley (1995) in her interviews with newly qualified midwives. Feelings of aloneness appeared to be linked with the transition to being responsible and accountable, especially in a litigious climate; lack of continuity with mentors and/or mothers; lack of support; and also to short staffing. Future research should explore the ways in which these factors interrelate, and also explore the ways in which practitioners construct the notion of accountability.

10.4.5 Research is needed to explore midwives’ attitudes to death, because this has implications for the way in which students are prepared and the care that women receive. Furthermore it would be useful to explore the ways in which the organisation of the maternity services affects women’s experience of perinatal death. My study and others (e.g. Mander, 1994; Lovell, 1997) suggest that a major difficulty for midwives caring for bereaved mothers is finding the time to give appropriate care. Further research could usefully examine this area with regard to both the psychological and the organisational aspects of care.

10.4.6 Participants in the study conducted by Fraser and colleagues suggested that coping with the difficult transition from student to midwife was determined to some extent by ‘individual coping styles and ... personality traits’ (Fraser, et al.,

1997, p105). They also commented that non-nurses were perceived by many interviewees as having more difficulty with the transition than those who were already trained nurses. There is a need for researchers to specifically examine the transition period, identifying those factors (both in students' own personalities and life experiences, and in the learning environment) that make a difference to students' and newly qualified midwives' levels of confidence.

10.4.7 Finally further studies are needed to build on work already carried out (see Annandale, 1988, 1996; Floyd, 1993) exploring the attitudes that underlie midwives' approaches to care as well as how their different philosophies affect the women for whom they care.

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APPENDICES

APPENDIX A

SOME MILESTONES IN MIDWIFERY FOLLOWING THE 1902 ACT (sources: Silverton, 1993; Leap and Hunter, 1993; Bent, 1993; Towler and Bramhall, 1986; Dingwall, 1988; Sweet, 1993)

1905

Publication of the First Roll of Midwives: 22,308 names - only 9,787 had undertaken a course of midwifery training. From now on no-one could assume the title `midwife' unless they had a CMB certificate. The CMB organised a quarterly exam which consisted of a three hour written paper and a fifteen-minute oral examination; approved institutions could offer a three month programme in preparation.

1910

Women who were not certified midwives were forbidden to attend women in childbirth `habitually and for gain' unless under the direction of a medical practitioner.

1911
National Insurance Act: workers to make a weekly compulsory payment entitling them to medical care and to sickness and maternity benefits.
83% of midwives were married or widowed and 70% were over the age of 45 (Lewis 1986).

1915
Notification of birth after the 28th week was made a statutory duty.

1916
Midwifery training lengthened to six months, with a remission of two months for those with a nursing qualification.

1917
Carnegie Trust report urged that all midwives should have some hospital experience; previously the CMB had allowed midwives to undertake training exclusively in domiciliary practice, either with a charity or as an apprentice to an independent practitioner.

1918
Second Midwives' Act: Local Supervising Authorities to be responsible for paying the doctor's fees in the first instance, but these fees still to be recovered from the patient if possible.
CMB given the power to suspend midwives from practice. (Previously they could only remove names from the Roll).

1923
Report commissioned by the Ministry of Health on the training of midwives (Campbell, 1924) recommended that training be lengthened to six months for qualified nurses and one year for non-nurses.

1924
Enquiry into maternal mortality recommended more trained midwives in order to reduce maternal mortality rates. This had remained static for 20 years at four per 1,000 births despite the introduction of the 1902 Act which aimed to reduce maternal mortality through the regulation of midwifery practice.
At this time midwives still paid for their training and when qualified their annual earnings ranged between £30 and £350. Due to the poverty of their clients, most midwives could not ask for high fees and many were therefore having problems surviving financially.

1926

Third Midwives' Act: ensures the monopoly of midwives and doctors over birth, making it a criminal offence for a person other than a midwife, midwife in training or a registered medical practitioner to attend at a birth, other than in an emergency.
Uncertified midwives attending births had to satisfy a court that 'the attention was given in a case of sudden or urgent necessity', otherwise they were liable to a fine of £10.
Also in **1926** the first specific course for midwife teachers was set up by the Midwives' Institute.

1927
General Register Office's first tabulation of live births in England and Wales by place of delivery: 85% of births taking place at home, 15% in institutions.

1932
76% of births occurred at home, 24% in institutions

1936
The Midwives' Act recognised the financial difficulties of midwives in independent practice. LSA's in England and Wales charged with providing an adequate salaried midwifery service; this service to be subsidised by the government. Midwives employed by the LSA's now had `off-duty', annual leave, pensions, provided equipment and uniforms plus financial security. Midwives could choose to continue to work independently.
By **1936** most pupil midwives were also registered nurses (Dingwall 1988)

1937
63.2% of births took place at home

1938
Midwifery training lengthened and divided into two parts, with an exam after each part. The first part consisted of the theory of normal and abnormal midwifery and neonatal paediatrics with hospital-based practical experience. The second part was partly or wholly based in the community. Each part would take six months for trained nurses and a year for non-nurses. The aim of splitting the training into two was to reduce the numbers of midwives who qualified and never practiced. The idea was that those who saw midwifery as a form of career advancement might take the first part only.

