A critical ethnographic study of encounters between midwives and breast-feeding women in postnatal wards in England

Fiona Dykes, MA, PhD, RM, RN (Reader in Maternal and Infant Health)

Midwifery Studies Research Unit, University of Central Lancashire, Preston PR1 2HE, UK

Received 2 July 2004; received in revised form 11 November 2004; accepted 10 December 2004

Summary
Objective: to explore the nature of interactions between midwives and breast-feeding women within postnatal wards.
Design: a critical ethnographic study using participant observation and focused interviews.
Setting: two maternity units in Northern England, UK.
Participants: 61 postnatal women and 39 midwives.
Findings: the interactions between midwives and women were encompassed by the global theme of 'taking time and touching base'. However, most encounters were characterised by an absence of 'taking time' or 'touching base'. This related to midwives' experiences of temporal pressure and inability to establish relationality with women due to their working patterns. The global theme was underpinned by five organising themes: 'communicating temporal pressure'; 'routines and procedures'; 'disconnected encounters'; 'managing breast feeding'; and 'rationing information'.
Key conclusions: the organisational culture within the postnatal wards contributed to midwives experiencing profound temporal pressures and an inability to establish relationality with women. Within this context, the needs of breast-feeding women for emotional, esteem, informational and practical support were largely unmet.
Implications for practice: transformative action is required to dramatically reorganise the provision of hospital-based, postnatal ward midwifery care in parts of the UK. This should include a re-conceptualisation of caring time, with recognition that midwives need sufficient time in order to give time to others. This, in turn, requires recognition that caring time is cyclical and rhythmical, allowing for relationality, sociability, mutuality and reciprocity. The midwifery staffing structure

E-mail address: fcdykes@uclan.ac.uk.

0266-6138/$ - see front matter © 2005 Elsevier Ltd. All rights reserved.
Introduction

In the UK, about 98% of women birth in hospital (DoH, 2002). This inevitably means that women's early experiences of breast feeding occur within a medicalised setting — the postnatal ward. Little research, however, has focused specifically on the hospital experience for breast-feeding women in the UK. In this paper, I present some of the findings from a recent critical ethnographic study conducted in the North of England, UK. The focus is upon the nature of encounters between midwives and postnatal women in the postnatal ward, and upon the organisational culture in which the interactions take place.

Postnatal wards

Breast-feeding women are carrying out a partially learned activity, which, in the absence of exposure within their own communities, requires support from health professionals. This is particularly the case when women enter postnatal wards and become geographically separated from their family and friends. However, the failure to meet women's needs in UK postnatal wards has been repeatedly highlighted (Maternity Services Advisory Committee, 1985; House of Commons, 1992; Ball, 1994, Garcia et al., 1998; Singh and Newburn, 2000). Even within innovative schemes such as 'One-to-One Midwifery', which raised women's general satisfaction with maternity care, women still tended to feel less satisfied with hospital postnatal care (McCourt et al., 1998). This low satisfaction with hospital postnatal care has also been reported in other countries (Stamp and Crowther, 1994; Bondas-Salonen, 1998; Yelland et al., 1998; Rice et al., 1999). This dissatisfaction partly results from the lowly position of postnatal care within the techno-medical hierarchy. It is frequently referred to as the 'Cinderella' of the maternity service owing to its impoverished resourcing and staffing (Ball, 1994; Garcia et al., 1998; Royal College of Midwives, 2000; Singh and Newburn, 2000). In addition, research across the industrialised world has failed to show any increase in the breast-feeding rates of women remaining in hospital for several days compared with women discharged early (Brown et al., 2003).

Support for breast-feeding women

The ways in which women need support with breast feeding is highlighted in research focusing specifically on the influence of professional encounters upon women's perception of their early breast-feeding experiences (which in most cases also encompasses aspects of their experiences of postnatal wards). The types of support may be broadly categorised under five headings: emotional, esteem, informational, practical, and network (Sarafino, 1994).

