Emotion work and boundary maintenance in hospital-based midwifery

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Summary
Objective: to identify and explore the emotion work of hospital-based midwives.
Design: an ethnographic approach using focus groups, observations and interviews.
Setting: South Wales, UK.
Participants: phase one of the study: self-selected convenience sample of 27 student midwives in first and final years of 3-year (direct entry) and 18-month (post-nursing) programmes. Phase two: opportunistic sample of seven qualified hospital-based midwives. Phase three: purposive sample of 10 hospital-based midwives working within one National Health Service Trust. Sample representative of a range of clinical locations, length of clinical experience and clinical grades.
Findings: the emotion work of midwives was strongly influenced by the context of practice. For hospital-based midwives, relationships with midwifery colleagues were of key importance, providing the main source of feedback on individual practice. Negotiating these relationships was a major source of emotion work. Although collegial relationships could provide support and affirmation, they were also a frequent source of conflict, particularly between junior and senior midwives. This discord was underpinned by conflicting ideologies of midwifery practice.
Key conclusions: the theoretical framework of boundary maintenance was used to interpret the findings. Senior and junior midwives frequently held contradictory models of practice, resulting in competing claims for occupational jurisdiction. Midwives made use of a variety of devices in order to establish and maintain intra-occupational boundaries. Senior midwives attempted to maintain their position through unwritten rules and sanctions, supported by their claim to greater clinical expertise and experience. Junior midwives rarely challenged this authority; their responses were often subversive and designed to create an appearance of compliance.

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Implications for practice: these findings contribute to our understanding of intercollegial conflict in UK midwifery, providing insights into workplace harassment and low staff morale, which are likely to exacerbate workforce attrition. The underpinning ideological dissonance experienced by midwives must be acknowledged and tackled for these issues to be effectively addressed. © 2005 Elsevier Ltd. All rights reserved.

Introduction

Until recently, there has been limited investigation into midwives’ experiences of emotion in the workplace. Studies of stress and burnout in midwifery in the UK (Sandall, 1997, 1998; Mackin and Sinclair, 1998) have drawn attention to high levels of occupational stress, and the work of Kirkham (1999) and Kirkham and Stapleton (2000) has provided important insights into emotional aspects of contemporary midwifery culture. However, this is the first study to focus explicitly on how midwives experience and manage emotion at work (Hunter, 2002).

A detailed description of the research design and discussion of the overall findings are provided in an earlier paper (Hunter, 2004). The findings indicated that the primary source of emotion work for the participants was the co-existence of conflicting ideologies of midwifery practice, characterised as a ‘with woman’ model and a ‘with institution’ model. These contradictory approaches to practice created dissonance for midwives, requiring management of emotion or ‘emotion work’ (Hochschild, 1983).

In this paper, the experiences of hospital-based midwives are considered. A key finding of the study was the significance of ‘context’ for midwifery work, particularly in relation to sources of emotion work. It was evident that, for hospital-based midwives, colleagues formed the ‘primary reference group’ (Lipsky, 1980, p. 47); that is, they were the ‘significant others’ in the midwife’s working day, who provided feedback, both formal and informal, on individual practice. Colleagues were thus key contributors to a sense of occupational esteem, and it was therefore not surprising to find that these relationships were also a key source of emotion work. In contrast, for community-based midwives, relationships with clients assumed key significance, and it was these interactions that required emotion work. This difference has been noted in other studies of midwifery practice (Curtis, 1991; Brodie, 1996).

The evidence from this study indicated that, although collegial relationships could provide support and affirmation for hospital-based midwives, they were also a frequent source of conflict. There were numerous accounts of difficulties within collegial relationships, and differing ideologies of practice were often at the root of these tensions. This was particularly apparent in the relationships between junior and senior midwives. Evidence is provided showing the nature of this discord, and an explanation is offered, drawing on the theoretical framework of boundary maintenance (Gieryn, 1983).

Although this study is the first to focus specifically on the emotion work of hospital-based midwives, other UK studies have considered aspects of hospital-based midwifery culture (Kitzinger et al., 1990; Curtis, 1991; Hunt and Symonds, 1995; Mackin and Sinclair, 1998; Sandall, 1998; Kirkham, 1999; Kirkham and Stapleton, 2000; Lavender and Chapple, 2004). Problematic working relationships have been described, both between midwives and between midwives and doctors (Kitzinger et al., 1990; Curtis, 1991; Mackin and Sinclair, 1998; Kirkham, 1999). These conflicts, combined with work overload and low levels of clinical autonomy, were likely to result in high levels of workplace stress (Mackin and Sinclair, 1998; Sandall, 1998).

An ethnographic investigation by Kirkham (1999) and Kirkham and Stapleton (2000) into the culture of midwifery in the English National Health Service (NHS) provides important insights into the gendered nature of midwifery. Their analysis identifies an ethic of service, self-sacrifice and conformity, in which midwives rarely acknowledged their own support needs. The result was guilt and self-blame, with a lack of awareness of the commonality of experiences. Kirkham (1999) argues that this disempowering culture fragments midwifery and limits the potential for change. However, it should be noted that, in this study, midwifery work seems to be considered as a whole. Although it is reported that participants were asked to ‘reflect upon the setting for their practice’ (Kirkham, 1999, p. 734), there is no apparent differentiation between hospital and community-based practice in the discussion. This precludes deeper analysis of the affect of context.
A recent study by Lavender and Chapple (2004), however, does distinguish between the views of midwives working in differing settings. A key finding was that all participants shared a common vision of ideal practice, which emphasised midwife autonomy, equity of care for women and job satisfaction. However, participants experienced varying degrees of success in achieving this, depending upon the setting in which they worked. Conducive factors were considered to be strong midwifery leadership and a unit culture that emphasised normality. Free-standing birth units were generally described as more supportive and satisfying work environments, in which midwives could establish rewarding relationships with women and their families. In contrast, consultant-led units were frequently perceived negatively, particularly because of the dominance of a medical model of childbirth, a task-orientated approach to practice and an atmosphere of ‘lots of criticism and no praise’ (Lavender and Chapple, 2004, p. 9).