1940
Rushcliffe Committee set up as a result of concerns about a shortage of midwives and pupil midwives.

1941
The Midwives' Institute became the College of Midwives.

1943

All midwives compelled to stay in their present posts for six months, later extended by another three months, and newly qualified midwives had to practice for a year. Ministry of Labour and National Service highlighted the shortage of midwives and mounted a publicity campaign to attract more midwives.
Rushcliffe Report identified midwifery as `a distinct profession with its own traditions' and provided mechanisms for negotiations between midwives and their employing authorities (Rushcliffe Committee succeeded by Whitley Council in 1948).

1944
55% of babies born at home.

1946
The NHS act: the Beveridge Committee began to formulate proposals for social legislation and restructuring of health services. Shortage of midwives critical as birth rate reached its post-war peak.

1947
The College of Midwives receives a Royal Charter and so becomes the Royal College of Midwives, the name it retains today.

1948
The National Health Service came into being, setting up a comprehensive health service, free at the point of service, paid for partly by contributions of those in employment, partly by local rates and partly from the General Exchequer funds. While the establishment of the NHS eliminated the previous economic competition between the general practitioner and the midwife, it also established her subordination (Dingwall, 1988). Women now tended to go to a GP to confirm a pregnancy and only to reach a midwife through him. (This arrangement continues today and is a major stumbling block to the instigation of midwife-led care.) At the same time there was an increase in the number of junior doctors and consultants in the hospitals.
The NHS Act retained the tripartite system for the delivery of health care. Domiciliary nursing, midwifery, health visiting and related services were under the control of local health authorities and were separate from both the hospital and GP services (Bent, 1993, p736).

1949
The Stocks report stated that there was a fundamental difference between nursing and midwifery and considered that it was neither necessary nor desirable for a midwife to have to undertake a full nurse training. It proposed that all posts in midwifery should be open to singly qualified nurses.

1951
The Midwives' Act consolidated previous Acts.
Midwives were still outnumbered by the medical profession on the CMB whereas nurses were a majority on the General Nursing Council and therefore had more national control of their profession.

1959
The Cranbrook Committee recommended that enough hospital beds be provided to enable 70% of births to take place in hospital. Cranbrook is seen as marking the beginning of the reorganisation of maternity services from community to hospital based care (Page, 1995, p132). Between **1958** and **1966** the rate of forceps deliveries increased by 50% and of Caesarean sections by 61% (Tew 1990, p 156).

1968
Hospital delivery rate 80.8%
The two-part training was replaced by the single period course, but in subsequent years staff at midwifery training schools maintained that 12 months was too short, particularly for students to develop confidence in clinical skills.

1970
The Peel Report, under the chairmanship of Sir John Peel (then President of the Royal College of Obstetricians and Gynaecologists) recommended sufficient facilities be provided to allow for 100% hospital delivery.

1974
The National Health Service (Reorganisation) Act brought the hospital and local health authority services under one administration, the newly established health authorities. The 1960's and 1970's saw the rise of technological obstetrics, with high induction and episiotomy rates. Commentators deploring the reduction in the autonomy of the midwife described her role as being that of a `doctor's handmaiden' or `obstetric nurse' (Walker 1976).

1976
The Association of Radical Midwives set up by a group of student midwives from different training schools who were alarmed at the apparent trend towards maternity nurse status in their training. One of their aims was `to re-establish the confidence of the midwife in her own skills'.

1979
The Nurses, Midwives and Health Visitors Act abolished previous statutory bodies, created the United Kingdom Central Council and the National Boards, dividing the functions between them apart from the supervision of midwives which remained the responsibility of the LSA's. Midwifery Committees are appointed to advise each body and are made up of elected and nominated professionals. Consultation with midwifery committees is mandatory on `all matters related to midwifery' but there is no definition of what constitutes such matters apart from the making or amending of rules of practice (Kirkham 1996, p13).

1981
The CMB lengthened midwifery education programmes to 18 months for nurses and three years for non-nurses. It was hoped that the extension of time would be used `to develop clinical skills and to give opportunities for the midwife to become

confident and wish to practice as a midwife' (Stewart, 1981). However Robinson and Owen (1994) from a longitudinal national study of two cohorts of midwives, found that the effect of lengthening the training had only a minimal effect on retention levels and that less than half were practising as midwives three years after qualification.

1983
The UKCC became operational. The CMB and other existing statutory bodies were replaced by the UKCC and the four National Boards Members were nominated by the four national Boards and by the Secretary of State.

1989
Management consultants Peat Marwick McLintock commissioned to review the working of the 1979 Act. Report was critical of the organisation of the Boards and the UKCC.

1992

Peat Marwick Mclintock recommendations were embodied in the Nurse, Midwives and Health Visitors Act. The role of the national boards was restricted to the accreditation of educational institutions, the validation of courses and to ensuring that the UKCC's standards of professional education are met. The education officers at the ENB now have a generalist role which means that a nurse from another education speciality may be responsible for midwifery education in a college or institute of higher education. When midwives expressed concern about this change the ENB agreed to include a practising midwife to accompany the generalist education officer on visits to midwifery institutions. This is still a cause of worry to midwives as it is seen as a basic right for a profession to be in control of its own education and practice (Sweet, 1993, p48).

