Midwives’ experience of organisational and professional change

Inger Lindberg, RNM, MSc (Lecturer)\textsuperscript{a, }\textsuperscript{*}, Kyllike Christensson, RNM, PhD (Professor)\textsuperscript{b}, Kerstin Öhrling, RNT, MEd, PhD (Senior Lecturer)\textsuperscript{c}

\textsuperscript{a}Division of Nursing, Department of Health Science, Luleå University of Technology, Hedenbrovägen, SE 961 36 Boden, Sweden
\textsuperscript{b}Department of Caring and Public Health Sciences, Mälardalens University, Eskilstuna, Sweden
\textsuperscript{c}Kerstin Öhrling Senior Lecturer Division of Nursing, Department of Health Science, Luleå University of Technology, Hedenbrovägen, Boden, Sweden

Received 27 May 2004; received in revised form 25 January 2005; accepted 9 February 2005

Summary

Objective: to describe midwives’ experiences of changes in their caring role and professional function in postpartum wards in the northern part of Sweden. In this part of the country, three out of eight maternity departments have been closed over the last 5 years. During the same period, hospital stays have reduced in length, and an early discharge model has been introduced.

Design: focus-group discussions.

Setting: four focus groups at two hospitals in northern Sweden.

Participants: 21 midwives experienced in midwifery practice in maternity wards.

Findings: the analysis revealed four categories of comments: ‘to have limited time when caring for the mother and the baby’; ‘no longer being valued as the expert’; ‘a wish to have responsibility for childbirth in its entirety’; ‘to see future possibilities in the development of the profession’. The theme identified is ‘being ahead in ideas about caring but still partly caught up in the past’.

Key conclusions and implications: the identified theme of being ahead in ideas about caring but still partly caught up in the past can be understood as representing a transition. The midwives experienced loss and grief over their former midwifery practice, but had ideas and visions for developing and expanding their future professional role. A healthy transition requires support, participation and skilled management.

\( \text{© 2005 Elsevier Ltd. All rights reserved.} \)

\textsuperscript{*}Corresponding author.
E-mail address: inger.lindberg@ltu.se (I. Lindberg).

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

In the northern part of Sweden, three out of eight maternity departments have been closed down over the last 5 years. During the same period, the length of hospital stays has reduced, and an early discharge model has been introduced. This structural change, with centralisation of emergency care and specialities to different hospitals, and the decentralisation of health-care services to patients’ homes, began on a nationwide basis during the 1990s (Molin and Johansson, 2004). As a result of this change, places of work and work assignments of midwives have shifted within the health system. Traditionally, people in this region do not change workplace because of the long distances involved. Today, the region faces new challenges with the development of telemedicine (Ds, 2002:3). In order to meet these challenges, it is considered important to understand midwives’ perceptions and experiences of changes within their profession.

In Sweden, institutional care for mother and baby was organised in the same way from 1940 until the late 1970s (Vallgårda, 1996; SOS, 1979:4). During that time, midwifery care focused primarily on the women’s physical health, whereas the nursery nurses took care of the babies (MF, 1960:40). The development of the early discharge system was prompted by a new law governing parental leave (SFS, 1973:473), which made it possible for the father to participate in the care of the newborn baby for the first 10 days after the birth. Development was also influenced by regulations concerning antenatal classes (SOU, 1978:5), participation in decision making (HSL, 1982:763) and in pain alleviation (MF, 1969:69). The expected financial savings to be made by introducing early discharge led the county councils to force the pace of change. At present, early discharge and very early discharge are already, or have become, standard practice in Sweden (Darj and Stålönacke, 2000), as in most other western countries (Brown et al., 2002).

In Sweden, the midwife plays a key role in caring for the woman during pregnancy, delivery and the postpartum period. Antenatal care and child health care is organised by the primary health-care centres; delivery and postpartum care in most places are the responsibility of the county council (SOS, 1996:7; State of the Art, 2001). In some places, the midwives rotate between different fields of midwifery activities, and in others the midwives are stationary, working, for example, in the delivery or the maternity wards. The organisation of postpartum care varies across the country. When the woman and her family are discharged from the maternity ward, follow-up visits/home visits are carried out in some places by midwives from the maternity ward or midwives working in early discharge teams. Within some systems, there are no visits (State of the Art, 2001). When the baby is about a week old, the child health-care organisation takes over the contact with the new family.