Emotional support seems to be crucial, and includes staff showing sensitivity, concern, empathy and care towards women (Tarkka and Paunonen, 1996; Bondas-Salonen, 1998; Bowes and Domokos, 1998; Svedulf et al., 1998; Tarkka et al., 1998; Vogel and Mitchell, 1998; Whelan and Lupton, 1998; Hoddinott and Pill, 2000; Hauck et al., 2002; Dykes et al., 2003). Women welcome receiving adequate staff time and availability in contrast to feeling rushed (Tarkka and Paunonen, 1996; Bondas-Salonen, 1998; Bowes and Domokos, 1998; Svedulf et al., 1998; Tarkka et al., 1998; Vogel and Mitchell, 1998; Whelan and Lupton, 1998; Hoddinott and Pill, 2000; Hauck et al., 2002; Dykes et al., 2003; Hong et al., 2003). They prefer a quiet environment in which the woman is assisted in feeling rested, confident and less anxious (Ball, 1994; Tarkka and Paunonen, 1996; Bondas-Salonen, 1998; Tarkka et al., 1998; Vogel and Mitchell, 1998). Esteem support, which relates to encouragement and confidence building, is highly valued by women (Ball, 1994; Schy et al., 1996; Humenick et al., 1998; Svedulf et al., 1998; Hoddinott and Pill, 2000; Gill, 2001, McCreathe et al., 2001; Hauck et al., 2002; Ingram et al., 2002; Dykes et al., 2003).

Women value provision of information that takes account of their existing knowledge and is tailored to their individual needs (Bowes and Domokos, 1998; Whelan and Lupton, 1998; Hoddinott and Pill, 2000; Gill, 2001; Hauck et al., 2002). They prefer information that is realistic, useful and accurate (Svedulf et al., 1998; Whelan and Lupton, 1998;
Hoddinott and Pill, 2000; Mozingo et al., 2000; Gill, 2001; Hauck et al., 2002; McKeever et al., 2002; McLeod et al., 2002; Dykes et al., 2003; Hong et al., 2003). This information needs to be provided by staff with appropriate knowledge about breast feeding and the ability to teach the necessary skills (Bowes and Domokos, 1998; Vogel and Mitchell, 1998; Raisler, 2000; Ingram et al., 2002; McKeever et al., 2002; Dykes et al., 2003). The information also needs to be consistent (Ball, 1994; Tarkka and Paunonen, 1996; Vogel and Mitchell, 1998; Hoddinott and Pill, 2000; Mozingo et al., 2000; Hauck et al., 2002; Ingram et al., 2002; Dykes and Williams, 1999).

Women generally welcome practical support with breast feeding when required (Hoddinott and Pill, 2000; Mozingo et al., 2000; Raisler, 2000; Hong et al., 2003). This, however, needs to be combined with sensitive respect for body boundaries (Vogel and Mitchell, 1998; Whelan and Lupton, 1998; Hoddinott and Pill, 2000; Mozingo et al., 2000; Ingram et al., 2002). Finally, assistance with maintaining existing networks of significant others, and the activation and establishment of supportive networks within the new situation, are important to women (Bondas-Salonen, 1998; Tarkka et al., 1998; Dykes et al., 2003).

Collectively, this literature presents a resounding chorus for the support of breast-feeding women in hospital. However, it takes little account of the cultural milieu within which women receive support, and of the effect of this culture on health professionals. It is crucial to incorporate this perspective, as a growing body of research relates to the influence of the organisational culture upon the activities of health professionals and their encounters with service users (Street, 1992; Kirkham, 1999; Woodward, 2000; Lugina et al., 2001, 2002; Hughes et al., 2002; Ball et al., 2002; Varcoe et al., 2003; Hunter, 2004). The culture in which women learn to breast feed and midwives provide, or do not provide, support is crucial to a critical study. It plays a key role in the emotional well-being of women, in how they cope with their emotions and change of role, and in their learning of new skills. It is also crucial in its influence upon midwives and how they cope with their emotions and role.

One way of incorporating a cultural perspective stems from ethnographic study of the specific setting. Observational studies that focus on breast-feeding women in postnatal wards include practice-development projects (Renfrew, 1989); exploration of specific activities, for example, supplementation with artificial milk (Cloherty et al., 2004) or pacifier use (Victora et al., 1997); decision-making by women (Marchand and Morrow, 1994); and general support for breast-feeding women (Gill, 2001). However, these studies do not adopt a critical theory perspective nor do they specifically explore the organisational culture. The aim of this study was to critically explore the nature of interactions between midwives and breast-feeding women within postnatal ward settings in northern England.

