

Past and present perspectives on power and empowerment in midwifery in Ireland

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I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work

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GLOSSARY

An Bord Altranais	Translates as the Irish Nursing Board established in 1951, the body responsible for the regulation of nurses and midwives
Clann na Poblachta	Translates as Family of the Republic A political party founded by Sean MacBride in 1946, with a social emphasis The party ceased to exist after 1965
Cuidiú	Translates as Assistance/Help, the Irish Childbirth Trust
Dail Eireann	The lower house of the Oireachtais
Fine Gael	Translates as Family of the Irish A political party founded in 1933 which currently is th second largest party in the country
Oireachtais	The national legislature, consisting of the President and the two houses Dáil Eireann and the Seanad
Seanad	The upper house of the Oireachtais
Taoiseach	The head of the Irish government, equivalent to a Prime Minister

Acronyms

AMP	Advanced Midwife Practitioner
CMB	Central Midwives Board
CMM	Clinical Midwife Manager
CMS	Clinical Midwife Specialist
CWEQ	Conditions for Work Effectiveness Questionnaire
DOMINO	Domiciliary In and Out of Hospital
HRB	Health Research Board
ICM	International Confederation of Midwives
INO	Irish Nurses Organisation
JAS	Job Activities Scale
NCNM	National Council for the professional Development of Nursing and Midwifery in Ireland
ORS	Organisational Relationships Scale
PCA	Principal Components Analysis
PAF	Principal Axis Factoring
PCEMS	Perceptions of Conditions for Empowerment in Midwifery Scale
SMC	Statutory Midwives Committee
TD	Teachtaí Daile, member of the Dail, Parliament
UES	Understanding of Empowerment Scale
UWO	University of Western Ontario
WHO	World Health Organisation

ABSTRACT

There have been calls for the empowerment of midwives in Ireland and internationally. This study explores past and present issues relating to power and empowerment in midwifery in Ireland. Historical research was carried out into particular episodes involving power in the history of midwifery regulation. Specifically, the background to the 1950 Nurses Act and its impact on midwifery was analysed. The findings provide a greater understanding of the broader social and political contexts within which midwifery practice and policy-making take place. They highlight the complex and contingent power relations and processes involved in midwifery's history.

Survey research was undertaken to elicit midwives' views about the conditions important for empowerment and their perceptions of their own levels of these conditions. Two cross-sectional surveys using random national samples of practising midwives were carried out, in 2002 (n=95) and 2005 (n=244). This research identified that empowerment in midwifery involves three domains: Autonomous practice, Effective management and Women-centred practice. These three domains comprise the sub-scales of the *Perceptions of the Conditions for Empowerment in Midwifery Scale*, developed and psychometrically evaluated in this study.

This research provides valuable insights into issues of power and empowerment in midwifery and identifies the means by which midwives can fully contribute to the Irish maternity care system.

Acknowledge the intellectual equipment you bring to the study of others,
be aware of the ways you change those with whom you interact,
and make your assessment of what others do explicit
But always do so in a way that is responsive to the evidence as best you can determine it,
and accountable to those whom it is writing for and about
Seek out the criticism of others (Fay 1996 p244)

-

CHAPTER 1

INTRODUCTION

In Ireland, approximately 60,000 women give birth each year (Central Statistics Office 2004). Childbirth is a major life event for women and their families. Women's memories of satisfaction with their birth experience remain constant over many years and can have a lasting impact on women and their families (Comhairle na nOspideal [Irish Hospitals' Council] 2003, Edwards 2005, Kitzinger 2005). Birth is not exclusively a women's issue, but has life-long effects, for each individual and family, and for society as a whole (Kitzinger 2003). The literature relating to the empowerment of birthing women highlights the importance of the role of the midwife to women's experiences (Berg *et al* 1996, Too 1996a, 1996b, Halldorsdottir & Karlsdottir 1996, Hunter 2001, Vague 2001, Edwards 2005). Thomas (2002 p32) summarises this succinctly as "good midwifery is good for women". These authors conclude that women's encounters with and experiences of midwives are important to women in the long-term.

Literature exploring birth from women's perspectives suggests that the empowerment of midwives will have positive implications for birthing women. Kirkham (1999) proposes that if midwifery practice is to empower women, then midwives must experience empowerment themselves. In an Irish context, O' Regan (1996 p57), the Chairperson of the Irish branch of the *Association for the Improvement of Maternity Services* (AIMS) concludes that "if we are serious about the creation of woman-centred and family-centred maternity care here in Ireland, Irish midwives must be fully empowered". These assertions are based on the premise that midwives without power and control over their own circumstances are unlikely to help women achieve their goals in childbirth. Calls for the empowerment of midwives have therefore become widespread in Ireland and internationally (Kirkham 1999, Kirkham & Stapleton 2000, An Bord Altranais [Irish Nursing Board] 2000a, Department of Health and Children (DoHC) 2000a, , Edwards

2000, 2001, and the International Confederation of Midwives (ICM) 2002) Despite the ubiquity of the term, there has been little previous research identified relating to empowerment in a midwifery context This research focuses on exploring past and present perspectives on empowerment and its constituent root power, in order to explicate the term empowerment in a midwifery context

1.1 Origins of the study

This study has its roots in a national initiative undertaken by the Irish Department of Health and Children In 2000, the Minister for Health and Children established a *Steering Group on the Empowerment of Nurses and Midwives in Ireland* In December 2000, a study of *Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland* was commissioned by the Health Research Board (HRB) on behalf of the *Meaning of Empowerment Sub-committee* of the *Steering Group* I was a member of a team of researchers at Dublin City University (DCU) commissioned to carry out that research The objectives of the study were to elicit nurses' and midwives' understanding and experiences of empowerment and to identify nurses' and midwives' views on the factors that enhance and inhibit empowerment The study had two phases - an exploratory phase using focus groups of nurses and midwives and a national survey of nurses and midwives to test the focus group findings

During the initial stages of analysis of the focus group data gathered during phase 1 of the study, it appeared that both nurses and midwives perceived that empowerment should be conceptualised differently for midwives vis-à-vis nurses (Scott *et al* 2003) Participants suggested that midwifery offered more potential than nursing for empowering practice, based on the notion of midwives being autonomous practitioners They discussed the under-utilisation of midwifery skills within the current consultant-led maternity services (see page 34 below for further details) Those preliminary findings suggested that a particular focus on empowerment in midwifery would be valuable, as the participants' comments were capturing the espoused defining characteristics of midwifery, namely

independent women-centred practice. Midwives also highlighted the constraints of working within a “medical model” of maternity care.

Similar concerns about the medical model of childbirth in Ireland had also been highlighted in consultations with midwives in the late 1990s (Commission on Nursing 1998, An Bord Altranais 1999). These concerns were linked to the lack of a visible identity for midwifery in Ireland. Midwives called for a separate regulatory framework for midwives (vis-a-vis nurses) to address this lack of identity. Under the 1950 Nurses Act, the Central Midwives Board² had been abolished in 1951. This Board had been replaced by a Statutory Midwives Committee of An Bord Altranais, the Irish Nursing Board. The statutory status of the Committee was itself abolished under the 1985 Nurses Act.

The Commission on Nursing (1998) recommended the re-instatement of a Statutory Midwives Committee in order to highlight the distinct identity of midwifery. This recommendation has not yet been implemented. These issues, related to the regulatory framework for midwives, appeared to be strongly linked to the issue of midwifery identity. This fostered my interest in the process by which the Central Midwives Board had been abolished, and the impact this had on midwifery. Robins (2000 p19) mentions that just prior to the abolition of the Central Midwives Board, members of the Board defended the term “midwife” and achieved the retention of this term, by interceding with An Taoiseach and the Minister for Health of the time, Noel Browne. There is no mention of resistance to the abolition of the Board itself. This appeared to be of relevance to subsequent developments in midwifery and to this study of empowerment in midwifery. Robins (2000 p30) mentions that the 1949 Nurses Bill (which *inter alia* abolished the Central Midwives Board) was “not treated as a political issue”. The historical research undertaken within this study highlights that the debates about the impact of the Bill on midwifery were highly political. An unanticipated volume and intensity of material relating to the Bill was

² In keeping with the official records of the Central Midwives Board, the non-possessive versions of the following are used throughout this thesis: the Statutory Midwives Committee, Central Midwives Board, various Nurses Acts (rather than Central Midwives’ Board etc).

accessed through the primary sources of the Central Midwives Board minutes and the Oireachtas [Irish Houses of Parliament] debates. These illustrate the intriguing politics of midwifery regulation, played out in the struggle to hold onto the power to regulate midwives and later attempts to regain this power. These historical findings, presented in chapter 5, constitute a new historical record in themselves and also form the backdrop for the findings on empowerment which are also presented in this study.

1.2 Aims and objectives

The current context of midwifery practice is one of a changing maternity service configuration and a changing midwifery educational framework. With a clearer understanding of the past and present issues facing midwives, midwives can take up the challenges that these developments offer, now and in the future. This study of issues relating to power and empowerment appears to be timely in order to facilitate the enhancement of the midwifery contribution to maternity services in the future. In this context, the overall aim of this study is **to explore past and present issues relating to power and empowerment in midwifery in Ireland**. Within this aim, historical and survey research was carried out to achieve the following objectives:

- 1 To explore issues relating to power in midwifery's regulatory history
(Historical research)
- 2 To identify the conditions which are important to facilitate empowerment in midwifery **(Survey research)**
- 3 To explore strategies to measure the conditions important to facilitate empowerment in midwifery **(Survey research)**

1.3 Outline of remaining chapters

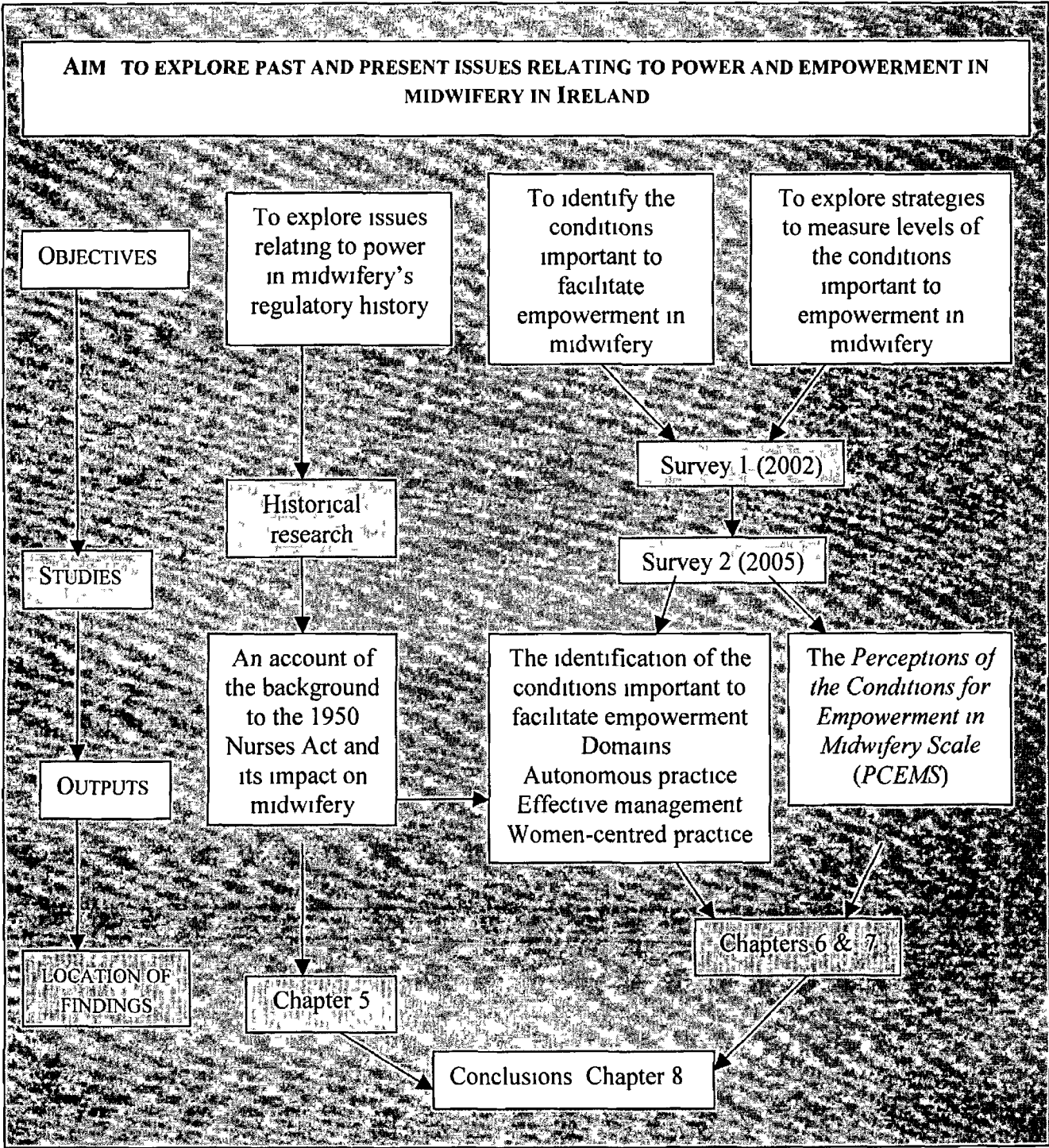
- Chapter 2 elaborates on the background to this study. It analyses the Irish maternity care system and presents a review of recent research on midwifery in Ireland within that context.

- Chapter 3 presents a review of the literature on empowerment. It examines various theoretical perspectives on empowerment and its constitutive root power. Given the structural constraints of midwifery practice, there is a focus on the organisational perspective on empowerment. Critical social theory also emphasises the role of history and structures and this approach is evaluated. Challenges to this approach including those of postmodernism are reviewed.
- Chapter 4 outlines the methodology of this study, describing the research design and methods of data collection and analysis. This study used both historical and survey methodologies. The historical research used primary sources, the minutes of the Central Midwives Board and An Bord Altranais and the historical debates of the Oireachtas in order to explore the background to the 1950 Nurses Act and its impact on midwifery. The survey method was used to collect empirical data on the conditions that are important to facilitate empowerment in midwifery and to measure midwives' perceptions of their own levels of those conditions. The survey research was undertaken in two stages, with surveys of practising midwives carried out in 2002 and 2005.
- Chapter 5 presents the findings of primary historical research into issues of power in the history of midwifery regulation. This specifically explores the background to the 1950 Nurses Act and its impact on midwifery.
- Chapter 6 presents and discusses the results of a cross-sectional national survey on empowerment of a random sample of practising midwives (n=95) undertaken in 2002. This study explored the conditions important for empowerment in midwifery. Midwives' perceptions of their own levels of conditions which facilitate empowerment were measured using existing validated empowerment measurement scales.

- Chapter 7 presents and discusses the findings of a further cross-sectional national random survey of practising midwives (n=244), carried out in 2005. This involved the identification of the conditions important for empowerment in midwifery and the development and psychometric evaluation of an instrument to specifically measure midwives' perceptions of their own levels of these conditions, the *Perceptions of the Conditions for Empowerment in Midwifery Scale (PCEMS)*
- Chapter 8 highlights the key findings of this study and draws conclusions about these findings. Recommendations are offered, based on these findings and future research directions proposed.

Figure 1.1 maps this study's research questions and modes of enquiry to its final outputs.

Figure 1 1 Overview of the study



CHAPTER 2

BACKGROUND TO THE STUDY

It was explained to her by her [midwifery] colleagues that consultants were clinically independent. They could not be questioned about their procedures. In particular, one could not interfere with the treatment of private patients.

“The Midwives”, Section 8.8, Report of *The Lourdes Hospital Inquiry* (2006 p188)

The above quote refers to “Ann”, the midwife who made the first complaint in October 1998 to the North Eastern Health Board (NEHB) solicitor about the peripartum hysterectomy rates at Our Lady of Lourdes Hospital in Drogheda in the North-East of Ireland. The report within which this quote is found, *The Lourdes Hospital Inquiry: An Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda* (Government of Ireland 2006), makes disturbing reading. It recounts in detail the circumstances within which 188 peripartum hysterectomies were carried out at the hospital between 1974 and 1998 at the hospital’s maternity unit. Forty percent of the women who had hysterectomies under Dr Michael Neary, who carried out 129 peripartum hysterectomies in total, were having their first or second baby. Two women “ended up childless” (p31). Almost one quarter of the records pertaining to obstetric hysterectomies have been apparently systematically removed from the hospital. The Inquiry concluded that these records had been “intentionally identified, traced and removed from the hospital” (p147). Judge Maureen Harding Clark, the sole member of the Inquiry, comments on the “general sense that what happened should not have been tolerated and serious questions should have been asked long before October 1998” (p316). She states that the midwives who raised their concerns prior to this should have been supported and their questions investigated. Elsewhere she comments that

We tried to understand why the midwives, who formed the largest group of health professionals involved and who were principled women of training and intelligence, did not take their concerns further (p156)

The Inquiry questioned why “so few had the courage, insight, curiosity or integrity to say ‘this is not right’”, after a failed attempt by one midwifery tutor in 1980 to highlight the problems. Many factors appear to have contributed to this culture. These include a management vacuum, the isolation of the maternity unit, authoritarian religious influences, a lack of clinical reporting, audit and peer-review and the overall unquestioning culture surrounding obstetric practice.

Ultimately, it was the part played by four midwives who voiced their concerns in 1997 and 1998 which brought about the action taken by the Health Board to address the tragic pattern. The Inquiry report notes that “it is worthy of note that [the four midwives] all trained outside the Lourdes” (p196). The midwife who made the complaint (which ultimately brought about the situation being addressed) had trained in Northern Ireland. She reported to the Inquiry a picture of “an inward looking maternity unit, where intense loyalty was shown to the obstetricians working there”. In addition, she reported 50% private care patterns, outmoded routine practices, task-oriented “nurses’ [sic] duties”, little continuity of care and that the concept of patient advocacy was unknown (p188).

The Lourdes hospital is described as having been in a “time warp” (p54). While there are references in the Inquiry report to the views of witnesses that the Lourdes was not unique in its practices, the research of the Inquiry suggests that the Lourdes hospital had particular problems. Ironically, the focus on maternity services and the dangers of uncritical acceptance of hazardous practice within the maternity services may galvanise a debate about the importance of evidence-based women-centred maternity care in Ireland. What is not being suggested is that this scarcely credible account is representative of all Irish maternity services. Nonetheless it highlights just how badly things can go wrong when midwives and other professionals work within a culture within which they cannot or do not

voice their concerns about serious issues. This stark example highlights how the maternity care environment within which midwives practice can significantly influence that practice. Therefore a review of the key features of the Irish maternity care system as a whole follows. The implications for midwives of working in the Irish maternity care system are highlighted and related to midwifery's espoused goals and values.

2.1 The Irish maternity care system

Begley & Devane (2003a) have heralded the welcome recent "resurgence of midwifery-led care" in Ireland which offers great potential for midwifery practice. This resurgence appears all the more welcome from the perspective of birthing women and midwives, against the backdrop of the highly medicalised Irish maternity services. Hyde *et al* (2004) recently chose childbirth as a case study of medicalisation in the text *Sociology for Health Professionals in Ireland*. Medicalisation refers to the process by which "more and more aspects of life come to be constructed as medical problems" (Hyde *et al* 2004 p205). Conrad (1992 p213) defines medicalisation as "seeing a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it". Childbirth in developed societies clearly falls under this description, though the perceived "problem", birth, is a natural physiological process.

The medicalisation of childbirth is reflected in both the levels of hospitalised birth and the high rates of intervention in childbirth. Hyde *et al* (2004) characterise this process as involving the move of the normative location of childbirth from home to hospital, with the birthing process managed by obstetricians rather than midwives. In Ireland, most maternity care is provided within obstetrician-led hospitals. In 1955, one third of births in Ireland took place at home (Hyde *et al* 2004). By 1998, 99% of birthing women had their babies in hospitals in Ireland (Cuidiu [Irish Childbirth Trust] 1999). In 2002, 336 (288 with independent midwives and 48 under hospital-administered schemes) women had their births at home, from a total of 60,865 births (Economic and Social Research Institute

2006)

The issue of the location of births has been a contentious and highly political one over recent decades, over which inter-professional lines can be tightly drawn (Hunt & Symonds 1995) It continues to be so, more recently replayed in the Irish context (McKenna & Matthews 2003, Murray 2004, MacFarlane 2004, Hanahoe 2004) Demand rates for home birth of between 10% and 14% are suggested in recent Irish research (Wiley & Merriman 1996, O'Donovan *et al* 2006) General Practitioners in the North-Eastern region of Ireland have been found to be quite negative about their involvement in intrapartum care, while welcoming their own involvement in antenatal and postnatal care (O'Connell *et al* 1998) This study was carried out eight years ago in a region of Ireland within which midwife-led care is being developed and systematically studied It would be useful to restudy this population about their attitudes, given their involvement in the MidU (Midwifery Unit) study in the HSE - North-Eastern Area (see page 12 below)

The homebirth rate in Ireland remains very low, though it has been increased by hospital integrated schemes in recent years The hospitalised birth pattern stems from explicit government policy regarding the location of births *Developing a Policy for Women's Health* (Department of Health 1995) reiterated government policy that childbirth should take place in consultant-staffed maternity units The *Report of the Maternity and Infant Care Scheme Review Group* (Department of Health 1997) again stated it was Department of Health policy that, on medical grounds, the delivery of babies should take place in consultant-staffed maternity units Accordingly, there are no free-standing midwife-led birthing centres in Ireland However, there are several hospital-linked community midwifery services (including DOMiciliary In and Out of Hospital (DOMINO) and home birth services) within which midwifery-led care is provided A project in Cork involves the independent midwives in the area In addition, fourteen independent midwives provide private midwifery care The review of the National Maternity Hospital pilot DOMINO project published in 2001 concluded that there were high levels of personal and professional satisfaction among midwives working in the project (Women's Health Unit,

Northern Area Health Board, 2001) These pilot projects were recently evaluated positively as part of the ongoing work of the “Expert Group on Domiciliary Births” Their evaluation has been concluded but not yet published A newspaper report suggests that the unpublished report concludes that midwives should be the lead providers for low-risk pregnancies and that the midwifery-led initiatives in the South, South-east and National Maternity Hospital should continue (Gartland 2005)

Most notably, in the North-East of the country, the region in which the Lourdes Hospital is located, there have been developments which break the mould of recent Irish maternity service provision In 2004, the NEHB commenced a pilot midwifery-led service for women “who are healthy and likely to have a normal pregnancy and labour” (The MidU Study 2006) This pilot service is being offered within the context of, and will be evaluated by, a prospective randomised trial, the MidU study Because the midwifery-led services are being set up on a pilot basis, all women who access the services will be taking part in the study Antenatal care commenced in July 2004 for women who are in early pregnancy These midwifery-led units are based in Our Lady of Lourdes Hospital in Drogheda and in Cavan General Hospital, hospitals which have obstetric services The first “MidU” birth took place on 30 December 2004 in Cavan’s midwife-led unit (The MidU Study 2006) There are two birthing rooms in each unit, with each having a water pool Women labour, birth their babies and are cared for in these rooms, without transfer to postnatal wards unless a problem develops Women are then transferred home between six and 48 hours later Thereafter, a midwife from the midwifery-led team visits the mother up to and including seven days after birth A total of 1,500 women will participate in the trial, 1,000 accessing midwifery-led care and 500 consultant-led care By April 2006, 409 women had been recruited to the study (The MidU Study 2006)

The midwifery-led units were established on the recommendation of the Maternity Services Review Group (Kinder Committee) which reported in autumn 2001 Prior to that, the first Maternity Services Review Group (Condon Group), established in 1998, had published a report in 2000 which primarily continued to support consultant-based care North-Eastern

Health Board members rejected the report and another review group (Kinder Committee) with a broader remit was set up. However, following the publication of the 2000 (Condon) report and the subsequent withdrawal of public indemnity insurance in February 2001, two maternity units (in Monaghan and Louth) were closed down. These remain closed, though the Kinder Committee also recommended that midwifery-led care should be provided in these sites at a later stage. Kennedy (2002) describes the midwifery-led developments in the North-east as a blueprint for a woman-centred quality maternity service, which is safe, accessible and sustainable. She states that it is “revolutionary in the Irish context as it is concerned with empowering women, both mothers and midwives” (p130). It is quite telling, though reasonable, that midwifery-led services must be characterised as revolutionary in an Irish context.

Notwithstanding these welcome developments, obstetric-led hospitalised maternity care is experienced by most birthing women in Ireland. Within this system, there are high rates of intervention in birth by international standards (Begley & Devane 2003b). Although somewhat dated, Cuidiu’s (1999) *Consumer Guide to Maternity Services* is the only published source of comparable maternity service data in Ireland. This document highlighted very high epidural rates for primiparous women in 1998. The highest rate was 90% for primiparous women at a private Dublin hospital. The other three Dublin public hospitals (albeit with public/private mix of patients) had rates of over 60%. Interestingly, it is noted that the low rates of epidurals in some units may have reflected limited availability rather than low uptake (Cuidiu 1999). Epidural rates have risen in most developed countries, with a rate of 66% in the USA (McGrady and Litchfield 2004). Other countries also experience variation across maternity service sites. For example, the national epidural rate was 45.7% for Canada in 2001/2 (Canadian Institute for Health Information (CIHI) 2005). There was significant variation across maternity sites and geographical areas, ranging from rates as low as 4.9%, up to 74.6%. The CIHI suggests reasons for variation in rates, including obstetricians’ attitudes and the availability of staff (particularly anaesthetists) and resources. One factor influencing women’s expectations in childbirth is the type and content of antenatal preparation they access. Hospital-based childbirth

education may be biased towards the practices that are common in those hospitals (such as epidurals) and may thus reinforce those practices (Mason 1996). Independent and community-based antenatal education offers alternatives to this influence. However antenatal preparation is not sufficient to explain this uptake of epidurals and other interventions. As Murphy-Lawless (1998 p30) states, it is “less easy to account for women’s reliance on and relationship to obstetric medicine”. This discussion is continued below when discussing postmodern approaches to the study of power (see page 67).

The World Health Organisation (WHO) has recommended that there is no clinical evidence to suggest a need for a caesarean section rate greater than 10-15% in any region (Royal College of Obstetricians and Gynaecologists (RCOG) 2001). High caesarean section rates of 20% or higher were found in 11 of the 24 maternity units in Ireland in 1998 (Cuidiu 1999). Twenty of the 23 units providing information had rates higher than 15%. In 2002, 22.4% of women gave birth by caesarean section. The ESRI (2006) reports a rise of 72% in the percentage of births by caesarean section between 1993 and 2002. The Nordic countries have kept their rates at the level recommended by the WHO, while rates for England, Wales and Northern Ireland were also greater than 20% in 2000 (RCOG, 2001). The caesarean section rates in Northern Ireland for 2002 ranged from 21.5% to 30.1% (Donegan 2006). In 2004 the rates ranged across units in Northern Ireland from 21.1% to 31.5% (BirthChoice UK 2006).

Within the medical model, birth is always viewed as potentially pathological and can therefore only be judged as normal in retrospect. Therefore, as noted by Murphy-Lawless (1998), the temptation to get it over with as quickly as possible is logical. Hence, the active management of birth was introduced as a system of birth time management. Active management of labour exemplifies a “technical rationality oriented to processing as many women as possible in the minimum time” (Hyde *et al* 2004 p213). Time management and clock-watching are central to active management (Murphy-Lawless 2000, Edwards 2001, Simonds 2002). Edwards (2001 p59) explains that “managing time manages uncertainty (the spectre of modernity and its experts) and inherent anxiety” and so is logical within this

model Kitzinger (2003) comments that the clock is an unevaluated technological intervention that has major impact on the conduct of birth. This impact is all the greater because of the cascade of interventions which stem from “insufficient progress”, as measured by the clock. Accordingly, Murphy-Lawless (2000) calls for the “re-instatement of women’s time in childbirth”, in order to return birth to women.

However, the critiques of the medicalisation of childbirth outlined above do not preclude the recognition that medical intervention is required in a small number of cases (Hyde *et al* 2004). This relates to Garry’s (2001 p262) untangling of “medicine” and “medicalisation”, written in response to Purdy’s (2001) feminist critique of medicalisation. This is an obvious but important distinction to make in the context of childbirth. Garry urges feminists critical of medicalisation not to “throw the baby [medicine] out with the bath water [medicalisation]”. The Home Birth Association (2004 p3) also acknowledges that obstetric medicine has saved and saves the lives of women and babies who might have otherwise died, but rejects it as the approach of first resort for all women. It concludes that the place of medicalised, technologised birth is where it is appropriate and required, not as a first line of care.

2.1.1 *Commercialised childbirth*

The hospital became viable for private initiative from the moment that sickness, which had come to seek a cure, was turned into a spectacle (Foucault 1994 p85).

Another key feature of Irish maternity care is its commercialised nature, specifically related to the significant role that private obstetrics plays in the system of care. All women in Ireland are entitled to free public maternity care, under the *Mother and Infant Care Scheme*. This scheme was introduced under the 1953 Health Act and eligibility was extended to all women in 1991 (Kennedy, 1996). The scheme covers the costs of ante-natal care, delivery and six weeks post-natal care of the mother and baby. The services of public hospitals and GPs are covered under the scheme. Women can choose public care (covered by this

scheme), semi-private care or private care (both of which can be partially covered by private health insurance)

The *Mother and Infant Care Scheme* applies only to hospital-based care. If a woman wishes to have a home birth and the services are not directly provided by the Health Service Executive³ or public hospital services, she may (following the 2003 Supreme Court ruling) receive limited compensation for fees for independent midwifery services. The Supreme Court judgement overturned the previous interpretation of the provisions within the 1970 Health Act for the funding of domiciliary care. The Supreme Court judged that the implication within the 1970 Act was that a home birth service would be directly provided by the Health Board itself. The Court concluded that where this is not the case, there was to be no obligation on the Health Board to fund private home births. The funding of home births by the Health Boards has been ongoing since 1970, to varying extents across Health Boards.

Despite this “free” hospital-based care, a stark feature of the Irish maternity system is the extent of private obstetric practice. This reflects a broader picture within the health service generally. The unusual public-private mix in Irish healthcare is debated by Wren (2003), Nolan & Wiley (2000) and The National Economic and Social Forum (2002). Hyde *et al* (2004 p263) describe Ireland’s public-private healthcare mix generally as a two-tier system which is associated with “systematic inequalities within healthcare”. Wren (2003 p16) similarly describes the Irish health care system as “institutionalised inequity”. She presents a full text on this topic, drawing attention particularly to public-private general practice and hospital care. While she does not focus in particular on maternity care, her analysis equally applies to the maternity services.

³ Until 2004, Irish health care services were administered by seven regional Health Boards and one Health Authority (for the larger Eastern region). Since 2004, the four “Area” structures of the Health Service Executive administer services.

O'Connor (2002) estimated that approximately 37% of women giving birth choose private obstetric health care. This is unsurprising since almost half of the population has private insurance despite a tax-funded public healthcare system. The *Health Insurance Authority* (2005) commissioned a study involving face-to-face interviews with a weighted sample of 1,002 Irish adults living in Ireland. Fifty-two per cent of the sample had private health insurance (PHI). This had increased from a similar study in 2003, within which 47% of adults had PHI (Health Insurance Authority 2003). Social class had remained a key determinant of ownership in the 2005 study (p7). In the maternity care context, Wiley & Merriman (1996) had similarly found that attendance at private antenatal clinics was associated with higher socio-economic groups.

Apart from the two private maternity hospitals in Ireland, the remaining "private patients" give birth in public hospitals, the "accommodation" costs of which are paid by themselves and private health insurers to the public system. Private health insurers generally cover consultants' fees directly (though women pay an excess of approximately €2,000 per pregnancy/delivery themselves). Hyde *et al* (2004) describe obstetrics practice in Ireland as a lucrative business. Ireland is not unique in that sense and Clarke (1995 p248) claims that, from the eighteenth century, doctors were "vigorously determined to gain access to the lucrative and previously untapped market of childbirth". Similarly Witz (1992 p56) refers to the creation of a "professional market" in childbirth with the movement of medicine into that area. She describes early developments following midwifery registration as ensuring that "the rich would employ the services of doctors and the poor would employ those of midwives" (Witz 1992 p 116). Nearly one hundred years later, this could also describe current Irish maternity service patterns.

2.2 Medicalised childbirth: the implications for midwives

The system of maternity care described above provides a challenging practice environment for midwives. The challenges relate to midwives' espoused goals of midwifery, in terms of autonomous and women-centred practice (An Bord Altranais 2001, ICM 2005). The implications of medicalised birth for these two aspects of midwifery practice are examined

2.2.1 *Autonomous practice*

Medicalised childbirth challenges the very stated identity and role of the midwife as an autonomous practitioner. Independent practice is described as “the primary distinguishing characteristic of midwifery” (Symonds & Hunt 1996 p29). This is what midwives state in order to distinguish themselves from nurses. The midwife is heralded as the most appropriate professional to look after women fully in uncomplicated pregnancy, labour and the puerperium. The WHO (1997 p9) states that

the midwife appears to be the most appropriate and cost-effective type of healthcare provider to be assigned to the care of normal pregnancy and normal birth, including risk assessment and the recognition of complications

However the WHO also recognised that

in many industrialised countries midwives function in hospitals under supervision of obstetricians. Usually this means that care in normal birth is part of the whole obstetrics department, and thus subject to the same rules and arrangements, with little distinction between high-risk and low-risk pregnancies (1997 p8)

This is an explicit acknowledgement of the effects of hospitalisation on women’s care and midwifery. Murphy-Lawless (1991) characterises midwives working within the medical model as being “piggy in the middle”. This is reflected in other literature (Kirkham 1999, Stapleton *et al* 2002) which highlights the difficulties midwives face in trying to fulfill their role in a medicalised environment. It is difficult to meet women’s needs within a medicalised institutionalised “technocratic” (Kitzinger 2005 p7) childbirth culture. This is due to the lack of authority that midwives have within this system, based on the medical “ownership” of birthing women. Murphy-Lawless (1998 p231) highlights that even when midwives are left to conduct the vast majority of births in a maternity hospital, they “work within and are directed by the power/knowledge system of obstetrics”. An interesting example of this is found in relation to the Midwives’ Clinic of an Irish regional maternity hospital. The policy guidelines drawn up in 2004 include the following points

- “An obstetrician sees all women at their first ante-natal visit”

- “The obstetrician will note their suitability to attend the Midwives Clinic on the booking visit”
- “Antenatal care is shared by the midwife and the General Practitioner”
- “At term women are referred back to the Obstetrician/Registrar”
- “Antenatal care in Midwives Clinic is provided by a small number of midwives thus providing continuity of care and carer throughout the antenatal period”

(Regional Maternity Hospital, Health Service Executive- Midwestern Area 2004)

Notwithstanding the limits of the (antenatal) continuity offered, this care clearly takes place within medically sanctioned parameters, shared with medical practitioners and returned to them “at term”

2 2 2 *Women-centred practice*

As well as independent practice, midwives also espouse women-centred practice. This can be articulated in different ways, using concepts such as caring, advocacy and partnership

2 2 2 1 Caring

The relationship between a midwife and a woman is seen to be of central importance to a woman’s experience. “In the end the relationship between a woman and a midwife lies at the heart of the birth process” (Vague 2001 p13). However, the process-nature of medicalised, institutionalised maternity services de-emphasise relationships (Edwards 2005). Begley & Devane (2003b p28) point to the “diminution of emphasis given to the importance of caring for the emotions” associated with medicalised birth. Begley (2002) points out that working within an industrial or economic model leaves little time for caring which is a source of frustration for midwives. Linked with this model of care, Herdman (2004) claims that “McDonaldization” has spread to many areas of social life, including “routine procedures for childbirth”. Efficiency, consumerism and rationalisation are the values which predominate in this culture, she claims. Furthermore, Mestrovic (1997) has described a “post-emotional” society, within which emotions are reduced to “bite-sized, pre-packaged” entities which, within the medical model, are manageable. Kitzinger (2000) claims that within the “technocratic model of birth”, emotional and spiritual aspects of birth

are ignored or treated as embarrassing. All of these patterns of consumerism, productivity and lack of emotion affect midwives, women and their relationships.