The fact that postpartum care in Sweden is organised differently from other countries makes it difficult to make international comparisons or to apply international results to Swedish conditions. Research into the profession of midwifery in England in recent years has focused on issues raised in the official report ‘Changing childbirth’ (DoH, 1993). Several studies have been published on ‘team midwifery’ (Sandall, 1995; Turnbull et al., 1995; Farquhar et al., 1998; Dowswell et al., 2001; Stevens and McCourt, 2002). In this model, continuity was an important factor when midwives worked in teams, caring for the pregnant woman during pregnancy, delivery and the postpartum period. In the USA, research into the profession of midwifery has often focused on legislative aspects of practice and the mixed societal image of midwifery, as a modern cost-effective practice versus informally educated individuals (Paine et al., 1999; Johnson et al., 2001; Roberts, 2001).

The new ideology of reduced hospital stays within the health-care system, as well as political decisions and financial savings, have obviously affected the midwives and their view of their professional situation. The organisational changes make increased demands on the midwives’ ability to be flexible within the caring system. The time available to establish a relationship with the woman and her family has been radically reduced. In the future, midwives will face new possibilities of developing professional competence and midwifery care, as county councils and the central government want to introduce telemedicine as a service to the citizens. Today’s highly developed information and communication technology (ICT) could be an alternative or a complement to midwifery practice in early discharge situations. ICT has been studied in many settings, such as emergency care (Benger, 2000) and homecare (Agrell et al., 2000). Within midwifery, Laazenbatt et al. (2001) studied support of breast feeding through videoconferencing, and Dawson et al. (1999) carried out antenatal care through telemonitoring in home settings. With these changes in mind, we considered it important to understand and describe midwives’ experiences of carrying out
midwifery care of the new mother, her baby and the family after a period of ongoing organisational change.

Aim

The aim of this study was to describe midwives’ experiences of changes in their caring role and professional function in postpartum wards in the northern part of Sweden.

Method

In this study, focus-group discussions were used to explore midwives’ experiences. According to Dawson et al. (1993), this method can provide insights into how a group thinks about an issue in terms of beliefs, experiences and practices. By encouraging people to talk to each other, the researcher can spur the focus group to go further and challenge the notion that opinion, as an attribute to the subject, is more than the utterance in specific situations (Kitzinger and Barbour, 1999).

Participants

The midwives were recruited from two hospitals in the northern part of Sweden. Four focus groups, comprising midwives who met the inclusion criteria of experience of working in a maternity ward in this part of the country, participated in the present study. The planned size of each focus group was a minimum of four and a maximum of six participants; according to Kitzinger and Barbour (1999), groups of this size are often preferred for studies investigating such aspects as structures in systems (i.e. health-care organisations) (Gibson and Bamford, 2001). In the present study, small groups were also preferable, as the number of participating midwives were limited. The number of participants who could attend on a given date determined the size of each group, three groups consisted of five midwives each, and the fourth consisted of six midwives.

Procedure

Initially three focus-group sessions were planned. The first contact was made at a staff meeting, in which the researchers gave information about the study and asked for volunteers. Posters advertising the focus-group discussions were also displayed. Letters containing information about the object of the discussion and the study were given to participants. Informed consent was given by all participants to the principal investigator/moderator. After listening to and transcribing the first three tape-recorded sessions, it was decided to have a fourth focus-group discussion to confirm theoretical saturation (Glaser and Strauss, 1967) to encompass diversity and to secure a more structured sample (Kitzinger and Barbour, 1999). Another hospital was contacted, the chief midwife was informed and interested midwives were recruited. The participating hospitals were chosen because they housed two of the five maternity departments in the most northern part of Sweden. One of these units had a longer experience of organisational change.