Relevant investigations have also been carried out into the experiences of student midwives, although again, there is often no clear differentiation between hospital and community experiences. The focus of these studies has been predominantly the socialisation process (Davies and Atkinson, 1991; Begley, 1999; Yearley, 1999), and the gap that exists between what is learnt in the educational area and what is actually experienced in the clinical setting (McCrea et al., 1994; Currie, 1999). Although only Yearley (1999) explicitly refers to the emotional labour generated by the transition from student to qualified status, many of the other studies allude to the emotions generated by the complex and often ambiguous process of learning to be a midwife. In particular, there is frequent mention of the need to gain the approval of senior midwives, in their role of gatekeepers to the profession. This is achieved by careful self-presentation, and what Davies and Atkinson (1991, p. 119) refer to as ‘sussing and sizing’, that is, the ability to identify expected behaviour in order to conform and gain acceptance.

**Methods**

The findings discussed in this paper are derived from all phases of the research study (for fuller methodological details, see Hunter, 2002, 2004), drawing specifically on the data relating to hospital practice (Box 1). Phase one consisted of four focus groups with student midwives \((n = 27)\) at a Welsh university, in first and final years of both the 18-month programme (for qualified nurses) and 3-year programme (direct entry). Students had undertaken hospital placements in a variety of geographical locations, thus their accounts do not relate to one specific institutional context. Student narratives were particularly illuminating, as their varied experiences meant that students were well placed to compare hospital and community environments.

Phase two of the study consisted of two focus groups with qualified midwives. One of these was a

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<th>Box 1</th>
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**Phase 1:**

- Dates: November 1997 to September 1998
- Population: student midwives at a Welsh university, first and final years of 18-month and 3-year programmes. Clinical experiences in both hospital and community settings.
- Sample: self-selected convenience sample \((n = 27)\)
- Method: focus groups (4)

**Phase 2:**

- Dates: November 1998 to March 1999
- Sample: opportunistic sample of qualified midwives, a representing variety of clinical locations and clinical grades \((n = 7)\)
- Method: focus groups (2)

**Phase 3:**

- Dates: November 1999 to July 2000
- Population: all qualified midwives working within one Welsh NHS Trust
- Sample: purposive sampling \((n = 10)\)
- Methods: focus groups (1), observation (6), interviews (6)
re-convened focus group from phase 1: four newly qualified, hospital-based midwives (who had previously participated in the study as students) expressed an interest in sharing their experiences since qualification. The other group consisted of qualified, experienced midwives undertaking undergraduate studies at the university, who had expressed interest in participating. Of the seven participants in this group, three were hospital-based, working in different institutions, and four worked within community settings in differning NHS Trusts.

Phase three of the study was conducted in a regional maternity unit in South Wales (about 3600 births per annum). At the time of the study, the 150 midwives employed by the NHS Trust worked in the hospital either as ‘core staff’ (n = 86) or in community-based teams (n = 51). All midwives working for the Trust were invited to participate (with the exception of those on maternity leave (n = 2), those on long-term sick leave (n = 5), those about to retire (n = 2) and those in senior management posts (n = 4). Ten hospital-based midwives and 19 community-based midwives participated. Of the sample of hospital-based midwives, nine were employed on E or F clinical grades and one was a G grade. (These grades relate to pay scales in the UK, and reflect level of clinical responsibility.) An E grade represents the lower end of the pay scale, and indicates junior status; G grade represents the higher end of the pay scale and senior status). All were employed as ‘core’ staff in the maternity unit; the G grade midwife worked on a combined antenatal/postnatal ward, the E and F grade midwives rotated through the various departments of the unit every few months. Length of midwifery experience for these hospital-based midwives was between 18 months and 21 years, with most participants having less than 8 years’ experience. Data were collected through observation and subsequent interview (n = 6), or through a focus group (n = 4).

Data analysis

Observational field notes and transcribed data from interviews and focus groups were analysed using a form of inductive thematic analysis (Hammersley and Atkinson, 1995; Coffey and Atkinson, 1996). The field notes and transcriptions were read and coded by hand. Key categories and the links between them were identified. Data were then regrouped into thematic files, and explored for patterns and inter-relationships (for a detailed description see Hunter, 2004).

Findings

The findings are based on data collected from student and qualified hospital-based midwives. Student midwives were from both 18-month (n = 12) and 3-year educational programmes (n = 15). All were white and female. Ages ranged from 22–45 years. The qualified midwives were all white, female and varied in age between 30 and 50 years. Pseudonyms are used throughout the discussion to preserve anonymity.