Traits such as “warmth” (Vague 2001), “caring” (Halldorsdottir & Karlsdottir 1996) and even “love” (Walsh & Newburn 2002 p476) are associated with positive accounts of midwifery. In a small study involving interviews with three mothers and their midwives, Vague (2001) concluded that time and continuity were key factors associated with ‘warm professional’. She stated that these factors were more easily facilitated when care was provided in the community rather than in the hospital. This was exemplified by the fact that a hospital based midwife commonly meets the woman for the first time when she is in labour. Time and continuity make it possible to build communication which “seems to form the core of the caring model” according to Vague (2001 p13). This in turn enhances the woman’s sense of security. The lack of continuity of midwifery care for most women in Ireland makes the achievement of this model of care impossible.

Discussing the notion of caring in a midwifery context may seem paternalistic, interfering with the woman’s autonomy. In a nursing context, McCance *et al* (1997) identify the following as critical attributes of caring: serious attention, concern, providing for and getting to know the patient. These notions are those also articulated in terms of the relationship between a midwife and a woman that is seen to be of central importance to a woman’s experience (Too 1996a, 1996b, Halldorsdottir & Karlsdottir 1996). Scott (2000 p123) states that many of nurses’ activities are with human beings who are “rendered vulnerable due to their illness and/or the process of institutionalised care”. Midwives and birthing women stress that pregnancy and birth are not illnesses, however institutionalised care is a feature of modern maternity care. Birthing women’s vulnerability in this context requires that midwives care about and for them. On the other hand, negative midwifery traits such as being uncaring or discouraging were found to be associated with women’s negative experiences of birth (Halldorsdottir & Karlsdottir 1996).

The participants in Levy's (1999) grounded theory study described the circumstances by which midwives, in their stated goal of facilitating informed choices for birthing women, thought it justifiable on some occasions to "frighten" a woman into following a particular course of action to protect her or the baby's physical safety. Midwives "released information to guide the women towards choosing courses of action perceived as safe by the midwife" (p111). Concerns for safety, arguably, should not preclude an emotionally sensitive response. Midwives also "gatekept information to protect themselves", in terms of their clinical credibility and their professional territory. Where birthing women's wishes were in conflict with midwives' wishes, midwives used their power to impose the latter. This appears at odds with women-centred claims. Midwives' exercise of power over women was explicitly studied by Sinivaara *et al* (2004). They carried out a survey of delivery care staff (midwives and nurses) (n=155) working in the delivery wards of four Finnish hospitals on their opinions about the exercise of power over birthing women. Their conclusion about their findings stresses that the exercise of power is not always negative and they summarise that "in respondents' opinions they worked for women's good and aimed at relationships based on a sense of equality and individuality" (p33). However the findings are pessimistic in a way that is not highlighted by the authors. Delivery staff stated that they made decisions on behalf of frightened women, quiet women, women with disabilities and women from different ethnic backgrounds. Women who were "aggressive", "insulting" and "distressed" were amongst those who were given limited information. Sixty-two percent of staff disagreed that the decision for pain relief is always left up to the client. Sinivaara *et al* (2004) state that it is difficult for carers to know exactly how much information they need to give in order that a woman can make an informed decision (p40). These findings suggest that there are other more serious problems highlighted by the research, which the authors appear to downplay.

2.2.2.2 Advocacy

Within the umbrella aspiration of women-centred care, advocacy is also espoused as a midwifery goal nationally and internationally (An Bord Altranais 2001, International Confederation of Midwives 2003). The "normal" sense of advocacy (Seedhouse 2000) is

reflected within the definition used by the *National Council for the Professional Development of Nursing and Midwifery* (2001 p9) which states that advocacy involves

communication, negotiation and representation of the client/patient values and decisions in collaboration with other professionals and community resource providers

Advocacy within this sense (involving loyalty, independence, confidentiality) appears difficult within most contractual employment contexts, since there will be a prior loyalty to the employer and a clear lack of independence (Miller *et al* 1990, Trandel-Koreenchuk and Trandel-Koreenchuk 1990, Hewitt 2002) The ability to negotiate on behalf of and represent individual women or women collectively assumes that midwives are in a position of power and authority to do so. Additionally the idea that a birthing woman needs an advocate also raises questions about the recognition of women's own birthing autonomy. This seems contrary to the notion of empowering birthing women themselves (Falk-Rafael 1995). There may also be fears of paternalism and the imposition of professionals' views (Allmark and Klarzynski 1992). The nursing literature offers many debates as to the desirability and/or possibility of advocacy in nursing (Bird 1994, Willard 1996, Hewitt 2002). The concept of advocacy has not been directly debated in the midwifery literature, although the studies discussed above (for example, Levy 1999) relate to its meaning. Advocacy, though widely espoused, remains a contested and controversial goal of midwifery practice.

2.2.2.3 Partnership

The notion of partnership addresses the issue of the relative roles of the midwife and birthing woman which advocacy raises. Partnership is espoused by midwives in Ireland (An Bord Altranais 2001) and internationally (ICM 2005). The partnership model is described as "one of equity where the midwife brings her knowledge, skills and experience and the woman brings her knowledge of herself and her family and her needs and wishes for her pregnancy and birth" (Pairman 2001 p7). However, similar to the case of advocacy, whether partnership is or can be reflected in institutionalised midwifery practice in reality has also been challenged. Stapleton *et al* (2002) found that loyalties and obligations to the

employer, other professionals and managers were stronger forces than partnerships with women. While this inescapably relates to the organisational context of practice, the difficulties of its achievement need to be openly debated. The authors of that study acknowledge that “going with the flow” of obstetric opinion was logical self-preserving behaviour on the part of the midwife. Murphy-Lawless (1991) also described midwives’ coping strategies as covert, rather than openly challenging the system. Research suggests that whatever midwives’ intentions about partnership are, women appear to be more aware of the “medical side” of midwives’ contact with them (Fleming 1998a, Murphy-Lawless 2002, Nolan 1999). Fleming’s (1998a) research focused on some of the contradictions apparent within midwives’ and consumers’ views of the same experiences. Women saw midwives as the “medical half” of the relationship, which was not that different to their previous interaction with obstetricians. Fleming stresses that it takes time to develop a participatory approach amongst women who are conditioned in a medicalised one and that midwives need to celebrate what is different about midwifery care. Many of Hunt & Symonds’s (1995) findings of an ethnographic study within the labour ward setting do not seem consistent with a partnership approach. For example, some midwives used “pet names” (“love”, “girlie”) which women found patronising (p81). Some midwives treated “deviant” mothers (on the basis of hygiene, weight, social status) differently (p93).

If there are limits to partnership at an individual level, the aggregate social or political level may provide more fruitful ground. Edwards (2001) claims that the future of midwifery and its innovations depends on how they mesh with political agendas. She describes midwifery by its very nature as “a political animal, often too sleepy an animal for its own good”. Roch (1996 xiii) in the Foreword to Symonds & Hunt’s book *The Midwife and Society* agrees that

midwives are sceptical of politics, even with a small ‘p’ and have only slowly begun to realise that political naivety is both dangerous and diminishing

Roch suggests that gaining an understanding of the sociological context of midwifery practice is a prerequisite for attaining that “proper political perspective”. It appears that

where midwives do engage politically for changes that will positively affect their practice, there can be positive outcomes for themselves and birthing women

Pairman (2001 p7) points out that while changes can be made to maternity systems in countries through legislation, the “most significant change comes from socialisation of midwives, and women, to a new way of looking at maternity services” Fleming (2000 p193) agrees that the legislation was just the vehicle through which change could happen, midwives had to “take up the challenge to foster creative ways of practising” Fleming (1998b) attributes the enactment of new legislation in 1990 in New Zealand (which returned to midwives the right to practice independently of the medical profession) to the combined efforts of both midwives and consumers who campaigned throughout the late 1980s for midwifery autonomy Hendry (2001) describes the opportunistic positioning of the midwifery profession in New Zealand which enabled their transition to autonomous practice in the 1990s The *New Zealand College of Midwives* was formed in 1989, following a breakaway from nursing colleagues, to stem the “nursification of midwifery” (Hendry 2001 p11) Hendry draws attention to the wider social and political contexts in which midwifery policy evolves, stating that in New Zealand,

the power of the women’s health consumer movement and the democratisation of the political environment at the time must be seen to be a key force in achieving what was achieved and thus politically aware midwives and midwife leaders seized the opportunities that presented (2001 p15)

In a UK context, Stapleton *et al* (2002 p610) says that explicit strategies are needed to achieve massive cultural change and a response that is woman-centred can only be made in alliance with service users On the basis of her research on women’s experiences of planning homebirths in Scotland, Edwards (2001) states that women needed midwives to engage with and support the women’s ethical stances about childbirth and provide opportunities to meet their needs But midwives were unable to do this within the framework of medicalised and fragmented care if midwives are not autonomous enough,

they cannot protect the woman's autonomy Edwards links this to empowerment, stating that "disempowered midwives disempower women" (p336) She concludes that women and midwives need similar ideological changes about the value and social nature of birth within society Midwives need supportive work cultures, due to the emotional nature of their work (Hunter 2001) Hunt & Symonds (1995 p20) highlight that it is involvement in emotional labour that defines the "semi-professional" status with which midwives have been characterised

Nolan (1999) found within her study of antenatal education that it is difficult for midwives to empower their clients when they themselves are undermined by the cultural and organisational tension of trying to deliver woman-centred care in a hierarchical system Kirkham (1999) states that trust, support and respect are the factors that will change the disempowering environment within which midwives currently work, to an empowering one Kirkham & Stapleton (2000) state that the current culture of midwifery in the UK must change They described a blaming culture as one which silences midwives' voices and called for a nurturing and generative culture They state that this requires support for midwives who otherwise do not have the capacity to provide optimum care for birthing women In an Irish context, the tragic impact of a blaming and silencing maternity service culture on women's experiences was exemplified within the findings of the recent *Lourdes Inquiry* report discussed above (see page 8)

In an Irish context, Murphy-Lawless (1998) calls for those who engage as users and practitioners to displace the hegemonic obstetric grasp of childbirth and to overturn obstetrics' claim and status In Ireland there are several groups which campaign on childbirth, including the Home Birth Association of Ireland (HBAI), Cuidiu- the Irish Childbirth Trust and the National Birth Alliance, La Leche League and the Irish branch of the Association for the Improvement of Maternity Services (AIMS) There are also local groups in the locations in which pilot community midwifery projects have been established These childbirth-focused groups share many aims with each other Indeed these groups share their aims with midwives' stated aims and values However at times quite polarised

and divisive debates take place between hospital-based midwives and these groups. At the recent joint conference of the Irish Nurses Organisation (INO) (Midwives Section) and the Royal College of Midwives (RCM) (Northern Ireland), calls for enhanced partnerships were made. The Home Birth Association of Ireland recently hosted a talk on *Midwives and women working together for improvements in maternity services* (Home Birth Association of Ireland 2006). These are positive developments, though it seems to be an area in which considerable constructive work needs to happen in order to match the achievements of New Zealand and elsewhere. There are clear lessons to be learnt which can enhance midwifery in Ireland and the Irish maternity services.

This discussion about the implications of working within medicalised childbirth highlights the difficulties in achieving the espoused aims of autonomous, women-centred midwifery practice. It also emphasises the experiences within other countries from which Irish midwives can learn. The medicalised structures within which most midwives practising in Ireland work, clearly do challenge their practice. However responsibility for the capacity of an individual midwife to respond appropriately and sensitively cannot be exclusively laid at the door of “structures” or organisations. This discussion about the relative role of the individual and structures within which they practice, links to competing perspectives on power and empowerment which are discussed in chapter 3 (see page 62). Before considering these perspectives in the next chapter, recent research on midwifery in Ireland is reviewed.

2.3 Research on midwifery in Ireland

The structural context described above and the literature about the constraints on midwives working within medicalised childbirth pose challenges for midwives practising in Ireland. In this context, the findings of recent consultations and research with midwives in Ireland are analysed.

During recent consultations, midwives practising in Ireland have stated their dissatisfactions about their lack of identity within the dominant “medical model” of

maternity services (*Commission on Nursing Reports 1997, 1998, Review of the Scope of Practice Reports* (An Bord Altranais 1999, 2000b)) These findings are outlined below

Following a recommendation from the Irish Labour Court, the *Commission on Nursing* was established by the Minister for Health in March 1997 to examine issues relating to both nursing and midwifery This followed the Court's deliberations on a series of industrial relations issues between the *Nursing Alliance* (of unions) and health service employers During the consultation process undertaken by the Commission on Nursing, midwives expressed the view that midwifery practice had become increasingly constrained in recent years They stated that midwives were becoming de-skilled in practice within medicalised services It was suggested that midwifery provided substantial scope for the development of woman-centred care before, during and after pregnancy

It is recorded that midwives were calling for the "the explicit acknowledgment of their distinct identity" which is linked with

the establishment of a Statutory Midwives Committee to reflect the different concerns and needs of midwives (Section 4 44/5 *Commission on Nursing Final Report*, An Bord Altranais 1998)

The Commission duly recommended that amending legislation should take account of the distinct midwifery identity It recommended that there be no provision in future that "the word 'nurse' includes 'midwife'", as was the case since the 1950 Nurses Act Section 4 44 of the Commission's report concluded with the suggestion that the matter of the terminology ("nurse includes 'midwife'") "is a small point but it is one which causes a lot of resentment" One could argue as to whether this is in fact a small point since it has clear indications of and implications for midwifery's visibility Ironically while the Commission itself examined both nursing and midwifery issues, because of this clause in the 1950 Act, it was called the *Commission on Nursing* and not the 'Commission on Nursing and Midwifery' The background to and impact of this Act are examined in depth in chapter 5

To address the recommendation pertaining to inclusion in legislation of the term midwife, two options were proposed. Firstly it was suggested that “midwife” was inserted in each place that “nurse” appears in the 1985 Act. Alternatively it was suggested that new legislation should use both nurse and midwife and be called a “Nurses and Midwives Act”. The Commission also recommended that a Statutory Midwives Committee be re-instated within An Bord Altranais. A Statutory Midwives’ Committee existed from 1951 to 1985. This Committee was established in tandem with the abolition of the Central Midwives Board via the 1950 Nurses Act which established An Bord Altranais (in line with Central Midwives Board minutes Central Midwives Board is used, rather than Central Midwives’ Board). Although the Commission recommended that such amending legislation be brought before the Oireachtas during 1999, it is still awaited. The lack of progress on these recommendations appears to highlight their lack of relative priority for the Department of Health and Children. The need to enact this legislation is highlighted in chapter 8. The primary historical research undertaken in this study explicitly examines the background to the 1950 Nurses Act, and its implications for midwifery, which has necessitated these changes.

An Bord Altranais carried out a project to review the scope of practice of nursing and midwifery between 1998-2000. During the consultations undertaken within this review, midwives again stated that they wished to be viewed as a profession distinct from nurses (An Bord Altranais 1999). A key issue which arose was that midwives wished to practise according to the internationally accepted definition of a midwife (WHO/FIGO/ICM 1992, [ICM amended definition 2005]). The report states that midwives pointed out that they were unable to practise at the level outlined in the WHO definition and the EEC Directive, documents which espouse independent women-centred practice. They reported experiencing difficulty with the medicalisation of maternity services and stated that they and others (including doctors and birthing women) perceive that their only role was to facilitate the obstetrician. They felt that midwifery and medical management structures are often unsupportive in empowering midwives to fulfill their midwifery role. Some midwives expressed a fear of speaking out, linking this to past experience of being socialised to “keep

their heads down” and not query or question the management structures. Midwives perceived that they have a lack of power within hospital structures which restricts their practice. They felt that they should be empowered and enabled to make scope of practice decisions with due regard to the relevant legislation and guidelines (An Bord Altranais 1999)

The consultations undertaken for the *Commission on Nursing* and the *Review of Scope of Practice* provide a flavour of the issues which are of concern to midwives. However, views gathered during such consultations have limitations in terms of judgement about representativeness, in contrast to studies which use adequately-sized random samples. However, many of the findings of these consultations are reflected in the findings of other recent Irish research on midwifery practice (Begley 1997, Pitman 2004, Hyde & Roche-Reid 2004). These studies also highlight the current concerns of midwives about the constraints under which they practice. In particular, issues relating to the structure of maternity services and midwifery management are highlighted.

Hyde & Roche-Reid (2004) carried out a qualitative study of midwives’ perceptions of their role within the Irish maternity system. Names of midwives who volunteered to take part in the study were passed to the researcher by clinical midwife managers in the labour wards of the three Dublin maternity hospitals. Four midwives who met the inclusion criteria from each of the three hospitals were selected from this list by the researchers. The authors do not comment on the implicit gate-keeping role played by managers and they do not state how many names were submitted. They do comment that Clinical Midwife Managers 2 (CMM2s) were included as they had a caseload.

The authors’ findings were presented under the themes “autonomy and centrality of the subject”, “the mastery of science over nature” and “the colonization of the life-world by an over-extended technocratic rationality” (Hyde & Roche-Reid 2004 p2618). Within the first theme, the findings suggest that the midwives did espouse the autonomy and centrality of the birthing woman. However, this was constrained, as described under the second two

themes Science was seen to master over nature for reasons other than the health and well-being of the mother or baby These reasons included the individual preferences of obstetricians, convenience because of staff shortages or because a woman was a private patient The authors conclude that labour was accelerated for “industrial” reasons so as to process as many women as possible in the shortest possible time They state that these findings lend empirical support to the construction of a modern maternity hospital as a factory with “reproduction as a form of production”

Hyde & Roche-Reid’s (2004) portrayal reflects Begley’s (1997) conclusion to her longitudinal study of the experiences of student midwives who began their midwifery training in Ireland in 1995 She suggests that the maternity services in Ireland are based on an economic or industrial model This model emphasises the hospital’s needs rather than the woman’s, resulting in process-centred care for women Hunt & Symonds (1995 p139) also liken the organisation of hospital birth to that of a “factory production process”, though one involving the skilled labour of midwives Begley (1997 p345) suggests that within this industrial model “midwives certainly are exhibiting all the signs of an oppressed group” She bases this on the horizontal bullying and hierarchical management of midwives Begley’s (1997 pp532-3) research revealed a level of “bullying, disrespect and belligerent behaviour” that can be characterised as “horizontal violence” of an oppressed group The students made frequent reference to the way in which women were treated by staff which illustrated the process-centred type of care “Women were on occasions subjected to overcrowding, virtual neglect, lack of continuity of care, harassment and rudeness”

The students in Begley’s (2001b) study themselves experienced differential treatment in a “them and us” type scenario vis-a-vis staff midwives This demarcation of work gave student midwives limited preparation for being qualified midwives, the stated purpose of their programme These students drew on positive role models, though Begley acknowledges that the strong powers of socialisation may result in them being more like those they criticise

The detrimental effects of the hierarchical style of management for students' learning are discussed by Begley (2001a). Begley cautioned that this boded ill for student midwives and child-bearing women alike. Specifically discussing the "hierarchical nature of midwifery organization", Begley (2002 p313) cites one participant who described the problem as "women doing it to themselves in the midwifery situation". This hierarchical structure within which there is a dislike of change and of the "putative troublemaker" ensures that "midwives will always be their own worst enemy" (p315). This horizontal violence resonates with what Roberts (1983 p23) describes as being proposed by oppressors as constituting "proof that oppressed persons are unable to govern themselves". She suggests that this behaviour facilitates the maintenance of the status quo, as claimed within oppressed group theory.

Serious issues for midwifery students, and midwives generally, are highlighted through Begley's comprehensive mixed-methodological research. This field-work took place between 1995 and 1997. There have been few changes since then which would suggest an improvement to the situation, as suggested by Pitman's (2004) research findings below. The recently approved direct entry degree level midwifery education and the associated integration of midwifery education into the third level sector offer scope for addressing some of the problems identified in Begley's research. These welcome developments are based on the recommendations of the *Expert Group on Midwifery and Children's Nursing Education* (2004).

Other recent research in the Dublin maternity hospitals has highlighted many of the same issues. Pitman (2004) carried out a study of the factors that influence recruitment and retention of midwives and nurses in the three public Dublin maternity hospitals. From the population of 820 midwives employed by the hospitals, a stratified random sample of 269 was selected and invited to take part in a cross-sectional survey. A total of 175 questionnaires were returned, a response rate of 64%. From that sample, 86% (n=151) were midwives and 14% (n=24) were nurses (p24). Pitman does not explain the nursing presence

in the sample, though these nurses probably work in neonatal care (see page 230 below where this issue is discussed further)

The background to Pitman's study was one of acknowledged ongoing problems with recruitment and retention of midwives in the three maternity hospitals (Pitman 2004) Although Pitman's findings are limited to the three Dublin maternity hospitals, these are the three largest training hospitals in the country, so these findings have important national implications for midwives and birthing women Midwives were dissatisfied with physical work conditions, recognition, rate of pay, industrial relations, chance of promotion, organisational management, and attention paid to suggestions that they made to improve the work environment Respondents expressed the highest level of concern on three key statements the increasing threat of litigation, stress, and clients becoming too demanding In addition a high percentage of respondents felt that they were not able to develop meaningful relationships with clients, although the majority of respondents felt that women and babies receive an appropriate standard of care and they as midwives are able to provide the type of care that they want to On the positive side, midwives reported high levels of collegial support, recognition from doctors for their midwifery skills and that as midwives they valued a feeling of pride in a job well done, feeling responsibility for one's work Just under half of respondents were optimistic about the future of midwifery

Juxtaposed, these findings are interesting clients are viewed as demanding, midwives were unable to form meaningful relationships with them, yet they felt that an appropriate standard of care was given The perceived "appropriate standard of care" thus appears to be quite low, if one views this as being characterised by a lack of meaningful relationships with demanding clients This suggests that midwives may be reluctant to judge the standard of their care negatively, while still being able to highlight the constraints under which they work This challenges the reality of women-centred care as described above References elsewhere in the report to stress, litigation threats, bullying and lack of senior management support may contribute to this ambivalence towards real partnership In particular midwives complained that low staffing levels frequently impacted on the quality of care This is

reflected in other sources (Department of Health and Children 2000b, 2002, Expert Group on Midwifery and Children's Nursing Education 2004) Pitman's findings are at times contradictory, reflecting the complexity of the midwifery role, in particular the tension between intrinsically "enjoying" being a midwife and feeling unsupported and undervalued within organisational settings. These findings point to the problems that Begley's (1997) research identified. The positive nature of collegial support and a belief in the value of midwifery are also highlighted. Problems which affect retention that were stressed include lack of access to opportunities for further education and inadequate staffing levels. Clearly the fact that this research was carried out on behalf of the Dublin maternity hospitals signals that problems associated with retaining midwives are acknowledged. The publication of the report in itself is also positive. The extent of the implementation of the actions to address the issues identified remains to be seen.

The studies reported above have particular key strengths in terms of their foci, designs and samples. Begley's (1997) work represents a comprehensive study of every midwifery training site in Ireland in the years of the study. While the focus was on midwifery students' experiences, the findings have implications far beyond education. A key contribution of this study was the overarching critique of the economic model of Irish maternity services. This was also highlighted by Hyde & Roche-Reid (2004), in their small-scale study in the labour ward setting. Pitman's (2004) study specifically focused on the recruitment and retention of midwives. While limited to the Dublin maternity hospitals, it highlighted many of the same problems that Begley's research had identified. Begley's study was a national one, while Pitman and Hyde & Roche-Reid's focused on the public Dublin maternity hospitals. There has been a relative dearth of research, with midwives, about midwifery practice undertaken outside Dublin. The three Dublin maternity hospitals account for approximately one third of national births, so most women give birth and most midwives practice outside Dublin. This suggests that national research on midwifery practice is required to supplement the findings analysed above. Preliminary analysis of the focus group data within the national study on empowerment (Scott *et al* 2003) suggested that a focus on midwifery through the lens of empowerment might be a useful means of

addressing midwives' concerns. These focus group findings are presented in the following section.

The national study on empowerment in nursing and midwifery (Scott *et al* 2003), an element of which comprises survey 1 of this thesis, provides further national data on midwifery practice and practice environments, viewed through the lens of empowerment. The first phase of that research involved the use of focus groups and these findings suggested interesting issues for empowerment in midwifery that warranted further study. These initial findings are presented in the following section.

During the initial stages of analysis of the focus group data, gathered during phase 1 of a national study of *Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland* (Scott *et al* 2003), it appeared that both nurse and midwife participants perceived that empowerment needed to be considered differently for midwives vis-a-vis nurses. Participants suggested that midwifery offered more potential than nursing for empowered practice, based on the notion that midwives are autonomous practitioners. Focus group participants discussed the under-utilisation of midwifery skills within the current consultant-led maternity services. Illustrating these themes, one midwife commented,

I feel that midwifery in particular has great scope for empowerment but then you have the problem of the medical obstetrics midwifery has turned more into an obstetric model than a midwifery model (FGD 4)

This suggests that the potential for empowered autonomous practice is constrained within the medical model, consistent with the literature described above. The effects of private maternity care were commented on by another midwife as follows,

[it] has a lot to do with money. In Ireland the women like to go to an obstetrician, it's a huge fee, the obstetricians don't actually spend very much time with the women, they're in and out in two or three minute consultations. Whereas

the care would probably be better if there was a midwife looking after them (FGD 8)

This quote highlights the process and time-constrained nature of maternity consultations with the private medicalised Irish system. The midwife was proposing that care would be better under a midwife, though clearly under the same process-type model, time would still be limited.

Reference was also made to midwifery education and its disempowering effects. One participant reported very negative experiences with going back to train as a midwife, having been a senior staff nurse,

when I went back to being a student again I was completely disempowered, it's the system the way it knocks against you (FGD 3)

This directly reflects Begley's (1997) findings about student midwives' experiences. On a positive note, participants also proposed that midwives are empowered through their work with women and through midwife-led services where these are in operation. One midwife commented that,

the fact that I run a midwife clinic for ante-natal patients that would be empowerment for midwives (FGD 3)

As suggested above, midwife-led care within hospitalised, obstetric-led environment is limited (see page 18). However, this is clearly positively perceived by midwives, as illustrated by the above quote. Compared to other midwifery allocations within maternity services, the midwives' clinic is relatively empowering.

These preliminary focus group findings suggested that midwives were able and willing to relate the notion of empowerment to the issues that concern them, the same sorts of issues

that had arisen in the other studies cited above. This indicated that further study of empowerment against the background described above would be fruitful and this was undertaken in this study.

2.4 Summary of key current issues for midwifery in Ireland

There are several key issues highlighted in this chapter. Notwithstanding recent initiatives, the maternity services in Ireland are highly medicalised, based on explicit government policy. This involves high rates of hospital births and interventions. The high rates of private obstetric practice reflect the two-tier nature of Irish health service generally. In a maternity context, this particularly affects midwifery practice, since midwives' autonomous practice is necessarily curtailed where women book for maternity care with a private obstetrician. This obstetrician sees women on each antenatal visit and guarantees to be at the birth. Even without this feature, all women book with an obstetric team, except those who access full midwifery-led care. This is increasingly available, though still limited to certain sites mentioned above. The prospective trial comparing the outcomes of midwife-led and obstetrician-led care in the North-eastern region currently being undertaken, offers great potential for evidence-based developments of midwife-led care in the future.

Within the broadly medicalised structural context described, midwives understandably report that they are dissatisfied with the lack of fulfilment of their midwifery role as laid out in definition and scope of practice statements from An Bord Altranais. They also report problems with midwifery training that fails to meet their education and development needs and other key issues such as autocratic management styles and workplace bullying. Research suggests that midwives intrinsically enjoy their work with birthing women. Midwives report having high levels of support from their midwifery colleagues. It is difficult to know when the constraints described will erode these positive vestiges of midwives' satisfaction with their clinical practice.

Midwives have also complained that they lack an identity that is distinct from nursing. This in part stems from the impact of the 1950 Nurses Act on midwifery. This Act saw the

abolition of the Central Midwives Board and the introduction of the clause into legislation that “nurse includes midwife” This is specifically explored in depth in chapter 5 which presents the findings of primary historical research undertaken into the background to and impact on midwifery of the 1950 Nurses Act

Related to all of these problems, there have been ongoing issues with attracting potential midwives The issue of attracting people to midwifery has been addressed by the work of the *Expert Group on Midwifery and Children’s Nursing Education* (2004) The *Expert Group* recommended the introduction of a direct entry midwifery degree and the integration of midwifery education with third levels institutes These recommendations have been approved and signal welcome opportunities for midwifery There have also been ongoing problems with recruiting and retaining midwives, especially in the Dublin maternity hospitals These issues have been addressed in part by the work of the *Steering Group on Recruitment and Retention in the Dublin Maternity Hospitals*, and research which focused on these concerns (Pitman 2004)

The studies reviewed in this chapter provide insights into midwifery practice and practice environments in Ireland Calls for the empowerment of midwives which have been made nationally and internationally must be considered in the context outlined in this chapter Within that context, there are many issues that relate to power in midwifery practice between doctors and midwives, managers and midwives and birthing women and midwives If the term empowerment is to have relevance and utility for midwifery, further examination of the concept of empowerment and power in the midwifery context is required and this is addressed in chapter 3

CHAPTER 3

EMPOWERMENT AND POWER A LITERATURE REVIEW

In every discussion, my dear boy, there is one and only one way of beginning if one is to come to a sound conclusion, that is to know what one is discussing, otherwise one is bound to entirely miss the mark. Now most people are unaware that they are ignorant of the essential nature of their subject.

Socrates's first speech in Plato's *Phaedrus* (Hamilton 1973 p15)

This study explores perspectives on empowerment and power in midwifery. Empowerment is not a new concept. Calls for the empowerment of healthcare users and workers have been made since the late 1970s. The term is liberally and variously used across healthcare and many other diverse areas. Because of this, empowerment and power have been written about and researched within a wide range of disciplines and contexts. This chapter reviews several perspectives on empowerment and its constitutive root 'power' which are prominent in this literature. The consideration of the concepts of empowerment and power take place within the explicit understanding of the context of midwifery practice described in chapter 2.

3.1 Literature search strategy

The literature reviewed was periodically accessed over the full course of this study from 2001 to 2006 using electronic databases such as Medline, CINAHL, Healthsource and Blackwell, with no date limits. Searches were made using appropriate database subject headings and the keywords "empowerment", "power" and "midwifery". As the study developed, other key related terms, such as autonomy, advocacy and partnership, were also used. Searches made use of broader terms, narrower terms, Boolean operators (and, or) and truncated terms. Searches used limits where appropriate (for example, peer-reviewed journals only). A search of the Cochrane Library's Reviews of relevant areas was also conducted. In addition, all available scholarly and lay book literature on midwifery and childbirth in Ireland and elsewhere was accessed. Key PhD theses were studied, in particular those of Begley (1997), Edwards (2001) and Leamy (2000) as well as PhD-based

texts such as those of Murphy-Lawless (1998) and Kennedy (2002)

3.2 Introducing the concept of empowerment

The language of empowerment trips too lightly off the tongue
Mullender & Ward (1991 p3)

More than twenty years ago, Kieffer (1984) stated that empowerment was ‘coming of age’ in a community development context. He argued then that while the idea of empowerment was appealing, its utility had been limited by conceptual ambiguity. To address this, he identified the need to clarify the term’s meaning. This advice is important within a midwifery context more than twenty years later. Writing about the empowerment of social work services users, Mullender & Ward (1991 p1) suggested that the use of the term empowerment might act “as a social ‘aerosol’ covering up the disturbing smell of conflict and conceptual division”. The authors, writing from a social work perspective almost fifteen years ago, stated that empowerment was a new buzz word that had entered the vocabulary of that discipline. If not satisfactorily explicated, as is currently the case in midwifery, this term is merely seen as a buzzword.

While the term empowerment is mentioned in the midwifery literature, it is not dealt with extensively within a midwifery context. In contrast, there is a vast nursing literature on empowerment. A feature of this literature is a tendency to describe empowerment as a pervasive, complex, multi-faceted, ambiguous, subjective and contested term (Gilbert 1995, Rodwell 1996, Ryles 1999, Lewis & Urmston 2000). Authors writing about empowerment often introduce their papers by stating that the use of the term varies between disciplines and is thus ambiguous (Hokanson Hawks 1992, Gilbert 1995, Ellis-Stoll & Popkess-Vawter 1998, Ryles 1999, Kuokkanen & Leino-Kilpi 2000). References to the ambiguity and complexity of empowerment ironically appear to facilitate a sort of resignation regarding the elusiveness of empowerment and the impossibility of defining it. For example, Ryles

(1999 p601) introducing a “concept analysis” of empowerment in mental health nursing, refers to empowerment literature in the fields of clinical sociology, social work, community psychology and health promotion and concludes that “the review reveals that there is a degree of ambiguity in the way empowerment is described” Ryles stated that he was reviewing literature on empowerment from these fields to see if there existed an agreement and therefore “a level of conceptual maturity between these disciplines as to the exact nature of empowerment within the ‘caring’ services” Such a search was futile, there could not be “an exact nature of empowerment within the ‘caring’ services”, rather, there will be a myriad of natures of empowerment within multiple contexts in the ‘caring’ services This illustrates a failure to acknowledge that empowerment will have multiple forms in different contexts This highlights that empowerment is a means to an end, and not an end in itself, which the rhetoric about empowerment suggests Empowerment does not stand on its own - it exists or is required for some purpose This position is consistent with Foster-Fishman *et al*’s (1998) ‘three critical assumptions’ which they describe as underlying empowerment theory

- empowerment’s multiple forms
- the contextual embeddedness of empowerment
- the dynamic nature of empowerment, particularly over time

This does not mean abandoning the term empowerment, but rather, appreciating that a generic understanding or definition and specific interpretations are possible Falk-Rafael (2001) makes a useful distinction between what she describes as a theoretical understanding of empowerment, which may generalise easily across disciplines, and the practical meaning of empowerment in particular contexts in terms of its integration into practice This position takes account of the assumptions adopted above (of the contextual, dynamic and multiple nature of empowerment) Her generalisable definition was that empowerment involves enabling people to gain some measure of power in their lives This definition of the theoretical understanding of empowerment locates power as central to considerations of empowerment However there are some limitations with her notion of “some measure of power” contained within the above quote, for example, about who will decide what the

appropriate measure of power will be

Other authors, particularly within the community psychology tradition, offer more useful generic definitions. For example, Fawcett *et al* (1994 p471) define empowerment as referring to “the process of gaining influence over events and outcomes of importance to an individual or group”. This definition is useful in that it states that empowerment must have an identified purpose or object. Also within a community development context, Foster-Fishman & Keys (1997 p349) suggest that

any empowerment endeavour necessarily includes power and control issues
Lacking influence in a particular domain, individuals seek and acquire power and resources to establish such control

Thus the acquisition of power facilitates control over the domain(s) important to a person or group. The espoused domains of importance to midwives have been suggested in chapter 2, namely, autonomous practice and women-centred practice. The definition cited above also highlights the intrinsic and constitutive position of power to discussions of empowerment which are examined further in the next section.