Ethics

Participants were assured that they could withdraw their participation from the study, and that the findings would not be linked to individuals and would be treated confidentially. The participants were asked not to talk about the content of the discussion with anyone other than members of their own group. The head of the maternity-care department and the Ethics Committee at Lulea University of Technology approved this study.

Focus-group discussions

The first author was the moderator, whose function was to facilitate the discussion and encourage the midwives to express their feelings and experiences (Nyamathi and Schuler, 1990). The third author or a co-investigator assisted in taking notes, supervising the tape recorder and pointing out questions that had not been asked (Dawson et al., 1993). The focus-group discussion was guided by semi-structured, open-ended questions that allowed the midwives to describe their experiences. The opening topic for the discussion was the midwives’ experience of changes in their caring role and professional function in the maternity ward resulting from changes in the health-care system. The first focus-group session was conducted as a pilot study, but was incorporated as a part of the study after the transcribed tape had been read. After probing for clarification or deeper thoughts, one specific question was asked about the influence of ICT in health care. The discussions lasted for 80–90 mins, and were tape-recorded (Kitzinger and Barbour, 1999; Alexander et al., 2002). The recordings were transcribed verbatim after each session to help in refining some of the questions. The focus-group discussion was followed by a
debriefing of the moderator and the co-investigators to record their impressions of how the group discussion had proceeded (Gibson and Bamford, 2001).

Analysis

In order to capture the midwives’ description of their experiences, a thematic content analysis (Baxter, 1991) was used after the transcription of the four discussions. The object of content analysis is to provide knowledge and understanding of the phenomena that are studied (Downe-Wamboldt, 1992).

The transcriptions were read through in order to gain a sense of the whole, and text units that answered the research question were identified. Text units that were similar in content were given a code and arranged into 65 categories that were then subsumed into four categories (Downe-Wamboldt, 1992). Once the final categories had been determined, the text units were re-read and checked for the appropriateness of their categorisation. All the categories were again compared, and a theme, or thread of meaning, emerged from the categories (Baxter, 1991; Söderberg and Lundman, 2001). To validate our interpretation and achieve authenticity for the result, the focus-group participants were invited to a seminar (Downe-Wamboldt, 1992). The participants reached agreement about the findings of the study.

Findings

The midwives were all women, and their professional experience varied from almost 2 years to 39 years, with a median of 25 years. The analysis revealed four categories: ‘to have limited time when caring for the mother and the baby’; ‘no longer being valued as the expert’; ‘a wish to have responsibility for childbirth in its entirety’; ‘to see future possibilities in the development of the profession’. The theme identified was ‘being ahead in ideas about caring but still partly caught up in the past’. The midwives’ discussion veered from being situated in the current midwifery role, with the new experience of having limited time to care for the mother and the baby, to looking backwards to the past when ‘the midwife’ was identified by the parents and themselves as ‘the expert’. The discussion also looked towards the future, where the midwives were seen as having a new and expanded professional role. The categories are presented in the text below, and are illustrated by quotations from the four focus groups.

To have limited time when caring for the mother and infant

The midwives felt that the reduction in time available for postpartum care in maternity wards, resulting from the introduction of the early discharge model, had led to care becoming brusque. They expressed a wish for a longer period of postpartum care in order to get to know the families better to enable them to make more careful assessments. It was especially difficult to discharge parents early when they were insecure about caring for the baby and breast feeding. Previously, the caring system allowed the midwives to make assessments over a longer period, to observe the weight of the babies, and experience the mothers’ satisfaction with the care provided by the midwives. Reducing the time for institutional postpartum care meant that there was only a limited period available for giving information to the mother, and thus the midwives themselves perceived their input as mechanical and predetermined, and not directed by the mother’s own needs:

It is difficult when you have to write a caring plan for the parents in the morning and then in the afternoon have the discharge talk; the parents have hardly had time to think about the childbirth and that they have become parents when they have to think about leaving the hospital. (Focus group 1)

Furthermore, the midwives discussed the fact that they felt irritated when fathers and siblings took time and space from the mother instead of being a support to her. The current organisation of postpartum care sometimes forced the midwives to push parents to ask for help, as the limited time available did not allow them to wait for spontaneous questions from the parents. Some of the midwives had positive experiences from hospitals that had visiting only for father and siblings of the baby. They thought that this system helped them to be more effective in their work, and enabled the parents to concentrate more effectively on learning about parenting.