Data analysis indicated that hospital-based midwives experienced considerable problems that arose from relationships within midwifery. There were extensive accounts of the negative effects of peer pressure and criticism from midwifery colleagues, especially those in more senior positions. For example:

Midwife: The most difficult thing for me is people (...)—colleagues can be the biggest thing, this animosity from senior staff (group agreement)—the issue of bullying at work (...) It can crush an atmosphere, it can crush a situation, it can crush a relationship with a woman, it can crush you professionally (voices in agreement). (Phase 3: focus group 10, E and F grade hospital midwives)

The extent of these negative experiences was an unexpected finding; previous literature has identified the tensions that exist between midwives and doctors as the primary source of relationship difficulties within maternity care (Kitzinger et al., 1990; Curtis, 1991; Murphy-Lawless, 1991). Findings from this study did not support this. Participants rarely cited difficult experiences with medical colleagues; indeed the impression was that this was a battle that had been fought, and, although not won, at least a workable truce had resulted.

Instead, the evidence indicated inter-collegial disharmony as a key source of emotion work. It seemed that differing occupational ideologies were at the root of many of these intra-occupational conflicts, with midwives dividing themselves into ‘us and them’ groups on the basis of ideology. Put simply, the more junior midwives generally positioned themselves as advocates of a ‘with-woman’, non-interventionist approach, and contrasted this with the approach of many senior midwives, who were perceived as being ‘with institution’ (Hunter, 2004). This was particularly true of ‘novice’ midwives (that is, student midwives and those with less than 1-year post-qualification experience).
However, although there were many accounts of these conflicts in the narratives of junior midwives, it was evident that, in the workplace, overt challenge was rare. Hospital-based midwifery seemed to be a strongly hierarchical culture, in which the status positions of senior midwives were maintained through unwritten rules, enforced through an informal system of reward and punishment.

Discussion of the findings is divided into two main sections, using data extracts to illustrate the key findings. In the first, the ways in which senior midwives seemed to maintain their position in the hierarchy are considered. Their authority was preserved by unwritten rules and sanctions, underpinned by a claim to greater clinical experience and expertise. The second section focuses on the response of junior staff to seniors. As junior midwives had little overt power, these responses were often subversive and designed to create the appearance of compliance.

Senior midwives: unwritten rules and idiosyncratic practice

Both fieldwork and interviews indicated that the work of senior midwives differed significantly from that of more junior staff, in that it involved more managerial and administrative activities and less direct client care. Senior midwives were responsible for delivering a universal service, and had to consider the 'bigger picture' in a way that junior staff did not. Their focus seemed to be 'with institution', ensuring that the needs of the organisation were met by effective deployment of workers and resources, in order to facilitate the efficient passage of women and babies through the maternity-care system. Indeed, completion of work was a visible sign of success, and one by which management could determine the competency of senior staff. This senior midwife described how administration dominated her work:

Midwife: everybody who comes through that door wants me (…) whatever queries they’ve got (…) so then I can’t get on with what I’ve got to do (…) things like making sure people are doing their updates and off duty rotas (…) Then at the end of the month there’s time sheets—we have to re-check that everybody has worked the shifts they say they’ve worked—so that takes time, and any other things that need sorting out (…) (Phase 3: interview 9, G grade hospital midwife)

From the perspective of the more junior staff, this focus on administration and management led to a task-orientated approach to care, and what was described as a 'clear the board' mentality (Hunter, 2004), as senior staff attempted to hasten women's progress through the hospital system. However, from the standpoint of the senior midwives, this approach was rationalised by the need to meet organisational goals of efficiency and task completion.

It was evident from observational fieldnotes that senior midwives used a 'realistic' discourse based on their lengthy clinical experience and expertise to justify their actions and attitudes. From this position, the opinions of less experienced staff (of whatever occupation) could be dismissed as ill-considered and even naïve. This claim to greater clinical 'know how' enabled senior midwives to practice in ways that were sometimes considered by the junior midwives to contradict the ideals of woman-centred care. Moreover, at times their approach seemed to conflict with current research evidence regarding best practice. These issues will be discussed in greater detail later in the paper.

The authority afforded by experience has been noted in studies of other professional groups. For example, in his classic ethnographic study of surgeons in the USA, Bosk (1979) noted that the lengthy clinical practice of senior staff made it difficult for juniors to challenge their authority. The status quo was maintained through a complex system of rules and sanctions, and as will be seen in the following section, this was also evident in this study.

Unwritten rules

Senior midwives seemed to retain their dominant position by means of unwritten rules, which were often idiosyncratic and varied between midwives. Descriptions of unwritten rules were most common in the accounts of student midwives and those who had recently qualified. All these novices were making the transition from being 'outsiders' in midwifery to 'insiders', and were keenly aware that senior midwives were the gatekeepers to this passage. Students were especially vulnerable in this respect, as it was the senior midwives who assessed their clinical ability. As a result, the rules were rarely questioned, even when they contradicted ideals, as in the following focus-group extract:

Student 1: ... if you don’t agree with what’s being done or you really feel strongly that somebody’s doing something wrong—it's very
hard as a student to stick your neck out (group agreement) and say 'I don’t think you should be doing that'.

Student 2: you wouldn’t have wanted a barny (argument) with the midwife (...) do I just walk out and drop everything because I don’t agree with what she’s doing? (Strong group agreement).

Student 3: especially if that midwife is assessing you at the end of your placement, isn’t it?