3.3 The power in empowerment

‘Empowerment’ does have an essence and that essential property is power
(Leamy 2000 p 212)

The Oxford English Dictionary (1996) states that the verb “to empower” can be defined *inter alia* as “to invest legally or formally with power” and “to impart power”. There are clear limitations to dictionary and thesaurus definitions and these are convincingly expounded by Downie (1994). He cautions that lexical or word-word definitions have tautologous tendencies. However in relation to empowerment, the value in such a definition is that it draws our attention to the constitutive “power” in empowerment.

The empowerment literature has also been criticised for its tendency to not directly address the issue of power (Gilbert 1995, Ryles 1999) Gilbert (1995) states that the relationship of empowerment to power must be central to any discussions of empowerment. He specifically highlights the need to analyse the ways in which power operates in specific contexts. Similarly, Ryles (1999) argues that there is a tendency to discuss empowerment without direct references to theories of power. He claims that this conceptual ambiguity undermines the implementation of empowerment.

A central assumption in adopting the empowerment concept is a perception that there is a situation that is in some way unsatisfactory for those for whom empowerment is deemed desirable or necessary (Kieffer 1984, Foster-Fishman & Keys 1997) and that this somehow relates to a lack of power. Discussing empowerment in mental health nursing, Ryles (1999 p602) suggests that

as a means of unifying the concept, empowerment can be seen as having a continuum that begins with an awareness of something tangible, usually a deficit

This deficit has been characterised as a condition of powerlessness. Conger & Kanungo (1988 p474) have stated that “the need to empower subordinates becomes critical when subordinates feel powerless”. At one level this seems tautologous, since much of the empowerment literature does not explicitly refer to power. However, it is perhaps necessary to highlight power or its lack as the imperative for empowerment. One possible reason for the lack of engagement with the power concept may be due to the fact that power itself is a complex concept. It has been widely described as the central and elemental concept of the social and human sciences (Giddens 1984, Clegg 1989). Power is an essentially contested concept, because of its value-dependent nature (Lukes 1974). Clegg (1989) agrees that the mistake would be in assuming that there is a single authoritative concept of power. In acknowledgement of this, several theoretical perspectives of power and empowerment are reviewed in this chapter. Before these perspectives are discussed, the overarching concerns of gender and its link with power are addressed.

3.4 Gender, power and midwifery

[it is] imperative that the matter of gender be at least considered when studying a virtually all-female sub-culture experiencing occupational socialisation in the male-dominated world of medicine (Begley 1998 p51)

A pervasive theme which runs through the consideration of power and empowerment in midwifery is that of gender. A focus on gender as “a fundamental category for understanding social order” seeks to

correct the invisibility and distortion of female experience in ways relevant to ending women’s unequal social position (Lather 1991 p71)

The very workplace context of most midwives, medicalised maternity care organisations, and the gendered nature of midwifery and medicine’s inter-professional relations place the issue of gender as central to this study. Gender is seen as a social construct or artefact (Miers 2000). Oldersma and Davies (1991 p4) state that “by introducing gender as a theoretical construct it became possible for the first time to transfer relations between the sexes from biology to society”. Miers (2000 p13) also discusses the advantages and limitations to viewing gender as binary, the main advantage being that there is then a focus on relations and in particular “structural relations of inequality including inequalities of power”. Of particular relevance to this study, Davies et al 1991 (pvi) contend that “the relationship between gender and power has always been a central concern of feminist scholarship”, though this is a relationship which gives rise to more questions than answers. The relationship is based on a view that “relations between men and women are integrally connected with power” (Davies et al 1991 pvi). These relations and inequalities have been described within the analysis of patriarchy. Walby (1989 p214) defines patriarchy as

a system of social structures and practices in which men dominate, oppress and exploit women

Similar to the point made above about the social rather than biological nature of gender, Walby clarifies that this definition, by focusing on social structures moves the focus from biology to society and from individuals to social level. In other words, in a patriarchal system, not every man dominates and not every woman is in a subordinate role. Walby also characterises six patriarchal structures, or “constellations of social relations which structure gender relations” (Walby 1989 p220). These are

- the patriarchal mode of production (within which women’s labour is expropriated by their husbands)
- patriarchal relations in paid work
- patriarchal relations in the state
- male violence
- patriarchal relations in sexuality
- patriarchal relations in cultural institutions (including the media and religion)

All of these structures have something to offer an analysis of modern maternity care. The focus in relation to midwives’ relations with others will be on patriarchal relations in paid work and patriarchal relations in the state. The other structures (for example, patriarchal culture, mode of production) form the backdrop to this more specific analysis.

Discussions within “patriarchal relations in paid work” usually focus on the segregation of women in certain occupations or their less favourable treatment in terms of pay and other opportunities within occupations they share with men. This is interesting in the case of midwifery, as midwives see midwifery as a feminised sphere of activity. Midwives claim that childbirth is rightfully “women’s work”. Midwives claim the “female prerogative over midwifery practice” (Witz 1992 p105). The objection is that

the management of reproduction has been throughout most of history and in most cultures, a female concern, what is characteristic about childbirth in the industrial world is, conversely, its control by men (Oakley 1980 p11)

Therefore it is not the segregation of women into midwifery that is at issue, rather there is a focus on the encroachment and diminution of the function and value of midwifery within

childbirth In a nursing context, Miers (2000 p27) claims that “the processes by which nurses’ work is devalued and denigrated are gendered processes” This same analysis can be applied to midwifery This process is described by Hyde et al (2004 p213) in their characterisation of modern medicalised maternity care systems as

an expression of patriarchal control over childbirth that creates a certain helplessness among women, socialising them to believe that they cannot give birth without technological assistance, the latter being controlled by men
(Hyde *et al* 2004 p213)

This masculinisation of services began in the seventeenth century This era saw the rise of “two new types of professional men with an interest in childbirth”, namely scientists and “trained medical men” (Devane & Murphy-Lawless 2005 p138) Devane and Murphy-Lawless (2005) analyse the texts of Wolveridge & Ould in 1671 and 1742 respectively, both written in Ireland and with an Irish focus The texts represent a trend towards a more scientific approach to birth that would be disadvantageous to midwives and would have mixed consequences for women Witz (1992 p127) relates this to the fact that “the surgical demands of obstetrics were discursively equated with masculinity” Specifically focusing on inter-professional relations, Devane & Murphy-Lawless (2005 p 156) observe that the objective of the “professionalising project” of obstetrics was for “male midwives to secure their presence as the most legitimate professionals in the field of birth, at the expense of the older practitioners, namely the female midwives” The authors report Ould’s eighteenth century treatise which claimed that “the assistance of a Surgeon particularly instructed in the Art of Deliveries, is generally necessary in most natural Labours” They conclude that this “set the scene for unchallenged professional hegemony until the late twentieth century” (Devane & Murphy-Lawless 2005 p157)

Witz (1992) specifically adopts a feminist framework to examine professionalising projects of groups including midwives According to this framework, dominant professions are shown to exhibit both exclusionary and demarcationary strategies Exclusionary strategies aim for intra-occupational control while demarcationary strategies aim for inter-

occupational control over related or adjacent occupational groups (Witz 1992 p44) Witz (1992 chapter 4) specifically examines the “troubled inter-occupational relations between doctors and midwives” through an analysis of the debate about midwives’ registration in England and Wales in the early twentieth century. She examines these relations under the beguiling heading of the “the spider legislating for the fly: medical men and midwifery registration” (p 109). Within demarcation, the strategies of de-skilling and incorporation may be employed by the dominant group, according to Witz. De-skilling involved bringing midwifery education and registration under the control of medicine and through the distinction between normal and abnormal labour. The other strategy of incorporation would involve the transfer of the full range of midwifery practice to medicine, which would result in the “demise of the independent midwifery practitioner” (Witz 1992 p105). These strategies will be re-examined in the Irish context in relation to the historical research undertaken in this study (see page 131).

Linked with this discussion of the gendered nature of inter-professional relations, Witz (1992 p12) claims that

Historically the role of the state has been central in professional projects

The nature of the state in relation to gender is therefore significant. The *patriarchal relations in the state* structure is also outlined by Walby (1989). This structure relates to the exclusion of women from access to state resources and power, including their lack of power within political forces operating in the state. Elsewhere Walby (1990 p21) claims that

The state has a systematic bias towards patriarchal interests in its policies and actions

In her distinction between private and public patriarchy, Walby defines public patriarchy as being based in public sites such as employment and the state. She states that

Public patriarchy does not exclude women from certain sites, but rather subordinates women in all of them (Walby 1989 p22)

Midwifery's subordination within modern medicalised maternity care is not in question and this reflects a long-term devaluing of midwifery's value. This resulted in the appropriation of the midwife's role and its demarcation within a medical framework. Midwifery practice is thus inherently "bounded, and its sphere of practice defined, by the dominant medical profession" (Hunt & Symonds 1995 p35). Within this system, Walby (1990 p173), further cautions that "patriarchy is a dynamic system in which men usually give up an activity only when they no longer wish to undertake it". The analysis of gendered roles and relations is seen to be critical both in relation to the overall construction of modern medicalised maternity care and in the related influences on midwifery development and practice. Specifically the emphasis on technology and intervention in medicalised care represent a masculine approach, rather than the connectedness of a feminised approach, including, for example, the traits of a women-centred care such as caring, covered in chapter 2. This study aims to examine aspects of the historical development of midwifery, paying close attention to inter-professional relations and the nature of the role of the state in this development. This will be examined in chapter 5 below in relation to the Irish case.

The embeddedness of gender within midwifery relations and environments will be seen within and throughout the discussion of each of the perspectives on power and empowerment in midwifery discussed below.

3.5 Perspectives on power and empowerment

When analysing power and empowerment in relation to midwifery, several theoretical approaches were examined. The perceived problems with organisational or structural influences, and constraints, on midwifery practice have been highlighted in chapter 2. Therefore it is appropriate to examine organisational perspectives on workplace power and empowerment. The critical social theory perspective on power also emphasises structures and this perspective is also examined. Challenges to the emphasis on structures come from

postmodernism and this is the third major perspective studied

3.5.1 *Organisational perspectives on power and empowerment*

The healthcare workplace is a complex one, because of the number of and relations between the professional groups in that workplace (Irvine *et al* 1999). In the case of maternity services, this includes a set of gendered relations, as discussed above. The organisational perspective on power and empowerment stresses the role of organisational and structural influences on employee behaviour and effectiveness. Within this approach, employee work behaviours are viewed as “responses to work conditions and situations and not manifestations of inherent personality traits” (Laschinger 1996 p26). From an organisational perspective, Kanter (1993 p166) defined power as,

the ability to get things done, to mobilise resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet

Kanter thereby proposes a productive conceptualisation of power. This portrays power as the ability to get things done, rather than viewing power as coercive or involving domination. She described empowerment as “control over conditions that make their actions possible” (1993 p166). However, the relative power held by individuals or groups within an organisation is also highlighted by Conger & Kanungo (1988), who highlight the outcomes of this relative power, whereby

organisational actors who have power are more likely to achieve their desired outcomes and actors who lack power are more likely to have their desired outcomes obstructed by those with power (p472)

Therefore, those who acquire and hold on to power will be most effective within the organisation. Kanter (1977 and 1993 (2nd edition)) identified the role of both formal and informal power in organisations within her *Theory of the structural determinants of organisational behaviour*. The emphasis within the theory was power as a structural determinant affecting behaviours and attitudes. Kanter highlighted the role that both formal

and informal power played. Formal power was described as that which is found in jobs that are visible, central to the purpose of the organisation and that allow for discretion in decision-making. Informal power is derived from the alliances of individuals from within and outside the organisation. These include alliances with sponsors, peers and subordinates, whereby such alliances result in the co-operation required to get things done. Kanter (1979) claimed that such forms of formal and informal power determine access to the conditions required to achieve one's aims. According to Kanter's theory, when people do not have access to these conditions, they experience powerlessness. Kanter's theory was based on her ethnographic study of a very large industrial production corporation, with more than 50,000 employees at the time of Kanter's fieldwork. There is an emphasis in Kanter's ethnographic account of the features of white-collar hierarchical organisations, within which she focuses on managers, their wives and their secretaries. She identified the importance of "movement" associated with rising status and authority as meaning success within such an organisation. On this basis Kanter characterised "opportunity", which involves mobility and growth as being determined by promotion rates, steps associated with a position, the range and length of career paths, access to challenge and increase in skills and rewards (1993 p246). Kanter's theory, based on an ethnographic case study of an industrial corporation, was a valuable contribution to the management and organisational literature, with its emphasis on the role that structural rather than exclusively individual characteristics play in influencing employee behaviours. It is the application of this work to nursing that will be of more relevance to this study and this follows, related to the work of Genevieve Chandler. Kanter's "men and women" of the corporation were managers and their "wives and their secretaries". This indisputably points to the gendered roles within the industrial corporation Kanter studied. Kanter explicitly addresses this within this work (1977, 1993) and also in other work (for example 1979). However, these aspects of Kanter's work were not featured in the theory as it was taken up by others and developed for nursing contexts, despite the gendered nature of healthcare organisations in relation to medicine and nursing, equally medicine and midwifery. This is a missed opportunity, given Kanter's original focus.

Chandler (1986) states that she adapted Kanter's "Working Conditions Questionnaire" for use in a nursing context. She states that the questionnaire was based on Kanter's theory of the structural determinants of organisational behaviour, as outlined above. Kanter's questionnaire was not included in the text within which she describes her ethnography and no other source is given by Chandler. She acknowledges that Kanter's questionnaire "did not have reliability and validity information but it was designed by the theorist who developed the theory being tested" (p38). This somewhat tautologous statement does not take from the first part of the statement, which elsewhere Chandler states more simply: the questionnaire "had no established validity or reliability" (p41). Chandler stated that a pilot study with nurses suggested face validity for the questionnaire for nursing. Her subsequent study of 268 nurses from two hospitals in Utah tested the questionnaire. In the first use of the Conditions for Work Effectiveness Questionnaire (CWEQ) in a nursing context, the questionnaire covered the five areas of opportunities, supplies, job activities, information and support. For each of the areas, respondents were asked to describe what they have now and what they would like to have in relation to each of the items (p41). Chandler tests the factors proposed by Kanter using exploratory factor analysis. Following a brief report on the adequacy of her sample size, she concludes that

the size of Cronbach's alpha confirmed that the factors were not simply an artefact but were tapping into some true underlying dimensions. With the factors so similar to the original sub-scales, the level of Cronbach's alpha as well as the support of the descriptive data the investigator considered the three factors to be a representative of reality (p48).

Following these statements, Chandler explains that the Principal Components Analysis (PCA) method was used as it is the "most accepted factoring method and those with limited experience with factor analysis should stay with this method" (p49). The alpha method was then used to test the robustness of the solution. Chandler does not discuss rotation of factors, but it appears from her results that Varimax rotation, an orthogonal rotation method, was carried out. Items with a factor loading of >0.40 were retained in factors. There were three final "factors for work effectiveness" identified: support, information and

opportunity Chandler offers recommendations based on her findings about the need for positive feedback, the active dissemination of information and opportunity for growth and development of nurses within their work environments. Chandler concluded her study by stating that her findings reflect a “paradigm shift in nursing from the individual perspective of work behaviour to an interactive perspective” (p79). She states that one of the limitations of the study is its case study nature, resulting in non-generalisability.

Since the University of Western Ontario (UWO) programme of research into nursing workplace empowerment grew and developed from this study, its findings are important. Notwithstanding the dangers of inadvisable claims of having revealed “true underlying dimensions” which are “representative of reality”, there are more specific limitations of the analysis as it is presented. The limitations of PCA as a method of factor extraction are discussed further below in relation to the factor analysis performed in this study (see page 109). Essentially component analysis is considered less theoretically sound than common factor analysis (Hair *et al* 1995, p 375). Factors derived from common factor analysis methods (such as Principal Axis Factoring) are based only on the common variance of variables, that is the variance that is explained by the factors alone. Components analysis is based on full variance, which includes common, error and (variable) specific variance. While in practice this might not make a huge difference to the first few factors, it is theoretically more sound, since it is common variance that is the basis of the factors being extracted. Orthogonal rotations assume that the factors being rotated are not correlated. Chandler does not discuss this assumption. Oblique rotation, in contrast, does not assume that factors are not correlated and is therefore considered preferable in the absence of a clear indication to use orthogonal rotation (Hair *et al* 1995 p 303). Finally, the overall reporting of Chandler’s results also suggests a “reality” waiting to be discovered, in the data being factor analysed. Factor analysis is a set of multivariate statistical techniques, which while suggesting patterns within the data, do not reveal a reality, should such a reality exist.

Despite the above comments about Chandler’s study, the final factors she proposed seem

intuitively reasonable and coherent. Chandler does not make explicit the clear gendered nature of the factors identified: support, opportunities and information and this analysis would have more explicitly addressed and accounted for the organisational contexts within which nurses work. Subsequent to and based on Chandler's work using Kanter's (1977) *Theory of the structural determinants of organisational behavior*, a substantial programme of research on nursing empowerment has taken place within the *Workplace Empowerment Program* at the School of Nursing, University of Western Ontario (UWO). Over the intervening years the instruments have been developed and refined. The current CWEQ-II (shortened version) measures levels of access to support, information, opportunity and resources, the *Organisational Relationships Scale* (ORS) measures informal power and the *Job Activities Scale* (JAS) measures formal power. Again, these are indisputably gendered constructs, with networks operating differently and to different extents for men and women. Arising from this UWO work between 1992 and 2002, at least 85 published studies have been reported on (Laschinger 2006). Research conducted under the *Work Empowerment Program* has tested relationships between the CWEQ and burnout, organisational commitment, job strain, organisational trust and many other workplace experiences (Laschinger 1996, Laschinger *et al* 1997, Laschinger and Wong 1999, Laschinger *et al* 2000).

Laschinger *et al* (2001a) subsequently related structural empowerment to psychological empowerment, based on the work of Spreitzer (1995, 1996). Spreitzer (1995) had defined psychological empowerment as the psychological state that employees must experience for empowerment interventions to be successful. Laschinger *et al* considered this to be the logical outcome of managerial efforts to create Kanter's structural conditions of empowerment. This was to thereby introduce the hypothesis that psychological empowerment is a consequence of structural empowerment. Laschinger *et al* (2001a) concludes that staff nurses felt that structural empowerment resulted in higher levels of psychological empowerment. Subsequent studies have supported these findings: if the structural conditions are right, then staff will feel that they are empowered (Laschinger 2001, Laschinger *et al* 2001a, Laschinger *et al* 2001b, Almost & Laschinger 2002, Shamian

et al 2002, Manojlovich & Laschinger 2002, Kluska *et al* 2004, Sarmiento *et al* 2004)

Most of the studies using the UWO tools (CWEQ, JAS, ORS) have been conducted in Canada under the UWO programme. Additionally, using these tools, Ellefsen & Hamilton (2000) undertook a comparative study between nurses in the US and Norway. The US sample comprised 135 nurses who wished to engage in collaborative governance work in the hospital. A 55% response rate was achieved. The Norwegian sample comprised 590 nurses, with a 70.5% response rate achieved. Using the UWO tools they concluded that the nurses had a moderate amount of power in both sites. The authors observed that the small difference between nurses from two hospitals in two different countries raised some questions. They conclude that the different organisational structures as well as differences in culture, did not seem to affect perceptions of empowerment. This is interesting, given the marked differences between the health care systems of the countries. There are three possible interpretations of this. The first is that conditions for nurses are perceived or experienced similarly by nurses collectively, regardless of structural differences. For example perceptions of access to nursing management support may be similar, despite differences in organisational structure. This would imply that certain patterns exist in nursing, culturally bound to nursing *per se*, rather than to a particular geographical or structural context. Nursing management structures have traditionally been seen as hierarchical within the apprenticeship model of nurse education. Even with knowledge of the importance of supportive and effective management and leadership, this has been slow to change (Kuokkanen *et al* 2003). This is therefore a plausible interpretation of these results, though one that requires further investigation.

A second interpretation may be that this tool might not be sensitive enough for the particulars of nursing environments. In her early work with Kanter's tool, Chandler (1991) had acknowledged that, while the scale appeared reliable and valid, it may not be sensitive enough for nursing samples. Possible explanations proposed by Chandler included that the 'information' factor could be broken down into items addressing information from patients, doctors, administrators etc. Certainly the nursing workplace environment is a complex one.

This does not negate the value of measuring particular structural conditions regarded and shown to be critical to work effectiveness. There may be other factors or conditions important for empowerment for particular groups. This study is focusing on identifying the most appropriate means to describe and measure midwives' perceptions of their levels of empowerment. Clearly organisational conditions such as support and resources are important. This study aims to identify which factors midwives identify as important for their empowerment.

The third and final interpretation of the similarity of Ellefsen & Hamilton's (2000) results relates to the sample profiles in both sites. The US sample comprised nurses who were motivated enough to become involved in collaborative governance, a self-selecting group who may not represent the broader nursing population. The Norwegian sample did not have this (explicit motivation about self-governance) feature. The Norwegian sample was much larger, with a higher response rate. The samples are therefore not strictly speaking comparable. Highlighting the similarity of their results may be misleading. Rather, these results may be suggesting that unlike samples have similar patterns of perceived empowerment. The expected self-selecting US sample arguably would have higher levels of perceived empowerment than those without this explicit characteristic, the Norwegian sample. It is important that these issues are taken into account and discussed more fully in the interpretation of results which are presented.

Dunlea (2003) used the Laschinger tools in an Irish midwifery study. The aim of the study was to examine "the relation between work empowerment and level of education preparedness to level of reported autonomy in midwifery practice". Using a survey design, questionnaire data were received from midwives working in three consultant-led service sites and four midwifery-led services in Ireland in 2003. From 250 questionnaires, a response rate of 60.8% (n=145) was achieved, with 110 midwives working in consultant-led services and 35 in "midwifery-led" services. Only 30 questionnaires had been sent to midwifery-led services, so Dunlea highlights the difficulty with defining this. Both were "convenience samples" due to time constraints.

Dunlea (2003 p38) claims to use the UWO validated scales and states that “some modifications were necessary for the Irish context” However many substantive changes were made which makes comparison of findings with those of other studies which used these scales difficult For example, all of the items on the Opportunity sub-scale included some rewording Some examples are given here, as this makes comparisons with the results of other studies which used the UWO tools difficult Within the Information sub-scale, the item relating to “information about the current state of your organisation” was changed to “information about the current financial state of your organisation” An additional item relating to discussion of further training or education was added to the resources sub-scale The resources sub-scale is preceded by a leading statement about “Sufficient time and staff numbers are seen as key resources to get the job done well” The term “midwifery help” replaces “temporary help” in the resources sub-scale Only two items are included in the calculation of the resources sub-scale mean, within the CWEQ Within the Job Activities Scale, the statement on “the rewards for innovation on the job” was changed to rewards for “showing initiative on the job” Additional items directly refer to birthing women’s care, such as “the freedom to facilitate the woman’s choice in care”

With all of these changes to the wording and composition of the scales made, Dunlea states that the internal reliability of scales is demonstrated to be acceptable While some interesting and relevant results are shown, these are not directly comparable to other results using UWO scales For example, she concludes that those working in midwifery-led services score significantly higher on the empowerment scales than those in consultant-led services Furthermore, those who trained in the UK showed a statistically higher level of education preparedness for autonomous practice than those trained in Ireland Despite the convenience sampling, aspects of these findings are relevant to this study, for example, relating to the findings of this study regarding overseas practice (see page 227)

The UWO tools have also been used to study the experiences of other healthcare workers Miller *et al* (2001) carried out a study of physical therapists (n=65) in Canada Using the

CWEQ, they found moderate levels of empowerment among the physical therapists, which were similar to staff nurses' CWEQ scores, found in previous published studies. They describe the CWEQ as a "useful framework for evaluating critical organisational factors". The fact that the findings were similar to those of nursing studies is interesting. These groups share the same overall organisational structure and these findings indicate that they perceive that they share common perceptions of access to support, resources, information and opportunities. Further multi-disciplinary studies using these tools would further test these suggestive indications, particularly in relation to gender differences in levels of formal and informal power and in access to these structures. This current study aims to explore the most relevant and appropriate strategies for measuring midwives' perceptions of empowerment. Implicit in that aim is the examination of the suitability of generic organisational tools such as the CWEQ. Exploring the validity and reliability of a midwifery-specific tool challenges the notion of a "one instrument measures all" approach. Some conclusions on this question are offered at the end of this study (see page 265).

This discussion of research undertaken using the UWO scales highlights the focus that has been given to the structural conditions underlying empowerment, especially in the nursing literature. Issues of support, resources, information and opportunity as well as informal and formal power are as relevant to midwives in their organisational settings as they are to other professional groups. These issues need to be interpreted taking into account the patriarchal nature of the organisational context within which midwives practice as outlined in chapter 3 (see page 43). While taking this into account, the wider social contexts within which such organisations operate need to be analysed. Socio-political conditions, processes and relations influence the very structure of maternity services and the relative position of various groups, including midwives and birthing women, within those structures. The critical social science approach explicitly takes account of the broader social structures and power relations. A discussion of the relevance of this approach to midwifery and maternity care follows.

3.5.2 Critical perspectives on power and empowerment

Only as the oppressed discover themselves to be hosts of the oppressor can they contribute to the midwifery of their liberating pedagogy. Liberation is thus a childbirth and a painful one (Freire 1993 p30)

Within the critical approach, the goal of theory and research is to understand the oppressive features of a society, so that this understanding stimulates its audience to transform their society and liberate themselves (Fay 1987). The domination of subordinate groups by dominant ones is posited as being dependent on the false consciousness of the oppressed group, whose members do not realise their real interests. Oppressed group behaviour also includes self-deprecation and fatalism, which can be misconstrued as docility (Freire 1993 p45). Horizontal violence is also a feature, whereby leaders of oppressed groups often have characteristics, beliefs and behaviours that resemble those of the dominant culture (Roberts 1983).

Critical approaches emphasise that oppressive social structures are maintained by the dominant ideology, or hegemony, of particular groups and traditionally this was based on class. Steven Lukes is an influential writer on hegemony, particularly in his seminal text *Power: a radical approach* (1974). Within this book he analysed existing approaches to understanding power. He then proposed a radical three-dimensional view of power, which characterises the nature and effects of hegemonic forces. This refers to

the supreme and most insidious exercise of power to prevent people, to whatever degree, from having grievances by shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things, either because they can see or imagine no alternative to it, or because they see it as natural and unchangeable, or because they value it as divinely ordained and beneficial (Lukes 1974 p24)

This supplements the aspects of narrower conceptions of power as being about observable conflict (one-dimensional) or both observable and potential conflicts (two-dimensional). Clegg (1989) describes conflict as being overt, covert and latent, the latter characterising

Lukes's three-dimensional view of power Within a maternity care context, the taken-for-grantedness of hospitalised medicalised childbirth supports Lukes's three-dimensional view of power This conception of power would suggest that midwives are not aware of, or do not value, alternatives to the current model, because they have been subtly though firmly prevented from having grievances about the current situation The focus then is on how this process happens, rather than just focusing on winners and losers in particular conflicts, or on potential conflicts that do not reach the stage of determination If applying this analysis to the maternity context, midwives' perceptions are cast as being shaped, almost imperceptibly, by the dominant ideology of medicine and also of patriarchy Thus their false consciousness prevents the realisation of their real interests The historical research conducted in this study will examine the taken-for-grantedness of the medical and patriarchal domination of midwifery regulation within the twentieth century (see page 131)

Previous research has also characterised midwives as demonstrating the traits of an oppressed group (Begley 1997) This is illustrated in midwifery's internalisation of medicalised childbirth and the hierarchical, unsupportive nature of midwifery management, suggesting horizontal violence Roberts (1983 p26) claims that nurses,

have internalised the values of physicians to such an extent that they can be said to be marginal and it has become clear that nursing has been highly infiltrated with the mechanistic model of medicine

Roberts suggests that nurses become marginal to survive in and be rewarded by the dominant culture Within medicalised birth, it would be difficult to suggest that this statement does not equally apply to midwives Therefore, there is little doubt that this perspective on power has some resonance with and relevance for midwifery and childbirth

The critical approach has been explicitly adopted in nursing research on empowerment (Fulton 1997, Daiski 2004), though not in midwifery Fulton wanted to explore how nurses conceptualised empowerment and whether her study would reveal nurses as an oppressed group She specifies that the data were analysed "focusing on oppressed group behaviour"

(p531), which she assumes as her starting point. Fulton acknowledges that this was a small-scale study. Two focus groups were carried out. The sample comprised participants in an *Empowerment for Practice* (EP) course which was led by Fulton at Southampton University School of Nursing and Midwifery. The course had a curriculum based on critical social theories. Fulton acknowledges the limitations of her small-scale study with a self-selected sample of participants who were about to undergo an educational unit on empowerment together. The course was from a particular (critical) standpoint where the focus group moderator (Fulton) was also course leader and assessor. Within her findings, Fulton writes that “the direct power of doctors was articulated as a problem”, with nurses saying that they waited for doctors to “jump down their throats” (p533). This power appeared to be a “potent mixture of gender and class”, far more overpowering than simply the differences between occupational groups. Doctors were seen to have the last word. Fulton comments that nurses seemed to acquiesce in this domination, it seemed to be “a given fact”. This, she claims, supports their characterisation as an oppressed group. She later says that nurses felt uncomfortable, knowing they were lacking something and wanted to have their voices heard.

As Fulton acknowledges, this was a small study undertaken with a group of nurses who were a self-selecting sample who had an interest in undertaking a course which adopted a critical perspective. This certainly limits the applicability and generalisability of Fulton’s findings. There is a danger that when one adopts a framework for analysing data such as oppressed group theory, then one will find data which fit that framework. However, within its own limitations this study illustrates how critical theory can be employed in a nursing research context.

Also from a critical standpoint, Daiski (2004) interviewed 20 nurses about their views on restructuring in healthcare in Canada. She aimed to explore nurses’ disempowering relationship patterns. She situates her study in the background of oppression group theory, as a way of explaining nurses’ behaviours. The findings were presented under themes which include

- 'nurses look up to other professionals'
- 'nurses eat their young'

The author comments that intra-professional relationships fare no better than inter-disciplinary ones. The young included both students (especially those with degrees) and those new to that particular setting who have previous experience. Daiski concluded that her findings confirmed that nurses remain an oppressed group. The features that support this are domination by medicine, lack of support from colleagues and bullying from managers. These findings echo those of the research on midwifery in Ireland described in chapter 2 (see pages 29 - 33). "Eating their young" reflects Begley's (1997) findings about the treatment of student midwives by staff midwives. On the other hand, Pitman's (2004) study found high levels of satisfaction with the level of midwives' collegial support. It appears that groups of "insider" midwives show each other support, though outsiders and juniors (students) might not receive such support. The findings of the *Lourdes Hospital Inquiry* (see page 8) suggest that outsiders can view the culture within a maternity care setting quite differently than those within that culture. While the Lourdes Hospital's experience of this culture of uncritical loyalty was linked with tragic outcomes, the effects of being an outsider, even in the absence of such drastic circumstances, are not positive.

These two studies on empowerment in nursing undertaken from a critical perspective (Fulton, 1997, Daiski 2004) suggest that elements of this approach can be usefully applied within nursing research, while acknowledging their limitations. They both highlight aspects of gendered aspects of power relations between, in their cases, nursing and medicine. There have been general critiques of the critical approach and its utility. The limitations of the critical approach mainly stem from the lack of its evident success in addressing the conditions it identifies as problematic for particular groups. It appears that there is not an awaiting proletariat, who, when they see their condition more clearly, move towards their own emancipation. This also links with the critiques of the role of critical researcher, whose perspective is somehow privileged and impositional, despite the claims of supporting the self-emancipation of groups (Browne 2000). Feminist critiques have centred on the

implication within the oppression paradigm of power, usually focused on class, that “one theory will meet all requirements”, thereby not taking account of the gendered nature of oppression for women (Oldersma and Davies 1991 p16) Critiques of the notion of “real interest” have been offered (Clegg 1989, Komter 1991) Clegg (1989 p2) cautions that the notion of false consciousness is only defensible if one believes that agents have one fixed identity which he/she is capable of recognising He also warns against “recourse to categories of a ‘dominant ideology’” within critical approaches He states that this is “analytically pre-emptive of a deeper understanding of the mechanisms of power” As well, many authors highlight the role that those who appear powerless play in their power relations with those who appear powerful over them Giddens highlights that in all power struggles, the “dialectic of control in social systems”, within which

all forms of dependence offer some resources whereby those who are subordinate can influence the activities of their superiors (1984 p16)

Clegg (1989) agrees that there must be the assumption of resistance to the exercise of power He clarifies that this might not necessarily be a ‘dramatic expression’ of resistance He gives the example of excessive politeness as a form of resistance He calls this the dialectic of power, whereby one agent’s resistance is necessary for the realisation of another’s power (p208) Within a postmodern view, Foucault (1980 p142) also highlights resistance as an intrinsic part of power relations He said

you see if there was no resistance, there would be no power relations, because it would simply be a matter of obedience So resistance comes first and resistance remains superior to the forces of the process, power relations are obliged to change with the resistance

These authors, by recognising the latent “power of the powerless” (Havel 1985), present a more promising depiction of the role of those presumed to be powerless This idea is continued below within an analysis of postmodernism Prior to that, further analysis of the relative role of structures are covered, by examining structure-agency debates which feature in debates about power

3 5 2 1 Structure versus agency debates

Power is one of the primary concepts of social science, all clustered around the relations of action and structure (Giddens 1984 p284)

Clegg (1989) claims that the central question in the debates about power is that of the relation between agency and structure. Structure-agency debates directly link with what Foster-Fishman & Keys (1997 p347) call the “ecology of empowerment”. They explain that this refers to the centrality to the empowerment process of the person-environment interaction. They describe this as “a dynamic interplay between people’s desires/capacities and contextual opportunities”.

Within sociological debate concerning structure versus agency, some theories emphasise the power of social structures and others emphasise the ability of individuals to choose their own life direction and conditions (Wicks 1998). Giddens (1984 p14) proposes that “agency implies power”, since “to be able to ‘act otherwise’ means being able to intervene in the world, or to refrain from such intervention, with the effect of influencing a specific process or state of affairs (Giddens 1984 p14). In other words, having agency means having a choice to act or not, implying power.