New demands, related to the short hospital stay, necessitated flexibility on the part of the midwives, and constant prioritising of their work to women with demanding care needs. Although they said that they ‘loved’ their job, they felt that this working situation ‘was too much’, and created
irritation among colleagues as well as feelings of worthlessness. The midwives suggested that separating normal from complicated deliveries would facilitate their concentration on the individuals. Furthermore, the midwives expressed feelings of stress, as the time available for caring made it impossible to receive feedback from the parents. They felt that it was like working 'blindfold', just hoping that the parents would manage at home. The midwives also felt stressed by their increased responsibility for giving the parents sufficient information to manage caring for their baby themselves:

I think it has been hard, frustrating and stressful never getting feedback about whether what you said or did for the parents was good and all went well, but when the midwives who make home visits say that everything is all right you have to believe it and work with that but without getting the feeling for it. (Focus group 3)

When the early discharge model was introduced, and the midwives started to make postpartum home visits, they felt a new and increased responsibility because they had to make their own assessment without having access to a physician for immediate consultation. They thought that this kind of responsibility in providing care demanded several years’ experience of clinical midwifery. Having increased responsibility for care in its entirety was, however, seen as positive by some midwives. Midwives working in the early discharge system expressed satisfaction when they met parents again, either during the home visits or at a follow-up visit to the hospital.

No longer being valued as ‘the expert’

The midwives described how frightened they felt at the beginning of the early discharge procedures, when handing over to the mother and trying to feel confident in the mother’s ability to care for her baby. As the midwives had traditionally been seen as the postnatal care experts, it took a long time to prepare for, and actually change, caring practices. The midwives thought that nowadays they had lost the possibility of checking on the baby’s health. They also felt that the new system concerning working hours did not allow them to follow up on advice given or other interventions as they wished. On the other hand, the midwives also discussed the fact that some of the earlier caring practices had disadvantages, as they perpetuated the idea that the midwives alone bore the entire responsibility for the mother, the baby and the breast feeding:

We didn’t think that the mothers could manage their children, we thought that we knew best. (Focus group 2)

The midwives described how previously their work had been more supportive and ‘hands on’, whereas midwives felt that, in the present system, they were not practising ‘midwifery’ any more. Instead, they felt that their work was to deliver general services, such as providing access to telephones and making baby photos for a website. Today the midwives also saw more psychological problems, which they did not feel prepared to deal with. It was only when caring for ‘patients’ with severe complications, that the midwife, in a more clinical role, still felt like the ‘expert’.

Some midwives said they found it difficult to give up the former, obviously controlling, function within their ‘expert’ role, whereas other midwives felt that this was a step forward in their professional development. The latter group said that instead of controlling everything and acting the ‘expert’ within postpartum care, they should support the parents’ ability to take responsibility for the care of their baby as well as for breast feeding. One of the participants expressed it as:

Having to sit on my hands and let the parents try for themselves. (Focus group 2)

Another said:

Definitely no loss of control, just a step in the right direction nothing else. (Focus group 4)

Some midwives experienced difficulties when meeting the new generation of parents who they thought had different expectations and priorities in connection with parenthood than the midwives themselves. The midwives felt that the parents valued time with friends and relatives more than time for information given by the midwife. They also said they missed the natural ‘woman to woman’ conversations, and believed that this so-called women’s world had been important for the mothers. This world was also thought to be important to the midwives who perceived that they had an obvious role in mothering the new mother, without interference from the father. It was also thought that single rooms prevented mothers from meeting and talking about their childbirth experiences with other women in the same situations:

Sometimes, the new generation of parents today are difficult to understand as they have other values and other demands, living in a different social structure than we [midwives] have done. (Focus group 3)
A wish to have responsibility for childbirth in its entirety