Student 2: oh God yes (group agreement). (Phase 1: focus group 4, first year 3-year student midwives)

Students identified many differences in the practice and personal style of individual midwives, which needed to be 'sussed out' and required constant alertness and adaptability on their part. For example, students described being bewildered by the variety of clinical techniques they encountered: where to 'put their hands' during the birth, whether or not to 'guard the perineum' or to 'bleed the cord'. These techniques seemed to be based on midwife preference rather than evidence-based practice, and led to confusion and frustration, as in the following:

Student 1: On my last labour ward placement I had 14 mentors (gasp from group) and I can honestly say I still don’t know which way to do it! (Group laughter) Like all the deliveries I’ve had (...) each one told me to do something different (...) my confidence just went and then when you do do something then they say 'why you doing that?' I said to her 'this is what we’re supposed to do you know—we do this...' and she said ‘no—don’t do it for me, you don’t do that when you’re with me...' (Phase 1: focus group 4, first year 3-year student midwives)

It was clearly evident from these accounts that the need for 'sussing out' the rules could have damaging effects on students’ confidence levels. This seemed to be felt most acutely by the 'short' course students (i.e. those who were already nurse trained), who contended that nursing provided a more standardised approach to clinical skills, with nurses carrying out tasks as per the ward norm, rather than using individual strategies. This view is supported by the literature related to the socialisation of student nurses (Melia, 1987; Smith, 1992; Randle, 2003), who describe unwritten rules in nursing as being ward-specific and emanating from the person in charge of the shift. In Melia’s classic study, student nurses described how they complied with 'the way sister likes it' and 'the way we do it on this ward' (Melia, 1987, p. 107), and more recent studies indicate that this situation persists (Smith, 1992; Randle, 2003). Thus, once the student nurse has learnt the rules for a particular ward, she can navigate daily work successfully. In contrast, student midwives described having to identify the unwritten rules of each individual midwife, as in the comment above: 'you don’t do that when you’re with me'.

Thus, unwritten rules seem to be 'practitioner-based' in midwifery and 'context-based' in nursing. Woodward (2000) has made similar observations regarding the absence of a shared approach to midwifery care, as opposed to a team-work approach within nursing. She suggests that 'the lack of a collective approach to practice may derive from the individualistic emphasis that midwives are independent practitioners in their own right' (Woodward, 2000, p. 74). It was notable in my study that many participant accounts referred to the autonomy and independent practitioner status of midwives. This seemed to be a strongly held belief that was rarely contested, and it is reasonable to propose that it is this concept that underpins the formation of practitioner-based rules.

These practitioner-based unwritten rules described by the novice midwives seemed to be related either to issues of clinical practice or to 'institutional etiquette', that is, the cultural norms of the institution translated through the preferences of the individual midwife. The following focus-group discussion between newly qualified midwives provides evidence of both types of rules. It also illustrates not only the ways in which senior midwives attempted to enforce the rules, but also how the novice midwives responded. The account is divided into two sections: in the first, one midwife describes the transgression of rules relating to clinical practice; in the second, those relating to clinical etiquette:

Unwritten rules: clinical practice

Midwife 1: within 2 weeks of qualifying I had three rows (...) one was for putting a woman in the bath and allowing her partner to sit alongside her holding the baby (...) and the senior sister went past and there was no baby—no mother—no partner—she went 'where’s the baby, where’s...' I said 'well they’re all in the bathroom' 'Oh my God!' (Loud dramatic shocked voice) she said 'use—your—head' (wags finger)—I said 'I thought I had' (laughs) 'what’s the problem?' 'condensation—on the baby’s chest!' I thought 'oh God alive!' So I just said 'oh right okay' (group laughter) I thought I’m not gonna
stand here and argue with this woman who’s been qualified for God knows long—I’m not gonna win (group agreement)...

Unwritten rules: institutional etiquette

Midwife 1: and one (row) was for missing out a gap in the birth register (...) and this midwife called me out (of the room)—I was in looking after somebody—she knocked on the door and she went ...(demonstrates aggressive beckoning with finger)
Midwife 2: ohhhhh—it’s the way isn’t it?
Midwife 3: yes!
Midwife 2: the finger!
Midwife 1: so I went out and she had the register open (...) and she just—no words at all—she just went (demonstrates pointing with stabbing motion) ‘oh I said ‘I know—I’m terribly sorry—I don’t know what came over me’—this is ten to six in the morning after a night shift—I’d had two deliveries and was in looking after my third woman and I’d left this gap (...) she said (sarcastic tone) ‘I’ve said it before and I’ll say it again—this place is full of lunatics’
Midwife 3: (sarcastically) charming. (Phase 2: focus group 6, newly qualified E grade midwives)

Both types of rules were problematic for the novice midwives. Those related to clinical practice frequently had no scientific basis, and seemed to be based on tradition rather than current research-based evidence (e.g. not allowing ‘low risk’ women to eat during labour). The imposition of these rules frustrated novice midwives, who considered them to be arbitrary, unscientific and illogical, in contrast to their own approach, which was described as focusing on normality, research evidence and a women-centred approach.

The rules relating to institutional etiquette seemed to be even more illogical and frustrating to these participants. The response of senior staff to transgressions of these rules seemed out of proportion to what were usually fairly minimal errors. A common feature of these situations was that a more junior midwife had attempted to act on her own authority (e.g. making personal decisions regarding when to take a ‘break’, rather than asking permission, or, as above, failing to write maternity notes in the accepted house style).

However, it was notable that, although there was criticism of these unwritten rules during the focus-group discussions, there was rarely evidence that participants had actually challenged seniors. A sense of powerlessness pervaded the accounts, as in the comment above: ‘I’m not gonna stand here and argue with this woman who’s been qualified for God knows how long—I’m not gonna win.’ The authority of the senior staff was in effect undisputed. This was also evident in Bosk’s (1979) study. He observed that senior surgeons were able to assert their authority on the basis of their greater experience, so that ‘arguments based on clinical expertise override those based on scientific evidence’ (Bosk, 1979, p. 85). As a result, senior surgeons were able to interpret and adapt research evidence ‘in the light of the current clinical situation and past clinical experience’ (Bosk, 1979, p. 87).Twenty-five years on, and in a different professional group, a similar situation exists, despite the current ethos of clinical effectiveness and research-based evidence in contemporary health care.