**Methods**

**Research design**

A critical ethnographic approach was used for the study. Ethnography originates from anthropology, and is therefore informed and infused by the notion of culture. It enables the eliciting of cultural knowledge within a specific community or setting by watching what happens, listening to what is said and asking questions (Hammersley and Atkinson, 1995). Critical ethnography addresses issues of ideology and power:

It deepens and sharpens ethical commitments by forcing us to develop and act upon value commitments in the context of political agendas. Critical ethnographers describe, analyse, and open to scrutiny otherwise hidden agendas, power centres, and assumptions that inhibit, repress, and constrain (Thomas, 1993, p.3).

**Setting**

The study was conducted from 2000 to 2002 in two maternity units in the North of England. Both units were consultant-led. Site 1 was a city hospital, in which about 3–4000 women birthed a year. Site 2 was situated in a town and supported about 1000 births a year. Postnatal stay in both units ranged from 1–5 days. Both hospitals served populations that spanned higher to lower socio-economic groupings. Neither hospital had WHO/UNICEF Baby Friendly Initiative accreditation. Breast-feeding rates at site 1 were comparable to the national rates for the UK (i.e. 69% initiation and 42% of women breast feeding at 6 weeks (Hamlyn et al., 2002)). The breast-feeding rates at site 2 were lower, probably relating to a more predominant bottle-feeding culture in the surrounding communities. The research took place in maternity wards that served antenatal and postnatal women.
Sample

Thirty-nine midwives and 61 postnatal women consented and subsequently participated. Seven postnatal women did not wish to participate. None of the midwives refused to participate, but they were often too busy to be interviewed. The study included women who were admitted to the postnatal wards who had commenced breast feeding and were able to communicate in written and verbal English. The study excluded women with a baby in the neonatal unit and women with serious obstetric, medical or emotional complications after childbirth.

Ethical issues

Ethical approval for the study was gained from the two Local Research Ethics Committees, and the approved procedures were followed for access, consent and participant autonomy. Access to the wards in which the study took place was granted by the head of midwifery at each site. Managers and staff were informed about the study through the cascade management systems. A clear notice about the study was placed on view in each ward, with contact details for any staff queries. The midwife in charge of the ward was informed before and at the start of each observational period. Each time a period of observation started, information sheets were provided to all midwifery staff during the report time. Midwives were also informed about the study verbally. They were informed that they could indicate at any stage during the observational period that they did not wish to be observed.

The postnatal women who met the inclusion criteria were approached at the start of each observational period or on their arrival in the ward. They were informed about the study and provided with written information. After 30 mins or longer, they were approached again and invited to participate. They were asked if they had further questions and then asked to sign a consent form if willing to participate. It was clarified that they could opt out at any stage or for any particular situation, and that there would be no compromise to their care if they preferred not to participate. At all stages, participant autonomy and confidentiality were protected (ASA, 1999). For quotations, pseudonyms next to the participant numbers are used (P for postnatal woman, MW for midwife).

Procedure

The study involved long periods observing activities in the postnatal wards so as to include interactions between midwives and breast-feeding women. Participant observation was conducted for 97 encounters between midwives and postnatal women during which breast feeding was discussed. In addition, 106 focused interviews were carried out with postnatal women and 37 with midwives. A tape recorder was used, where appropriate, and when permission from all parties was obtained.

Analysis

The analysis was cyclical, involving the discovery of new questions during the field work, which in turn guided the data collection through a process of iterative, concurrent data collection and analysis (Hammersley and Atkinson, 1995). The interview and observational data were transcribed and developed into basic, organising and global themes using thematic networks analysis (Attride-Stirling, 2001). To support a critical analysis, further readings of the transcripts were carried out to identify issues relating to ideology, power and control (Thomas, 1993). Each global theme constituted a ‘core, principle metaphor’ that encapsulated the main point of the text (Attride-Stirling, 2001, p. 393). A constant process of refinement and verification of the networks took place throughout the research process until no further basic themes emerged, there was no further movement of the themes and the relationship between the themes was well established. Grounded theorists refer to this as ‘theoretical saturation’ (Strauss and Corbin, 1990, p.188).

Actions and interpretations throughout the research process were guided by the need to maximise the trustworthiness of the research. The process of concurrent data collection and analysis, with progressive focusing and seeking out discrepant cases, assisted depth in the theoretical process (Spradley, 1980; Hammersley and Atkinson, 1995). Periods away from the field enabled deep reflection upon the developing analytical themes. Respondent validation (Appleton, 1995) was obtained from the women who were interviewed on more than one occasion by presenting them verbally with key issues that they had highlighted the day before, during the interview, and asking whether or not they felt that, for them, these were the key issues. Throughout the research process, the decision trail and thematic analysis was made transparent through peer review (Koch, 1994).