The midwives were positive about the experience of their new role with entire responsibility for mother and baby. It felt positive to be working in teams with nursery nurses and assistant nurses, compared with the previous system when each member of staff had separate tasks. With the aim of improving midwifery practice and getting to know the mothers better, they described visions of being able to care for the mother during the entire childbirth period, including the pregnancy. Some midwives were happy about caring for the whole family in their home, as they thought that the home environment helped their own supportive role and the parents to feel more comfortable in their new role:

If I could have a wish I think it is that the woman who is going to give birth should be able to have her own midwife during the pregnancy, the delivery and the postnatal period. (Focus group 4)

The participating midwives discussed how proud and satisfied they felt in current practice, seeing themselves as more effective in their work in the maternity ward. They were also happy that they could offer some flexibility for mothers during their hospital stay, and could provide safe care through telephone support and home visits. None of the participating midwives in the focus groups expressed a wish to return to traditional postpartum care. However, some midwives did not share all the positive opinions about family centred care:

Now that we have the opportunity to offer longer caring periods to those who need it, and home care, we don’t discharge them with no care at all as we can phone them, make home visits and they can come and visit the maternity ward, I don’t think this is wrong. (Focus group 1)

The midwives expressed satisfaction with society’s recapture of childbirth as something healthy and normal, and with the change in midwifery practice, which now seemed to emanate from the mother’s needs and a belief in her own resources. They felt it was encouraging to see that mothers cared for in the early discharge system matured faster than women cared for in earlier systems.

To see future possibilities in the development of the profession

The midwives discussed the development of the health-care system from the perspective of future maternal care depending on social structure, political decisions and the economy. Midwives were frightened and worried by ongoing political discussions about possibly closing maternity wards to women with normal deliveries and those with uncomplicated caesarean sections. It was thought that, after a short introduction to breast feeding and other postpartum issues, these women could be discharged even less than 12 hrs after the baby’s birth without access to a maternity ward.

The midwives emphasised that, even in the future, the midwife will continue to be the most suitable person to provide support and care for the new parents in their homes. They expressed a wish to work with a more promotional and preventative approach to breast feeding and other problems. They also wanted to extend the postpartum care to up to 2 months after the birth, and to assist parents in finding other groups of parents to share their experiences with. Furthermore, the midwives discussed future collaboration with child health-care nurses in order to improve the parents’ feelings of security. Visions of an extended postpartum home care required the parents, especially expectant fathers, to be better prepared for taking care of the newborn baby.

The midwives felt that they had to develop their knowledge about problems related to breast feeding and the health of women and babies. In addition, if, in the future, they were supposed to collaborate with primary health-care staff, they felt a need for more general knowledge about child development. As making home visits had forced the midwives to change their attitude towards the parents, some of them felt a need to learn more about behavioural science in order to improve such meetings. They also discussed the need for more communication skills, such as the best way to give information or have difficult conversations:

We, or at least I, lack competence and have a lot to learn about having a good conversation with the new parents or a conversation when things haven’t gone so well. (Focus group 2)

The midwives also discussed professional improvements through the use of mentorship for new midwives. Some midwives considered their own experience, rather than theoretical knowledge, an important ingredient for improved maternal care in the future.
In answer to a specific question about information and communication ICT, the midwives discussed how the development of ICT had influenced them, as well as society at large. They foresaw the possibility of communicating through websites, or through video-conferencing equipment, with parents in their homes. It was thought that the development of ICT within the health-care system had contributed to midwives feeling that they needed more understanding of technological development. They valued the possibility of using pictures as a complement to a telephone call when giving advice. Some of the midwives welcomed such development, although they preferred face-to-face contact:

Well, the advantages could be, if I think about caked breast and breast-feeding problems, that she could show the lump and tell about the pain and then I can say it is just the milk that is coming and give advice about that without having them come for a visit [to the maternity ward]. (Focus group 4)

Discussion

The findings from this study should not be transferred to other maternity units without careful consideration of change within the health-care organisations. In this northern part of Sweden, dramatic changes have taken place in maternity health systems through the reduction of the number of delivery institutions and length of hospital stays. Despite the relatively small number of focus groups, it is considered important to study the midwives still working in the remaining maternity wards, their experience of the organisational changes and the effect on their profession role. This study’s findings could be considered an important tool in guiding future organisational changes (e.g. the development of tele-nursing/midwifery) in addition to being of relevance for other health-system planners in similar situations.