Ensuring compliance

Senior midwives seemed to ensure compliance with unwritten rules by means of overt and covert sanctions. Overt sanctions often took the form of aggressive verbal and non-verbal behaviour, as described in the previous data extract: wagging fingers, sarcastic comments and the use of simplified commands (‘use-your-head’, “don’t-you-ever”). In such situations, the senior midwife is in an ‘authoritative parent’ role, with the novice midwife reduced to the role of a naughty child. These accounts were, sadly, far from uncommon, and frequently resulted in considerable distress, particularly for students. Participants became upset during focus-group discussions as they described being shouted at, having their hands slapped and being the subject of both overt and covert criticism.

Compliance was also achieved by more covert sanctions: novices described ‘behind your back criticism’, being allocated ‘difficult cases’ (or ones that were not likely to result in the normal birth that students needed for completion of clinical competencies) and being ‘overlooked’ when other staff were sent for ‘breaks’. Again, such accounts were common throughout the data:

Student 1: one girl in the group hasn’t particularly hit it off with one of the sisters and this sister made things really difficult for her
Student 2: yeah they can
Student 1: really difficult
Facilitator: In what ways would they do that?
Student 1: embarrassing her (...) in front of women. Belittling her. And if you don’t get on with them they’re not going to send you with women who’ll go and deliver—they’ll make sure
you go and look after patients in LDU (low dependency unit) or high dependency unit
Student 3: and sometimes you have to ask somebody in charge whether you can go on a break and if it's them they won't let you go. (Phase 1: focus group 3, first year 18-month students)

Junior midwives' responses: 'illusions of compliance' and 'discursive resistance'

It is hardly surprising that junior midwives rarely challenged seniors. This was particularly true of student and recently qualified midwives. Their goal was successful registration and acceptance into the profession, and they described keeping a low profile and 'not rocking the boat' in order to achieve this. There was also evidence that juniors attempted to construct their own separate occupational identity based on a 'with woman' ideology. This emphasised the woman-centred nature of the care they gave and their commitment to the normalcy of childbirth. Rather than being outsiders in midwifery culture, they created their own 'insider' group and defined the seniors as outsiders.

However, for some, these tactics were not enough; despondency and disillusionment created grave doubts about their choice of career:

Midwife 1: I got to a stage where I thought 'I hate it—I don’t want to go to work at all'—because I was so fed up—I felt I was bullied all the time to do things I didn’t want to do, it wasn't in the woman’s best interest. (Phase 3: focus group 4, E and F grade hospital midwives)

The junior midwives' responses to the rules and sanctions were categorised into two key themes, which will be considered in turn: (1) 'illusions of compliance', achieved by 'playing the game' strategies; and (2) peer support in the form of 'discursive resistance', whereby the ideology of juniors was reinforced.

Illusions of compliance: 'playing the game'
References to 'playing the game' were common in the accounts of junior midwives, as in the following:

Student 1: I think you have to know how to play the game really don’t you? (Group agreement)
Student 2: yes it’s being the norm...(Phase 1: focus group 1, final year 18-month students)
Student 1: you feel like you’re playing the game while being a student (…) just to keep the peace really—the status quo (group agreement).

(Phase 1: focus group 2, final year 3-year students)

The use of the term 'playing the game' suggests that juniors were fully aware that they were creating an illusion. A variety of strategies were used in order to appear compliant with occupational norms:

Student 1: that’s the stressful part of being a student, trying to do what’s right by the other midwives and especially the sister in charge
Student 2: you remember how they like things and then you switch into their mode and you get an interest
Student 1: you do it cos you want to look good, you want them to remember you as ‘she’s a nice student’
Facilitator: How do you get to be a nice student then?
Student 2: oh conforming
Student 3: doing all the obs (observations of vital signs) I suppose
Student 4: making the tea!
Student 1: you try and get on—and remember what they like! (Phase 1: focus group 3, first year 18-month students)

The emphasis was on 'impression management' (Goffman, 1969) in order to gain approval, as in the comment: 'you want to look good'. Junior midwives 'sussed out' the idiosyncrasies and practitioner-based rules of senior staff ('you remember how they like things and then you switch into their mode' 'remember what they like!') and made calculated efforts to 'conform'. Volunteering for the more menial tasks such as 'making the tea' and 'doing all the obs' was likely to increase senior approval, particularly as by doing so juniors gave the appearance of accepting their lower status in the hierarchy.

Juniors also described adopting covert strategies in order to avoid confrontation with seniors: for example, 'fibbing' (lying) and 'lying low' (keeping a low profile) were commonly referred to. These tactics not only gave the appearance of compliance, but were also used to provide opportunities for keeping birth normal and hence achieving 'real' midwifery:

Midwife 1: that’s right—I used to tend to fib (lie) a lot—cos the thing (the sister) would like to do was to rupture the membranes. So I used to fib an awful lot cos she’d catch you and she used to say (sharply) ‘membranes ruptured yet?’ and I’d say ‘head’s too high!’ and run off (laughs).
During fieldwork, junior qualified midwives were observed to subtly manipulate information to keep senior midwives "happy", while practising in a way that was congruent with their own beliefs regarding natural, woman-centred childbirth. For example, one E-grade midwife working in the labour ward was observed to use a number of other covert tactics, such as underestimating cervical dilatation in order to 'give the woman more time' (Field notes 12, E grade hospital midwife). Similar covert strategies have been identified in previous studies as devices for protecting midwifery 'territory' by maintaining boundaries between midwives and doctors (Kitzinger et al., 1990; Curtis, 1991, 1992). What is significant in this study is that they also seemed to be used within midwifery. As another junior hospital midwife commented: 'The restrictions that are on midwives are not applied by obstetricians, they're applied by other midwives' (Interview 5, E grade hospital midwife). There are similar observations in the recent study by Lavender and Chapple (2004). The possible reasons for this are explored later in the paper.