This paper focuses specifically on the findings that relate to the nature of encounters between midwives and breast-feeding women and the organisational cultural underpinnings. In particular,
it highlights the ways in which midwives’ experiences of temporal pressure and absence of relationality with women influenced interactions.

Findings and discussion

Forty-eight of the participating women gave birth vaginally, 11 being instrumentally assisted. Thirteen women had a caesarean section. Forty women were primiparous and 21 multiparous. Five women were Asian and 56 white, as defined by the Office of National Statistics classification (Hamlyn et al., 2002). The women represented a range from higher to lower socioeconomic occupational groupings and ages 17–42 years. These demographic profiles were broadly representative of the two local communities. The midwives ranged in age from 23–54 years, and from newly qualified to over 25 years of experience. Thirty-eight of the midwives were female and one was male. One midwife was Asian and 38 were white.

The interactions between midwives and women are encompassed within the global theme of ‘taking time and touching base’, which refers to the midwife taking time with women and touching their personal experiences. However, most encounters were characterised by an absence of ‘taking time’ or ‘touching base’. This global theme was underpinned by five organising themes: ‘communicating temporal pressure’; ‘routines and procedures’; ‘disconnected encounters’; ‘managing breast-feeding women’; and ‘rationing information’.

Communicating temporal pressure

Most of the midwives at site 1 worked in teams within the global theme of ‘taking time and touching base’, which refers to the midwife taking time with women and touching their personal experiences. However, most encounters were characterised by an absence of ‘taking time’ or ‘touching base’. This global theme was underpinned by five organising themes: ‘communicating temporal pressure’; ‘routines and procedures’; ‘disconnected encounters’; ‘managing breast-feeding women’; and ‘rationing information’.

The main problem is never knowing when you might be moved. Can you really get to know anyone when you may be shifted off at a moment’s notice. I mean some staff can be working on the ward, clinic, delivery and theatre all in one day. On top of that there aren’t enough staff. Therefore, we can only try to give breast-feeding advice but often that’s not enough.

At site 2, most midwives were designated to practice in teams, crossing the hospital-community interface. In practice, some midwives tended to be located primarily in the hospital and others in community, with a degree of flexibility. The midwives in the mixed antenatal and postnatal wards would often commence a ‘shift’ with enough staff to enable them to ‘take time’ with breast-feeding women, supporting and encouraging them in a flexible and individually focused way. However, once they knew that delivery suite was ‘hotting up’, they started to process work in the same way as at site 1:

At site 2, women were less likely to comment about how busy midwives were because they were in closed four-bedded rooms. At both sites, when women were aware of the pressures on midwives, they tended to struggle on quietly recognising that asking for support or information was to request scarce midwifery time, as reported by others (Bowes and Domokos, 1998; Kirkham and Stapleton, 2001). The less assertive women tended to be those from lower socio-economic occupational groups. Therefore, the inverse care law applied, as reported in other studies (Lipsky, 1980; Townsend and Davidson, 1992; Kirkham et al., 2002a).

Routines and procedures

A substantial part of activity carried out in the postnatal ward centred upon performance of
routines and procedures, such as the standard postnatal observations and examination. Although aspects of these activities fulfil a clinical purpose, they also constitute a mechanism for giving people a feeling of being in control, especially when experiencing pressure, ambiguity and unpredictability (Menzies, 1970; Fox, 1989, Kirkham, 1989; Davies and Atkinson, 1991; Ball, 1994; Begley, 2001; Waterworth, 2003). Midwives displayed a central and instrumental preoccupation with completing tasks and ticking boxes that related to their temporal pressures:

They were very busy yesterday. I’d sort of approached her (the midwife) and then all of a sudden, ooh, I’ll do all your notes while you’re here sort of thing (laughs). She was taking her opportunity. I mean nobody spoke to me then all afternoon which was fine; I didn’t need anything and I would have called if I had. I think it was the pressure that had contributed. She thought ‘I’ll get all this done’, you know. I don’t know if there was a box that she had to tick, to say that she had covered everything. To me she seemed to be only interested in checking my pulse, filling all her forms out and ticking the boxes. I mean I think that whoever is looking after you should come at least twice a day and say, ‘how are you doing’ and ‘how are you getting on’, you know, just check that everything is going all right. I got the impression that it was more, ‘oh I’ll get this done’. I mean they should at least touch base with you once or twice a day. (Louise, P14)

Frankenberg (1992) highlights the paradoxical influence of time within biomedicine as patients endure long periods of waiting interspersed by sudden intrusions upon their temporal and spatial boundaries. For the health professional, as Fox (1989) argues, hospital maternity care can become a mechanical act and a time-bound process, with time being reduced to a rational, intelligible, measurable means of orientation’ (p. 126). Thus, she argues, introducing orderliness to health provision invokes feelings of being in control, and provides concrete evidence of personal productivity.