1997
Consultation exercise initiated on a review of the 1979 Act, reviewing the legislation and the role of the National Boards and the UKCC. Some midwives campaigning for separate legislation for midwives.

1999
Report published by JM Consulting Ltd advocating a new single UK-wide statutory body, creating a new ‘streamlined’ regulatory structure.

APPENDIX B

CHANGING CHILDBIRTH INDICATORS OF SUCCESS (DoH, 1993)

Within 5 years:

1. All women should be entitled to carry their own notes.

2. Every woman should know one midwife who ensures continuity of her midwifery care - the named midwife.

3. At least 30% of women should have the lead midwife as the lead professional.

4. Every woman should know the lead professional who has a key role in the planning and provision of her care.

5. At least 75% of women should know the midwife who cares for them during their delivery.

6. Midwives should have direct access to some beds in all maternity units.

7. At least 30% of women delivered in a maternity unit should be admitted under the management of the midwife.

8. The total number of visits for women with uncomplicated pregnancies should have been reviewed in the light of the available evidence and the RCOG guidelines.

9. All front line ambulances should have a paramedic able to support the midwife who needs to transfer a woman to hospital in an emergency.

10. All women should have access to information about the services available in their locality.

APPENDIX C

CATTELL PF PERSONALITY TEST

APPENDIX D

TEMPLER DEATH ANXIETY SCALE

APPENDIX E

INITIAL INTERVIEW SCHEDULE

History - how did you come to midwifery?

Nursing experience and job history

What was your first experience of death?

(For nurses) What was your first nursing experience of death? - perceived support?

Do you think about death?

Have you thought about death in the context of midwifery?

APPENDIX F

PARTICIPANTS - DEMOGRAPHIC DETAILS AND RESULTS OF INITIAL PARAMETRIC TESTS (results from July 1992)

NURSES

Angela: Age 30. No children. Qualified 6 months before starting midwifery. Personality characteristics (PF test): self assured, relaxed.

Templer Death Anxiety (DA) score: 14

Brenda: Age 24. Married, one 6 year old daughter. Qualified 7 months before starting midwifery. PF test: Concrete thinking, sensitive, trusting, conservative.

DA score: 14

Carol: Age 25, married for two years. No children. Qualified 3 years before starting midwifery. Worked mainly on male surgical ward. PF test: Concrete thinking, conscientious, trusting, socially precise.

DA score: 2

Deirdre: Age 22, married, no children. Qualified for two years before starting midwifery, worked on Gynaecology ward. PF test: Emotionally stable, venturesome, imaginative, forthright.

DA score: 7

Emma: Age 23, single, living alone. Roman catholic. After leaving school, worked as a waitress, and then as a care assistant in an old people's home. Once qualified, worked on a mixed surgical urology ward. PF test: Concrete thinking, venturesome, group oriented, socially precise.

DA score: 2

NON-NURSES

Frances: Age 35, married, two children. Jobs since leaving school: pre-nursing course aged 16, children's nanny for 7 years, supervisor at large chain store for 7 years, A levels at night school. PF test: disregards rules, sensitive, trusting, socially precise.

DA score: 7

Gail: Age 38, divorced, 3 children. Jobs since leaving school: laboratory technician 7 years, auxiliary nursing 3 years, full-time at FE college, 2 years. PF test: Concrete thinker, trusting.

DA score: 14

Irene: Age 30, single, no children

PF test: Reserved, affected by feelings, disregards rules, sensitive, hard to fool, self-sufficient.

DA score: 5

Josie: Age 37, married, 2 children. Jobs since leaving school: part time work while student teacher, shop assistant and factory work, teacher, part-time nursing auxiliary. PF test: Outgoing, concrete thinking, dominant, socially precise.

DA score: 4

Kath: Age 19, living with parents. Did BTEC at college then midwifery. PF test: Concrete thinker, venturesome, tough-minded, practical, shrewd, experimenting.

DA score: 11

Other participants:

Mary: Age 35, qualified midwife, non-nurse, working at another hospital

Lisa: Age 26, Qualified midwife, nurse, working at another hospital

A group made up of seven qualified midwives.

APPENDIX G

CATEGORIES FOR ANALYSIS: INITIAL OPEN CODING AFTER FIRST INTERVIEWS

Biographical details
Why came into midwifery - always wanted to be a midwife
did nursing to get into midwifery
Nurse training: stress
preparation for dealing with death
Nursing `routine'
Control
Death - nurse training
First resuscitation
First `laying out'
Personal experience of death
Guilt
Continuity
Being `busy'
What can you say?
Good deaths
Bad deaths
Religion
`Personality'
Views of midwifery - it's a normal, healthy thing
Views of pregnancy loss
Support
Mentors
Theory and `ologies'

APPENDIX H

PART OF TRANSCRIBED INTERVIEW WITH INITIAL OPEN CODING APPLIED

APPENDIX I

Department of Health Midwifery Recruitment Advertisement March 1998