Agency is defined by Murphy-Lawless (1998 p26) as “the capacity to act as well as to form a judgement about one’s action. agency involves reflections, decisions and actions taken together”. Another definition of agency, of interest relating to empowerment discussions, is that it involves “the faculty of acting or of exerting power” (Webster’s Revised Unabridged Dictionary 1996). While the term agency is often taken to directly refer to a person, Clegg (1989 p187) suggests that “agency is not a generic term for people. it may well often refer to collective forms of decision-making, such as organisation”. This is useful in that it highlights the various levels by which individuals, such as midwives, might make collective decisions and actions. Those who support the centrality of agency over structures stress the status of individuals as subjects rather than passive objects. They demonstrate that

individuals “act and manoeuvre in the world, make strategies and reflect in spite of the frames and perhaps limitations set by the structure of societies” (Samuelson & Steffen 2004 p4) Clegg 1989 (p 147) claims that in debates over structure and agency, for both Lukes and Giddens “agency predominates”, because of moral relativism. Ultimately, since only people, and not structures, can think, act and reflect on those actions, the place for change rests with people, however and wherever they are situated within structures.

However, even those who support the position that agency prevails over structure, acknowledge the limits of agents. For example, Fay (1996 p67) suggests that

agency is a relative trait- one can be more agential than another by virtue of their place in the social order, their skill, their dispositions etc. all people in so far as they are interpreting and responding creatures are agents- they enact their agency in more or less effective ways.

Similarly, Giddens (1984 p16) highlights that in power struggles “what use agents in subordinate positions can make of the resources open to them differs very substantially between different contexts”. This is critical to acknowledge in a midwifery context, particularly when the gendered social order is accounted for. Midwives are situated within a definite “social order”, to borrow from Fay (1996 p67) as cited above. This needs to be kept in mind when exploring how midwives might have acted, for example, in the case of the Lourdes Hospital as discussed above (see page 8). To ignore their relative position is unfair to midwives, while acknowledging this brings an imperative to examine the social order and to facilitate midwives’ enhancement of their own position within this order. This requires the critical education and politicisation of midwives described within critical theory. Freire (1970) used the word *conscientização* to refer to learning to perceive social, political and economic contradictions and then to take action against the oppressive elements of reality. Those who lead and educate midwives have a role to play in facilitating this process for midwives so that they can enact their agency and this is returned to at the end of this study (see page 270).

3 5 2 1 1 *The theory of structuration*

Stressing the centrality of agency, and to overcome the agency-structure dichotomy found in the sociological literature, Giddens proposed the theory of structuration outlined in *The Constitution of Society* in 1984. Giddens (1984) distinguishes between structures and systems, seeing structures as sets of rules and relations which are out of time and space and systems as the sets of relations and practices which are reproduced across time and space. His structuration theory holds that structure and agency interact, and it is only through the action of agents that structures are socially reproduced. A core tenet of this theory is the duality of structure, whereby “the structural properties of social systems are both medium and outcome of the practices they recursively organise” (p 25). In other words, it is actors’ reproduction of structures that maintain them and the systems they inhabit. Giddens suggest that human beings are knowledgeable actors, that they know a great deal about the conditions and consequences of what they do in their everyday lives. This is embedded in “practical consciousness” whereby routine is the dominant form of day-to-day activity, as routine reduces unconscious anxiety. Giddens (1984 p xxiii) explains that “practical consciousness consists of all things which actors know tacitly about how to ‘go on’ in the contexts of social life without being able to give them direct discursive expression”. However he suggests that actors can usually explain what and why they do something discursively, if required, normally only if the activity seems puzzling or departs from habitual modes of conduct. Routine is the means by which structures are “constantly recreated out of the very resources which constitute them” (Giddens 1984 p xxiii).

Giddens’s theory has been widely commented upon and critiqued. He is accused of merely combining several other sociological and psychological theories, and failing to present a coherent theory at all (Hardcastle *et al* 2005). In particular his theory is criticised as being silent on gender (Wolffensperger 1991, Davies 1991). Wolffensperger (1991 p93) proposed the notion of “engendered structures”, to place gender at the heart of Giddens’s theory and to “grasp the connection of gender, agency and system” (p106). In her study of Dutch education she concluded that “although the rules are different for men and women, female agents are held responsible for their own fate” (p98). This conclusion links back to

discussion above about the constraints on enacting one's agency, particularly in the context of gendered organisational, professional and social relations

However many of the components of his theory are unmistakeably useful in analysing the relation between agency and structure in midwifery. As mentioned in chapter 2, midwives often refer to their difficulties of working within the "medical model" or medicalised system of childbirth. Structuration theory suggests that midwives perpetuate this system through their own actions. This is particularly relevant in the widespread routinisation within medicalised maternity care, in which midwives actively participate. There are many examples from within the active management of labour model practised in most Irish maternity services. These include routine admission electronic fetal monitoring, routine early amniotomy ("breaking of waters"), oxytocin infusions for failure to progress, all procedures which are not based on efficacy evidence (Begley & Devane 2003a). Hunt & Symonds (1995 p xvii) also highlight the routine nature of admission of women, which sets the scene for the continuing taking of women's control over birth involving "ritualistic phrases and expressions". On the other hand certain routines such as routine enemas and perineal shaves have now been largely discontinued, offering some hope for the ongoing evaluation of the appropriateness of routine interventions in childbirth. Giddens's theory certainly challenges the tendency to blame the system, rather than to acknowledge one's role in perpetuating the system, as structuration theory implies. In her foreword to Hunt & Symonds's *The social meaning of midwifery*, Bryar (1995 px1) hints at this same idea, when she asks

how often have we considered the extent to which our basic concepts about midwifery care are demonstrated in the social world of which we are a part, which we have helped to create and thus have the potential to change

Bryar was commenting on the value of observing the things the midwives take for granted, in Giddens's terms their activities in "practical consciousness"

Within the nursing literature, specifically writing about professional socialisation, Clouder

(2003) focuses on the dynamic nature of the structure/agency relationship. She urges a move away from the dichotomous approaches to studying professional socialisation towards a “means of understanding how individuals construct their professions, which in turn constructs individual professionals”. She concludes that we can acknowledge the power of social forces while still not seeing nurses as purely passive victims. Similarly, also in a nursing context, Wicks (1998 p27) calls for an approach which is

capable of holding on to a sense of power of social structure, at the same time as acknowledging that nurses also have power in their daily work, in the knowledge base that underpins their work and through their professional organisations and unions to resist, evade and confront that power

Equally, there is a wide recognition in the literature that organisational constraints affect midwifery practice (Clarke 1995, Murphy-Lawless 1991). However this is not to claim that they are determining in nature (Clegg 1989). Structural determinism appears less constructive than an acknowledgement of structural constraints. The latter does not negate a belief in the importance of agents’ roles in challenging these limits, and in accordance with Giddens’s structuration theory, actually reproducing these structures. Returning to the ‘ecology of empowerment’, it appears most useful to place the interaction of the person and the environment, or of structure and agency, as central to the analysis of power.

In conclusion, critical social science approaches emphasise the role that dominant groups play in imperceptibly shaping the preferences of others, how the oppressed are unaware of their real interests and behave in a way similar to their oppressors towards others. Critiques of this approach have emphasised the role of agency (that is, the individual’s capacity to think, act and reflect), the need to take account of different oppressions, including patriarchy, the nature and role of resistance, and on the role that individuals play in perpetuating putative “systems”. The postmodern perspective challenges the critical approach’s overarching conception of power as negative and oppressive. A fuller discussion of postmodern perspectives on power follows.

3.5.3 Postmodern perspectives on power and empowerment

While the very notion of postmodernism itself is contested, a flavour of its meaning is given by Foucault (1980 p80), who stated, in a 1976 lecture, that

what has emerged in the course of the last ten or fifteen years is a sense of the increasing vulnerability to criticism of things, institutions, practices, discourses. A certain fragility has been discovered in the very bedrock of existence

Postmodernism essentially stresses multiple, fluid interpretations, in contrast with grand theories or meta-narratives, which claim to have the final word on a subject (Lyotard 1993). While Foucault was not comfortable with the label of postmodernism being applied to his work, he is generally considered to be one of the most influential writers within this tradition, particularly in his writings on power.

Clegg (1989) observes that to approach Foucault's work on power is no easy matter. Power permeates his work but not always explicitly so, as Foucault acknowledged himself, when he stated that

What else was I talking about in *Madness and Civilization* and the *Birth of the Clinic*, but power? Yet I'm perfectly aware that I scarcely ever used the word (Foucault 2001 p117)

Clegg also signals the dangers associated with the "cult of obscurantism" that has grown through the voluminous secondary literature on Foucault, which Foucault (1988) himself had earlier observed. He complained that

it's true one isn't read anymore – what is serious is that, as one goes on writing books, one is no longer read at all, and from distortion to distortion, reading out of others' readings, one ends up with an absolutely grotesque image of the book (p52)

An example of this relates to the claim by Fillingham (1993) that for Foucault, "knowledge is power". In an interview Foucault had stated that

it has been said but you have to understand that when I read- and I know it has been attributed to me- the thesis “knowledge is power” or “power is knowledge” I begin to laugh, since studying their relation is precisely my problem. If they were identical I would not have to study them and I would be spared a lot of fatigue as a result (1988 p43)

Gordon (1980 p 233) described the interaction and interdependence of power and knowledge as the “strategic fulcrum of Foucault’s work in the late 1970s”. For Foucault “truth and knowledge are implicated in power” (Apperley 1997 p17). This entwining of truth and knowledge with power is described by Foucault in the following terms,

in a society such as ours, but basically in any society, there are manifold relations of power which permeate, characterise and constitute the social body, (1980 p93)

Thus power and knowledge are intrinsically linked and perpetuate each other’s existence, and these concepts were often combined into one, “power/knowledge” (“pouvoir/savior” in Foucault’s own language). Within this view, Foucault proposed an expanded conception of power. He stated that seeing power only as repressive and prohibitive, associated with the rule of law, is a “wholly negative, narrow, skeletal conception of power” (Foucault 1980 p119). He also saw power as positive, as a productive network running through the whole social body. He states that

what I am attentive to is that every human relation is to some degree a power relation. We move in a world of perpetual strategic relations (1988 p168)

Because of this web-like dispersal of power, Foucault was concerned with the “micro-politics of everyday life” (Manias & Street 2000). He actually proposed that power in the substantive sense (as a force held or emanating from any point) does not exist, but that “in reality power means relations, a more-or-less organised, hierarchical, co-ordinated cluster of relations” (1980 p198). Within these relations, Foucault rejected a focus on the agency and the subjectification of actors, preferring to suggest that people take up temporary positions within different sets of power relations at different times. In other words, Foucault

viewed the “self as a product of specific configurations of power and is thus a spatially and temporally located phenomenon” (Apperley 1997 p15) Giddens (1984 xxv), appearing to agree with this position, proposes that “each person is positioned, in a ‘multiple way’ within social relations conferred by specific social identities” While this is not fully consistent with Foucault’s position, since Foucault opposed social constructs which implied an identity, it stresses the fluidity of relations and the nature of power What this analysis suggests is that it is conceivable that midwives’ relative positions and strengths will alter depending on their different sets of relations (with doctors, other midwives, birthing women) For example, midwives’ claims that they are relatively powerless vis-a-vis medicine, does not imply that they are powerless *per se* This becomes important particularly in relation to midwives’ relationships and power relations with birthing women

Additionally, consistent with his depiction of the dispersal, rather than the centralisation, of power, Foucault rejects the notion of a supreme state power, since

the state for all the omnipotence of its apparatuses, is far from being able to occupy the whole field of actual power relations, and, further, because the state can only operate on the basis of already-existing power relations (Foucault 1980 p122)

He thereby sees the state as “super-structural”, operating above but also making use of the multiple power relations that exist This challenges conceptions of the overarching control of the state or its agents However, there are those who critique the adoption of a view of power as dispersed They claim that this shifts attention away from the larger patterns of power and domination, which critical approaches emphasise Equally feminist critiques that postmodernism underemphasised the nature of patriarchal power have been debated (Desling 1991, Miers 2000) However, Foucault did not propose a naive view of power Gordon (2001 p xv) highlights that Foucault was aware that “the apparent neutrality and political invisibility of techniques of power is what makes them so dangerous” This reflects Lukes’s (1974) radical conception of power discussed above, although these writers have little else in common in their work on power Foucault does not view discourses as

dominant and marginal, which critical approaches emphasise. However he acknowledges that certain discourses are more dominant than others (Manias & Street 2000). He also calls for recognition of the forms of hegemony, social, economic and cultural, within which power operates at a given time. Within the dispersal of power, Foucault (1980 p93) also emphasises that multiple relations of power

cannot themselves be established, consolidated, nor implemented without the production, accumulation, circulation and functioning of a discourse. We are subjected to the production of truth through power and we cannot exercise power except through the production of truth.

This is another key aspect of Foucault's work on power, namely the role of disciplinary power in producing "truths". Within this analysis, he highlights the role that disciplinary power plays in regulating social life. Within disciplinary power, truths and falsehoods are constituted historically and they then appear to be self-evident, as in medicine. The features of medicalisation which he describes all point to the nature of the disciplinary power of obstetrics, namely the regulation of bodies, confinement and the spatialisation of "patients", normalising judgements, minute control of timetabled activity, repetitive exercises, and a focus on principles, calculations and procedures rather than individuals (Foucault 1994). Feminist postmodern researchers have also demonstrated the value of treating "gender ideology as a disciplinary discourse" and the need to study "gender ideology as a power discourse in its own right" (Desling 1991 pp149-150) within the analysis of the medicalisation of maternity care.

Surveillance is the central issue to disciplinary power for Foucault (Clegg 1989 p 191). He saw the power of medicine as being in the "clinical gaze" (Henderson 1994 p936). Foucault (1994 [1977] p107) describes this gaze as an observing one which "refrains from intervening. It is silent and gestureless". Clearly obstetric science intervenes as well as observing. Within an Irish maternity service context, the overarching disciplinary power of obstetrics is evident. This medicalised context is immersed in discourses about risk in particular, which tend to be undertaken in a "taken for granted manner" (Manias & Street

2000 p52) In particular, regarding confinement (of those with mental illness and those who had committed crimes), Foucault (1988 p 96) had stated in an interview in 1978 that

what struck me about the practice of confinement was [that it was] accepted by both sides as absolutely self-evident

While this refers to confinement in prison, it could have been written about confinement in childbirth Murphy-Lawless stresses the self-evidential nature of obstetric discourse and the need to be aware of the extent to which the conceptual framework of the medical sciences including obstetrics is shared by doctors and women alike Murphy-Lawless (1998 p190) states that it is extremely difficult to move outside the obstetric frame of reference, particularly regarding risk and its meanings Within this process of “scientific enculturation” (Murphy-Lawless 1998 p249), women’s reliance on and relationship with obstetric medicine has grown stronger and appears to be inescapable

However, in a lecture in 1976, Foucault (1980 p80) also heralded the “insurrection of subjugated knowledges” as being possible within postmodernism’s movements and shifts He defined subjugated knowledges as

disqualified as inadequate to their task or insufficiently elaborated naive knowledges, located down on the hierarchy, beneath the required level of cognition or scientificity

Within a maternity context, women’s and midwives’ (in other words, feminised) subjugated knowledges about childbirth were displaced by obstetricians’ scientific encroachment into childbirth from the eighteenth century In an Irish context Murphy-Lawless (1998 p264) calls for those who engage as users and practitioners to displace the hegemonic obstetric grasp of childbirth and to overturn obstetrics’ claim and status In keeping with Foucault’s celebration of subjugated knowledges, Gordon (1980 p258) suggests that what Foucault has to offer is

A set of possible tools, tools for the identification of conditions of possibility which operate through the obviousness and enigmas of our present, tools perhaps for the eventual modification of those conditions

A Foucauldian approach therefore highlights the possibilities for the exercise of productive power, despite perceived constraints Manias & Street (2000 p52), while acknowledging the dominance of certain discourses (such as medicine), suggest that there is also “the possibility of expressing other practices that fall outside these regimes, such as the use of complementary therapies” Surprisingly, given the nature of the maternity services outlined in chapter 2, this is an interesting example Reflexology has been in use in the National Maternity Hospital in Dublin since 1995 (McIlraith 2006) This hospital is the oft-cited original home of the active management of labour The reflexology service was established by six midwives and now reflexology is practised by 50 midwives throughout the hospital This exemplifies Manias & Street’s point It suggests that things are not as fixed as they might seem, and that movement and shifts in thinking are possible, in keeping with a Foucauldian view of power Foucault (1998 p294) himself encapsulates this as follows,

The important question here, it seems to me, is not whether a culture without restraints is possible or even desirable but whether the system of constraints in which a society functions leaves individuals the liberty to transform the system

There is little doubt that maternity systems involve constraints, and as Foucault highlights, it is unlikely that such a system could function without them The challenge for midwives lies in identifying ways to transform the system to enhance their own practice for the benefit of themselves and birthing women Therefore, Foucauldian analysis, by emphasising the multiple and productive nature of power, challenges the notion of the oppressed “powerless” midwife It does this by highlighting the power relations between many groups in healthcare (Gastaldo & Holmes 1999 p238) Midwives have power in situations, particularly relating to the women with whom they work Research has shown how they operate this power to the detriment of women in certain circumstance (Levy 1999, Simvaara *et al* 2004) Acknowledging and optimising the use of this power appears more constructive than adopting an assumed resigned “powerless” stance This highlights their

potential to influence the experience of birthing women, in one direction or another Foucault views power as both positive and negative This means that power is seen as fragile, and that “nothing is ever settled and there is always everything to play for” (Apperley 1997 p16) This offers a dynamic and more optimistic perspective on power and empowerment in midwifery which will form part of the backdrop against which the findings of this study will be interpreted

3.6 Concluding thoughts a tool box approach

This chapter has examined the literature on power and empowerment Both of these concepts are complex and contested Debates about the relative importance of structure and agency are at the root of debates about power and empowerment Taking cognisance of the ‘ecology of empowerment’ means taking account of the person and the environment, or agency and structures The interaction between these and their relative weight forms a central plank in sociological debate Equally in the study of empowerment in midwifery, the agency of midwives and the structures within which they work and the interaction of structure and agency are all critical The examination of different theoretical perspectives on power and empowerment allows consideration of the relative merits of each perspective Central to the analysis of power and empowerment is the question of gender as outlined earlier in this chapter This analytical lens operates both within and above these approaches

Within the organisational perspective on empowerment there is an emphasis on the structural conditions which influence employees’ work behaviours Accordingly, a large body of research work on empowerment in nursing has been conducted to examine structural workplace conditions using the *Work Empowerment Scales* of the UWO One study has used amended versions of these tools in a midwifery context (Dunlea 2003) They appear relevant to the structural aspects of the practice environment since many of midwives’ concerns relate to dissatisfaction with structural conditions relating to management or the “system” It is therefore appropriate to examine the midwifery workplace by adopting an organisational perspective on empowerment, while acknowledging the underlying patriarchal nature of maternity care organisations The UWO

scales were used in both surveys conducted within this study. Further information about these scales is outlined in the Methodology chapter (see page 105).

The other perspectives examined above (critical and postmodern) contribute different sorts of value to the analysis of empowerment in midwifery. This is not to suggest that this study was carried out from either a critical or postmodern perspective, since this would have had considerable epistemological and methodological implications as these approaches have different ontological bases. However, Manias & Street (2000) examine the possibilities of a “toolbox approach” for converging both critical social theory and Foucauldian frameworks. Drawing on both of these frameworks permits different though complementary types and levels of analysis to be carried out. Using different approaches, allow the broader “polyvocal” (Manias & Street 2000 p50) analysis of the nature of power and its operation at the social level. This supplements the adoption of an organisational approach to the empirical study of the midwifery workplace.

Critical approaches offer important tools to those seeking to understand the nature and operation of power. This is because power analyses are central to critical approaches. In particular, the key contributions to understanding power and empowerment in midwifery are based on two of the key features of critical approaches, namely the characterisation of oppression and hegemony. However in their analyses of power relations in nursing, several authors have emphasised the limits of considering only the macro level of domination by medicine, which reflect a critical approach (Wicks 1998, Farrell 2001, Clouder 2003). They claim that this ignores the everyday practice of power relations within nursing environments, which are in a more postmodern vein.

In acknowledgement of the critiques of critical approaches in general, postmodern perspectives on power and empowerment offer ways of focusing on dispersed power networks, which operate throughout society. They also stress the positive as well as negative potential of power. Postmodernism stresses the value of fluid and multiple interpretations of facets of social life, rather than a focus on grand theories. These varied

theoretical approaches thus constitute the toolbox with which the findings of this study on power and empowerment in midwifery will be analysed. The means of studying these are outlined in the Methodology chapter which follows.

CHAPTER 4

METHODOLOGY OF THE STUDY

Marshalling and comparing a sufficient number of observable or measurable facts as evidence, rarely, if ever, leads to the one correct conclusion. Intellectual flexibility, tolerance of ambiguous and discordant information obtained from different methods from differing viewpoints and at different conceptual levels, the judicious yet knowingly fallible, theory-derived construction, selection and interpretation of observations and empathically derived experiences typify the scientific method (Harari 2001 p729)

4.1 Overview of the methodology of the study

The overall aim of this study is to explore past and present issues related to power and empowerment in midwifery in Ireland. The study involves historical and survey research. While exploring the background to this study, particular historical episodes were highlighted as being of relevance when considering issues of power in midwifery. In particular the abolition of the *Central Midwives Board* through the 1950 Nurses Act seemed critical. The background to this event and its impact have not been studied previously. In order to provide a deeper understanding of the process by which the *Central Midwives Board* was abolished and its implications, historical research was conducted using key primary sources.

The survey methodology to elicit the conditions important to facilitate empowerment in midwifery. Two cross-sectional surveys were carried out, one in 2002 and another in 2005. Self-reporting questionnaires were used to collect data from random national samples of practising midwives. This survey design was used in order to obtain quantifiable data. The randomness of the samples used increases the potential generalisability of the findings. The underpinnings and methodological considerations of both historical and survey research are outlined below.

4.2 Historical research

A researcher who chooses [the] historical method must exhibit more than just a curiosity about the past. The researcher formulates a thesis about the relations between ideas, events, institutions, or people in the past. Chronologically ordering events over time does not explain the links and ties established between them (Lewenson 1995 p196)

Many authors have extolled the value of historical research to nursing (Church 1987, Lewenson 1995, Fealy & O'Doherty 2005) and this value can be extrapolated to midwifery. Church claims that the study of the history of professions represents "the potential for the discovery of a unity and continuity in one's identity". In other words it allows us to locate and contextualise current issues and events along a developmental professional trajectory. However this is not to assume its uncritical adoption. Ashley (1978 p29) cautioned that "much of the written history of nursing has been used to support illusions that foster false pride". Church (1987 p277) had cautioned that "the profession's self-congratulatory efforts in past historiography restrained the potential of critical analysis so necessary if history was to meet its major objective of self-knowledge". Church (1987 p276) also cautions that by studying past we may become "troubled by the persistent obstacles of the past that continue to confound us".

In their introduction to a recent text on Irish nursing and midwifery history, Fealy & O'Doherty (2005 p27) state that nursing and midwifery history has been a "much-neglected area of Irish social and labour history". The authors describe the early "celebratory, progress-oriented, leadership-dominated trend in nursing historiography" (p20).

4.2.1 *The historical research process*

Sarnecky (1990) outlines the stages to be followed in undertaking historical research. These include choosing a problem, specification of the data required, searching for available data, assessment of validity of data (external and internal criticism), the synthesis of the data and the application of the historical findings to future directions. This last stage involves the "organisation, integration and analysis of the collected data into a logical sequence".

characterised by lucidity, coherence and an absence of lacunae”(Sarnecky 1990 p5) Lusk (1997 pp358-9) describes external and internal criticism External criticism is concerned with the authenticity of the document - whether it is what it purports to be Internal criticism is concerned with the reliability of the information contained within the document, in terms of ascribed meanings, language and terminology used and the accuracy and objectivity of the writer Austin (1958 p6) cautions that the data are not the events themselves but “traces or remains of events” or “statements of events” Ashley (1978 p30) highlights the role of the analysis of historical data, saying that

Facts, events, ideas, institutions and societal trends do not speak for themselves but must be interpreted by a human mind hard at work trying to analyze the continuity, diversity and change involved in the complex inter-relationships that characterise human history

4 2 2 Sources of historical data

Primary sources are the preferred sources for historical research Lusk defined primary sources as documents recorded by people “who participated or witnessed an event” Fealy and O’Doherty (2005 p16) state that the “veritable renaissance that the writing of nursing and midwifery history now enjoys in Ireland can be seen by the greater usage of primary sources by scholars” The authors highlight “the minute books of the General Nursing Council for Ireland and An Bord Altranais as important records for historians of nursing and midwifery” The authors do not mention the Central Midwives Board, a telling omission in itself, in the context of the invisibility of midwifery The records of the Central Midwives Board are rich resources for those interested in the history of midwifery, and these were key sources for the historical aspect of this study

The primary sources used in this study are the official minute books of the Central Midwives Board, The General Nursing Council, An Bord Altranais and the Statutory Midwives Committee of An Bord Altranais These data sources were accessed during May/June 2005 Minute books covering the periods outlined in Table 4 1 were

methodically searched and relevant material was noted. In the case of the General Nursing Council and An Bord Altranais the minutes of the meetings shown in Table 4.1 were primarily searched for references to midwifery. These minute books are available upon application and can be accessed within the offices of An Bord Altranais under the guidance of an appointed Education Officer. As official records, these have particular importance but also limitations in terms of the informal relations and influences on developments. Nonetheless within these limitations, they do provide invaluable documentary evidence of formal interactions and decision-making.

Material quoted verbatim from the minutes is included within quotation marks. Where this refers to individuals' recorded contributions this is not to imply that this is a verbatim quote, but the exact record held in the minutes.

Table 4.1 Minute books of regulatory bodies studied

Body	Dates covered (as organised within bound minute books)
Central Midwives Board	1918-1931, 1932-1935, 1935-1939, 1939-1942, 1942- 1951
General Nursing Council	1920-1943, 1949
An Bord Altranais meetings	1951-1953, 1954-1959, 1959-1964, 1964-1967, 1968-1969, 1969-1972, 1973-1976, 1976-1982, 1982-1985
Statutory Midwives Committee	1951- 1960, 1963-1985

In addition, during periods when midwifery legislation was being considered by both houses of the Oireachtas (legislature), the Dáil (Parliament) and Seanad (Senate), the records of the debates of the Oireachtas were examined. The periods covered are shown in Table 4.2. These were accessed through the website of the Oireachtas Historical debates (<http://historical-debates.oireachtas.ie>)

Table 4 2 Records of Oireachtais debates studied

House of the Oireachtais	From	To
Seanad (Fourth)	Volume 28 (23 March 1943)	(Note Accessed for debates on Midwives Bill 1943)
Seanad (Sixth)	Volume 37 (starts 12/10/1949)	Volume 39 (ends 25/07/1951)
Dail (Thirteenth/Fourteenth)	Volume 112 (starts 13/07/1948)	Volume 120 (ends 28/11/1951)

The relevant statutory Acts (and Bills where possible) (Midwives Act (Ireland) 1918, Midwives Act 1944, Nurses Act 1950, Nurses Act 1985) were also directly accessed

Both the minutes of the relevant regulatory bodies and the Oireachtais debates meet the criteria for external and internal criticism as they are official records recorded and verified at the time of the events described within them

Secondary sources on midwifery history were also used in this historical research. There are few published accounts of aspects of the history of midwifery in Ireland. Recent contributions include McMahon (2005) and Devane & Murphy-Lawless (2005), two chapters in Fealy's (2005) text on nursing and midwifery history in Ireland. McMahon's chapter focuses on the role of the Royal College of Physicians in Ireland in the 1918 Midwives (Ireland) Act. Devane and Murphy-Lawless's chapter examines aspects of childbirth in Ireland during the period 1650-1750.

Other related secondary sources were consulted such as Robins's (2000) commemorative history of An Bord Altranais, within which O'Dwyer & Mulhall's (2000) chapter focuses on midwifery. Scanlan's (1991) comprehensive history of nurse education in Ireland was also examined for midwifery material. As Fealy and O'Doherty (2005 pp26-27) observe, these particular sources are more descriptive than critical. Other relevant sources available include histories of maternity hospitals (for example Browne's 1995 commemorative history of the Rotunda Hospital) and histories of midwifery in other countries (for example

Donnison 1988) However, as Fealy & O'Doherty (2005 p23) observe most hospital histories are written as commemorative histories and the aim is to celebrate rather than to analyse In these commemorative histories the authors state, "nursing tends to receive cursory mention only" (p23), with a chapter written by nurses with "anecdotes and reminiscences" included That is also the case with the histories of the maternity hospitals, with for example the Matron of the Rotunda of the time contributing a chapter on midwifery in the hospital to Browne's (1995) book Oral histories make a valuable contribution to our understanding of the past, through the voices of midwives No oral histories of midwives who practised in Ireland were located Those from other geographical areas (Leap and Hunter 1993) show the potential value of such a research approach

4.3 Survey research

This section reports on the survey methodology used in this study All practical aspects of the conduct of the empirical component of this study are outlined This includes the sampling strategies, research instruments, methods of data analysis and the ethical considerations and procedures

The relationship of the data collection strategies to the overall theoretical and epistemological stance must be clearly articulated (Oliver 2004) Surveys are said to exemplify the quantitative approach to research (Bryman 1988 p1) According to Oliver (2004 p122) quantitative studies are drawn from the positivist paradigm, based on an approach that sees knowledge as "objective, verifiable and replicable" Sarantakos (1993 p34) proposes that positivism

defines reality as everything that can be perceived through the senses, reality is out there independent of human consciousness, is objective, rests on order, is governed by strict natural and unchangeable laws and can be realised through experience

In contrast to positivism, interpretative epistemologies explore "different understandings" and "would tend to treat knowledge as created and negotiated between human beings" Positivism has its roots in Comte's concern that the methodology of studying social

phenomena was descriptive, philosophical and speculative with metaphysical or theological explanations being sought for social problems (Sarantakos 1993 p3-5) The positivist tradition in the social sciences came under increasing attack with the development of qualitative approaches to data collection from the mid twentieth century Bryman (1988 p13) records that the term positivism was used “glibly and indiscriminately” by many writers in the 1960s in their critique of quantitative research and in fact it “became a term of abuse”, which inhibits reasonable debate about the nature of methodologies and methods of data collection

Bryman (1988 p14) proposes that the positivist position “rules out any possibility of incorporating metaphysical notions of ‘feelings’ or ‘subjective experience’ into the realms of social scientific knowledge unless they can be rendered observable” May (1997 p11) expands on the meaning of objectivity in the context of positivism and empiricism

there is a world out there that we can record and we can analyse independently of people’s interpretations of it

However the reflection of these tenets of positivism in most social surveys is not immediately apparent As May (1997 p83) observed “surveys have their origin in the positivistic tradition, though to describe surveys nowadays as ‘positivist’ is an over-simplification” However it is important to acknowledge the roots of surveys within the quantitative tradition that is based on positivism and it is necessary for those who use surveys to have an awareness of the implications of this ancestry As surveys fall within the quantitative tradition, the essential features of quantitative research are next explored

4 3 1 The essential features of surveys

Surveys usually collect quantitative data Sarantakos (1993 p41) states that apart from positivism, “the ideological bases of the quantitative school of thought” include ‘quantitativism’, that is “placing emphasis on measurement and quantification” The purpose of the survey is to produce statistics, that is, quantitative or numerical descriptions

about some aspects of the study population Carter (2000 p165) states quite simply that “if the collection of numerical and measurable information is a priority, a quantitative approach is called for” Thus it is clear that all surveys are based on the principle of quantitativism and whether or not they are based in positivism depends on what questions they ask, how these questions are asked and how responses are analysed

Quantitativism is also the basis for the other essential features of surveys, namely causality, generality and replication Regarding causality, Bryman (1988 p30) states that “quantitative research is often highly preoccupied with establishing the causal relationships between concepts” Clearly the “experiment” involves an intervention or independent variable being introduced or altered and the effects of this on the dependent variables being measured Thus causality is measured directly, if of course stringent conditions are in place to out-rule extraneous effects On the other hand cross-sectional surveys which measure certain variables require that the “temporal order” be imputed by the researcher - in other words, causality is imputed However the substantive commonalities as well as distinctions within types of quantitative research need to be borne in mind In characterising the family of quantitative research, Fink identifies two strands studies that test differences either (a) between groups (control, intervention groups etc) which have been created for the research (experimental), or (b) between variables (correlational), carried out on results from existing groups, without the creation of new groups The latter are also described as non-experimental, observational design (Fink 1995 p23, Punch 2005 p73) Punch (2005 p75) cautions that “the logic behind correlational designs is based on the logic behind experimental designs Researchers have applied the principles of experimental reasoning to non-experimental situations”, for example with the use of techniques such as multiple linear regression This applies the same principles and statistical assumptions as are used to examine differences between groups within experiments This is not to suggest that there are no differences between experimental and survey designs, but their shared genealogy needs to be acknowledged

Another feature of quantitative research is generalisability Bryman (1998 p34) clarifies that

The quantitative researcher is invariably concerned to establish that the results of a particular investigation can be generalized beyond the confines of the research location

Within surveys, generalisability can be achieved when certain conditions, mostly relating to sampling strategies, are met This requires that attention be paid to sampling procedures and the representativeness of samples, since most statistical inferential techniques only make sense in the context of randomly selected samples Bryman acknowledges that national random sample surveys are quite rare in the social sciences and this may affect generalisation potential This study uses national random samples of practising midwives

Related to generalisability of a study is its replicability Replication provides “a means of checking the extent to which findings are applicable to other contexts” beyond those claimed by the study (Bryman 1988 p37) This acts as a means of checking the biases of the researcher, Bryman states A challenge to replicability is offered by Morgan (1983 pp394-5) when he states that by replicating others’ studies,

[researchers] structure reality in an identical way and hence improve the chance of seeing the same things and of confirming or rejecting the findings produced by the original research The replication of such research projects to determine the generalizability of such findings is in essence a replication of the social [sic] constructed way of seeing built into the protocol that guides the research

This critique arguably overstates the case against the possibility of replication and is actually addressing another broader issue of the self-delimiting properties or the “social [sic] constructed way of seeing” of any research design Morgan’s (1983 p395) own conclusion regarding validity serves as a caution to overstating claims of validity, as he states,

The validity of the knowledge generated relates to a specific aspect of the phenomenon being studied. Once one recognises the existence of the phenomenon in a sense wider than that dictated by the research design, the limitations of the knowledge generated within that design become very clear.

This is so because a particular design depends on the operationalisation of a particular framework or way of viewing a topic. Kerlinger (1986 p29) cautions against a measure of a phenomenon becoming how that phenomenon is defined, rather than the explicit acknowledgement that the definition came before the measure. The philosophy of science literature echoes this, with Popper (1968 p62) stating that,

it can be shown that measurements presuppose theories. There is no measurement without a theory and no operation which can be satisfactorily described in non-theoretical terms.

Couvallis (1997 p25) points out that Popper correctly argues for two important points. Contrary to a naive theory of value-ladenness, “we do not always perceive what we expect” and just because our attention is directed towards the observation of specific things “does not mean we are not being objective” (p25). Similarly, in a nursing theory context, Paley (1996 p577) has disputed the arguments of those who seek theoretical understanding by examining how they measure a phenomenon, stating that they have the order wrong and that “there is only theory, with meaning and methods of measurement being part of what a decent theory supplies”. What these authors highlight is that operational definitions are indispensable ingredients of scientific research. This is so because they enable researchers to measure variables and because they are bridges between the theory level and the level of observation. However we need to recognise their limitations in terms of yielding “only limited meanings of constructs” (Kerlinger 1986 p29).