Disconnected encounters

When midwives were under temporal pressure, communications tended to be disconnected from the woman’s context and personal agenda. This also related to the fragmented ways of working due to frequent relocation of midwives to other areas and short time that women stayed in the postnatal ward. Consequently, there was little opportunity for continuity of carer. Communication was often rushed, didactic and monologic:

Anna (P1): I’d be better bottle feeding. What’s the problem with not breast feeding?
Holly (MW7): It’s better for the baby.
Anna: Yes, but I’m going home today, so I might as well give the bottle. What’s the point of staying here and not sleeping. I’m going home.
Holly: It’s good to give her some breast milk.
Anna: I don’t want to give breast milk.
Holly: It is better.

These monologues contrasted with women’s needs:

It would be nice if somebody could just come and spend 10 minutes with you to talk about breast feeding. If they did that they could learn about your concerns and anything you feel you need help with. I mean I’m not very confident at all. (Helen, P35)

The notion of developing any form of relationship with women was largely absent. Under these circumstances, midwives were constrained from developing what Varcoe et al. (2003) refer to as an ‘authentic presence’ (p. 966). Midwives tended to make rapid judgements about women that were not based on a trusting relationship. This inevitably led to labelling and stereotyping of women for the purposes of rapid action. This absence of relationality, lack of presencing and stereotyping was strikingly resonant with descriptions of others (Lipsky, 1980; Kirkham, 1999; Kirkham and Stapleton, 2001; Ball et al., 2002; Kirkham et al., 2002b).

Managing breast feeding

There was a sense of breast feeding being a technically managed activity, with the primary concern being the transfer of milk to the baby. Instrumental, managerial and authoritative approaches adopted by midwives related to competing demands and a lack of confidence in the bodily process of breast feeding. Many of the encounters between postnatal women and midwives relating to breast feeding involved teaching of specific techniques in reductionist ways and the issuing of pre-defined packages of information:

Alex (MW9): Would you like me to show you how to hand express?
Louise (P14): No thanks, I don’t really want to.
Alex: Well it would reassure you that you have milk.
Louise: Oh I can see that when she feeds.
Alex: It’s a technique we like to teach ladies. I’ll just show you.
Alex then demonstrated on herself.

Louise discussed her feelings related to this afterwards:

I wasn’t ready for her telling me how to express. I wasn’t at the stage where I wanted to know about that. I felt that things were going well and she was latching on really well and I didn’t see the need for expressing and I thought well she was determined to tell me. She was trying to be helpful but I was saying, “no it is all right, I’m OK”. I just think she wasn’t listening to what I had to say. I think she thought she was doing me a favour but I didn’t want to know. I thought, “well, if I need to know I’ll ask you then”. I think they feel they have got to tell you certain things. (Louise P14)

Another aspect of the technical approach, on both sites, centred upon teaching effective positioning and attachment. Although this is crucial in supporting effective breast feeding (Renfrew et al., 2000), when midwives were rushed it was often simply ‘chanted’ as a set of technical steps. Di (MW18), for example, lifted Veronica’s (P27) baby and physically attached her to her breast saying: ‘Right, so point the nipple to nose, then you’ll see more of the areola above than below and the bottom lip turned down. Look you can see his lips’. Shildrick (1997) refers to ways in which women’s bodies are seen as containers or bounded spaces within which specific processes occur. The reproductive organs are then conceptualised as discrete entities to be managed. This leads to a compromising of the wholeness of ‘one’s being-in-the-world’, so that ‘the woman as a person plays little or no part but is obscured as an intentional agent by the clinical concentration on a set of functional norms’ (p. 25).