Although the use of covert strategies in order to 'play the game' may have short-term success, the need for continued pretence and impression management creates dissonance and frustration, particularly when there are ideological conflicts:

Student 1: like Cerys said, you have to play the game don’t you, because you want to get assessed.

Student 2: it’s terrible because we’re thinking of ourselves all the time then aren’t we? Are we really putting our women first, if we’re thinking like this and being put in that position? You know that’s very frustrating

BH: mm that sounds like a conflict of interest?

Student 2: terrible conflict (group agreement). (Phase 1: focus group 1, final year 18-month students)

The emotion work necessary in such situations seems to take its toll on some midwives. There was evidence that it was not always possible to manage impressions effectively. Novices described becoming distressed and tearful at work, thus challenging the accepted feeling/display rules (Hochschild, 1979) that emphasise professional detachment or 'affective neutrality' (Parsons, 1951) in the workplace. These situations were frequently related to conflicting ideologies, which novices felt powerless to challenge. Self-criticism was common in such situations: blame was internalised, rather than attributing causality to broader factors relating to the context of midwifery. In the following account, the student recalls a situation earlier in her clinical experience:

Student 1: I had conflict with a midwife one day—I was very worried about how it would look so I was very upset, cos I was very angry with myself and very angry with the system (...) I didn’t want her (senior midwife) to see me getting upset again, because I thought she’s just going to think I’m just some blubbering mass of student who can’t get her life together. If I see her again and get upset I’m going to lose even more credibility. (Phase 1: focus group 1, final year 18-month students)

The findings suggest that it was particularly the more junior students who experienced such extreme feelings of impotence in their relationships with seniors. As the socialisation process continued, students seemed to develop a stronger sense of peer-group solidarity and alliances with other juniors, which enabled them to create boundaries between themselves and the senior midwives, and thus resist the dominant culture. Although this rarely seemed to result in overt challenges, sharing experiences through talk clearly provided a powerful source of support and affirmation, described here as 'discursive resistance'.

Peer support and 'discursive resistance'

It was apparent from fieldwork and focus-group data that dissent was suppressed until junior midwives were in a safe environment with peers. Within their peer group, junior midwives were able to re-affirm the validity of a 'with woman' model of midwifery and establish the superiority of this over the perceived 'traditional' practice of senior staff, thus resisting and subverting the powerful authority claims of seniors. Junior midwives presented their practice as 'with woman' and 'natural', and hence beneficial both to clients and to the future of midwifery. They also made appeals to research evidence to support the legitimacy of their claim. In contrast, senior midwives were presented as, at best, task-orientated and rule-bound, and at worst, as punitive and cruel. The following extract illustrates the frustration that these conflicting perspectives created:

Student 1: I’ve seen it with a woman wanting to hold the baby and the midwife—’no the baby’s got to have a bath’ or ‘the baby’s got to go in the cot’ and the woman—her arms are following the
baby where the baby went. And I keep thinking – oh give the woman her baby, it’s more important (…) (group agreement).

Student 2: but there’s tasks isn’t it? They need to get the tasks done after the delivery, they want the tags (identification bands), they want the weighing, they want the wash, they want the woman to have a bath, cup of tea, bit of toast—it seems that cuddle doesn’t appear on the list –

Student 1: it’s way down the list...

Student 2: they’re very task orientated, midwives (strong group agreement) (...)

Student 1: but then you read in articles about the importance of warmth and physical contact for the baby, for its development (…) in fact better for the baby if it was on the mother’s chest or being cuddled. If that’s the priority then it should be all right for the mother to do that, no matter what the midwife’s priorities are (group agreement). (Phase 1: focus group 1, final year 18-month students)

There was a strong sense of collective identity among junior midwives, with frequent allusion to a shared perspective: ‘we think …’ (Phase 1 focus group 3, first year 18-month students) ‘we’ve got our own view of what is nice’ (Phase 1 focus group 2, final year 3-year students.) It was evident that this sense of group cohesiveness was important in constructing and maintaining a viable alternative midwifery identity.

Data analysis revealed that the accounts of junior midwives frequently took the form of ‘atrocity’ stories (Dingwall, 1977; Bosk, 1979; Allen, 2001). In the sociological literature, atrocity stories are identified as dramatic accounts by which: ‘a straightforward complaint or slight is transformed into a moral tale inviting all right-thinking persons (the audience) to testify to the worth of the teller as against the failings of the other characters in the story’ (Dingwall, 1977, p. 393).

Dingwall (1977) argued that these stories should not be taken as accurate accounts of reality, but, rather, as symbolic narratives aimed at establishing identity and merit. In particular, they are commonly used by those in less powerful positions, to establish the legitimacy of marginalised points of view.