Alongside quantitativeness, causality, generalisability and replication, the last assumption relating to quantitative research outlined by Bryman (1988) is individualism. Quantitative research tends to focus on the individual as the unit of inquiry, and responses are aggregated to form overall responses, rather than the unit of inquiry being other social

groups such as families and various other collectives. This is in contrast to other approaches such as ethnography and methods of data collection, such as focus group discussions, where the explicit emphasis is on the group and/or cultural context. This is not to discount either approach but to acknowledge another assumption of quantitative research.

The defining features of quantitative research are also at the root of their limitations. With their inherent focus on measurement, a central limitation of surveys is that they are generally non-interactive, with little opportunity for researcher or participant to seek *clarification regarding uncertainties in interpretation*. According to May (1997 p 104) the survey method has been criticised as “it rules out the possibility of understanding the processes by which people come to adopt particular values or behaviours”. However as May points out, scales are usually generated through theory and or qualitative developmental work. They are therefore based on an understanding of agents’ perspectives, social processes and context. The lack of interactivity should not be confused with objectivity and this is expanded by examining the potential - in fact the propensity - of social surveys to elicit subjective data. What is highlighted within this study is that it is possible to use a quantitative method such as a survey and still treat knowledge as subjective and created by human beings. This is expanded upon in the next section.

4.3.2 Subjectivity in surveys

Surveys using questionnaires can elicit objective, verifiable data. However more often than not, all questions contain some level of subjectivity on the part of respondents, despite apparent objectivity. For example, asking how many hours people work or how they view their clients are open to subjective interpretation and response and may or may not be objectively or indeed accurately answered. In many cases therefore what is obtained is the respondent’s subjectively interpreted and motivated response. Schuman & Presser (1996 p1) acknowledge that surveys generally deal with subjective phenomena and furthermore recommend that “it is well to keep in mind that many questions commonly regarded as factual have a large subjective component”. Thus the validity of a tool relates to its ability to accurately measure perceptions rather than some objective reality. This is not stated here

as a limitation but as an explicit focus on what is being asked and why. These are based in core ontological and associated epistemological questions, so that,

To concentrate on subjectivity we focus on the meanings that people give to their environment, not the environment itself (May 1997 p13)

Fay (1996 p24) develops this further in terms of how we are trying to understand what something means to a person, asking,

When we want to know someone or some group, what is it we want? By understanding I mean a *sense* of it, a grasp of what it means. *It is not feeling but meaning* which we must have to be said to know someone (even ourselves)

Fay states that we understand others not when we become them, but “only when we are able to translate what they are experiencing or doing into terms which *render them intelligible*” He states this as “knowing others is being able to interpret the meaning of their acts” (p26), and “to be able to make sense of their experience” (p28). This study interprets the meaning of what midwives communicated. There is an explicit acknowledgment here that the process of interpretation is that of the researcher.

The objectivity-subjectivity spectrum has been explicitly debated in the context of empowerment research. Under the heading “The importance of perception” Spreitzer (1995 p486) states that “it is individuals’ perceptions of their working environments that shape [their experiences/perceptions of] empowerment [sic] rather than some objective reality”. She states that “because empowerment is defined as a set of cognitions it too must be assessed through perceptions”. This reflects a constructionist standpoint, “whereby reality is reproduced by people acting on their interpretations and their knowledge of it” (Palys 2003 p12). Thus surveys are capturing respondents’ interpretations of their worlds, highlighting the subjective elements of all research which is based on participants’ perceptions of a situation, even when these perceptions are recorded or measured within quantitative research approaches. As stated above the non-interactivity of quantitative research means that there is no opportunity to probe meanings or to develop a deeper

understanding of the perspective of participants. The ostensibly positivistic method (the survey) of collecting data based on participant-generated meanings is capturing subjective perceptions and beliefs in any case.

Bryman (1988 p142) states that “one facet of the distinction between quantitative and qualitative research is that the former is oriented to the specific concerns of the investigator and the latter to subjects’ perspectives”. Punch (2005 p58) states that quantitative data “reflect researcher-imposed constructs” and that “quantitative designs typically have well developed pre-specified conceptual frameworks” (p64). Similarly it is reported that a criticism of quantitative research is that it “often results in ‘meanings’ that are closer to the beliefs of the researchers than to those of respondents” (Sarantakos 1993 p42). However it is possible, as this study shows, to keep participants’ beliefs and perceptions central in terms of how the phenomenon of interest is studied. Thus a subjective interpretivist strand can feature in a quantitative study, though the non-interactivity limitation is acknowledged in this regard. “Insider and outsider perspectives” can be combined within a single study. In this study, the surveys draw on both insiders’ (midwives’) perspectives, while acknowledging the role that a researcher plays as outsider.

Fay (1996 p2) charts the emergence of perspectivism which “asserts that every epistemic endeavour - including science - takes place from a point of view defined by its own intellectual and political commitments and interests”. According to perspectivism we cannot see directly into anything - much less *Reality* “it is never phenomena themselves which are the facts but *phenomena under a particular description*” (p73, emphasis in original). This links with the Popperian premise about theory presupposing investigation discussed above. Fay describes perspectivism as the “dominant epistemological mode of contemporary intellectual life” (p72). Within this approach, all seeing is from a particular perspective.

Midwives’ perspectives are explicitly those captured in this research. This is not to deny others’ perspectives, such as those of birthing women or other maternity care professionals,

but that they are not being researched in this study. Seeking to capture what midwives understand by empowerment explicitly involves a perspectivist stance. It deliberately privileges practising midwives' perspectives in order to engage practitioners' understandings. This is consistent with Foster-Fishman et al's (1998: 510) discussion of empowerment measurement, when they highlight that by

utilizing singular measures of empowerment and limiting our operationalization of the construct to our own or leaders' meanings of empowerment, we significantly risk silencing the unique and personal empowerment experiences of the targeted population. We risk excluding groups or individuals who do not share the leader's or researcher's desires for or definition of empowerment.

This approach explicitly underpinned the development of the scale to measure conditions for empowerment in midwifery.

This study used qualitative data to generate quantitative scales. Thus, a "sequential exploratory strategy" (Creswell 2003: p214) was involved in the development of the *Understanding of Empowerment Scale* (UES) from the qualitative data gathered in the focus groups of phase 1 of the national study on empowerment (Scott et al 2003). This facilitated insider perspectives to generate the UES, which ultimately led to the development of the *Perceptions of Conditions for Empowerment in Midwifery Scale* (see chapter 7).

Some qualitative data were also collected via the questionnaires, "in the participants' own words". Clarification on issues raised was not possible given the nature of questionnaires and that anonymity was a feature of the surveys. Combining approaches under a strategy of mutual corroboration exhibits greater confidence in their method of investigation (Bryman 1988: p131). However the purpose of including open questions was to allow for completeness as well as confirmability, the two goals of triangulation identified by Begley (1996). Notwithstanding these aspects of the study, the method of empirical data collection is a quantitative one, the survey. An examination of the features or components of surveys follows.

4 3 3 *The components of surveys*

The components of surveys are listed by Fowler (2002 p4) as sampling, question design and data collection. The key issues relating to each of these will be considered in turn as a basis for the presentation of the methods of this study in the next section. “Question design” will be re-titled here as “Question/questionnaire design” to also capture the aggregate level of question design.

4 3 3 1 Sampling strategies

How well a sample represents a population depends on the sample frame, the sample size and the specific design of the selection procedures (Fowler 2002 p10)

As discussed above, central to the basis of the quantitative approach to research is a search for representativeness and therefore generalisability. A critical factor influencing the extent to which this is achieved is the sampling strategy. Each of the key elements to which Fowler refers above will be explored before considering this study’s sampling strategy.

The sample frame is the set of people that has a chance to be selected given the sampling approach that has been chosen. Fowler clarifies that a sample is only representative of the sampling frame. This highlights the importance of the appropriate selection of a sampling frame: the nearer the sampling frame corresponds to the full population being studied the better.

The next decision relates to the method by which the sample is identified or extracted from the sampling frame. The extraction of a sample can be one-staged or multi-staged, the latter used in clustered sampling. The most common method within one-staged sampling is simple random or probability sampling, whereby a sample is systematically drawn from a computerised list of all those in the sampling frame (Fowler 2002 p14). Each person in the sampling frame has an equal chance of being selected. Moser & Kalton (1971 p116) stated that “randomness forms the base of the entire structure of sample design” and if this is met then statistical procedures and conclusions are meaningful.

The next issue to consider is sample size. There are many factors to be taken into account when deciding what sample size is required. Although “a large sample size is not sufficient to guarantee accuracy” (Moser & Kalton 1971 p146), an inadequate sample also has limitations. Ultimately the sample size depends on the purpose of the research, how the data will be analysed (including sub-groups), what claims will be made on the basis of the research and what non-response is expected. Decisions must be made on a case-by-case basis, with a specified population fraction or customary number (for example 1,500 for a national survey) being meaningless unless all aspects of the research and sample requirements are taken into account. Fowler (2002 p36) emphasises the importance of having adequate sub-groups and planning for this at the outset.

In conclusion, ultimately the quality of a sample depends on three factors: the sampling frame including the full population, probability sampling, and the size of a sample taking into account the distribution of what is being estimated (Fowler 2002 p37). These three aspects will be dealt with in relation to this study later in this chapter (see page 99).

4.3.3.2 Question/questionnaire design

Within the survey method there are several ways of collecting data, including face-to-face interviewing and the use of self-report questionnaires. Self-report questionnaires were used in this study. The advantages and disadvantages of using self-report questionnaires are listed by Murphy-Black (2000 p 302). The advantages include distribution in large numbers, ease of administration, especially by post, and the possibility of anonymity. These advantages were part of the reason for the choice of using questionnaires rather than face-to-face structured interviewing for example. The disadvantages on the other hand include low response rate, the limitations of closed questions, which may also influence response rate, the lack of opportunity to clarify issues and the effects of questions order. In particular non-response is important in that it begs the question about the differences between those who replied and those who did not. Ways of examining reasons and effects of non-responders, as well as techniques to reduce non-response are outlined at length by Fowler (2002). He recommends that researchers' primary efforts go into enhancing response rate.

initially through the questionnaire design in terms of its length, clarity and perceived relevance to the sample. Strategies for improving initial response rates are recommended as well as strategies for addressing shortcomings in response rates. For example if particular demographic groups are seen not to have proportionately responded, the responses that were received from members of that group can be weighted. However he stresses the measures relating to the structure of the questionnaire to a greater extent.

Nuttall (1979 p43) discusses the “principles of measurement” in a dated but still useful *Open University* research methods course book on *Classification and measurement*. Therein he states that “through measurement we make public an operational specification of our concept that allows others to attempt to replicate or refute our world”. He cautions that while the roots of measurement in the social sciences are based on those of the natural sciences, the concepts in the natural sciences are easier to measure (length, temperature etc.) than in the social sciences (social class etc). Kerlinger (1986 p 391) further cautions that we are measuring ‘indicants’ (something that points to something else) of the properties or the characteristics of objects rather than objects. Then we are inferring these properties or characteristics from observation of presumed indicants of the properties. He goes on to state that the indicants from which properties are inferred are specified by operational definitions, definitions that specify the activities or “operations” necessary to measure variables or constructs (p396).

There are many important issues to consider relating to how a phenomenon is studied, in terms of its operationalisation and measurement. Schuman & Presser (1996) present a textbook full of the results of their studies into the effects of question form, wording and context within attitude surveys. They address the extensive list of areas of concern including question order, response order, open versus closed questions, the assessment of “No Opinion”, the assessment of non-attitudes, the assessment of the “middle position”, the difficulties with one-sided (biased) statements, the issues of acquiescence and social desirability and the difficulties with picking up attitude strength. They report extensive and varied results of experimentation in relation to all these facets of questionnaire design. Most

researchers who use questionnaires have contemplated these effects, though Marsh (1982) has a refreshing approach. She says that these issues have been dealt with in a simplistic way and claims that it is a futile search for some “true” value of the person, uttered spontaneously - there is always a context (Marsh 1982). Once this is acknowledged then there need not be angst about it. Nonetheless most researchers aim to minimise spurious effects by following the advice of those, such as Schuman & Presser (1996), who study the effects that are discernible.

A broader consideration when undertaking surveys relates to the fact that what is being measured is a perception or attitude and the limitation to which this reflects what people's real attitudes are or how they actually act or behave. Edelman (2000 p277) proposes that attitudes are “consistent and enduring thoughts, beliefs and feelings” rather than transient feelings or moods. They comprise three aspects: an emotional/evaluative component, a belief/cognitive component and an action/behavioural component. The cognitive and evaluative components generally correspond to each other, but the relationship of attitude to action is harder to establish. Edelman (2000 p277) thus states that “while people's beliefs or thoughts may relate quite closely to whether an attitude object is evaluated positively or negatively, such evaluations do not necessarily relate to subsequent behaviour”. Related to this discussion about the measurement of attitudes is the acknowledgement that, in common with many other data collection methods, “social desirability” effects may come into play with surveys. As Bryman (1988 p112) points out, unless they do not know they are under investigation, “people's behaviour or responses may not be indicative of their normal behaviour or responses”. Edelman (2000 p286) agrees that “a problem with any self-report measure of attitudes is that people may wish to conceal rather than reveal their true attitudes”. People may wish to make a desirable impression, based on what they think they ought to say or what they think the researcher wants them to say. Social desirability may feature less by using an anonymous self-reporting questionnaire rather than a face-to-face interview (Fowler 2002 pp99-100). Self-reporting questionnaires were used in this study and anonymity was guaranteed. Nonetheless social desirability effects cannot be out-ruled and will be reconsidered when analysing the findings of this study.

4.3.3.2.1 Likert-scales

The Likert scale is used within this study and specific comments are included here about its use. The Likert scale (Likert 1932) “consists of a set of opinion statements about a particular issue, event or person”. Participants are asked to rate their responses according to the options offered, commonly ranging from “Strongly disagree” to “Strongly agree” across a five-point scale. Likert scales are used in both stages of this study. These scales are generally considered to be ordinal rather than interval scales, which has implications for data analysis. Edelman (2000 p281) states that there is no assumption that the intervals on Likert scales are equal, since the difference between points on the scale vary according to respondents’ perceptions. There is therefore an inherent interpretative process in the use of questionnaires. However in contrast Kerlinger (1986 p401) states that “it is probable that many scales and tests used in psychological and educational measurements approximate interval measurement well enough for practical purposes”.

Another difficulty relating to the calculation of scores based on scales is highlighted by Edelman (2000 p281). This relates to the calculation of scores of responses whereby the aggregated total score on the scale may reflect very different patterns of responses. For example, a person who “strongly agrees” with 5 items (1 point each = 5 points) and strongly disagrees with 5 items (5 points each = 25 points) on a 10 item scale (total score of 30) would have the same score as someone who neither agreed nor disagreed with all 10 items (3 points each = 30 points).

4.3.4 *Reliability and validity in surveys*

Litwin (1995) in a short book entitled *How to measure survey reliability and validity* states that psychometrics is the branch of survey research that enables you to determine the precision of measurement of the constructs being studied (p1). The key indicators of the quality of measurement tools are usually reliability and validity. Simply stated “a reliable instrument is consistent, a valid one is accurate” (Fink 1995 p4). Reliability is seen to reflect the accuracy and precision of an instrument. Nuttall (1979 p67) draws our attention to the “important and lob-sided relationship between reliability and validity”. He uses the

example of an archer consistently missing the target being of little value. Likewise a tool that appears consistent in its measurement properties is of little value if it is not measuring what it purports to measure, that is, if it is not a valid measure.

Within quantitative research, “validity” is often portrayed in an objective light. However, Irvine *et al* (1999 p92) usefully remind us that “though we can never prove validity, we can develop support for it”. Furthermore, Nuttall (1979 p48) reminds us that “the validity of a measuring instrument is dependent on context” - that is, an instrument may be appropriate for one context or application and not another. It is also worthwhile to examine the basis of the various aspects of validity as described in the literature, namely face validity, content validity, criterion validity and construct validity. Such an evaluation suggests that there is an element of subjectivity in most aspects of validity evaluation. Face validity is dismissed as “a cursory review by untrained judges” and said to be “worthless” by Litwin (1995 pp32-33). Seale (1999 p35) states that even in measurement theory,

the concept of face validity depends on a view that we live in human communities that have constructed a system of linguistic symbols to refer to our common experiences, so that we can talk to each other about them.

This highlights the socially constructed nature of the language used in questionnaires.

Content validity is described by Irvine *et al* (1999 p92) as “a qualitative type of validity where the domain of a concept is made clear and the analyst judges whether the measure fully represents the domain”. Criterion validity assumes a “gold standard measure” against which a new instrument is measured. Criterion validity can be either concurrent or predictive. Concurrent criterion validity is assessed by the use of concurrent measures and predictive by reference to later outcome measures. They are both established by examining the correlations between existing and new instruments. A basic assumption about how a “gold standard” measure could be identified is hinted at in the definition of construct validity which Litwin (1995 p44) states “may be said to result from the continued use of a survey instrument to measure some trait or quality”. He further states that “indeed over a

period of years the survey instrument may itself define the way we think about the variable” Litwin states that construct validity is said to “assess how meaningful the scale is in practical use” and acts as “a theoretical measure of how meaningful a survey instrument is” (p44) This description of the various customary facets of validity evaluation suggests less objectivity and certainty than is generally displayed

4.3.5 *Summary Survey methodology*

Regarding the empirical data, it has been suggested above that while surveys may gather quantitative data, these data are not necessarily objective, nor should they be claimed to be so. In the case of this study the data are essentially subjective, since the data explicitly reflect respondents’ perceptions and beliefs about what is asked within the various questionnaires used. For example, asking respondents whether or not they have a supportive manager is actually asking whether they perceive they have a supportive manager? There may be other ways to attempt to objectively assess the level of supportiveness of a manager. Some questions in the demographic section of the questionnaire are more likely to be objective and verifiable - age, grade etc. In reality though, very little substantive data collected in social surveys are objective.

In this study, both the subjects’ (midwives’) and the researcher’s (using existing tools) perspectives were combined. Midwives’ perspectives led to the construction of a tool designed specifically to measure perceptions about levels of empowerment in midwifery, based on midwives’ own beliefs about the nature and meaning of empowerment. The initial items of the *Understanding of Empowerment Scale* (UES), were drawn from the qualitative phase of a national study of empowerment of nurses and midwives, from which this study of empowerment in midwifery grew. Therefore the initial generation of items was inductive. In this sense this study has features of a “sequential exploratory strategy” (Creswell 2003 p214).

In addition, in both surveys respondents were given the opportunity to respond to open questions and were invited to comment on the research or the topic of empowerment. In

survey 1, open questions invited respondents to suggest factors that enhance and inhibit empowerment, to add items not covered by the list in the *Understanding of Empowerment Scale*, and to include any further comments they wished to make. In survey 2 again respondents were invited to comment on any aspect of the survey or topic.

4.3.6 Overview of the surveys undertaken

Surveys were used to collect data because of their ability to provide quantifiable, generalisable data (when certain sampling conditions are met), while concurrently meeting the requirement to collect data that is sensitive and relevant to practising midwives. An overview of the surveys undertaken is presented in Table 4.3.

Table 4 3 An overview of the surveys undertaken

	Stage 1	Stage 2
Design	Cross-sectional postal survey	Cross-sectional postal survey
Data collection tool	Self-report questionnaire	Self-report questionnaire
Components of questionnaire	<i>The Understanding of Empowerment Scale</i> University of Western Ontario (UWO) Work Empowerment Scales <i>Conditions for Work Effectiveness Questionnaire II</i> (CWEQ-II), <i>Job Activities Scale II</i> (JAS-II), <i>Organisational Relationships Scale II</i> (ORS-II), 2 global empowerment items Open questions factors that enhance and inhibit empowerment	<i>Perceptions of the Conditions for Empowerment in Midwifery Scale</i> (developed from stage 1) University of Western Ontario (UWO) Work Empowerment Scales <i>Conditions for Work Effectiveness Questionnaire II</i> (CWEQ-II), <i>Job Activities Scale II</i> (JAS-II), <i>Organisational Relationships Scale II</i> (ORS-II) 2 global empowerment items
Date of pilot study	November 2001, further pilot December 2001	March 2005
Data collection time frame	January-2002	May 2005
Target sample	Practising nurses and midwives (for full study, see Scott <i>et al</i> 2003), practising midwives reported in this study	Practising midwives
Sampling frame	Live Register, An Bord Altranais, 6 divisions for full study	Midwives' Division of the Live Register, An Bord Altranais
Sample size	4,050 for full study, 750 from Midwives' Division	2,000 from midwives' division
Number of respondents (n)	95 practising midwives	244 practising midwives
Response rate	46% for full study (not possible to estimate practising midwives' response rate)	49% response rate

In order to meet the aims of the research and within the approach outlined above, a two-staged cross-sectional survey design was adopted. This outline will be expanded upon below with an emphasis on the sampling strategies, dissemination procedures and research instruments used. Response rates are reported with the results for survey 1 and 2, in chapters 6 and 7 respectively.

4.3.7 *Sampling strategies and questionnaire dissemination procedures*

Essentially the sampling strategies in both stages of this study were similar. Both used random national samples drawn from sampling frames which were representative of the population being studied. The specific sampling procedures of both stages are outlined below.

4.3.7.1 Survey 1

When a sampling frame was sought for the national study of empowerment (Scott et al 2003) it was acknowledged that there is no centrally held record of midwives (or nurses) in current practice. Thus, a specific national sampling frame of currently practising midwives (and nurses) was not available. The dearth of reliable and accurate data on the numbers of midwives (and nurses) in practice was highlighted in the *Interim report of the Nursing and Midwifery Resource Steering Group* (Department of Health and Children, 2000b). There are incomplete sources of health service employment data, such as the Annual Census of Public Sector Health Employees. Another possible source of data is the Live Register of An Bord Altranais. However there are several potential problems with its use as a sampling frame for practising midwives. These include:

- There is no record of the current area of practice on the Live Register, just of the divisions on which a nurse/midwife is registered. In the case of midwives, the Live Register of An Bord Altranais records those with a midwifery qualification but does not indicate whether they are currently in midwifery practice. It is therefore not possible to target only those currently working in midwifery.
- Previous postal nursing/midwifery surveys using the register have had low response rates. The *Review of the Scope of Practice* survey had a response rate of 8% (An Bord Altranais, 1999).

- Only the home addresses of nurses and midwives on the Register are available, with no indication of workplace location. It is the responsibility of individual nurses/midwives to update their records and it is not possible to ascertain the accuracy of the records
- A proportion of people on the Live Register are not actually in current nursing or midwifery practice. This had not been quantified until the early 2000s (Scott *et al* 2003)

However in the absence of an alternative means of generating a random national sample it was decided that the pilot study should test the Live Register for these potential problems. A pilot study was carried out in November 2001. Questionnaires were sent out to a random sample of 395 nurses and midwives on the Live Register of An Bord Altranais (for HRB study of nurses and midwives). This included 65 of those on the Midwifery division of the register. The total response rate of the pilot survey was 34.6%, with 106 completed questionnaires received. Thirty two (49.2%) of those selected from the midwives' division replied, with six of this number stating that they were not in current clinical practice. Of the 26 respondents from the Midwives' division of the Register who completed questionnaires (i.e. who are in clinical practice) only six were in midwifery practice. In addition four respondents from the General division were in midwifery practice.

While the potentially problematic issues raised before the pilot survey (numbers not in practice, inability to identify area of practice and generally low response rate to postal questionnaires) were shown to be somewhat borne out, in the absence of an alternative sampling frame, the Live Register of An Bord Altranais was used for the national survey in 2002. The questionnaire was directly mailed by An Bord Altranais in early January 2002. All available strategies to maximise response rate were employed including the inclusion of a pre-paid envelope, a follow-up mailing two weeks after the initial mailing and the use of a targeted advertisement about the project through professional channels including websites and conferences.

A sample of 750 was drawn from the Midwives' division of the Live Register of An Bord Altranais. This number was chosen in order to obtain responses from at least 100 practising

midwives As in the pilot study, it was again stipulated that a geographical spread across the country was also required of the sample However, it was acknowledged that since the addresses held by An Bord Altranais are home addresses it is not possible to guarantee a spread by workplace location

A covering letter introducing the project and guaranteeing anonymity was included with the questionnaire and pre-paid return envelope Participants were asked to respond even if they were not in current practice and if this was the case to return the cover letter indicating such Participants were asked to respond within two weeks of receiving the letter A unique identifying number (though anonymous to the research team) was recorded on the return envelopes for the purposes of a follow-up mailing for non-responders A follow-up mailing to non-responders was carried out at the end of January 2002

In an attempt to raise the profile of the research project, a poster presentation describing the background, objectives and timeframe of the project was displayed at the Annual Conference of the National Council for the Professional Development of Nursing and Midwifery in November 2001, with over one thousand leaflets describing the project distributed The survey was also advertised on the National Council and Irish Nurses' Organisation websites, both at the time of the mailing of the questionnaire and the subsequent follow-up mailing

4.3.7.2 Survey 2

For survey 2 in 2005 the Live Register was again used to extract a midwifery sample A random sample of 2,000 persons from the midwifery division of the Live Register was requested of An Bord Altranais in April 2005 This number was chosen as it represented the maximum possible sample within resources, while taking account of non-response and those not in midwifery practice Again alternatives to using the Live Register were considered, including clustered sampling within work units in maternity care services across geographical areas However, in order to obtain a random and national sample, the Live Register was again chosen

The criterion for inclusion in the sample was registration on the midwives' division of the Live Register. Until recently a midwifery qualification has been a requirement for public health nurse training. Therefore all public health nurses are on the midwives' division of the register. In order to try to target those who were in midwifery practice most efficiently, the exclusion criterion for selection was registration on the public health nursing division of the Register. The only potential unintended exclusion is of those who have a public health registration and are now working in midwifery. However based on the experiences in survey 1, the benefits were considered to outweigh the potential problem of inappropriate exclusion. At the time of the extraction of the sample there were 13,179 people on the midwives' division and 2,084 on the public health nurses' division. This means that the sampling frame was 11,095 people. Since a sample of 2,000 was requested, this represented just over 18% of the total sampling frame. It is estimated that only 2,000 individuals are actively practising midwifery in Ireland (Higgins 2005). (O'Connor (2002 p9) had made a similar estimate in 2002). Therefore it was anticipated that a number of people who were qualified midwives but were not practising midwifery at the time of the survey would receive questionnaires. The sample size of 2,000 was considered to be sufficient to achieve approximately 200 completed questionnaires from practising midwives. (The basis for this was as follows: given that 2,000 of the 11,095 midwives on the sampling frame were in practice, there was almost a 1:5 chance of each person selected being in current practice. Therefore by selecting a sample of 2,000 it was likely that 400 individuals in midwifery practice at the time would receive the questionnaire. With an anticipated response rate from this group of 50%, consistent with other postal surveys, then at least 200 responses could be anticipated).

This sample was randomly extracted in May 2005. Questionnaires in stamped envelopes were delivered to a distribution company used for mailings by An Bord Altranais and the questionnaires were directly mailed by this company on 19 May 2005. Again a cover letter (Appendix A) and pre-paid return envelope were enclosed and recipients of the questionnaire were asked to complete the questionnaire only if they were in midwifery practice. The cover letter provided a space for recipients to indicate if they were in nursing

practice or in neither nursing nor midwifery practice and if relevant, recipients were asked to return this section of the cover letter. Again the purpose of the study was outlined and anonymity was guaranteed. Full contact details for the researcher were given. For survey 2 there was no follow-up mailing as the resources available for the study were instead used to double the initial sample to a maximum of 2,000 from a proposed 1,000. The subsequent response patterns and rate were monitored carefully to ensure that an adequate rate was achieved without this follow-up.

4.3.8 *Research instruments*

4.3.8.1 Survey 1

In survey 1, the questionnaire comprised the following components (See Appendix B)

- A Demographic questionnaire
- The *Understanding of Empowerment Scale* (derived from stage 1 of the study)
- The University of Western Ontario Work Empowerment Scales
 - *Conditions for Work Effectiveness Questionnaire-II* (CWEQ-II) (comprising four sub-scales to measure access to
 - Opportunity
 - Resources
 - Support
 - Information
 - *Job Activities Scale-II* (JAS-II) (to measure formal power)
 - *Organisational Relationships Scale-II* (ORS-II) (to measure informal power)
 - Two *global empowerment* items
- Open questions about the factors that enhance and inhibit empowerment
- An open comments section

The rationale for the inclusion of these components and issues relating to their development or selection are described below.

4.3.8.1.1 Demographic questionnaire

A one-page demographic questionnaire was prepared to elicit all relevant demographic and professional details. This covered the domains of professional qualifications, education, current workplace, years of midwifery experience and overseas experience. It comprised

nineteen questions in total. The aim was to gain a comprehensive and useful demographic profile while also being mindful of keeping the questionnaire user-friendly and therefore as concise as possible. All questions were closed.

4.3.8.1.2 The Understanding of Empowerment Scale

On the basis of the findings of the focus group discussions which comprised the exploratory phase of the national study of empowerment in nursing and midwifery (Scott *et al* 2003), an exhaustive list of forty-seven statements relating to the meaning of empowerment was compiled. Factor analysis of the responses to this Scale in the pilot study facilitated the reduction of this number of items from 47 items to 24 (See Scott *et al* 2003). This achieved a more parsimonious scale while retaining coverage of core items relating to empowerment that had emerged from focus groups and the literature.

In addition, to address the positive skew of responses, the wording of the scale was revised, to reflect degrees of importance to empowerment. The six possible response options on which respondents were to rate each item were

- crucially important to empowerment
- quite important to empowerment
- important to empowerment
- somewhat important to empowerment
- a little important to empowerment
- not related to empowerment

In addition a ranking exercise was included, with respondents asked to rank from 1 to 10 in descending order the ten items (from the 24 provided) that they felt were most important to empowerment.

To test these revisions, and specifically the usability of the ranking exercise, a second pilot survey using the *Understanding of Empowerment Scale* only was conducted. A convenience sample of 54 practising nurses attending further education was used. Responses to the newly-worded responses were less skewed than in the first pilot study.

Therefore the new wording of the scale was retained. It was also decided to include the ranking exercise in the main survey as pilot respondents successfully carried out this exercise.

An open question was also included. This invited respondents to include anything relating to their understanding of empowerment that had not been covered in this list of items covered in the Scale.

4.3.8.1.3 Open questions: Factors that enhance and inhibit empowerment

Two open questions asked respondents to suggest factors that they felt inhibit and enhance empowerment.

4.3.8.1.4 Scales to measure levels of empowerment

The literature on empirical research into empowerment in midwifery and nursing was reviewed to explore the instruments previously used to investigate this subject. On this basis, the scales developed within the Workplace Empowerment Program at the School of Nursing, University of Western Ontario, led by Professor Heather Laschinger were used in this study.

The first three of these UWO scales (CWEQ-II (12 items), JAS-II (3 items) & ORS-II (3 items)) are measured on a five point Likert-type scale with three headings- None (score of 1), Some (score of 3) and A Lot (score of 5). The other two points (between 1, 3 and 5), namely scores 2 and 4, are not named though respondents can select them.

Also included are two global statements relating to workplace empowerment. These statements are:

- “Overall my current work environment empowers me to accomplish my work in an effective manner”
- “Overall I consider my workplace to be an empowering environment”

The two global empowerment statements have a five-point Likert-type scale which read from Strongly Agree to Strongly Disagree

The results demonstrating the validity and reliability of these scales are reported in Laschinger (1996) and in all later studies which also used these scales (Laschinger 2006) Shorter versions of CWEQ, JAS and ORS have been in use since 1996 and are denoted as follows CWEQ-II, JAS-II and ORS-II These versions were used in this study Professor Laschinger was contacted and permission was granted to use the empowerment questionnaires Small language changes for cultural sensitivity were permitted

The CWEQ, JAS, ORS and the two-item global empowerment scale were used to measure empowerment from a structural perspective in surveys 1 and 2

4 3 8 1 5 Additional Comments

The questionnaire concluded with an open question inviting comments on the questionnaire This was included to give the opportunity for comments on the topic of empowerment or the questionnaire itself

4 3 8 2 Survey 2

In survey 2, the following questionnaires were included

- A Demographic questionnaire (see 4 3 8 2 1 below)
- The University of Western Ontario (UWO) *Work Empowerment Scales* (as above)
 - *Conditions for Work Effectiveness Questionnaire-II*
 - *Job Activities Scale-II* (JAS-II) (to measure formal power)
 - *Organisational Relationships Scale-II* (ORS-II) (to measure informal power)
 - Two *global empowerment* items
- The *Perceptions of the Conditions for Empowerment in Midwifery Scale* (developed from phase 1)
- An open comments section

4 3 8 2 1 Demographic questionnaire

A short demographic questionnaire was prepared for stage 2 of the survey. This comprised seven questions relating to age, grade, geographical work location, hospital/community practice setting, employer and length of midwifery experience, overseas experience, practice area (for example, labour ward, antenatal ward). While part of the questionnaire was kept as short as possible, key demographic variables were included in order to explore variance of other scales according to key demographic characteristics.

4 3 8 2 2 The Perceptions of the Conditions for Empowerment in Midwifery Scale

The *Understanding of Empowerment Scale* that was developed and tested in stage 1 of this study was adapted for use as a measurement tool for stage 2. It was named the *Perceptions of the Conditions for Empowerment in Midwifery Scale*. This involved the adaptation of the scale as previously used into a five-point Likert-type scale, whose points were Strongly Agree, Agree, Neither Agree nor Disagree, Disagree and Strongly Disagree.

This change to an evaluative scale also required a re-formulation of the wording of the items, since now the perceptions of participants relating to their experience of each item rather than their judgement of the importance of the items to empowerment was being explored. For example "Being valued by managers" (stage 1 scale "crucial to empowerment" to "not related to empowerment") became "I am valued by my manager" (with scale options Strongly Agree to Strongly Disagree). This represents a shift from participants' beliefs about empowerment (generally) to their evaluations or perceptions of their own situations. Six statements were negatively worded in an effort to protect against mechanical response patterns.

The Scale in that format was tested in a pilot study carried out in April 2005. The questionnaire used in the pilot study comprised a demographic section, Laschinger's scales (Conditions for Work Effectiveness, Job Activities Scale and Organisational Relationships Scale and global empowerment items) and the newly developed *Perceptions of the Conditions for Empowerment in Midwifery Scale*. A convenience sample of practising

midwives pilot-tested the questionnaire for survey 2, in particular the new scale. Since usability alone was being tested, convenience sampling was adequate. Voluntary participation from practising midwives was sought via an electronic midwifery discussion group and within student groups at the School of Nursing. Twelve responses were received from a possible total of 20 who received questionnaires. Pilot study participants were asked to complete an additional one-page questionnaire which specifically asked about the amount of time taken to complete the questionnaire, any difficulties experienced, any changes suggested, any problems experienced with terminology and any other comments on the questionnaire or the study. Some minor changes relating to the formatting of the questionnaire were suggested. It took between five and ten minutes for pilot participants to complete the full questionnaire. These comments were taken into account when finalising the questionnaire for dissemination in the survey. The questionnaire used in survey 2 is contained in Appendix D.