As in the above interaction with Di, there were frequent occasions, on both sites, when midwives invaded the spatial boundaries of women by attaching a baby to the breast using a ‘hands on’ approach. They then tended to move on to the next person or task without observing part or all of a breast feed. This physical management of women’s bodies undermined women’s sense of confidence in that they were unable to repeat the actions themselves requiring them to request help on several occasions during the course of a feed. Women used emotive language to describe midwives handling their breasts:

I tried expressing. The midwives tried. They mauled at them but nothing came. (Anna P1)

He wasn’t latching on properly so one of the midwives came and said, ‘be a bit more forceful’. She did it herself. (Sophie P61)

Midwives seemed to be unaware that this ‘hands on’ approach might be unacceptable to women. This was surprising given recent research indicating women’s dislike of their breasts being handled, the baby being ‘rammed’ on to their breast and their desire to be taught breast-feeding skills verbally (Vogel and Mitchell, 1998; Whelan and Lupton, 1998; Hoddinott and Pill, 2000; Mozingo et al., 2000; Ingram et al., 2002).

Rationing information

The sense of temporal pressure upon midwives affected the ways in which they ‘delivered’ information, with speed being the essence:

The nurses are very good. They tell you everything very quickly, so sometimes it’s like you’ve got to pick up everything very quickly. They’re very quick but thorough. (Jane P12)

This meant that midwives did not ascertain women’s understanding either before or after giving information. Consequently, women often felt that they had insufficient information to enable them to breast feed effectively and with confidence. This resonates with Kirkham’s (1989) labour ward study, in which time pressures led to ‘information being compressed into dense routine packages’ (p. 127).

There were several instances of conflicting information that related, in part, to a lack of continuity of carer:

I’ve seen different people this morning and they have all had a different approach. (Kate P39)

Bryony commented:

There are just so many people. Um, there isn’t a consistent game plan. I find it all so confusing. It leaves me feeling guilty at not following advice. A team front is needed. They should be presenting one approach. There should be a leaflet on the problems too. That would be useful (P7).

Conflicting information is repeatedly referred to in relation to hospital practices and, as Krogstad et al. (2002) reflect, it often relates to a lack of a common approach, co-ordination and co-operation among health professionals. Conflicting information is also reported by others to be a continuing problem that undermines women’s confidence in relation to breast feeding (Ball, 1994; Garcia et al., 1998; Tarkka et al., 1998; Vogel and Mitchell, 1998;
Dykes and Williams, 1999; Dykes, 2002; Dykes et al., 2003).

Bryony’s reference to needing a leaflet reflects the situation, on both sites, in which there were information leaflets available but they were commonly issued and referred to at discharge along with numerous other issues. In this way, the leaflet information was not effectively used, as described by Stapleton et al. (2002).

Taking time and touching base

There were situations, on both sites, in which midwives were able to ‘take time and touch base’ with women. This related to their determination to overcome temporal and relational barriers, and to situations that allowed them time and space in which to support women. For example, Jenny (MW14) supported Jocelyn (P18) each day during her 5-day hospital stay. Jocelyn came from a lower socio-economic occupational group and her baby was born at 36+ weeks gestation and was also small for gestational age. Jenny touched base with Jocelyn in several ways, meeting her needs for emotional, esteem, informational and practical support. One example of confidence building, an aspect of esteem support, may be seen in the following dialogue:

Jocelyn: Is he feeding all right?
Jenny: Your body feelings are the best guide. What do you think?
Jocelyn: I can hear him sucking.
Jenny: Yes and I can hear him swallowing. Oh look you can see milk dribbling out on to his chin! That’s good.

Here Jenny assisted Jocelyn in connecting with her own embodied signals and confirmed these by way of reassuring her about the adequacy of her milk. This ‘process of inspiring confidence in women by our confidence in their abilities,’ is referred to by Leap (2000, p. 7). Another key way in which Jenny built Jocelyn’s confidence centred upon emphasising a sense of progress and achievement: ‘Oh that’s great! He’s really suckling keenly there. He’s really progressing’.

Jenny demonstrated a growing understanding of what Jocelyn needed, tailoring information to meet her individual requirements. This could only occur in a situation in which the midwife and postnatal woman had time together to get to know each other. Jenny formed a relationship of trust with Jocelyn and helped Jocelyn to cope with uncertainty. This ability to form a trusting relationship is now emerging in the literature as enormously beneficial to women and the quality of their maternity care experience (Kirkham, 2000; Curtis et al., 2001). Jocelyn’s trust in Jenny seemed to be fundamental to the incremental confidence building that took place:

I couldn’t have done it without Jenny. She’s been fantastic. She has been with me every day and has really helped me, building my confidence by praise and saying, ‘You’re doing fine’. She was there regular like, you know, same midwife. She knew exactly what was going on. She spends time with you.