The analysis of the focus-group discussions resulted in the creation of four categories: 'to have limited time when caring for the mother and the infant'; 'no longer being valued as the expert'; 'a wish to have responsibility for childbirth in its entirety'; and 'to see future possibilities in the development in the profession'. The theme that was identified 'being ahead in ideas about caring but still partly caught up in the past' can be understood as representing a transition. The midwives’ discussions embraced their former expert role, their present situation with limited time to care for the mother and baby, and looked towards a future with a new and expanded role for midwifery. A similar movement is also described by Meleis et al. (2000) in a study of transition, as a non-linear movement between multiple places, spaces, situations and identities.

There is no clear definition of transition as a concept (Chick and Meleis, 1986; Murphy, 1990), but a general recognition is that it entails some movement between two relatively stable states (Murphy, 1990). According to Chick and Meleis (1986), transition is associated with experiences of the process involving the individual's response to the disruption that the transition causes. Time span is associated with the first awareness of transition until a new stability within the transition is achieved. Perception reflects how the individual experiences role conflict and threat to self-concept. The midwives participating in the present study discussed their experiences of the process in terms of reaction to the implementation of the early discharge system and the time span of the consciousness of the change. Perception was discussed as the change in their professional role, from the past and possible future changes. The identified theme is similar to Kiefer's (2002) findings that individuals experiencing organisational change discuss how their everyday activities and work identity are affected, as well as where they will be positioned in the future.

Our findings show that, as a result of being partly caught up in the past, the midwives tried to give the same amount of care as they did before the new caring system was introduced, but within a shorter period of time. This created stress and frustration, as the midwives could not live up to their self-imposed expectations. Rosser and King (2003) found similar feelings of disappointment when hospice nurses had high expectations of being allowed to practice holistic care but were restricted in their ability to do so. The limited time available also resulted in feelings of frustration, as the midwives in the present study had to care for mothers whom they knew only briefly in an unfamiliar way and sometimes in competition with fathers and siblings. Feelings of stress and frustration during transition according to Schumacher and Meleis (1994) are often linked to feelings of difficulty, which can lead to feelings of low self-esteem and an inability to reframe the self. These authors believe that such experiences can lead to an inability to concentrate on work, and a hesitation to take risks or meet the unknown.

Feelings of anxiety were experienced when the midwives had more responsibility for making their own assessments of the health of mothers and
babies. During organisational change, fear of the unknown or individual doubt about competence and ability to cope in the future organisation is a common problem (Nadler, 1987). Some of the midwives in the present study felt that the limited time available forced them to practice midwifery contrary to their beliefs. If people receive orders to do something they do not understand or believe in, they might react by resisting or sabotaging the new arrangements, which is not constructive for either the individual or the organisation (Bolman and Deal, 1999).

Some midwives, with no experience of making home visits, described their work as fragmented, predetermined and mechanical. These findings are in agreement with Woodward (2000), who found that midwives practising in a maternity ward with short-stay women and a rapid turnover were routinised, task-oriented and sometimes unresponsive to the women’s needs. The midwives in the present study said that they never saw the result of interventions, as the limited time available made it impossible for them to receive feedback. This could be understood as their work having in some way lost its meaning. Schumacher and Meleis (1994) consider that, in order to understand transition, it is essential to be aware of the meaning connected with events inherent in it. Such awareness of meaning may foster or hinder a healthy transition (Meleis et al., 2000). Despite the limited time available for the practice of midwifery, some midwives felt positive about the change, as they thought having responsibility for the entire care produced a better caring system.