4.3.8.2.3 The UWO Work Empowerment Scales

The UWO Scales (CWEQ-II, ORS-II, JAS-II and two global items) were again used in stage 2. The purpose of using these tools again was to provide for concurrent criterion validity by examining correlations between the newly developed scale and the established and validated scale.

Additionally the use of the same UWO scales in 2002 and 2005 mean that aggregate levels of empowerment - as measured by these scales - can be tracked over time. Since these are two cross-sectional surveys with two anonymous midwifery populations there are limitations to this claim. However as both surveys used random national samples of practising midwives, certain conclusions can be drawn and these will also be outlined when discussing both sets of results pertaining to these scales.

4.3.8.2.4 Additional comments

Respondents were invited to add any comments they wished to make about the topic of empowerment or the study itself.

4 3 9 *Methods of data analysis*

4 3 9 1 Quantitative data

Quantitative data, which comprises most of the questionnaire, were analysed using Statistical Package for the Social Sciences (SPSS) version 12. Descriptive and inferential analyses were performed. Descriptive analysis presents summary statistics such as frequency distributions and percentages, central tendencies (means) and results of variability measures (standard deviation). Inferential analysis examines relationships between variables and relationships between groups. Relationships between variables were examined using cross-tabulations, one-way univariate (using one dependent variable) and analysis of variance (ANOVA). Relationships between groups were examined using correlations, which examine the relationships between two continuous variables (Punch 2005).

In this study “data reduction” techniques were also used on the two scales developed during this study. Exploratory factor analysis was performed in both stages of this study, on responses to the *Understanding of Empowerment Scale* and the *Perceptions of the Conditions for Empowerment in Midwifery Scale* respectively. Factor analysis is described by Kim & Mueller (1994 p1) as a “variety of statistical techniques” whose objective is to represent a set of variables in terms of a smaller number of underlying variables or factors. It is a multivariate statistical technique used to help researchers “make sense of large bodies of interrelated data” (Hair *et al* 1995 p404). Thus factor analysis was used in this study to identify whether the items on the scales developed within this study grouped together into a smaller number of theoretically coherent factors. This analysis assists in the identification of conditions that are important to facilitate empowerment in midwifery.

The two major decisions to be made when undertaking factor analysis relate to the choice of factor extraction and rotations methods. These have been briefly discussed above in relation to Chandler’s factor analysis procedures and decisions in her testing and development of the CWEQ for nursing (see page 50). Principal Axis Factoring is a method of common factor analysis. Principal Components Analysis (PCA) is commonly used for

data reduction. While the emphasis in PCA is to reduce the original variables to a minimum set of factors, common factor analysis is used to "identify underlying factors or dimensions reflecting what the variables share in common" (Hair *et al* 1995 p375). The factors which result from common factor analysis are based on common variance only. PCA is based on total variance which includes common, unique (specific, to each variable) and error variance. Hair *et al* (1995 p376) state that because common factor analysis is based on common variance only it is considered more theoretically sound. There are some problems with common factor analysis, including invalid communalities (the common variance of each item), but in this case all communalities are valid (i.e. not less than zero or more than one).

Hair *et al* (1995 p380) advise that rotation is usually advisable because it simplifies the factor structure and usually results in more meaningful factors. Hair *et al* (1995 p384) state that "if the goal of factor analysis is to obtain several meaningful factors or constructs, an oblique solution is appropriate". This is so because "oblique rotation does not arbitrarily constrain the factor solution" so that factors are independent of, or orthogonal to, each other. Rather it explores the relationship between factors that may or may not be independent (Hair *et al* 1995 p366). Having examined solutions resulting from both orthogonal and oblique rotations, ultimately a decision was made to use an oblique rotation. Since it was possible that the factors underlying the scale being examined in this study were correlated, the choice of oblique rotation was the most appropriate one. When an oblique rotation is carried out, information is provided (within a factor correlation matrix) about the correlations between factors.

A number of methods of factor extraction and rotation were run when factor analysing responses to the two scales developed during this study. Extraction and rotation methods were varied to assist in confirming the robustness of the chosen solution (Tabachnick & Fidell 2001 p618). This included Principal Axis Factoring with Varimax rotation, Principal Axis Factoring with Oblimin rotation, Principal Components Analysis (PCA) with Oblimin rotation and Principal Components Analysis with Varimax rotation. The results across

these methods were broadly similar, suggesting a robust solution. Ultimately Principal Axis Factoring with an oblique (Oblimin) rotation was chosen in both surveys, because it could not be assumed that factors would not be correlated.

4.3.9.2 Qualitative data

ATLAS/ti (version 4.2), a computer package for qualitative data analysis, was used to assist in the management and analysis of the qualitative data. Packages such as *Atlas/ti* have significant strengths in terms of organising, facilitating coding and retrieving data. They allow the searching of large volumes of data for all segments of data which have been coded with specified codes. These segments of coded text are termed “quotations” within *Atlas/ti*. Packages do not assign codes, this is the responsibility of the researcher and involves interpretative and creative skills. Within *Atlas/ti* a project is called a “hermeneutic unit” and text-only formatted “primary documents” are assigned to these units. Coding types facilitated include open, “in vivo” (where the code is directly generated by copy specified text) and list, where codes are selected from the developing list attached to that hermeneutic unit. Open coding, that is coding freely based on the interpretation of the meaning within the data, facilitates the generation of data-generated codes and in turn themes (Punch 2005 p205). This is in contrast to theoretical coding, whereby data are viewed within an existing framework. Open coding on the other hand “opens up theoretical possibilities within the data” (Punch 2005 p205). Codes can be merged, grouped into families and mapped into networks which are visually displayed within the package. A perceived advantage of *Atlas/ti* over other packages is that it does not assume a hierarchical coding structure, which earlier versions of NUD*IST, another popular package did. While NUD*IST’s replacement with NVivo has addressed that limitation somewhat, NVivo still contains an assumption of hierarchical codes, though this can be circumvented using free codes. One perceived advantage of NVivo over *Atlas/ti* might be in the latter’s text-based and inflexible visual format, while NVivo works within a Word format and is visually more attractive.

4.3.10 Ethical issues and procedures

Ethical considerations were central at all stages of this study. As Fowler (2002 p147) points out, with all research that involves humans “the survey researcher needs to be attentive to the ethical manner in which the research is carried out”. Fowler acknowledges that the real risks and costs for respondents to most surveys are minimal, nonetheless the same ethical principles apply and the same ethical standards are required as with other research approaches. These were upheld in this project, namely beneficence, respect for persons, confidentiality and justice. It was not anticipated that the content of the questionnaire would cause distress to participants and no adverse outcomes for individuals were foreseen. The benefits of the research were perceived to be its contribution to current empirical knowledge about the midwifery profession in Ireland. Therefore the benefits were indirect for participants. Fowler (2002 p151) states that the main benefits to participants are intrinsic - feeling that they contributed to the research. Within both stages of the research many participants expressed their interest in this topic and their willingness to contribute to the research. There were no direct benefits, in terms of remuneration. The issues involved in paying research participants are debated by Sears (2001) and she concludes that non-payment is preferable, though no model will fit all projects.

Institutional ethical procedures were fully adhered to. Approval to carry out the survey in 2005 received institutional approval from the Dublin City University Research Ethics Committee. During 2002, at the time of survey 1, this Committee was not yet in place in Dublin City University. The questionnaires for both surveys were disseminated by An Bord Altranais. This was carried out in accordance with An Bord Altranais’s policies on Surveys and Statistics (An Bord Altranais 2004 p7). Questionnaires and cover letters for both surveys were approved for use by the Education Officer of An Bord Altranais. In accordance with these policies, An Bord Altranais does not release the names and addresses of those in the sample to researchers. Therefore the researcher is not aware of the identity of recipients of this questionnaire and responses are completely anonymous. This was clearly stated to respondents. Those who received the questionnaire were invited to contact the researcher in confidence with any concerns about the questionnaire or its contents.

The cover letters for both surveys included a brief background to the research, contact information, details about the purpose of the study, the sample selection and they highlighted the anonymity of the sample. It was stressed in both surveys that participation was voluntary and return of the questionnaire signalled implicit consent.

For the first survey all participants were assigned an identification number which facilitated a follow-up mailing to non-responders. In no way did this breach the anonymity of participants, but as a consequence of queries about the purpose of this number, the follow-up letter to survey 1 described more explicitly the purpose of the number and re-stated that anonymity was being upheld. The concerns raised by recipients of questionnaires highlighted the sensitivity of the topic under study and the need for anonymity. Within the responses to open questions participants sometimes either inadvertently or directly identified themselves. All references that could identify individuals were removed. As described above, the questionnaires for both surveys were approved by An Bord Altranais.

The methodological issues and procedures for the historical research and two surveys have been outlined. The results are presented in the following three chapters.

CHAPTER 5· HISTORICAL RESEARCH FINDINGS

It is always useful to understand the historical contingency of things, to see how and why things got to be as they are

(Foucault 1988 p302)

The twentieth century saw many changes to the midwifery regulatory framework in Ireland. The Central Midwives Board for Ireland was established under the 1918 Midwives (Ireland) Act. The 1902 Midwives Act (England and Wales) had not extended to Ireland, though it granted regulatory recognition to some training sites in 1902 and additional ones in 1904⁴. From 1918 to 1951 the Central Midwives Board of Ireland was responsible for the regulation of midwives in Ireland. The Board was abolished under the Nurses Act of 1950 and a Statutory Midwives Committee of An Bord Altranais [the Irish Nursing Board] was established. This Statutory Committee was itself abolished in 1985 under the 1985 Nurses Act.

While researching the background to this study, it appeared that several features of the 1950 Nurses Act seemed to have had a far-reaching impact on midwifery. In particular, the abolition of the Central Midwives Board and the introduction of the clause “nurse includes midwife” into legislation seemed to be significant. As described in chapter 2, these issues have surfaced during recent consultations with midwives (Commission on Nursing 1997, 1998, An Bord Altranais 1999, 2000). Midwives have called for “the explicit acknowledgment of their distinct identity and the establishment of a Statutory Midwives Committee to reflect the different concerns and needs of midwives” (Section 4.44/5 Commission on Nursing 1998). The Commission on Nursing subsequently recommended the establishment of a Statutory Midwives Committee and that the term “midwife” be included in the title and content of future legislation. Specifically it was recommended that

⁴ Until the Anglo-Irish Treaty of 1921 established the Irish Free State, legislation for Ireland emanated from Great Britain.

“there is no provision in future legislation that the word ‘nurse’ includes ‘midwife’”, as has been the case since the 1950 Nurses Act. These recommendations were to be included in legislation planned to be brought forward by 2002, but that legislation is still awaited in 2006.

This chapter will place these midwives’ demands, the Commission’s recommendations and the awaited legislative changes in context. Within the overall aim of this study of exploring issues relating to power and empowerment in midwifery in Ireland, this chapter focuses on the background to and the impact on midwifery of the 1950 Nurses Act. The two particular episodes which are the focus of this chapter relate to the struggle of the Central Midwives Board members to retain the powers of the Board, and later, when unsuccessful, to regain those powers. These two episodes are:

- 1 “Attempts to retain power” Resistance to the abolition of the Central Midwives Board 1947-1951
- 2 “Attempts to regain power” The Memo to An Bord Altranais from the Statutory Midwives Committee on the “unsatisfactory position of Statutory Midwives Committee which has arisen resultant on the limited powers of the Committee” 1955-6

5.1 “Attempts to retain power” Resistance to the abolition of the Central Midwives Board 1947-1951

The minutes of the Central Midwives Board detail the resistance of Board members to the proposed abolition of the Board until the ultimate resolution of that issue. This episode will be described chronologically, following developments as they unfolded.

5.1.1 News breaks

A special Central Midwives Board meeting was held on 1 October 1947 to consider a “confidential letter” dated 20 September 1947 received by the Central Midwives Board Chairman Dr Falkiner from the Minister for Health (Dr James Ryan). This related to

“proposals to be considered under new Health Act 1947” The text of this letter is not available with the minutes, though the minutes suggest that it included proposals relating to two key issues which were to prove critical for the Central Midwives Board

- the proposal to create one Board to regulate nursing and midwifery
- the proposal that the same nurse/midwife should look after women in the maternity period and their infants up to one years of age

Both matters caused the Board members concern They believed that a separate Board should regulate midwives They opposed the “nurse-midwife” proposal on the grounds that this would be dangerous, given the incidence of infectious diseases in infants The matters raised by this letter were to consume the Central Midwives Board for the remainder of its existence

A deputation of Central Midwives Board members met with Department of Health officials on 13 November 1947 The Board’s concerns were raised It was recorded in the notes of that meeting that “Dr Falkiner said there was one most important point which he felt should be put before the Minister”, namely

that the Central Midwives Board as a Body were in a completely different position to the General Nursing Council regarding its powers and procedure - the Central Midwives Board exercises disciplinary control over midwives and with a combined Body the problem would be as to how such a Body could deal with this The medical members of the Board in particular had strong views in this matter and Dr Cunningham had spoken often about it

Mr Kennedy (Secretary of the Department of Health) said “there was a feeling that the mother and baby should be looked after by one nurse” but the matter was to be considered In a resounding defence of the essence of midwifery the notes of the meeting record that Dr Falkiner said that

there was one important point of difference and one which was constantly being overlooked in dealing with these matters that is, that midwives practice without a doctor and therefore it must be agreed that they had the greater responsibility It was

agreed that this was a great difference - the practice of midwifery was a profession in itself

Subsequent meetings of the Central Midwives Board were preoccupied with the proposals to abolish the Board. At the meeting of 14 December 1948, the minutes record that members felt that "apparently whoever was responsible for drafting of the document before them could not be aware of the differences in procedure between the two bodies. The Minister [Noel Browne] should be asked to receive a deputation". It was recorded at this meeting that the Board had wide experience of penal (misconduct) cases and that it was essential to have adequate midwifery representation dealing with those cases. The minutes record that "in this Bill it was agreed that the proposed midwifery representation was utterly inadequate- even if sub-committees were appointed, there were only two midwifery representatives on the Board". It is recorded that Dr O'Kelly, a medical member of the Central Midwives Board, said that

while the Chairman [of the new Board] might be a medical man who was a specialist in some other branch, he did not consider he could deal with midwifery problems such as constantly came before the Board

This interesting distinction highlights that those working in obstetrics saw themselves as being more rightfully in a position to regulate midwives than other doctors. The midwives appeared to agree with this, insofar as it was not an issue

5.1.2 The Nurses Bill 1949

The next phase in resistance to the proposals took on even more urgency, as the Nurses Bill 1949 had been introduced into the Seanad on 22 June 1949. On 30 June 1949 the Central Midwives Board held a Special Meeting to consider this development. Mr Hicks, the legal adviser to the Board, was in attendance. Reference to the Bill had been seen by accident in the press and copies were purchased for the Board by the Secretary. Dr Falkiner said it was for the Board to decide as to whether they should give any more advice to the Department. His question seemed to imply that since they had not been listened to, there may be no

further point in continuing to state their dissatisfaction. There were very obvious mistakes within the Bill as perceived by Dr Falkiner and the members “felt that the Bill had been very hurriedly and carelessly drafted and it was a very important and drastic change”. Dr Cunningham is recorded as saying that the Board was being treated “with scant courtesy”. It is recorded that “Dr Falkiner said that he thought a lot of trouble could have been avoided by a proper approach”. There had been discussion with officials only and Central Midwives Board members had never met with the Minister. The result was “that people who could not know of the technical requirements took a hand with results such as they had now to face”. It is stated that Mr Hicks thought it unusual to treat a Board like this. He stated that a Board carrying out work for 25 years would have knowledge of what was required. Dr Falkiner referred to a meeting he had had in London regarding mutual recognition of qualifications. He reported that there was concern at the possible absorption of the Irish Board and the implications of this for the existing reciprocal arrangements about recognition of qualifications.

5.1.3 The importance of “terminology”

A critical matter arising from the proposed Bill then emerged. Mrs Martin said that as a practising midwife representing midwives she must protest as a member of the Board at the use of the term “maternity nurse” instead of “midwife”. She believed that this was quite different in interpretation, a maternity nurse could only attend under the direction of a doctor and she would not be subject to the same rules as a midwife. Dr Cunningham agreed that the expression midwife should be retained. Dr Falkiner observed that this term appeared throughout the Bill, and was “entirely wrong and would lead to all kinds of difficulties and confusion”. In seeking to understand the motivation behind this, Dr Falkiner suggested that the term might be meant to be complimentary, believing that there might be some prejudice to the word “midwife”. He also raised the point of problems of “reciprocity with England”. Dr Kearney, a medical member of the Central Midwives Board, said they “must ask the Minister to retain the word midwife”. Mr Hicks agreed that this would affect rules and certificates, concluding that the “authorities may have meant well but it is bad”. Dr Falkiner asked if they should make a detailed criticism of the Bill or

whether they should write and say that the principle of the bill was wrong. They agreed that the Bill was unworkable. The following resolution, which was passed unanimously, and signed by all, was sent to the Minister:

The Board having studied the Nurses Bill 1949 consider that the dissolution of the Central Midwives Board is not advisable. The Board consider that the Bill in its present form would not be possible to administer.

At the next meeting on 6 October 1949 "Dr Falkiner said that as far as he knew certain amendments would be considered and incorporated but he thought the government still intended to retain the expression maternity nurse in spite of objections put by the Board". He said that he had been promised a copy of the further amendments before the Bill came back to the Senate. Mention was made in the minutes of the "proposed maternity nurses' committee" which would be doing the former Central Midwives Board work, with only three midwifery members on the full combined nursing/midwifery Board.

A meeting item entitled "Matters arising under Nurses Bill 1949 re procedures etc" covered issues such as Central Midwives Board property and the issue of certificates. The question of whether certificates issued to "maternity nurses" would be recognised by other midwifery boards was raised. Dr Falkiner said he could not understand how the suggestion to adopt the term maternity nurse had originated. Miss A H Lister, a midwife member of the Board, asked if "the midwives could be approached". Dr Falkiner said that there was no Midwives Institute to represent the midwifery point of view. It is recorded that Miss Healy, a midwife member of the Board, thought that the original idea envisaged by Dr Deeny, Medical Adviser at the Department of Health, was that

the ideal nurse should be trained in every branch- fever, general, midwifery etc and described as a nurse but this idea had apparently been abandoned as the separate classifications remained.

Notwithstanding the apparent acceptance implied here that midwifery is a branch of nursing, this rationale (that a “nurse” should be qualified in all things including midwifery) did seem to be the driving force behind the change. This astute observation was the exact reason given by Dr Browne when defending the use of the term “maternity nurse” in the Seanad [Irish Senate] debates to follow. At this meeting members agreed that “the most important matter in connection with the 1949 Nurses Bill was to press for the retention of the expression midwife”. It appears that this meant that their other concerns (dissolution of the Central Midwives Board, low midwifery representation on the new Body etc.) were of necessity overshadowed. It is recorded that “the members of the Board unanimously requested that Dr Falkiner ask for a personal interview with Dr Browne Minister for Health”. With an apparent sense of hopelessness, the minutes recorded that “Falkiner felt he had done all he could, but would request a meeting”. At the meeting of 10 November 1949, Dr Falkiner stated that he had sought an interview, which had not taken place, and that the “authorities seemed anxious to keep maternity nurse”. The Committee Stage of the Bill had been postponed, due to the question of reciprocal arrangements. It was agreed that a letter be sent to An Taoiseach [Prime Minister] Mr Costello, with copies of previous letters on the matter. This letter was later recorded as being sent 2 January 1950 (a copy was not included in the minute book).

5.1.4 Senators get involved

In Seanad Éireann on 1 December 1949 the Nurses Bill 1949 was at Committee Stage. One of the Senators present was Joseph Warwick Bigger. He was Professor of Bacteriology and Preventative Medicine at Trinity College Dublin from 1924 to 1951 (the year of his death) and, interestingly, the son of Sir Edward Coey Bigger. Sir Coey Bigger was the Chairman who had led the Central Midwives Board for most of its existence till his own death in 1942. While nowhere in the Seanad debates is this family history and connection with the Central Midwives Board articulated, doubtless it is an interesting and important one.

At the first opportunity after Dr Browne’s introduction of the first proposed government amendment, Senator Bigger asked about a matter “which has fairly wide implications

throughout the country”, namely “as to why the term ‘maternity nurse’ is used rather than the time-honoured term “midwife” In reply, Dr Browne stated that

This term was considered, first of all, in consultation with the representatives of the midwives We were anxious to change the name, as we felt that it was important to introduce a new name for these nurses because their duties will be enlarged and their status, we hope will be improved We felt that the old connotation which is associated with the word “midwife” could be improved I do not in any way wish to take away from the tremendous work which midwives have done down through the years In relation to the repercussions elsewhere, we have been pursuing that point and do not think that there will be any deleterious or disadvantageous effect by the introduction of this new name for this section of the nursing profession [sic]

Browne’s assertion that this change was considered first of all in consultation with midwives’ representatives is scarcely the case, given the lack of consultation about the Bill with midwives generally and particularly with the members of the Central Midwives Board Later in the debate Professor Bigger said that he wished to raise “a matter which seems to be of the utmost and first-class importance” This related to the issue of reciprocity of recognition of qualifications between states He proceeded to mention that letters had been received from the Boards of Scotland, England and the Joint Council for Northern Ireland Bigger suggested that consideration of the Bill be postponed until negotiations had been successfully conducted

Professor Bigger’s reference to these letters appears to have been instrumental in postponing the passage of the Bill Following directly after his contribution, Senator (Miss) Butler agreed with the suggestion to postpone She stated that she did “not think that it can be too strongly stressed that hardships and injustices will be inflicted on many people if the arrangements at present are not continued” She said she believed it necessary to have utmost reciprocity with “Northern Ireland and Britain, irrespective of political issues” Senator (Mr) O’ Reilly stated that these were “alarming documents” and that this was an alarming position that had been unknown to him and other members He asked Senator Bigger to elaborate, stating that it was Senator Bigger’s “desire for brevity that caused him

to give us such a short summary, but he can of course say more in a short time than most other Senators” Professor Bigger responded as follows

I do think that one of the difficulties is the abandonment of the word “midwife” There is no strict border line I think between “midwife” and “maternity nurse”, but “midwife” is taken to be a woman capable of practising without the aid of a doctor On the other hand, the “maternity nurse” has only the responsibility of an ordinary nurse practising under the charge of a doctor - practising under the doctor as an assistant The doctor is responsible for the care of the patient and the maternity nurse carries out his instructions I think that is the essential underlying difference, although I cannot define it exactly

He then referred to the fact that the British government was thinking about changes regarding the medical profession and were planning to enter into negotiations with the Irish government, although this was a “domestic measure” His inference was that if the British were willing to negotiate with Ireland about mutual recognition of professional qualifications, then the Irish should also

Bigger’s reference to “assistant” (to a doctor) raised the question of the register of “unqualified nurses” (assistant nurses) held in England Mr O’Reilly asked if this would mean that

if we elect to call our nurses ‘maternity nurses’ rather than ‘midwives’ these people in England seem to take the view that we are putting them in the same class as assistant nurses in England

Despite the fact that it was “our midwives” rather than “our nurses” who were in question, Bigger, perhaps seizing an opportunity, stated “It may be possible I do not know” O’Reilly responded with a statement that the Minister has the right to legislate for Ireland and that no other body should tell him what to do Bigger responded that

there has been no suggestion that these bodies in these three countries should legislate for this country It is within the competence of the Oireachtas to pass the Bill and enact it To arrange for midwives or maternity nurses and call them any name they please No one would interfere, but this change of name may take away

the right of girls trained in this country to practice midwifery in other countries. We do not presume to tell the people of England or Scotland- I will not say anything about Northern Ireland- what their standard for midwives is to be. We control ourselves completely and there can be no interference with anything that is done in this country, but we are anxious to avoid doing anything which would have unpleasant repercussions on girls going out of the country.

Given the recency of the establishment of the Irish Free State, the focus on reciprocity had a danger of backfiring and misguidedly ensuring difference from our geographical neighbours. It is however unfortunate that Bigger in his initial explanation of the problem with titles, gave an impression of there not being much difference between a midwife and a maternity nurse. He had then directly proceeded to highlight a significant difference, that midwives practice independently of doctors. Minister Browne picked up his initial point, replying that

the point which is of concern to the midwives Board arises out of such a small point that Senator Bigger said he found difficult to define it: the difference between "maternity nurse" and "Midwife". As I said at the beginning, as far as we are concerned the difference between the one and the other is nearly indefinable, but we felt that in altering the name to "maternity nurse" we would try to convey that the status of the new nurse would be improved and that, if possible, the standard, qualifications and ability of the nurse, in so far as her experience would be enlarged, would also be heightened. We do not intend to reduce the standard of these girls but rather to improve them. We propose to have a girl with certain specific qualifications and the fact that she has a different name should not affect the issue one iota. I can also say that I am fully conscious of my responsibilities to these girls who might be anxious to pursue their training outside the State. I also feel that where we are reasonably sure that we are being progressive we should not lightly abandon that progress unless conditions make it impossible to carry it out. I hope to have decision [regarding reciprocity] in relation to this matter by the next stage.

Browne's speech, while playing to those fearful for "our girls", continued to downplay the importance of what was being raised by Bigger and others. It appears that his vision of a comprehensive maternal and child health service was his guiding mission and within that he saw "maternity nurses" as having a more significant impact. What was at stake was

more than a name change - it meant a fundamental change to service delivery and the professional identity of nurses and midwives

5.1.5 *"Midwife" saved, Central Midwives Board lost*

At the Report Stage of the Nurses Bill 1949 on 8 March 1950, the Senate debates report that Dr Browne proposed 27 amendments "which relate entirely to the replacement of the expression "maternity nurse" by the word "midwife". He explains that this change was made because of views of Senators at the Committee Stage of the Bill regarding reciprocity "for this section of the nursing profession" (again, midwives as nurses) and also

in view of certain representations which have been made by the Central Midwives Board who were rather anxious to keep the word "midwife" in preference to the term "maternity nurse". In relation to the question of reciprocity, we have been able to establish that, even if we were to continue to use the expression "maternity nurse", this would in no way endanger the reciprocity which exists between Great Britain and our own country at the present time. My main reason for introducing this amendment is in deference to the wishes of the members of the Seanad, expressed in Committee, and also to views held by the Central Midwives Board. The change is purely one of nomenclature and is not one which affects in any way the basic principles of the Bill. It is in these circumstances that I introduce the amendment.

Following Dr Browne's introduction of this group of amendments, two Senators spoke, Mr S. O'Farrell and Mr Hawkins. Mr O'Farrell stated that he and Senator Bigger had raised these matters "on representations of the Midwives Board". Even if top level reciprocity had been assured, O'Farrell said there might still be local problems in England and Northern Ireland for candidates seeking jobs. He concludes "I am very glad and am sure Senator Bigger and the midwives will be glad that the Minister has facilitated them and has done what they requested". Mr Hawkins continued that "in view of the assurance given by the Minister that the changes are made as a result of consultation between the two organisations, we are prepared to accept the amendment". It is not clear to which two organisations Hawkins refers, it might be the Central Midwives Board England and Joint Council Northern Ireland, or might include the Irish Central Midwives Board. Browne appears to have appeased the Senators. Undoubtedly members of the Midwives Board

would have been relieved that the term midwife was retained, though they would be hardly joyful, given their opposition to the fundamental point of the abolition of the Board which was still going ahead

It is unclear why Dr Browne stated that the members of the Central Midwives Board's views had made an impact at this late stage when their fundamental objection to the Bill had been made very clear to the Minister, his predecessor and their officials. The Central Midwives Board had written to An Taoiseach on 2 January 1950 and this may have been a key factor. This, with the pressure of the Senators, seems likely to have had a greater effect on the Minister than the Central Midwives Board members did themselves. In any event it was not a question of mere nomenclature. What resulted was that the phrase "nurse includes midwife", replaced "nurse includes maternity nurse", which had a more logical basis. These changes were suggested in the specific amendments referred to, for example "In page 4, Section 2 lines 34 and 35 And substitute "'midwives division' means the division of the register of nurses applicable to midwives" and "in page 4, Section 2, lines 39, after "nurses", to add "and include midwife and the word 'nursing' includes midwifery". At the Fifth Stage, on 15 March 1950, Professor Bigger congratulated the Minister, firstly on "the changes he has made in the Bill" and later on "the very real improvements he has made in excellent measure"

At a special meeting of the Central Midwives Board held on 13 March 1950, Dr Falkiner updated members that the term 'maternity nurse' had been replaced by the term 'midwife' throughout the Bill. It was recorded that since "issues put forward against unification [of the nursing and midwifery regulatory bodies] had already been stressed, it was agreed that nothing further could be done". On the new Nursing Board only 3 out of 23 members would be midwifery representatives: a Master/Assistant Master of a maternity hospital and two midwives. It was recorded that their "objection is not that Board would act unreasonably but that it could reasonably happen that none of the three could attend" a given meeting where midwifery matters were to be decided. They agreed to write another letter to An Taoiseach with their concerns. This letter would acknowledge the retention of

the term “midwife” and of reciprocal recognition with UK Boards. They would include an “appreciation of the action taken by An Taoiseach”

On 22 November 1950 the meeting heard that the Nurses Bill had passed the second stage in the Dail. The Central Midwives Board met on another three occasions (21 December 1950, 28 February 1951, 11 April 1951) prior to a “General and Final Meeting of the Board prior to Dissolution” (as recorded in the minutes) which took place on 30 May 1951. This was a full meeting which considered examiners’ report, committee reports, correspondence and midwifery training centres. Thus ended the work of the Central Midwives Board.

The first meeting of An Bord Altranais took place on 7 June 1951. It was opened by Mr J A Costello “S C [Senior Counsel] Taoiseach and Minister for Health”. The minutes recorded that An Taoiseach stated that An Bord Altranais had “wider powers and functions than previous bodies”. While it could be said that this was the case for nursing and nurses, it was less so for midwifery, certainly in the eyes of the former Central Midwives Board members. The Taoiseach was acting Minister for Health after the resignation of Noel Browne. There is a sense of irony in this, since it was Browne who ultimately put through the 1950 Nurses Act.

5.2 “Attempts to regain power”. The Memo to An Bord Altranais from the Statutory Midwives Committee on the “unsatisfactory position of Statutory Midwives Committee which has arisen resultant on the limited powers of the Committee” 1955-6

The second episode which is highlighted relates to attempts by former members of the Central Midwives Board to recover the power that the Central Midwives Board had held. At a meeting of An Bord Altranais on 2 November 1955, under the item “Midwives Committee”, the CEO of An Bord Altranais stated that he was asked by the Statutory Midwives Committee

to seek the Board's approval to the committee sending a deputation to the Minister for Health to discuss a number of matters relating to the practice of Midwifery. It was also desired to avail of such an interview to present to the Minister for Health a number of points regarding the unsatisfactory position of the Midwives Committee.

The President said it would be a good idea if the Statutory Midwives Committee first submitted a Memo to the Board regarding the matters which it was anxious to discuss with the Minister for Health (The unnamed Minister in question was Mr T. F. O'Higgins). The Board could discuss them first and see if there were any issues which could be "straightened out", and the remaining points could then be put to the Minister for Health with the added strength of the Board's approval. At the meeting on 9 November 1955 it is recorded that Dr Falkiner said that the fact of having to submit a Memo and the considerable delay this involved illustrated the very difficulties that existed. Dr Kearney is recorded as having stated that he thought that "in the meantime it would be well if this Memo was prepared".

At a subsequent meeting of the Statutory Midwives Committee (SMC) on 30 November 1955, when the proposed Memo was being considered, it is recorded that Dr Falkiner

pointed out that the Committee did not have the same powers as the former Central Midwives Board and that the problems of midwives could only successfully be dealt with by a board consisting of a preponderance of midwifery experts.

He read correspondence between himself and An Taoiseach when it was first proposed to dissolve the Board. It is recorded that Dr Falkiner said that

although the correspondence from the Taoiseach implied that the scheme envisaged in the Nurses Act 1950 would work successfully, this had not proved to be so.

After some discussion the minutes noted that it was agreed that a Memo should be prepared by the Chairman Dr Falkiner and the CEO of An Bord Altranais. Subsequently a special meeting of the Midwives Committee was held on 15 December 1955 to consider the Memo.

that had been drafted on the “unsatisfactory position of Statutory Midwives Committee which has arisen resultant on the limited powers of the Committee” (as the notes record) This was “considered in detail and approved” and a copy was to be sent to each member of An Bord Altranais A copy of this Memo is held in the minute book of An Bord Altranais and is summarised as follows

- Midwifery was stated to be different to nursing, as midwives are practitioners in their own right
- Under the heading “Desirability of an Autonomous Body”, a separate autonomous body for midwives was called for
- It was stated that the position since the 1950 Act had meant that the Midwives Committee had limited powers, and with limited midwifery representation on the Board, this had caused a “regrettable diminution of interest in all matters relating to the practice and training of midwives”
- While not detracting from the work of the Board for nursing, in order to maintain the good reputation of Irish midwives, an autonomous midwifery body would indicate that midwifery was not subordinate to nursing

The Memo was considered at a meeting of An Bord Altranais on 11 January 1956 under the item “Consideration of Memorandum re Power of Midwives Committee” The President of An Bord (Bob O’ Connell) is noted as saying that “the present composition of the Board gave it “considerable strength as it was empowered to speak for all Divisions of the Register” Other members of An Bord Altranais (who were not members of the Central Midwives Board) stated that separating the An Bord Altranais and the Midwives’ Committee would be “a very retrograde step” and that it might prompt similar requests “from the other divisions” of An Bord Altranais Central Midwives Board members in attendance defended the Memo In the end it was agreed that further discussion should be postponed until Dr Falkiner was present (although he had drafted the Memo and therefore his views on the matter would have been clear) This postponement was in fact to mean that the Memo was never again considered Over the next two years, during which time 23 meetings of An Bord Altranais were held, Dr Falkiner did not attend Though his apologies are noted only twice, it is elsewhere recorded that he had stated that he could not attend meetings before 5pm on Wednesdays due to other unstated (but perhaps clinical)

commitments. He appears to still have been involved with An Bord, since at the meeting of 15 January 1958, although his apologies are not recorded and he is not present, he was nominated to the penal committee. Dr Falkiner was present at the Statutory Midwives Committee meetings of 14 March 1956, 7 June 1956, 12 March 1957 and 18 September 1957, though the Memo is not mentioned in the notes of any of those meetings. The next An Bord Altranais meeting at which he was present was 29 May 1958 where, although he dealt with midwifery examinations and problems with district training for midwives, in which he valiantly defended the need for domiciliary training for midwives, the Memo was never again mentioned.