Jocelyn’s emphasis upon time resonates with the findings of Curtis et al. (2001), who reported that maternity-care service users described staff who ‘made time for them’ as giving ‘good care’ (p. 128). However, Jenny pointed out that the opportunity to follow a woman through and develop a relationship was quite unique:

I’ve been involved with Jocelyn from transfer to this ward. It’s one of those lovely situations where she’s had the same person most of the time. I mean so often you see someone one day, you set things in motion and the next day someone else has scuppered it. The thing is; this is the exception. We’ve been quiet over the weekend. I’ve spent hours with her. Normally though, she just wouldn’t have got anything like this attention and she would have ended up most probably with the baby in neonatal unit. She’s got a poor ability to retain information and she just could not have coped with minimal attention. Then because of lack of staff she would have ended up separated from the baby and all that extra time and expense would be involved with a baby on neonatal unit. That is what happens when there aren’t the staff. It’s just been lovely to be able to support someone through this process like this.

When asked about how her care might have changed in a busier situation, Jenny stated:

Well, I think there’s more pressure when you’re busy not to discuss things and just to tell a mother what to do, and, because most mothers, particularly in a stressed situation like that, will just do what you tell them its very easy to fall into a situation where you almost exploit that. I mean given the current situation you cannot give woman-centred care. I mean I would hope I still discuss things with women and try to discuss things with them. But it’s incredibly difficult with someone who’s a bit slow, who needs time;
time to burst into tears and then settle down afterwards.

The encounters between Jenny and Jocelyn, when compared with some of the interactions described above, show that, despite the organisational culture, there are different styles of caring. Jenny's style was facilitative in contrast to more authoritative, directive and insensitive approaches of some of the midwives referred to earlier. This difference in approaches by individual midwives, ranging from unsupportive to supportive encounters, is described by others (Berg et al., 1996; Halldorsdottir and Karlsdottir, 1996a,b; Fenwick et al., 2000; Kirkham, 2000). Nevertheless, as Jenny suggests, the ability to support women in a facilitative way is hindered by organisational constraints.

Discussion and implications

The aim of this study was to critically explore the nature of interactions between midwives and breast-feeding women within postnatal wards in northern England. In particular, it shows ways in which midwives' experiences of temporal pressure and absence of relationality with women influence interactions. When the midwives were interviewed, they spoke about interactions with women in the context of these structural constraints upon them. For service-users, the postnatal ward represented the last stop in a medicalised journey. Here they entered another strange environment and were surrounded largely by relative strangers at a time during which they were adapting to mothering a new baby and learning new skills such as breast feeding. Given the temporal and relational constraints upon midwives, women's needs for emotional, esteem, informational, practical and network support were often unmet.

This study involved two maternity services and therefore cannot be said to represent the postnatal ward experiences of women across the UK. As is acknowledged within anthropology, cultures vary considerably from place to place. Nevertheless, the findings regarding the constraints upon midwives and the experiences of women have many resonances with other ethnographic accounts within UK maternity services (Kirkham, 1999; Woodward, 2000; Kirkham and Stapleton, 2001; Hunter, 2004). The study was not set up as a comparative ethnography of two units. The second site was selected to add depth. There were, however, some differences between units, as highlighted above, but there were substantially more similarities.

The 'Hawthorne effect' may have manifested in this study. This relates to the effect of being studied on participants' behaviour (Bowling, 1997). The support for breast-feeding women may have improved because of my presence. As the encounters observed were often far from ideal, any attempted improvements owing to my presence do not seem to have fundamentally compromised the extent to which the situation is critiqued. In any event, it has to be acknowledged that my presence in the situation was an inevitable part of the construction of the social situation that was exploited in a reflexive manner (Hammersley and Atkinson, 1995).