There were many examples of atrocity stories in the data, particularly in the focus-group data, which seemed to be used to construct the practice of seniors as out of date, ridiculous, inappropriate, unreasonable or even dangerous. In contrast, juniors were presented as innocent victims, as in the previous data extract illustrating the ‘rows’ experienced by newly qualified midwives. Data analysis indicated that atrocity stories commonly became collective enterprises, with participants in the focus groups eager to contribute their own experiences. The stories seemed to serve to construct boundaries between ‘new’ and ‘old’ midwifery, and also to create a common occupational identity among ‘new’ junior midwives. The participative nature of storytelling thus seems to be an important strategy, that enables junior midwives to re-establish their version of ‘real’ midwifery. This is essential if they are to ‘hold on’ to their ideals and successfully navigate the socialisation process.

Discussion

This study has some limitations, which should be taken into account when considering the findings. These accounts are predominantly from student and junior midwives, and there was only one G grade hospital midwife participant. Discussion of the practice of senior midwives is thus based largely on how their behaviour was perceived by midwives with less clinical experience and lower status in the midwifery hierarchy. Analysis is, therefore, biased towards the juniors’ explanations of seniors’ behaviour, rather than the accounts of seniors themselves, and the findings must therefore be interpreted in this light. There is clearly scope here for additional investigation with more senior staff. However, the experiences of the junior midwives were reiterated throughout data collection. Junior midwives described the same conflicts with senior colleagues regardless of the maternity unit in which they were working or their level of experience.

Bearing in mind these limitations, the study nevertheless raises important issues relating to sources of emotion work in hospital-based midwifery. These may assist our understanding of problems currently identified within UK midwifery, particularly those of intimidation and bullying (Hadikin and O’Driscoll, 2000; Ball et al., 2002; Robertson, 2004). It was evident from the data that the junior midwives experienced many significant difficulties in their relationships with senior colleagues, that led to an ‘us and them’ culture, underpinned by differing ideologies of midwifery practice.

One way of interpreting these findings is to use the concept of boundary maintenance or boundary
work. This concept is derived from the work of Gieryn (1983), a social scientist who described how scientists have attempted to improve the public image of science, by defining it as superior to non-scientific activities. Gieryn (1983) argued that boundary work is a political process most often used when there is a desire to expand into another occupation’s territory, to monopolise a particular domain or to maintain occupational autonomy. It is most commonly enacted through occupational discourse (i.e. the way an occupation presents itself through words, either verbal or textual).

More recent authors have taken up Gieryn’s ideas and applied them to health care; for example, Allen (2001), in her analysis of nurse–doctor relationships, and Norris (2001), in her study of the competing claims by various practitioners for the treatment of musculo-skeletal disorders. However, these studies focus on how boundary work is used between occupations, in order to lay claim to occupational territory. In contrast, there was evidence in this study of boundary work within midwifery (i.e. intra-occupational boundary work), as different factions within midwifery competed for occupational jurisdiction. This is an interesting finding, which may be explained by the differences in ideological position. The current moves towards a ‘new’ midwifery, characterised by continuity of care, partnership with women and increased midwifery autonomy may be perceived as a challenge by those with different beliefs and expectations. Sandall (1995, 1996) has described ‘new midwifery’ as the ‘new professional project’, and has argued that it needs to be understood not merely as an altruistic exercise to improve care for women, but also as an attempt to redefine and extend midwifery territory. It is not surprising then, given the incompatibility of these varying approaches to midwifery, that differing factions use boundary work to maintain their respective territories. Indeed, in many ways, senior and junior midwives seemed to act as two different occupations competing for authority over the same domain.

Boundary work may be achieved in various ways by the various parties involved. In this study, the senior midwives defined the boundaries of acceptable midwifery practice through the use of unwritten rules and sanctions, backed by their power to ‘gate-keep’ admission to the profession. As noted, idiosyncratic practice and unwritten rules are forms of social control. They act as powerful symbols of ‘the way we do it in midwifery’, and serve to maintain occupational boundaries and construct hierarchical positions (Bosk, 1979). In such situations, juniors are continually wrong footed as they attempt to identify the occupational norms. Their sense of frustration is compounded by their lack of power to question or challenge.

Internalisation of these norms is necessary for acceptance into the profession. However, successful qualification as a midwife did not bring with it instant acceptance. Newly qualified midwives were still required to ‘play the game’ and comply with the wishes of seniors. In contrast, Bosk (1979) found that newly qualified doctors were no longer required to observe idiosyncratic rules, but instead were welcomed into the profession and encouraged to develop their own style. This variance in attitudes to newly qualified practitioners may be explained by the ideological differences identified in this study. Junior midwives who espoused a ‘with woman’ approach threatened the established culture of hospital midwifery. Moreover, the shift to a more woman-centred model of care necessitated a shift in affiliation from colleagues to clients that may have been experienced as destabilising if not threatening (Hunter, 2004). The result is that newly qualified midwives retained a problematic status for seniors until their conformity to the status quo could be assured.

In response to the boundary work strategies of senior midwives, juniors made use of impression management and contrastive rhetoric. These strategies can also be interpreted as boundary work. Contrastive rhetoric is used to construct one approach as ‘superior’ to another and commonly takes the form of ‘atrocity stories’ (Dingwall, 1977; Allen, 2001). It has been identified in other studies of boundary work in health care (Allen, 2001; Norris, 2001). As Norris (2001) explains: ‘rhetorical strategies do not necessarily reflect real differences, but instead are a way in which practitioners in different occupations establish and maintain a collective identity for themselves and others. These are stories about how ‘we’ know who ‘we’ are, and know that ‘we’ are not ‘them’ (p. 42).’