In time, the statutory basis of the Statutory Midwives Committee was itself to be lost. The minutes of the meeting of 1 May 1984 record that members were concerned that the Midwives Committee should retain its statutory status under the new proposed legislation. This was the first mention of the impending loss of statutory status. At the meeting of 5 July 1984 the members again expressed their concern that the midwives committee be a statutory committee under the new nursing legislation. On 4 October 1984 the members again discussed the loss of statutory status of the Committee under the Nurses Bill 1984 and in particular the fact that the Fitness to Practice Committee as outlined in the Bill may have no midwifery representation. In response to queries, the Deputy CEO of An Bord Altranais said that An Bord Altranais, when making its submission to the Minister on the Nurses' Bill 1984, had not raised the issue. There were no follow-up responses to this comment. At the meeting of 6 December 1984 there is no mention of the Bill.

At the Statutory Midwives Committee meeting of 7 February 1985, under Any Other Business, Miss E Kelly, a midwife, informed the committee that she had made representation to the Minister for Health regarding the loss of the statutory position of the Committee under the Nurses Bill 1984. She said that the Minister appeared to be unwilling to alter this provision. No comment was made and no action proposed. At the 18 April 1985 meeting the Bill was not discussed, though inspections, examinations, complaints, and

the EEC were discussed. Regarding the community nursing sub-committee, it was agreed that a meeting could be arranged between the community nursing sub-committee of An Bord Altranais and the midwives' sub-committee to discuss the midwifery qualification requirement for PHNs in the future, a topic of more recent focus and interest also.

At the last meeting in the Statutory Midwives Committee minute books, on 6 June 1985 again many issues were discussed including inspections, examinations, and a letter from Ms Monaghan of the Rotunda Hospital regarding the non-recognition of midwives as a separate professional group in An Bord Altranais's Code for Nurses. The Committee agreed to recommend to An Bord Altranais that future printing of the code should say "Code for Nurses/Midwives", which it duly did. The next meeting was scheduled for 5 September 1985, though thus ends the minute book. The notes of the 6 June meeting are signed by Dr George Henry, Statutory Midwives Committee Chairman and dated 5 September 1985.

Following the abolition of the Statutory Committee, Ad hoc Midwifery Committees stood between 1986-91 and 1991-95 to review regulation of midwifery practice. The Chair of the first Ad Hoc committee was a midwife. There were no midwifery committees in An Bord Altranais between 1995 and 1998. Between 1998 and 2003 responsibility for the review of midwifery developments rested with the Midwifery Sub-Committee of the Education and Training Committee of An Bord Altranais. The focus of the Sub-committee's work was the introduction and ongoing monitoring of the Pilot Midwife Registration Education Programme (Direct Entry) (which concluded in Spring 2003), the supervision of independent midwives and the preparation of the 3rd edition of the Guidelines for Midwives. The new Board of An Bord Altranais, at its 13 February 2003 meeting, agreed to set up a new Midwifery Committee on a non-statutory basis "in keeping with the spirit of the Commission on Nursing" (An Bord Altranais, 2003 p11), pending the new legislation that would allow the establishment of a Statutory Committee.

5.3 Discussion of historical findings

It is important to remember that social policies do not just happen. They are the product of social structures and processes. Social policies have had a significant effect on the lives of everyone and especially upon women. To an extent the framing of policies is structured by both cultures and power structures
(Symonds & Hunt 1996 p214)

The events described above relate to attempts to retain and subsequently to regain the power to regulate midwives. Ireland's experiences regarding midwifery regulation discussed in this chapter were not unique, but the circumstances in which these events unfolded were particular to the time and place within which the new state was grappling with new responsibilities and new political relationships. Ultimately the abolition of the Midwives Board and other changes which seemed to undermine the distinctiveness of midwifery appear to be symptoms rather than causes of the loss of midwifery identity over the twentieth century. Midwifery did not appear to be visible enough to withstand the competing political interests that ultimately resulted in the abolition of the Central Midwives Board. These findings will be explored in greater depth under the themes of gender, politics, the 'nursification'⁵ of midwifery, and language and identity.

5.3.1 Gendered relations in midwifery regulation

A key theme underpinning the historical findings is that of gender. Within the social and cultural context of early and middle twentieth century Ireland it appears inevitable that two "medical men" stand out in the history of the statutory regulation of midwives in Ireland, namely Sir Edward Coey Bigger and Dr Ninian Falkiner. Witz (1992 p126) explains that "at this historical juncture women's relations to the patriarchal capitalist state had necessarily to be mediated by men and therefore indirect" (Witz 1992 p126). Witz further wrote of the "necessity for women to mobilise proxy male power to represent their interests in the institutional arena of the state legislature" (p125). This appears to have been the case for the Central Midwives Board. Within these confines, the two men to have had the most

⁵ Borrowing from Hendry (2001 p11), see page 24 above

significant involvement with midwifery regulation were Dr (later Sir) Edward Coey Bigger and Dr Ninian Falkiner. Bigger was a key figure in Irish public health developments in early twentieth century Ireland. He is described as an “energetic campaigner for better public health provisions for mothers and children” (Robins 2000 p16). Bigger, who was to steer the Central Midwives Board through most of its life, had also been a “far-sighted” member of the Viceregal Commission on Poor Law Reform from 1903 to 1906 (Barrington 1987 pp25, 28, 78). He was later to be appointed Medical Commissioner of the Local Government Board and was the person who prepared the Irish report on maternal and child health for the Carnegie Trust in 1917 in which he drew attention to the high infant mortality rate (of 90 per 10,000) (Barrington 1987 p78). Coey Bigger was later appointed Chairman of the Irish Public Health Council in 1919 (Barrington 1987 p83), a key role in the evolving public health arena being addressed by the state. Bigger is cited by Miss Healy after his death as having been responsible for the “status of midwives”, through the 1918 Act. It was his son, Senator Joseph Warwick Bigger, who effectively saved the term midwife from extinction when this was proposed in the 1949 Nurses Bill.

Medical men seemed to be as powerless, in terms of not being listened to, in their defence of the Central Midwives Board as their midwifery colleagues. However the very involvement of medical doctors in midwifery regulation is the taken-for-granted context whereby medical men were seen as the natural regulators of midwives in Ireland as elsewhere. This involvement is consistent with both patriarchal and medical prominence in society and childbirth in particular, a pattern that had developed since the eighteenth century. There is little doubt that the retention of the Central Midwives Board suited the purposes of the obstetricians who saw themselves as the rightful regulators *of* midwives, albeit *with* midwives. On the other hand those who defended the Central Midwives Board appeared to do so on the basis of a robust defence of midwifery, in terms that read like a manifesto of midwifery. The minutes of the Central Midwives Board and subsequently of the Statutory Midwives Committee suggest that all the members of the Central Midwives Board took their work very seriously and showed commitment in the face of practical difficulties particularly during the World War II “Emergency period” in Ireland.

According to Witz's (1992) feminist framework for analysing professional projects, the strategy employed by the medical profession towards midwifery regulation in Ireland, as elsewhere, can be characterised as a "demarcationary" one (see page 45). Within demarcation, the strategies of de-skilling and incorporation may be employed by the dominant group, and these findings suggest that de-skilling was the strategy employed in the Irish context. Witz (1992 p113) does ask the question as to why a section of medical men appeared to champion the cause of midwives (as happened in Ireland) rather than hasten their demise? In other words, why did a de-skilling rather than an incorporatist strategy ultimately prevail? In the Irish case, the attempts of the medical men on the Central Midwives Board (with their midwifery colleagues) perhaps ensured that midwifery did continue to be recognised, while the Department of Health's workings could have seen its demise in the 1950 Act, if the term 'midwife' had been abolished as planned by the Minister. Hunt & Symonds (1995) in any case challenge the basis for the idea of de-skilling, commenting on the low status and stigmatisation of midwifery before regulation. They highlight that one of the main skills of a midwife is to know the "limits to her own skill". On one level whether or not this is problematic must be questioned. Team-work implies a complementarity of skills and modern healthcare systems operate in this way. However, since the limits to midwifery care were set historically by medical men who encroached the childbirth domain traditionally inhabited by women midwives, these limits are not value-free or neutral. Hunt & Symonds (1995 p22) highlight the need to take account of the systems within which midwives currently work and they caution against the notion of a loss of identity, and view "the likelihood of there being 'a lost golden age of midwifery'" as remote. The very processes of regulation and registration may have been double-edged in that it brought recognition on one hand and control by medicine (and later nursing) on the other, but prior to that midwifery's status was in any case quite low. Hunt and Symonds (1995) highlight that hospitalisation brought an "occupational space" for midwives (p142). This is mostly viewed negatively by midwives, although more positively it bestowed validity on midwifery practice within "professional healthcare". This acknowledgement needs to temper notions of the "loss of identity" of midwifery which feature in midwifery discourses.

5.3.2 *The politics of midwifery regulation*

The theme of 'politics' is used to explore the role of the state in the events described in this chapter. The Irish cultural and political context of these events was deeply conservative and patriarchal, and this remained the case until the 1960s saw the beginnings of economic and social growth and a move away from stagnation. This patriarchal conservative model is reflected throughout other social and cultural arenas. Galligan (1992 p187) examines "the dearth of women in positions of power in parties and political life" which she says is only part of the wider patterns of women's absence from decision-making centres generally. For example, between 1937 and 1977 there were only 19 women in the Seanad. Galligan explores the reasons and includes socialisation into a traditional division of labour by church, school and family (Galligan 1992 p189). In this context it is unsurprising that the state did not interfere with the gendered inter-professional relations and social order described in the previous section. This can be interpreted in various ways, based on different interpretations of the role of the state in gendered relations proposed in chapter 3. Walby's (1990, see page 46 above) analysis would suggest that the state directly supports and upholds patriarchal practices such as the demarcation of the midwifery role. Foucault's (1980, see page 69 above) description of the state as "super-structural" in any case implies the state relying on pre-existing gendered relations and social order. In either case, the state does not challenge these gendered relations.

Following the advent of the Irish Free State in 1922, the Central Midwives Board Order (1923) passed the functions of the previous Board to the new Board. Barrington (1987 p88) states that "the sense of continuity between the periods before and after independence for the development of Irish health services cannot be over emphasised" and this analysis applies accurately to midwifery regulation. Interestingly, Ryan (1997 p255) argues that childbirth is highly medicalised in Ireland as "the result of two mutually reinforcing patriarchal phenomena: the masculinisation of childbirth and the effects of colonial legislation".

Ryan (1997 p255) inaccurately states that until 1950 the

control of training and registration of midwives in Ireland [was given] to the London-based Central Midwives Board. The colonial control of childbirth did not cease with independence, the Act [1902 Midwives and Health Visitors Act] remained in force until 1952 when An Bord Altranais took over midwifery training

This analysis ignores the existence of the Central Midwives Board in Ireland from 1918 to 1951. Ironically colonialism meant that Ireland at least had a Midwives Board for a certain period of time. Those who took over the “fledgling Irish Free State” (Ní Ghiolla Phádraig 1995 p 609) continued with this Board, until of course the new Department of Health established in 1947 would revisit this wisdom in the late 1940s.

The role of Ministers and Department of Health officials were critical in the changes that befell midwifery in the period discussed. However lack of consultation and recognition rather than an overt plot against midwives appear to have been behind the abolition of the Central Midwives Board, and the near abolition of the term “midwife” itself, were it not for the intervention of Seanad members and perhaps the Taoiseach. This account suggests a dispersal of power and a “muddling through” or incrementalist approach to policy-making at best, rather than any rational approach to policy in relation to midwifery regulation (Walt 1994 p46).

The rescue of the term ‘midwife’ highlights the contingent nature of policy-making. The concerns raised by the Central Midwives Board appeared not to resonate with Departmental officials and since the Board never met with the Minister there is no reason to think that their message resonated with him either. The officials may have believed that the Central Midwives Board members were acting in self-interest, to retain their personal power on the Board. While this cannot be discounted fully, the commitment with which the members carried out their functions suggested that they gave more than they received from their positions. The Minister was fighting battles on many fronts, not least with the medical profession on the matter of the Mother and Child Scheme, and perhaps the Central

Midwives' Board was to him another front in that battle. The collective medical profession were however more successful in their other struggles with the Minister. Hensey (1988 p44), writing as a former civil servant, states that after the period of the Mother and Child Scheme, the Department of Health established satisfactory working relations with the medical profession and the other health professions. This was not to be of use to the medical and midwifery members of the former Midwives Board.

Noel Browne's valiant, though ultimately unsuccessful, efforts to radically reform Irish health services appeared to blinker him against the particulars of the role of midwives and of the Central Midwives Board. Browne was one of ten TDs (Teachtaí Dála, [MP]) from Clann na Poblachta which joined with Fine Gael and three other small parties and one independent TD to form the state's first coalition government on 18 February 1948. Farrell (1992 p 154) observed that Ministers can expect to have served for about seven years as a TD before entering the cabinet. He stated that the "notable though not necessarily successful exceptions" include Browne in 1948 who was made Minister on his first day in the Dáil. Burke (1999 pp 28) describes Browne as a "young and energetic" Minister who threw himself wholeheartedly into reforming the Irish health services. However she also states that he was "very much a loner and did not consult his cabinet colleagues about the problems he encountered" with the "powerful vested interests" of the medical profession and the Catholic hierarchy (p29). Ultimately this was the cause of his undoing. The government had found itself in "the impossible position fighting both the bishops and the doctors" over Noel Browne's proposed Mother and Child Health scheme (Burke 1999 p 29). The legislation on which Browne's "Mother and Child" scheme was being implemented had been passed in 1947 but the part dealing with Mother and Child Scheme had remained dormant until 1950 when Browne took up the issue. Browne was sacrificed in any case and it was demanded by his party leader Sean MacBride that he resign on 10 April 1951. He did resign on 12 April 1951. A medical doctor himself, Browne appeared not to share the views of Central Midwives Board members that there were dangers in the proposed maternity nurses looking after pregnant women and mothers and infants. The concerns of the Board members were linked with the high incidences of childhood

infectious diseases, which would be communicated from infants to pregnant women and young infants

Noel Browne, in the year before he was to unceremoniously resign from office as Minister for Health, steered through the Nurses Act which dissolved the Central Midwives Board despite the Board's protests. When Browne conceded the change in "terminology" from maternity nurse to midwife in the 1950 Act he claimed this is based on the views of Midwives Board members and Senators. The Taoiseach, to whom the Board wrote in very early 1950, may have intervened and perhaps the Board members could have played a more politically astute role and taken such measures earlier. Certainly they seemed capable of enlisting the support of certain Senators (in particular Senator Bigger), supplying them with documentation in the form of letters from other Midwives' Boards that were to be persuasive in its delay of the Bill moving through the Seanad. Falkiner had specifically visited London to discuss the reciprocation issue with those Boards and shortly after this these letters are cited by various Senators. This suggests a realisation of the power of such alliances, though under-used and used too late to save the Midwives Board.

Burke (1999 p25) describes the period between 1922 and 1951 as one of "Survival", for the new Irish state, which was dealing with the aftermath of the civil war which followed independence. She states that in this context, the ideology of the new state was deeply conservative (p26). There were to be eight changes of government in the period 1932- 1952 (Coakley & Gallagher 1992 p241). Within this context of political instability, the significant role played by Departmental officials is highlighted by Barrington (1987 p 167) who outlines that the Department of Local Government and Public Health had a "coherent and radical blueprint for the reform of the health services by the end of 1945". With the unstable political landscape it was likely that civil servants steered the policy agenda over the longer term. The members of the Board certainly believed that those involved with drafting the proposals and subsequent Bill had little knowledge and little respect for the Board, evidenced by the lack of consultation with the Board.

As well as the substantive issue of the 1950 Nurses Act, several other incidents in the minutes of An Bord Altranais suggest that the Department exerted significant control over the working of An Bord Altranais, especially relating to financial matters. Throughout the minutes between the late 1950s and the 1980s permission of the Department of Health about various minor operational matters were sought. For example there was a plan stated to seek Ministerial sanction for the provision of tea and biscuits to nurses undertaking public health lectures. There were also various references to travelling expenses for An Bord Altranais officers which suggests a considerable level of involvement and interest in the (especially financial) matters by the Department of Health.

5.3.3 The 'nursification' of midwifery

Another set of 'politics' relates to the interaction between nursing and midwifery bodies. Around the time of the proposed abolition of the Central Midwives Board, those involved in nurse regulation appeared to favour a situation whereby midwives were subsumed into a Nursing Board. The role of the General Nursing Council and later the nursing-dominated An Bord Altranais certainly did not advance the cause of midwifery. However it appears that the administrative lack of knowledge about midwifery, particularly at the Department of Health, suited, rather than was overtly influenced by, these bodies. Prior to 1951, the General Nursing Council and the Central Midwives Board had worked independently of each other. The minutes consulted suggest tensions between those involved in nursing and midwifery regulation. For example at the General Nursing Council's "half-yearly meeting" of 23 February 1949 a report was given about "a Conference held between the General Nursing Council and Officers of Department of Health" on 3 February 1949. It is reported that Dr Deeney (of the Department of Health) had said that the suggestion for a Statutory Midwives Committee had emanated from the Central Midwives Board. This claim is strange given the stark opposition to the abolition of the Central Midwives Board in any case. At the first meeting of An Bord Altranais the newly elected President of An Bord (and former Chairman of the GNC), Dr MacCarvill queried why Item 6 of the agenda was "First meeting of the Midwives Committee". It was explained that under the Nurses Act, the Midwives Committee was established with An Bord Altranais on 7 June 1951. It was

therefore necessary to fix a date for its first meeting and members of An Bord Altranais were the only people who could deal with this. Apparent tensions continued in the early meetings of the Statutory Midwives Committee, with Dr Falkiner finding it necessary to seek clarification from the Minister on the scope of the Statutory Midwives Committee.

Parallels for the concern of the Central Midwives Board about the loss of the Board are found in the work of authors writing about the UK. Symonds & Hunt (1996 p201) state that many midwives rejected the carrot of self-regulation that came with the UKCC and four National Boards structure introduced following the 1979 Nurses, Midwives and Health Visitors Act, on the grounds that “midwifery was in danger of exchanging medical dominance for rule by nurses”. Similarly, Donnison (1988 p204) stated in the UK context that

a further factor contributing to the attrition of the midwife’s identity as an independent practitioner, has been the abolition of the Central Midwives Board [and that the Statutory Midwives Committee] was subordinate to the nurse-dominated U K C C

Also writing in the context of the UK, van der Kooy (1998 p10) highlights that the UKCC and four National Boards framework had “not been helpful to the midwifery profession due to the numerical dominance of the nursing profession on the Council”. When the UKCC was being established she states that midwives fought hard for a measure of control in the regulation of the profession, resulting in a Midwifery Committee within the UKCC. She argues that after

Eighteen years of trying to strengthen its role, the Committee still lacks power because of the unequal structure of the organization. There is a constant struggle to ensure all issues related to midwifery are considered by the Midwifery Committee and not simply passed by the Nursing dominated Council.

Van der Kooy could have been writing about Ireland, her words reflect those of the Statutory Midwives Committee Memo of 1955 Symonds & Hunt (1996 p 203) state that in the UK context during the 1990s, the

arguments and passions for a new Midwives' Act are inextricably linked with midwives' autonomy and independence in the past midwives had their own statutory body, the Central Midwives Board, and were largely independent practitioners giving care throughout pregnancy, labour and the puerperium

There is little doubt that these matters are linked and they are raised by midwives in Ireland on the same basis. However, there is a danger of assuming that legislative backing for a separate regulatory Board for midwives would restore the independent nature of midwifery practice. There are many other structural influences on this. Symonds & Hunt (1996 p204) in a UK context highlight that new legislation would depend on "midwives' willingness to resume their former responsibilities and accept accountability for their actions". The same could be said to apply in the Irish case, in relation to the impending Nurses and Midwives Act. The authors state that as most midwives previously trained as nurses, a helper rather than leader role in care is more familiar.

With the possibilities offered by direct entry midwifery programmes and the recent exciting midwifery-led innovations, the challenge to lead maternity care can be taken up increasingly by midwives. The direct entry midwifery programme has led to an increased visibility for midwifery, evidenced by recent advertisements, which seek those interested in careers in nursing *and* midwifery. Previously this would have been limited to nursing. The *Nursing and Midwifery Career Centre* has replaced the *Nursing Career Centre*, further to another welcome recommendation of the *Expert Group on Midwifery and Children's Education* (2004). Its fruits are seen already in these sorts of advertisements.

5.3.4 *Language and identity*

The preceding discussion points to the importance of identity as it is portrayed by language. What was not to serve the resistance to the abolition of the Central Midwives Board well.

was the loose use of language relating to the terms “nursing” and “midwifery” On various occasions throughout the account in this chapter the term “nurse” appears to involuntarily slip out when a key point about midwifery is being made This was seized upon by Browne and others alluding to nomenclature regarding the maternity nurse/midwife wrangle, which was in any case about more than that This occurred despite the leadership and valiant defences of key medical men and midwives In particular policy decisions based on competing (public health) concerns within politically charged times ensured that the abolition of the Midwives Board went ahead Later, the nursing-dominated An Bord Altranais seemed reluctant to revisit the issue of a separate regulatory framework for midwives

Related to the issue of language, one feels a certain despondency when Robins (2000 p41) entitles the section of the chapter on An Bord Altranais 1950-1970 which deals with midwives’ regulation, as “Maternity nurses” This section directly referred to midwives from the first sentence and is unselfconscious about the use of the title “maternity nurse” that had caused so many problems for the Central Midwives Board The adoption of this description and role for midwives would have presumably had even worse implications for them and for midwifery than the abolition of the Central Midwives Board and the “nurse includes midwife” clause Earlier in that chapter (p19) Robins had referred to the near-miss nature of the proposed use of the title “maternity nurse” for midwives in the 1950 Act, so its use as a heading for midwifery development subsequent to that Act is curious at best It is again perhaps symptomatic of the lack of awareness of midwifery’s distinctiveness, even for someone writing a history text on *Nursing and Midwifery in Ireland in the Twentieth Century* Elsewhere Robins states that the 1950 Nurses Act brought “into association the regulation of midwifery with other aspects of nursing” (p30), the inference being that midwifery is an aspect of nursing He also states that the 1949 Nurses Bill was not treated as a political issue The findings of this study would certainly challenge that claim, as it applies to midwifery These references highlight the fact that midwives need to significantly address this lack of awareness about their identity and cannot wait for, or expect, legislative changes to singly do that

One recent example of an attempt to address the perceived poor public awareness of the midwife's role is the recent pamphlet "The role of midwives caring for mothers and babies in Ireland" This was developed by the National Midwifery Advisory Committee, Department of Health and Children (2004a) Its stated purpose was to "provide the public with information about the role of midwives within the maternity services of Ireland" It opens with the statement that "pregnancy and childbirth are a normal part of life" It says that "midwives care for women throughout the pregnancy, at the time of birth and after the baby is born" "Care involves physical, emotional and social support", it claims It acknowledges that midwives work in different settings and that "some or all" of the choices (community midwifery, midwife-led clinics, home birth, midwifery-led units, postnatal community midwifery care) "may be available depending on where you live" While this unequal access is certainly the case, this pamphlet nonetheless attempts to raise awareness of midwifery's identity and role within the public arena

5.4 Conclusions

For Foucault the task of historical investigation lies in making the contours of the present strange rather than the past familiar Historical investigations, when chance and contingency are given their due, may be mobilised to the work of unsettling rather than bolstering current certainties

(Tyler 1997 p78)

This historical analysis serves to highlight both the "the concealed possibilities of the past" (Barrington 1987 p viii) and the possibilities for the future This history requires us to challenge the taken-for-grantedness of the current situation regarding the regulatory framework of midwifery It also offers an opportunity to reflect on the taken-for-grantedness of the patriarchal control of the medical profession in midwifery regulation and the role of the state in facilitating this

There were certainly elements of chance and contingency at play surrounding the enactment of the 1950 Nurses Act. While the word “midwife” was spared by contingency, the Midwives Board was lost and with it some of midwifery’s visibility. These findings place the current demands of midwives for separate regulatory structures in clear historical context. The long-awaited Nurses and Midwives Bill may only restore a Statutory Midwives Committee. The Commission’s recommendations to reinstate the statutory basis of that Committee may be seen as a limited solution to midwives’ concerns about the lack of a regulatory framework for midwives. Certainly the former members of the Central Midwives Board highlighted their perceptions of the limited power of such a Committee from its inception in 1951 to its loss of statutory status in 1985. The lack of resistance to the loss of that statutory status suggests a resignation about the ineffectiveness of the Statutory Midwives Committee in any case. Nothing short of a separate midwives’ regulatory body would have satisfied the former Central Midwives Board members.

The findings presented in this chapter are ostensibly about regulation and the regulatory structure of midwifery. But their significance casts a wider and longer shadow than might be suggested. Policy-makers appeared to have a lack of understanding of midwifery’s distinctiveness. They then failed to consult those who had such an understanding, members of the Central Midwives Board. The effects of those failings have been far-reaching, stretching into the new millennium. The lack of consultation with, and arguably the lack of respect shown to, midwifery leaders of the time did not bode well for the intervening period. The late intervention of Senator Bigger in particular saved the word “midwife” from extinction. Personal circumstances saw to it that he was a very appropriate person to mount such a defence, though there is a sense of him being in the right place at the right time when the 1949 Nurses Bill was at Committee stage in December 1949.

Ultimately those who sought to retain the power to regulate midwives as a separate group, and to have that separation recognised, were ineffective. Despite their ardent resistance and subsequent efforts to regain ground, midwifery lost its separate legislative recognition and has not regained this to date. This chapter reveals an unanticipated level of political interest

in midwifery regulation and highlight the need to study professional issues such as regulation in their broader socio-political contexts. These findings are a valuable record in themselves and also form part of the contextual backdrop against which the other findings of this study are interpreted. The survey findings on empowerment are presented in the next two chapters.

CHAPTER 6

SURVEY 1 - RESULTS AND DISCUSSION

The objectives of the survey research undertaken within this study are to identify the conditions important for empowerment in midwifery and to explore strategies for the measurement of those conditions. To meet these objectives a cross-sectional survey of practising midwives was carried out in January 2002. A questionnaire was disseminated which involved the collection of the following quantitative and qualitative data

Quantitative data

- A demographic section, to provide a demographic profile of respondents
- The *Understanding of Empowerment Scale*, developed for this study, within which midwives rated and ranked a series of items in terms of their importance to empowerment
- The University of Western Ontario *Work Empowerment Scales*, which measure respondents' perceptions of their levels of certain structural conditions for empowerment and their levels of formal power and informal power

Qualitative data

- Open questions about the factors that enhance and inhibit empowerment. This facilitated the identification of the factors that influence empowerment, qualitatively
- An open *Additional Comments* section, to provide an opportunity for respondents to include additional views on the topic of empowerment

6.1 Results of survey 1

In this section, the results of survey 1 are presented as follows

- Response rate
- Demographic profile of respondents

Quantitative data

- Midwives' understanding of empowerment. Results of Understanding of Empowerment Scale
 - Results of rating exercise
 - Results of ranking exercise
 - Factor analysis of rating responses
- Midwives' perceptions of their levels of empowerment. Results of UWO Work Empowerment Scales

- Correlations between scales

Qualitative data

- Factors influencing empowerment
 - Factors that enhance empowerment
 - Factors that inhibit empowerment
- Conclusion regarding factors influencing empowerment
- Respondents' additional comments

6 1 1 Response rate

Completed questionnaires were received from 95 practising midwives within the national study of empowerment described above (Scott *et al* 2003). These respondents comprise the sample whose results are reported in this chapter. It is not possible to estimate a response rate for practising midwives. This is because the total number of midwives in practice within the target sample cannot be known. In the absence of official national figures, it is estimated that approximately 2,000 midwives are currently practising in Ireland, thus this group represents 4.75% of that estimated total. However the proportion of the total population is not a meaningful way of establishing the adequacy of a sample (Fowler 2002). Of more importance when considering sample adequacy is the absolute size of the sample and the means by which it was obtained. In this case, the sample is random and at 95 almost meets the criterion of a minimum of 100 cases recommended for the purposes of most analyses.

6 1 2 Demographic profile

Selected sample characteristics are shown in Tables 6.1a and 6.1b. In summary, the midwifery sample (n=95) was predominately female and hospital-based. Midwives were drawn from all geographical regions across Ireland. Almost three-quarters of the midwives were employed by Health Boards⁶. Just over half of the midwives in the sample had worked overseas. Almost all were Irish. Two-fifths were working part-time. Just less than a third

⁶ Since 2005 the Health Board structure has been replaced by the establishment of the Health Service Executive, with its constituent administrative regions.

were aged under 40 years old. Almost half were working as staff midwives, a third as senior staff midwives, four as Clinical Midwife Specialists and 16 as managers.

Table 6 1a Demographic characteristics of the sample, survey 1

Characteristic	n	Valid %
Sex		
Male	3	3
Female	92	97
<i>Total</i>	95	100
Age breakdown		
20-29 years	9	10
30-39 years	25	26
40-49 years	41	43
50-59 years	20	21
<i>Total</i>	95	100
Nationality		
Irish	90	97
Other nationality	3	3
<i>Missing</i>	2	
<i>Total</i>	95	100
Role		
Staff midwife	41	44
Senior staff midwife	32	34
Clinical Midwife Specialist	4	4
Manager	16	17
<i>Missing</i>	2	
<i>Total</i>	95	99

Table 6.1b Demographic characteristics of the sample, Survey 1

Geographical distribution		
North-east	6	6
East	30	32
South-east	11	11
South	13	14
West	14	15
North-west	4	4
Midlands	4	4
Mid-west	13	14
<i>Total</i>	<i>95</i>	<i>100</i>
Work-status		
Part-time	56	60
Full-time	38	40
<i>Missing</i>	<i>1</i>	
<i>Total</i>	<i>95</i>	<i>100</i>
Place of work		
Hospital	91	96
Community	1	1
Hospital & Community	2	2
Other	1	1
<i>Total</i>	<i>95</i>	<i>100</i>
Employer		
Health Board	68	73
Voluntary Hospital	21	23
Private sector institution	4	4
<i>Missing</i>	<i>2</i>	
<i>Total</i>	<i>95</i>	<i>100</i>
Practised outside Ireland		
Yes	48	51
No	46	49
<i>Missing</i>	<i>1</i>	
<i>Total</i>	<i>95</i>	<i>100</i>

6 1 3 Quantitative results

Quantitative data were collected on midwives’ understanding of the conditions important to empowerment and their perceptions of their own levels of empowerment. These results of two elements are presented below.

6 1 3 1 *Midwives’ understanding of empowerment: Results of Understanding of Empowerment Scale*

As described above, within the *Understanding of Empowerment Questionnaire* respondents were asked to rate and rank the importance to empowerment of the 24 statements which comprised this scale. The results are presented in the following order:

- Results of the rating exercise
- Results of the factor analysis that was carried out on those rating responses
- Results of the ranking exercise

6 1 3 1 1 *Results of rating of items on Understanding of Empowerment Scale*

The full results of the rating exercise are shown in Table 6.2

Table 6 2: Results of rating exercise, UES

Note For clarity of presentation, only valid percentages (and not numbers) are shown, denominator is 95 and % of missing cases per item are shown in right-hand column		Response options (valid %)						Missing (%)
		Crucially important to empowerment	Quite important to empowerment	Important to empowerment	Somewhat important to empowerment	A little important to empowerment	I don't think that this item is related to empowerment	
1	Being valued by my manager	51	28	17	2	1	1	2
2	Being an advocate for my patients/clients	60	22	15	-	1	1	4
3	Knowing what my scope of practice is	70	23	7	-	-	-	-
4	Having the skills to carry out my role	85	12	3	-	-	-	2
5	Being recognised for my contribution to patient care by my manager	47	29	18	4	1	-	2
6	Having access to resources for patients	42	38	16	4	-	-	2
7	Delegating non-midwifery tasks to auxiliary staff	32	24	23	13	3	4	4
8	Having a supportive manager	64	23	12	-	1	-	-
9	Having support from my colleagues	57	32	9	1	1	-	1
10	Having effective communication with management	68	23	9	1	-	-	2
11	Being listened to by members of the multidisciplinary team	58	36	7	-	-	-	2
12	Being informed about changes in my organisation that will affect my practice	58	30	11	1	-	-	3
13	Having control over my practice	53	37	8	1	1	1	2
14	Being adequately educated to perform my role	67	25	6	1	-	-	-
15	Performing tasks that were previously performed by doctors and other professionals	15	19	19	20	5	20	2
16	Being able to say no when I judge it to be necessary	64	22	13	-	-	1	1
17	Being accountable for my practice	72	20	6	1	-	1	1
18	Being recognised as a professional by the medical profession	60	22	13	2	-	3	2
19	Being involved in midwife-led practice	54	30	10	4	-	1	3
20	Empowering my patients/clients	43	32	20	-	1	5	6
21	Having access to resources for staff education and training	48	38	11	1	-	2	2
22	Having autonomy in my practice	58	28	11	1	1	1	4
23	Having the back-up of my manager	62	29	8	1	-	-	3
24	Being recognised for my contribution to patient care by the medical profession	44	38	8	5	-	5	2

The 5 items that were rated “Crucial to empowerment” by the highest percentage of midwives were (% of midwives who rated the item as “crucial” in parentheses)

- Having the skills to carry out my role (84 9%)
- Being accountable for my practice (71 6%)
- Knowing what my scope of practice is (69 5%)
- Having effective communication with management (67 7%)
- Being adequately educated to perform my role (67 4%)

Drawing from the literature in chapter 2, several items from the scale can be grouped together under a theme that could be seen as being related to woman-centred practice. These results are as follows (% of midwives who rated the item as “crucial” in parentheses)

- Being an advocate for my patients/clients (60 4%)
- Being involved in midwife-led practice (54 3%)
- Empowering my patients/clients (42 7%)
- Having access to resources for patients/clients (41 9%)

Several items could also be related to a theme of interaction with the medical profession. These results are grouped below (% of midwives who rated the item as “crucial” in parentheses)

- Being recognised as a professional by the medical profession (60 2%)
- Being listened to by members of the multi-disciplinary team (58 1%)
- Being recognised for my contribution to patient care by the medical profession (44 1%)

The only item that was rated by more than 6% of midwives as “not being related to empowerment” was “Performing tasks that were previously performed by doctors and other professionals” (20 4%)

6 1 3 1 2 Results of ranking exercise

In addition to the Likert-type scale offered to respondents, upon which factor analysis is based, respondents were also asked to undertake a ranking exercise. They were asked to rank the ten items (of the 24 provided, See Appendix B) that they considered most important for empowerment, from 1 to 10, with 1 being the most important and 10 being least important of the ten chosen items. This exercise was included to further tease out the core items involved in empowerment, given the expected positive skew of

responses to the rating exercise. Eleven midwives (12%) did not complete this section of the questionnaire or completed it incorrectly. While this was included in a second pilot survey specifically to check its usability, clearly for some it proved difficult to complete. The full results for this ranking exercise are shown in Table 6.3 below.