The key conceptual lens through which these data were viewed stemmed from the contrasting notions of cyclical and linear time (Cipolla, 1967; Kahn, 1989; Adam, 1992; Bellaby, 1992). Linear time, measured by the clock, is pitched relentlessly towards the future and is centred upon the notion of efficient production (Kahn, 1989). This concept of production is deeply embedded within western capitalist societies. In contrast, cyclical time, as Kahn (1989) argues, is a bodily, rhythmic time that is a part of one’s ontology and not separate and 'outside' like linear time. For midwives, in postnatal wards, there were powerful constraints of linear time upon them that related, in part, to the experience of unpredictability so that they never knew at any time how much or little time they might have to complete their tasks. As Lynch (2002) argues, ‘hospitals are organised as corporate work places overseen by managers whose job is to economise health care’ (p. 180). Within this model, as demand outstrips supply, like other public services, hospitals are always likely to be under-resourced, and it is the personal aspect of the service that is usually sacrificed (Lipsky, 1980, Lynch, 2002).

Unrelenting pressure upon midwives’ time is a source of oppression. As Foucault (1977) states: ‘time penetrates the body and with it all the meticulous controls of power’ (p. 152). Lynch (2002) cogently argues that we seem to have lost our understanding of the 'rhythm of work and rest', of 'being' as well as 'doing', of recognising the need for 'spaces of contemplation, meditation and mediation’ (p. 184). In addition to experiencing temporal pressure, midwives were also endeavouring to support women who were relative strangers. Their work was thus usually conducted outside a relational context despite the importance of relationships for both midwives and service-users (Sandall, 1997; Kirkham, 2000; Ball et al., 2002). These conditions compromised midwives’ occupational autonomy, which is identified as crucial to
well-being in the work place (Sandall, 1997; Mackin and Sinclair, 1999; Ball et al., 2002; Stevens and McCourt, 2002). Consequently, when under pressure, midwives coped by gaining satisfaction from rapid processing of work and completing procedures. In this way, the work of hospital midwives was institutionally orientated rather than woman-centred, as described by others (Kirkham and Stapleton, 2001; Ball et al., 2002; Lock and Gibb, 2003; Hunter, 2004).

As shown above, even within the same organisation, a range of approaches to supporting women is evident when observing different midwives. The encounters were in some cases authoritative and didactic and in others more facilitative. Therefore, the organisational culture is not the only factor in determining the nature of interactions between health professionals and service users. Nevertheless, the political ramifications of the pressures upon midwives’ time are enormous and pressing, and a re-conceptualisation of time must form an essential part of any transformative action. There needs to be recognition that women need time in order to give time to others. This, in turn, requires recognition that caring time is cyclical and rhythmical, allowing for relationality, sociability, mutuality and reciprocity (Kahn, 1989; Street, 1992; Lynch, 2002).

A crucial aspect of reorganising the maternity system would necessarily require a re-visioning of midwife-mother relationships. Although educational programmes for midwives, which support personal and practice-based reflection, are essential to raise awareness about ways of effectively supporting women, this must be accompanied by a review of the organisational culture within which midwives work. If hospital postnatal care is to continue, then it is time to reconsider the work patterns in such places. It seems to be unacceptable to use such areas as a hub of activity from which staff may be dispensed to other more medicalised areas. Opportunity for relationality and adequate time is crucial if women’s needs are to be met. This raises the question of whether breast feeding requires some form of supplementary support given the shortage of midwives (Sikorski et al., 2003). Specially trained healthcare assistants, or alternatively breast-feeding peer supporters, may be able to provide additional support to women in hospital, as described in a recent government-funded evaluation (Dykes, 2003). However, more research is required in this area.

More radically, perhaps it is now time to challenge the suitability of the hospital as the place and space within which women begin to establish breast feeding. Although a hospital setting will always be required for some women and desired by others, if an appealing alternative were to be available for immediate and supportive postnatal care in the home, then women might well opt for it.

Conclusion

This ethnographic study explores the nature of, and influences upon, encounters between midwives and breast-feeding women within postnatal wards. It emphasises the interaction between structural constraints and individual agency on the part of midwives and postnatal women. It illustrates that the postnatal ward culture, with its related temporal pressures and scarce opportunities for relationality, have a profound effect on the activities of midwives and experiences of service users. The 21st century seems to be a time in which we should seriously challenge the suitability of the current organisation of hospital postnatal care in the UK.

Acknowledgements

This study was supported by the University of Central Lancashire, Faculty of Health infrastructure funding. I would like to thank Professor Mavis Kirkham, University of Sheffield, for her support throughout the study, the participants in the study and the anonymous reviewers for their constructive comments on the paper.

References


Encounters between midwives and breast-feeding women in postnatal wards in England


McCreath, W., Wilcox, S., Laing, V., et al., 2001. Improving the number of mothers breastfeeding in the postpartum period. Primary Care Update 8, 41–43.