**Implications for practice**

The findings of this study have various implications for midwifery practice in the UK, particularly in relation to workplace conflict, staff morale and workforce retention. There was substantial evidence of ideological divisions within midwifery, which led to a sense of dissonance and frustration. Such a situation inevitably affects the emotional well-being of the midwifery workforce and, in turn, is likely to have a negative effect on the quality of care that women receive.
These ideological differences also have a deleterious effect on relationships between midwives and are frequently the source of conflict. These clashes include behaviour that could be described as intimidation and harassment. They are of particular significance to midwives working in hospital units, for whom colleagues play a central role. Although ideological differences between community-based midwives are similarly likely to exist, interactions between colleagues are limited and thus likely to be less noteworthy.

There have been many discussions related to intimidation and bullying in the contemporary UK midwifery literature (Leap, 1997; Kirkham, 1999; Hadikin and O’Driscoll, 2000; Robertson, 2004), with the current President of the Royal College of Midwives identifying it as a key issue for attention during her time in office (Gwyn, 2004). However, attempts to eradicate bullying are unlikely to be successful, unless the underpinning reasons are understood.

The concept of horizontal violence (Leap, 1997) is often used as an explanation for aggression within the midwifery workforce. Kirkham (1999) draws on the work of Freire (1972) and Roberts (1983) to explain how oppressed groups internalise the values of those in power and reject their own principles and identity. As a result, criticism is directed within the group in the form of horizontal violence, particularly towards those whose views are considered to deviate from cultural norms. The findings from this study indicate that differing ideologies of practice play a key role in these cultural norms. It would seem that tackling a bullying culture will require attention to the fundamental ideological underpinnings of practice, addressing any paradoxes that exist. Anti-bullying policies and procedures, staff workshops and counselling may have some short-term success in tackling workplace intimidation, but are unlikely to be of long-term benefit without this.

It is of key importance to the emotional well-being of the workforce that these issues are addressed. There was substantial evidence in the data that junior midwives experienced frustration and distress resulting from inter-collegial conflict, especially with senior midwives. Although some were able to re-establish a degree of equilibrium through peer support, others were seriously considering discontinuing their education or leaving the profession. This is clearly problematic, especially given the current concerns regarding recruitment and retention in UK midwifery (Ball et al., 2002).

Even when the attitudes of seniors were not experienced as bullying, the co-existence of differing ideologies and the sense of an ‘us and them’ culture required emotion work on the part of junior midwives. The common use of covert strategies in order to ‘play the game’, however, seemed to be something of a double-edged sword. Although effective in the short term, in the long term nothing changed. The outcome was apparent collusion rather than challenge, and thus the underpinning differences and ambiguities were not overtly addressed. The danger in such situations is that ideals become diluted or eroded. As Lipsky (1980) has argued, ultimately this type of compromise ‘discourages innovation and encourages mediocrity’ (p. 144). The approach of the seniors will be confirmed as the most realistic and effective, and the ideals of junior midwives will become more and more unattainable. This has implications for any attempts to move towards a more social model of childbirth.

Occupational ideals are a potential strength in any service work, and need to be nurtured, rather than squashed (Lipsky, 1980). Without such idealism in the past, it is unlikely that midwifery would have been retained as a separate occupation in the UK, and the future of midwifery would look very bleak. However, it is important that midwives acknowledge the ambiguities that currently exist, and tackle them collectively. Idealism needs to be tempered with pragmatism, if disillusionment and frustration are to be prevented. As it is, the reality of clinical practice is frequently at odds with the vision of midwifery that initially attracted new recruits, and, as a result, there is the danger of losing those very midwives who may have the most to offer. There is empirical evidence to support this in the recent study of why midwives leave midwifery (Ball et al., 2002), which identified ‘a real problem created by the contradiction that midwives experience between what their education prepares them to expect, and what they find in practice’ (p. 94). Those most likely to cite dissatisfaction as their reason for leaving midwifery tended to be younger, more recently qualified and having higher educational qualifications. As Ball et al. (2002) observe, these should be ‘the midwives of the future’ (p. 94), and it is thus essential that these issues be addressed as a matter of urgency.

On a positive note, the findings identify the key role of peer support in maintaining morale and a sense of common purpose among junior midwives. Although it was evident that this peer support could have negative outcomes, potentially encouraging divisiveness and reinforcing an ‘us and them’ culture, there were also many examples of its benefits. There is the potential for these positive
aspects to be harnessed and developed further, for example, through peer support groups for newly qualified midwives, which could form part of preceptorship programmes.

Finally, it is important that we attempt to understand these differing midwifery ideologies in order to unravel this complex issue. Although it is easy to identify the basis for the ‘with woman’ model held by junior midwives, as this ideology pervades contemporary midwifery policy and education, it is less easy to explain the perspective of senior midwives. A detailed study of their experiences is required, in order to explore how their professional authority is maintained when, by all accounts, they seem to hold a ‘with institution’ ideology that is counter to the prevailing occupational culture.

**Conclusion**

In this paper, I have explored the emotion work of student and qualified midwives working in various hospital settings within South Wales. Using the theory of boundary maintenance, I have argued that junior and senior midwives hold conflicting models of midwifery practice, which resulted in competing claims for occupational jurisdiction. Midwives made use of a variety of devices in order to establish and maintain intra-occupational boundaries. These strategies created emotion work for midwives, and were likely to compound rather than reduce differences. These findings are of relevance to other midwives, both within the UK and internationally, and have implications for staff morale and workforce retention. It would be valuable to undertake further research into the experiences of senior midwives in order to gain a deeper understanding of the issues raised.

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