In the second category, the midwives discussed the loss of their previous role as the expert in postpartum care, acknowledged by the parents and by themselves. It was only with the mothers with severe complications that the midwives felt like experts. The findings of Ewens (2003) show that, to be able to take up new roles, it is essential that the identity remains in the individual’s self-concept of her/his professional role. If the individual is constrained or held back by the organisation, she will either quit her role or move back to a more traditional view of herself. The findings in our study indicate that some of the midwives were still partly caught up in the past, and had difficulties in re-orientating themselves in their new midwifery role. Some midwives thought that performing family-centred care with the whole family in the maternity ward hindered their ability to care for the mother/baby pair. This finding is in contrast to those of Stoltem et al. (1994) and Janssen et al. (2001), who found that single-room care and family-centred care increased midwives’ job satisfaction. Our findings can partly be understood as a sign of lack of clarity in assignments or constraints within the organisation (Rosser and King, 2003). These authors suggest that, to become confident and effective in a new role, the individual must be allowed to grow, both personally and professionally.

The midwives also described a loss of control and of familiar caring practices, and were experiencing a discrepancy between their own and the parents’ values concerning important issues in postpartum care. According to Bousfield (1997), being an experienced practitioner is signified in striving to influence patient care and to use advanced knowledge, expertise and leadership skills. It is possible that, once the midwives lost the initiative in their midwifery role, they felt outside the caring situation and thus also lost their identity. According to Trist (1981), the individual creates a special meaning through work, and identifies herself with her professional role. Selder (1989) discusses the concept that, when an individual’s reality is disrupted, she/he might feel like an outsider, a stranger cut off from her/his well-known environment.

Experiencing a disrupted reality can create feelings of threat or incongruity, between expectations based on the past and those based on the future. In the present study, some of the midwives did not recognise their professional role, as they were not able to perform midwifery in a practical way, and were unsure what the future would demand of them. Organisational change implies a change in the power of individuals or groups who take actions based on how their own power and balance within the organisation are affected by the future change. Those who resist change are often those who lose power (Nadler, 1987).

Although our findings revealed feelings of disappointment and grief related to organisational change among some of the midwives, they also expressed satisfaction with that change, and had visions of the future. The midwives were proud of the quality of the care they gave and wanted to expand their caring role to encompass the whole of the childbirth period. Having ideas about a future expansion of the midwife’s role towards the parents is understood as attempting to improve the care and also regain continuity. In previous studies (Turnbull et al., 1995; Stevens and McCourt, 2002; Rogers et al., 2003), midwives who extended their role to include larger parts of the childbirth period, experienced satisfaction in performing a holistic form of midwifery. The expression of visions for expanding and developing the midwife’s role to cover the whole of childbirth can be understood as a re-definition of identity and the finding of a new meaning within the professional role.
The findings in the present study show that the midwives were aware of the need for new knowledge and skills to support the development of future midwifery practices. This is supported by Meleis (1997), who believes that, in order for transition to have a positive outcome, the individual must be able to gain new knowledge, change behaviour and redefine the self in a social context. Not all midwives shared these opinions about the need for new knowledge, and thought that personal experience was the most important attribute for their future professional role. These expressions can reveal a lack of awareness concerning future demands, unclear assignments or an unwillingness to acknowledge the changing professional role.

One important implication for successful transition in nursing identities (Ewens, 2003; Rosser and King, 2003) and organisational change (Bousfield, 1997; Rosengren et al., 1999) is that support from the organisation is essential if the individual is to become confident in her/his new professional role. For a person to fulfil their new professional role, there has to be a clear definition of that role (Bousfield, 1997) and a perception of core values within the profession (Rogers et al., 2003). Other important criteria for successful organisational change are the individual’s ability to participate in the process (Turnbull et al., 1995; Rosengren et al., 1999), the role of leadership (Rosengren et al., 1999; Ewens, 2003) and access to mentorship or clinical supervision (Rosser and King, 2003). Although midwives saw themselves as key people in future postpartum care, and had visions about an expanded role for midwifery, they felt that it was beyond their ability to influence decisions about future maternity care.

As the findings in the present study reveal negative comments about the presence of fathers in the maternity ward, further research is needed into the effect this presence has on the midwife’s professional role.

Acknowledgement

We wish to express our thanks to the Department of Health Science and Centre of Distance Spanning Healthcare, Luleå University of Technology.

References


Turnbull, D., Reid, M., McGinley, M., et al., 1995. Changes in midwives’ attitudes to their professional role following the implementation of the midwifery development unit. Midwifery 11, 110–119.