Table 6.3 Results of ranking exercise, UES

		Position in which item was ranked										
		Not ranked	1	2	3	4	5	6	7	8	9	10
1	Being valued by my manager	65 5	7 1	4 8	6	3 6	2 4		1 2	3 6	1 2	4 8
2	Being an advocate for my patients/clients	54 8	7 1	4 8	6	3 6	2 4		3 6	3 6	4 8	2 4
3	Knowing what my scope of practice is	34 5	17 9	17 9	2 4	3 6	3 6	3 6	6		6	4 8
4	Having the skills to carry out my role	27 4	20 2	15 5	11 9	4 8	6	4 8		3 6		6
5	Being recognised for my contribution to patient care by my manager	67 5	1 2	2 4	6	6	3 6	1 2	2 4	7 2		2 4
6	Having access to resources for patients	69 9	1 2		4 8	3 6	3 6	1 2	1 2	4 8	6	3 6
7	Delegating non-nursing tasks to auxiliary staff	86 7	1 2			1 2	1 2	1 2	1 2	1 2	3 6	2 4
8	Having a supportive manager	46 4	7 1	6	10 7	9 5	4 8	4 8	2 4	2 4	4 8	1 2
9	Having support from my colleagues	51 2	3 6	4 8	9 5	3 6	6	3 6	6	3 6	6	2 4
10	Having effective communication with management	39 8	7 1	3 6	1 2	3 6	10 8	3 6	9 6	4 8	7 2	8 4
11	Being listened to by members of the multidisciplinary team	54 2	1 2	3 6	1 2	6	3 6	4 8	6	4 8	8 4	6
12	Being informed about changes in my organisation that will affect my practice	54 9		1 2	3 7	4 9	4 9	9 8	4 9	4 9	6 1	4 9
13	Having control over my practice	60 2	4 8	3 6	3 6	2 4	2 4	3 6	3 6	6	3 6	6
14	Being adequately educated to perform my role	34 5	7 1	6	4 8	10 7	11 9	9 5	4 8	4 8	3 6	2 4
15	Performing tasks that were previously performed by doctors and other professionals	91 7	1 2			1 2		3 6	1 2	1 2		
16	Being able to say no when I judge it to be necessary	52 4		4 8	3 6	3 6	4 8	7 1	3 6	6	10 7	3 6
17	Being accountable for my practice	40 5	3 6	4 8	4 8	6	7 1	6	6	7 1	7 1	7 1
18	Being recognised as a professional by the medical profession	58 3	6	1 2	3 6	4 8	1 2	3 6	10 7	4 8	3 6	2 4
19	Being involved in midwife-led practice	56	2 4	4 8	6	2 4	3 6	6	6	8 3	2 4	2 4
20	Empowering my patients/clients	73 2	1 2	2 4	2 4	3 7	3 7		3 7	3 7	1 2	4 9
21	Having access to resources for staff education and training	59 5	1 2		1 2	4 8	2 4	4 8	6	7 1	6	7 1
22	Having autonomy in my practice	59 5	4 8	3 6	3 6	3 6	4 8	7 1	3 6	3 6	2 4	3 6
23	Having the back-up of my manager	65 5	1 2	6	4 8	2 4	6	4 8	1 2	1 2	3 6	3 6
24	Being recognised for my contribution to patient care by the medical profession	72 6	3 6	3 6	2 4		1 2	3 6	4 8	3 6	1 2	3 6

The items ranked 1 "the most important to empowerment" by the highest number of midwives are shown in Table 6 4

Table 6.4: Items ranked 1 “the most important to empowerment” by the highest number of midwives

	%
Having the skills to carry out my role	20.2
Knowing what my scope of practice is	17.9
Having effective communication with management	7.1
Being an advocate for my patients/clients	7.1
Being adequately educated to perform my role	7.1
Being valued by my manager	7.1
Having a supportive manager	7.1

Those items that were ranked (anywhere from 1 to 10) by the highest % of midwives are shown in Table 6.5:

Table 6.5: The items that were ranked (anywhere from 1 to 10) by the highest % of midwives

	%
Having the skills to carry out my role	72.6
Being adequately educated to perform my role	65.5
Knowing what my scope of practice is	65.5
Having effective communication with management	60.2
Being accountable for my practice	59.5
Having a supportive manager	53.6

On the other hand, a large number of items were not ranked (in the “top 10”) at all by the highest % of midwives are shown in Table 6.6:

Table 6.6: The items were not ranked (in the “top 10”) at all by the highest % of midwives

	%
Performing tasks that were previously performed by doctors and other professionals	91.7
Delegating non-midwifery tasks to auxiliary staff	86.7
Empowering my patients/clients	73.2
Being recognised for my contribution to patient care by the medical profession	72.6
Having access to resources for patients/clients	69.9

In order to take into account ranking scores across the full (1-10) spectrum, the total ranking score for each item was calculated by adding the ranking scores for each item of each respondent (where an item ranked 1 it was given 10 points, ranked 2 it was given 9 points etc. and where an item was not ranked it got 0 points). The maximum summed

score for the highest ranked item was 840 (84 respondents by 10 points) The results of the summed ranking scores is shown in Table 6.7

Table 6.7: Rank order of items by sum of scores

	Item	Sum of ranking scores
1	Having effective communication with management	302
2	Being accountable for my practice	300
3	Being adequately educated to perform my role	269
4	Being able to say no when I judge it to be necessary	257
5	Being listened to by members of the multidisciplinary team	249
6	Having access to resources for staff education and training	241
7	Being informed about changes in my organisation that will affect my practice	240
8	Knowing what my scope of practice is	216
9	Having support from colleagues	214
10	Having the skills to carry out my role	212
11	Being involved in midwife-led practice	207
12	Being recognised as a professional by the medical profession	197
13	Having a supportive manager	195
14	Having control over my practice	193
15	Having autonomy in my practice	180
16	Being an advocate for my patients/clients,	176
17	Having access to resources for patients	160
18	Having the back-up of my manager	152
19	Being recognised for my contribution to patient care by my manager	143
20	Being valued by my manager	131
21	Empowering my patients/clients	132
22	Being recognised for my contribution to patient care by the medical profession	129
23	Delegating non-midwifery tasks to auxiliary staff	78
24	Performing tasks that were previously performed by doctors and other professionals	38

As can be seen in Table 6.7, the five items with the highest total scores in the ranking exercise were

- Having effective communication with management
- Being accountable for my practice
- Being adequately educated to perform my role
- Being able to say no when I judge it to be necessary
- Being listened to by members of the multidisciplinary team

The 5 items with the lowest total scores in the ranking exercise were

- Being valued by my manager
- Empowering my patients/clients
- Being recognised for my contribution to patient care by the medical profession
- Delegating non-midwifery tasks to auxiliary staff
- Performing tasks that were previously performed by doctors and other professionals

6 1 3 1 3 Factor analysis of rating responses

As described in chapter 4, exploratory factor analysis was performed on these data to see if these items grouped into coherent factors. The raw data were used, although it was skewed towards agreement that the statements/items included were important to empowerment. This skewness was *a priori* quite likely, given that these statements themselves emerged from literature and focus groups exploring the meaning of empowerment. While dichotomising the data is an option to take account of this skewness, there is controversy about whether it is valid to factor analyse dichotomous data. Kubinger (2003 p106) states that factor analysis of dichotomised variables will often lead to artificial factors. Norman & Strenier (2000 p 175) strongly advise against factor analysis of dichotomised data due to the instability of the correlations with slight changes in the data. Kline (1994 p126) states that with dichotomised variables there is “relatively little variability” and this leads to factors of small variance. The decision was taken therefore to use the raw skewed data for factor analysis. Normality of distribution is not critical if the intent is to explore, summarise and describe relationships among variables (Pett *et al* 2003 p5, Hair *et al* 1995 p374). Hair *et al* (1995) continue that the critical assumption is that the data matrix has sufficient correlations to justify factor analysis and it is the extent to which normality influences this that is important.

Twenty-three of the 24 items in the scale were included in the factor analysis. The item that was excluded was “Performing tasks that were previously performed by doctors and other professionals”. Only 15% of midwives rated this as crucial to empowerment, in contrast with the high levels of agreement with all other items.

Seventeen cases had missing values across their responses. There were no patterns apparent in the missing data, with missing values scattered across items and cases. In order to retain the sample, variable means for missing values were imputed for the

purposes of the factor analysis (Hair *et al* 1995 p49) Hair *et al* (1995 p57) discuss the impacts on variance and correlations of mean substitution as an imputation method and recommend a reasoned judgment of the situation. In this case, a reduction of the sample to 78 (if the 17 cases with missing values were excluded) was judged to be more problematic than the implications of using the mean substitution method.

To determine the suitability of the data for factor analysis, the correlation matrix was firstly visually examined to explore its factorability (Hair *et al* 1995 p392). This visual inspection confirmed an adequate number of correlations. It is also possible to undertake statistical tests to ascertain whether it would be appropriate to proceed with factor analysis, specifically if there are sufficient numbers of significant correlations among items (Pett *et al* 2003 p72). *Bartlett's Test of Sphericity* tests the null hypothesis that there is no relationship between items within the correlation matrix, i.e. that the matrix is an identity one (Pett *et al* 2003 p73). It tests the overall significance of all correlations in a correlation matrix (Hair *et al* 1995 p365). Bartlett's test was significant at the $p < 0.0001$ level.

In addition, the overall Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy (MSA) was 0.780, a level described as "meritorious" within Kaiser's (1974 p35) criteria for evaluating the size of the overall KMO. The KMO statistics for each individual item found on the diagonal of the anti-image correlation matrix were all greater than 0.6 as required (Pett *et al* 2003 p78). (The individual KMOs were ≥ 0.8 for 10 items and ≥ 0.7 for 11 items, with the remaining 2 items ≥ 0.6). Therefore all items were retained and included in factor analysis. While the limitation of the small sample size is acknowledged, the overall KMO of 0.78 suggests that factor analysis is justified. The individual KMOs of greater than 0.6 justifies the use of all 23 items.

Another issue of importance when conducting factor analysis is sample size. Ninety-five practising midwives responded to this survey. With 95 cases and 24 variables being factor analysed, a case-to-variable ratio of just less than 4:1 is achieved. Hair *et al* (1995, p373) suggest that as a general rule, a minimum sample size of 100 is required in order to calculate correlations among variables, with a case:variable ratio of at least 5:1. They acknowledge that a 10:1 ratio is more acceptable. Tabachnick & Fidell (2001 p588) suggest stricter criteria, at least 300 cases or 150 cases where solutions have

several high (> 80) factor loadings Hair *et al* (1995 p374) advise that “when dealing with smaller sample sizes and/or a lower cases-to-variables ratio the analyst should always interpret any findings cautiously” The findings reported and discussed below were considered tentative, pending further work with this scale (within survey 2, reported in chapter 7)

As advised by Pett *et al*, (2003 p115) a number of criteria assisted in the decision on the numbers of factors to extract, including an initial extraction of factors with eigenvalues >1 (The Kaiser-Guttman rule), observation of cumulative variance and individual factor variance and an examination of the scree plot (see Figure 6.1) Tabachnick & Fidell (2001 p620) comment that the number of factors extracted is probably more critical than the methods used to derive the factors Unrotated and rotated solutions for different numbers of factors were examined for interpretability The final solution chosen was based on the interpretability of the various solutions particularly in relation to “the factors’ theoretical coherence, [and] a desire for simplicity” (Pett *et al* 2003 p167) As Hair *et al* (1995 p379) conclude, “the factor analyst should always strive to have the most representative and parsimonious set of factors possible” These concerns influenced the choice of final solution in this study As described in chapter 4 the method of factor extraction was Principal Axis Factoring and the method of factor rotation was oblique (Direct Oblimin) (see page 110)

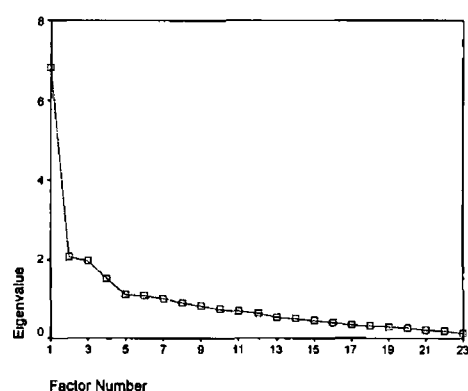


Figure 6.1. Scree plot for survey 1 factor solution

Factor loadings are the correlations between the original variable and the factors, “the key to understanding the nature of a particular factor” (Hair *et al* 1995 p366) Hair *et*

al's (1995 p385) guidelines suggested a factor loading cut-off point of 0.55 for this sample size of 95. Ultimately, a cut-off point of 0.50 was used, to preserve two items in factor 4. These two items were found within factor 4 in all other solutions when extraction and rotation methods were varied, and thus this factor is deemed to be a robust one.

The pattern matrix for the factor solution chosen is shown in Table 6.8. Hair *et al* (1995 p. 388) comment that most factor analysts report the results of the pattern matrix, rather than the structure matrix, since the loadings contained within the latter also include the correlation among factors, as well as the individual correlation of each item with the factor.

Table 6.8: Pattern matrix (loadings of <0.5 suppressed) Factor loading cut-off point of 0.50

	1	2	3	4
Factor name	Control	Support	Recognition	Skills
Being adequately educated to perform my role	0.64			
Having access to resources for staff education and training	0.60			
Having control over my practice	0.57			
Having access to resources for patients	0.54			
Having a supportive manager		-0.83		
Having the back-up of my manager		-0.71		
Having support from my colleagues		-0.62		
Having effective communication with management		-0.54		
Being recognised for my contribution to patient care by the medical profession			-0.69	
Being recognised as a professional by the medical profession			-0.67	
Having autonomy in my practice			-0.60	
Being an advocate for my patients/clients			-0.55	
Having the skills to carry out my role				-0.59
Knowing what my scope of practice is				-0.52
Internal reliability of factors (Cronbach's coefficient alpha)	0.70	0.84	0.75	0.69

For illustrative purposes, the results relating to the amount of variance explained by this solution are shown in Table 6.9. Since these factors are correlated it is not correct to total the variance (displayed in Table 6.9 as cumulative variance) and therefore this is not proposed here.

Table 6 9 Variance explained by factor solution, survey 1.

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	6 828	29 689	29 689	6 293	27 362	27 362
2	2 076	9 025	38 714	1 582	6 879	34 241
3	1 957	8 510	47 224	1 424	6 190	40 431
4	1 508	6 557	53 781	937	4 074	44 506

Pett *et al* (2003 p210) advise that “naming factors is a poetic, theoretical and inductive leap” The authors offer some guidelines for naming factors the item with the highest loading should provide a clue, the title should be brief and the name should attempt to capture the underlying construct On this basis the four factors were interpreted and named as described below

The first factor is named **Control** This factor relates directly to having control over midwifery practice and having access to adequate resources for birthing women and midwives Midwives being adequately educated is linked with their having control over their practice within this factor It is also linked with having access to resources for staff Lewis & Urmston (2000 p211) offer a distinction between power and control, whereby they suggest that “power necessitates an interpersonal situation, but control also includes successful manipulation of environmental variables, physical resources and one’s own behaviours” Thus the term control is most appropriate to describe this factor

The second factor is named **Support** This includes support from managers and colleagues In addition, this includes having effective communication with and the back-up of managers

The third factor is named **Recognition** This relates to the recognition of the midwife’s role by medical colleagues and that this role involves autonomy and advocacy for birthing women This factor encompasses both of the items from the questionnaire that relate to midwives being recognised by the medical profession - both as professionals and for their contribution to the care of women

The fourth factor is **Skills**. This comprises items related to knowledge about one's scope of practice and having adequate skills to carry out the midwifery role.

Cronbach's coefficient alphas were calculated to measure the internal consistency or reliability of the scale and of each factor. The coefficient alpha for the full scale was 0.888. These results per factor are shown in the bottom row of Table 6.8. This indicates acceptable reliability of ≥ 0.7 for all factors (when rounded to one decimal place) (Cronbach 1951).

As described above, since an oblique rotation was performed, a factor correlation matrix is presented (see Table 6.10). This shows variable correlations between factors, ranging from <0.1 (between factors 3 and 4) to -0.43 (between factors 1 and 3). The negative correlations are due to the negative loadings for factors 2, 3, and 4 shown in Table 6.8.

Table 6.10: Factor correlation matrix

Factor	Control	Support	Recognition	Skills
Control	1.00	-0.33	-0.43	-0.20
Support	-0.33	1.00	0.28	0.08
Recognition	-0.43	0.28	1.00	0.06
Skills	-0.20	0.08	0.06	1.00

These factor analysis results are discussed below (page 169) with all the survey results.

6.1.3.2 Midwives' perceptions of their levels of empowerment: Results of UWO Scales

Further quantitative data were collected about midwives' perceptions of their levels of empowerment. These perceptions were measured using the UWO empowerment scales developed by Laschinger (1996) as described on page 49. An overall empowerment score is calculated by summing the means of the four sub-scales (information, resources, support, opportunity), within the *Condition for Work Effectiveness Questionnaire* (Laschinger *et al*, 2001a). The mean scores for these scales are shown in Table 6.11 below. The internal reliability of all the scales is satisfactory (Coefficient Alpha scores shown in right-hand column of Table 6.10 are all satisfactory at >0.7).

Table 6 11: Mean scores for empowerment scales, survey 1

	Potential range	Mean	Standard Deviation	N	alpha
Condition for Work Effectiveness Questionnaire	4 (none) to 20 (a lot)	11.33	0.2984	95	0.884
Opportunity sub-scale	1 (none) to 5 (a lot)	3.74	0.815	95	0.719
Information sub-scale	1 (none) to 5 (a lot)	2.58	1.108	95	0.919
Support sub-scale	1 (none) to 5 (a lot)	2.48	1.097	95	0.845
Resources sub-scale	1 (none) to 5 (a lot)	2.53	0.846	95	0.788
Job Activities Scale (formal power)	1 (none) to 5 (a lot)	2.59	0.945	87	0.788
Organisational Relationships Scale (informal power)	1 (none) to 5 (a lot)	3.18	0.924	95	0.765
Global Empowerment item 1	1 to 5 (High to low)	2.87	1.135	93	n/a
Global Empowerment item 2	1 to 5 (High to low)	3.18	1.077	94	n/a

The overall scores suggest that midwives have “some” or “mid-range” empowerment as measured by the CWEQ, JAS, ORS and the global empowerment items. Midwives had higher levels of informal power than formal power, although they again only have a mid-range level or “some” informal power. Midwives had greater access to opportunities (in terms of challenging work, gaining new skills and knowledge on the job and using all their skills and knowledge) than to information, support and resources.

Individual items from the above scales can be examined in **Table 6.12**

Table 6 12 UWO Scales· Valid percentage per item

How much of the following do you have in your present job?						
		None	None-some	Some	Some – a lot	A Lot
1	Challenging work	1 1	4 2	23 2	21 1	50 5
2	The chance to gain new skills and knowledge on the job	2 1	22 1	34 7	23 2	17 9
3	Tasks that use all of your own skills and knowledge	1 1	8 4	33 7	30 5	26 3
4	Information about the current state of your organisation-service	12 6	17 9	41 1	14 7	13 7
5	Information about the goals of top management	33 7	14 7	31 6	16 8	3 2
6	Information about the values of top management	35 1	17	34	9 6	4 3
7	Specific information about things you do well	34	18 1	29 8	8 5	9 6
8	Specific comments about things you could improve	31 6	17 9	29 5	15 8	5 3
9	Helpful hints or problem solving advice	29 8	13 8	33	17	6 4
10	Time available to do necessary paperwork	20	28 4	36 9	11 6	1 1
11	Time available to accomplish job requirements	12 8	23 4	48 9	13 8	1 1
12	Acquiring temporary help when needed	25 3	25 3	30 5	15 8	3 2
	In your work setting	None	None-some	Some	Some- a lot	A Lot
1	The rewards for innovation on the job are	38 3	19 1	27 7	6 4	8 5
2	The amount of flexibility in your job is	14 9	23 4	41 5	11 7	8 5
3	The amount of visibility of your work-related activities within your organisation/service is	12 6	21 8	47 1	14 9	3 4
	In your present job, how much opportunity do you have for these activities?	None	None-some	Some	Some- a lot	A Lot
1	Collaborating on patient care with doctors	7 4	11 6	42 1	22 1	16 8
2	Being sought out by peers for information	5 3	13 7	34 7	28 4	17 9
3	Seeking out ideas from professionals other than doctors, e g , Physiotherapists, Occupational Therapists, Dieticians	16 8	17 9	37 9	20	7 4
		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
1	Overall, my current work environment empowers me to accomplish my work in an effective manner	5 4	44 1	19 4	20 4	10 8
2	Overall, I consider my workplace to be an empowering environment	2 1	30 9	26 6	27 7	12 8

In summary, midwives report that they do not have “a lot” of most items on these scales apart from those that relate to access to opportunities (challenging work, tasks using skills and knowledge) On the information, support and resources sub-scales there appear to be shortfalls, with small numbers reporting high levels of information about the values and goals of the organisation, feedback and access to resources

On the global empowerment items, 49.5% of midwives agreed (5.4% strongly agreed, 44.1% agreed) that their current work environment empowers them. 31.2% disagreed (10.8% strongly disagreed, 20.4% disagreed) with this statement, with 19.4% who “neither agreed nor disagreed”.

Thirty-three percent of midwives agreed (2.1% strongly agreed, 30.9% agreed) that they consider their workplace to be an empowering environment. 40.5% disagreed (12.8% strongly disagreed, 27.7% disagreed) with this statement, with 26.6% neither agreeing nor disagreeing.

6.1.3.2.1 Correlations between scales

Correlations are calculated between scales’ summed scores in order to measure the strength of relationship between constructs as represented by scales and sub-scales. Strong correlation (>0.7) was found between both global empowerment statements ($r = 0.816, p < 0.001$). Moderate correlation (>0.5) was found between empowerment (as measured by **CWEQ**) and the following:

- Informal power (JAS) ($r = 0.573, p < 0.001$)
- Formal power (ORS) ($r = 0.573, p < 0.001$)
- Global empowerment item 1 ($r = -0.550, p < 0.001$) (negative correlation explained by reverse scoring direction of scales - see Table 6.11)
- Global empowerment item 2 ($r = -0.614, p < 0.001$) (negative correlation explained by reverse scoring direction of scales - see Table 6.11)

Formal power (JAS) and informal power (ORS) were also moderately correlated ($r = 0.506, p < 0.001$).

The implications of all these findings are discussed below. Because of the size of the sample, further tests such as univariate analysis of variance were not carried out.

6.1.4 Qualitative results

To achieve the survey aim, it was mostly quantitative data that were collected using the questionnaire shown in Appendix B. Some qualitative data were also collected within the questionnaire, through the use of open questions. Responses to open questions were analysed with the assistance of the Atlas.ti package as described in chapter 4.

Given the non-interactive nature of postal surveys, the qualitative nature of these data is limited, as meanings cannot be clarified. Nonetheless, it provides an opportunity for respondents to use their own words and to expand as they need to on the points they raise. Specifically, open questions were included relating to

- Midwives' understanding of empowerment, not covered by UES
- Factors that enhance and inhibit empowerment
- Additional comments on empowerment or on the survey

6.1.4.1 Open question: understanding of empowerment

Given the closed-response nature of the *Understanding of Empowerment Scale*, respondents were invited to include anything else that they felt was related to empowerment that was not covered in the Scale.

Eleven midwives (10.5% of the sample) replied to this section. Their responses included the following:

- Responsibility for setting high standards and maintaining them
- Not allowing doctors to take over my role
- Job satisfaction, empowerment leading to a positive outlook in the workplace
- Empowerment is a combination of knowledge, clinical skills, autonomy, accountability in clinical practice that in turn allows a nurse to empower her/his own colleagues and patients in decision-making about practice
- Being recognised by fellow professionals
- Confidence to practice appropriately and to empower women themselves
- Being part of setting ward policies and protocols
- Professional recognition at government level and academic recognition

One midwife freely offered a definition of empowerment within this section, stating that,

empowerment is a combination of knowledge, clinical skills, autonomy, accountability in clinical practice that in turn allows a nurse [sic] to empower her/his own colleagues and patients in decision-making about practice

This covers many of the aspects which are raised in the empowerment and midwifery literature. It is interesting that a practising midwife makes reference to a “nurse” rather than a midwife in such a definition. This tendency is found throughout the findings of this study, including the historical findings described above (see page 140).

While asked about the concept of empowerment itself, several midwives mentioned factors that could influence empowerment such as

- not having money for education
- a feeling that “we have been neglected” compared to their experience in London
- lack of Health Board money to replace skilled staff

6.1.4.2 Factors influencing empowerment

Open questions to elicit respondents’ views on the factors that enhanced and inhibited empowerment were included in the questionnaire. While some respondents wrote lengthy descriptions and explanations as part of their responses, others chose to list factors that either enhance or inhibit empowerment. The enumeration of the frequency with which factors were suggested can, therefore, to some extent take place. For example, many respondents listed “education”, “management”, “skills”. Where respondents elaborated on the factors they suggested, this provided valuable qualitative data.

6.1.4.2.1 Factors that enhance empowerment

Almost three quarters of respondents (74%, n=70) suggested factors that enhance empowerment. The factors that were most frequently identified during analysis are shown in Table 6.13.

Table 6 13. Factors that enhance empowerment

Item	Number of times code was assigned
Education	26
Communication	18
Good management	18
Knowledge	12
Skills	10
Adequate staffing	9
Confidence	8
Recognition	8
Support from management	8
Self-esteem	7
Ability	7
Autonomy	6
Colleagues	6
Good working environment	6
Teamwork	5
Willingness to change	5
Respect	5
Knowing your scope of practice	5

More than one-third of the midwives who responded to this part of the questionnaire mentioned education as a factor that enhances empowerment. Most simply included the word “education” as a single term. Some elaborated, for example

Education gives confidence, knowledge and empowerment

Very few who mentioned education specified the content or level of this education

6 1 4 2 2 Factors that inhibit empowerment

Many midwives (74%, n=70) also suggested factors that inhibit empowerment in response to this open question. Many said that the factors that inhibit empowerment are the opposite of those that they said would enhance empowerment. Others suggested specific factors. The factors that were most frequently identified during analysis are shown in Table 6 14

Table 6 14• Factors that inhibit empowerment

Item	Number of times code was assigned
Unsupportive management	31
The medical profession/model	14
Poor/lack of communication	10
Not being valued	11
Staff shortages	8
Unsupportive colleagues	8
Lack of access to education	7
Resistance to change	5
Bullying/constant criticism	5
Lack of knowledge	5
Workload	4
Lack of resources	4
Pay issues	4

Lack of support from management was mentioned by almost one-fifth of midwives who responded to this part of the questionnaire. In addition, the global term “management” was also included as a factor that inhibits empowerment by many of the midwives who responded to this section. The level of management or the specific problems with management were not usually specified. Many also mentioned the medical profession and poor communication as inhibiting empowerment.

Specific reference to bullying was made by five midwives. Some just mentioned the term “bullying” itself, while one midwife elaborated as follows:

bullying constant criticism, actually stopping you doing your job. Atmosphere of negativity and uncertainty with regard to when you will be targeted for ‘abusive behaviour’

In addition to direct references to bullying, there were references to constant criticism, being belittled, put down and harassed.

All references made to the medical profession were negative. These related to doctors not valuing the input of midwives. In addition, there were several references to the medical model of maternity care in Ireland. The following comment of one midwife refers to both the system of maternity care and the perceived attitudes of the medical profession towards midwives:

In midwifery, the Irish health system does not facilitate empowerment. The consultant led obstetrics units do not allow midwives to be practitioners in their own right. Most consultants/obstetricians do not value a midwife's role.

On the basis of these findings, the factors that were most frequently identified within these qualitative data are shown in Table 6 15

Table 6 15 Factors enhancing and inhibiting empowerment

Factors enhancing empowerment	Factors inhibiting empowerment
Education	Unsupportive management
Communication	The medical profession/medical model
Management	Poor communication
Knowledge	Not being valued
Skills	Staff shortages

Considered together the following factors that influence empowerment were identified from the qualitative data

- Management style
- Level of education
- The style and extent of communication
- The role of the medical profession
- The extent to which one is valued
- Level of knowledge
- Level of skills
- Staffing levels

6 1 4 3 Respondents' additional comments

Almost one third of midwives (n=31) included additional comments, as invited at the end of the questionnaire. Many comments welcomed the research, and expressed satisfaction at participating. Apart from these all other comments were negative.

Midwifery in Ireland was unfavourably compared to midwifery elsewhere, with those who practised in the UK believing that they had more empowerment and autonomy there. Several midwives reported difficulties in coming back from working overseas. These difficulties in returning to practice in Ireland were said to be related to medical staff and midwifery colleagues as these quotes illustrate (interestingly the first midwife refers to "nurses" rather than midwives)

Since I have been abroad until one year ago and now returned I feel I have very little autonomy in my present job and will shortly look for another job. Consultants are calling the "shots" and they need to listen to nurses more as we are their medium with the patients when they are not there.

I was professionally educated in the U.K. and in comparison to Ireland there is not much empowerment for staff (in Ireland). In my experience colleagues like to put you in your place very quickly, and like to point out that one is not Irish trained.

Bullying was again mentioned in this section. One midwife related this to leadership style and style of midwifery practice.

My professional empowerment is severely hindered by the bullying and autocratic leadership in our organisation and the defensive way midwives have to provide care.

Lack of autonomy in midwifery in Ireland was seen to contribute to low morale. This was also linked to the failure of midwives to distinguish themselves as a separate profession to nursing.

Lack of management suitability and hierarchies were also criticised. Burnout and its effects were mentioned by several midwives. Some effects included unwillingness to attend study days while not working and plans to leave midwifery due to burnout. The following long quote from one midwife describes her apparent disillusionment with midwifery.

Over the years I have seen how the best of staff have been treated like pawns. Presently, the hospital I work in produces newly-qualified midwives who want to get as far away from the hospital and school of midwifery as possible. The tutor who makes their lives miserable through bullying. When I leave nursing I will only remember it for all times I was told "if you don't want to be here, there is someone waiting to step into your place." No empowerment in that! In the last three years I have learned more about study, myself, and empowerment through the Open University than in 19 years in nursing. I count myself lucky that I was forced to emigrate so I could see how things were done differently and get the same result if not better. England also showed me how to look into further education and that this was my way forward. Sadly even in 2002 student midwives in Ireland are being let go without this quest for further knowledge."

This emotive response raises many issues which other midwives also brought up about working overseas, low morale, education needs and poor management

Other concerns were raised regarding the lack of recognition for the job being done, whether in an “acting” position or a midwife with years of clinical experience. Not being valued (and paid) unless you have a diploma and are graded as a clinical midwife specialist was also seen as a problem. Several midwives described what they felt were “non-midwifery tasks”. These included making appointments, answering phones, doing clerical work. These tasks were seen as taking them away from the “more patient centred care”

Most of these issues were raised in the previous section, relating to factors that influence empowerment. These additional comments are conspicuously negative and link several of the themes which emerged from the data on the factors that inhibit empowerment. For example the issue of not being valued was linked to bullying, leaving midwifery and lack of education

6.2 Discussion of survey 1 findings

The findings presented above will be discussed as follows

- Demographic profile
- Quantitative findings
 - Midwives’ understanding of empowerment
 - Midwives’ experiences of empowerment
- Qualitative findings
 - The meaning of empowerment
 - Factors influencing empowerment
 - Respondents’ additional comments

6.2.1 Demographic profile

Many aspects of the demographic information described above (see page 146) provide interesting insights into midwifery in Ireland at the time of the survey. Given the urban hospital-based location of maternity services in Ireland as described, it is unsurprising that the midwives in this sample were predominantly urban and hospital-based

More than half of midwives said that they worked in a specialist area, while only four midwives stated that they were Clinical Midwife Specialists. There is a distinction between specialist practice and working in a specialist area (Wickham 2003). These respondents were not claiming to be specialist midwives. The fact that the labour ward, ante-natal and post-natal were characterised by some respondents as “specialist areas” raises an interesting question about what might be considered a specialist area for a midwife and why. Clearly the whole range of maternity services are within a midwife’s “normal” sphere of practice. However midwives in Ireland generally work in one part of the maternity service/hospital for many years. This is being addressed in a number of maternity services, with rotation around clinical units. The general absence of continuity of midwifery care for birthing women fosters the above characterisation of specialist areas. The structure of maternity services within which midwifery operates clearly has implications for the profession and this is reflected in the above.

Just over half of the midwives in the sample had trained and/or practised outside Ireland though almost all are Irish. Historically the movement of midwives overseas has been an established and recognised trend. It was a key influence in the saving of the term midwife for reciprocal recognition purposes during the enactment of the 1949 Nurses Bill (see page 120). This reflects a past tradition of exodus of Irish midwives particularly to the UK for training and/or practice. This pattern of mobility provides those who have practised elsewhere with an alternative with which to compare their current experiences. Unfavorable comparisons with Ireland are raised by a number of midwives in the qualitative data of the survey.

6.2.2 Discussion of quantitative results

6.2.2.1 Midwives’ understanding of empowerment

The items relating to skills, scope of practice, education, accountability and effective communication with management were those which were judged by midwives to be most important to the meaning of empowerment. It is perhaps no surprise that issues of skills and education feature so strongly in a practice-based profession. However, what cannot be established from these data is the level or content of the education and skills which are clearly identified as important to midwives. This might suggest a perception of inadequate “professional preparedness” or it may indicate a desire for advanced or expanded skills and education. The Scope of Practice Review (An Bord Altranais 1999)

revealed that the highest number of midwives identified education as the main support required to expand their practice. Again in this source the type (level and content) of education was not identified. The qualitative data confirms midwives' concerns about education, with education as the factor to enhance empowerment mentioned by most midwives. Again the global term "education" was used with little expansion on what this might entail. Knowledge and skills were also amongst the five most frequently mentioned factors that will enhance empowerment within the qualitative data. This issue is further discussed below in the context of the findings of survey 2 (see page 245)

Issues relating to "scope of practice" and accountability were particularly topical within nursing and midwifery in Ireland when this survey was carried out, as the national Scope of Practice Review 1998-1999 (An Bord Altranais 2000) had recently taken place. Items relating to these two aspects of professional practice are rated as critical for empowerment by the midwives in this sample. Related to scope of practice is the ability to "say no", and the importance of this was also affirmed by the midwives in this survey.

Only two-fifths of midwives rated client empowerment as crucial to the empowerment of midwives. The inclusion of the item on client empowerment essentially asks if client empowerment is crucial to the midwife's empowerment. It is possible that midwives see a need for client empowerment but do not link this to their empowerment. This cannot be established from these data. The question of how midwives and birthing women perceive the empowerment of birthing women is not addressed in this study. It is important for women's satisfaction with maternity care and for midwifery practice and education and is proposed as an area requiring further research below (see page 272)

The other grouping of items which shows interesting results relates to interactions with the medical profession. "Being recognised as a professional by the medical profession" was rated by three-fifths of midwives as being crucial to empowerment. "Being recognised for my contribution to patient care by the medical profession" was rated as crucial to empowerment by two-thirds of midwives. This suggests an interesting distinction between being recognised as a professional *per se* and being recognised for one's contribution to client care. These findings need to be interpreted in terms of the

overall patriarchal structure of maternity services within which midwives are subordinate to the dominant medical profession. In one sense, seeking recognition might signify a need for approval from the dominant group, particularly in relation to being recognised as a fellow professional. This was seen to be crucial to their empowerment to a greater extent than being recognised for their contribution to care of birthing women. This suggests the importance that midwives place on being recognised as a professional *per se*. This is unsurprising, given the inter-professional relations which have developed historically and which are structurally enshrined today within maternity care structures, where medicine-led care is the norm. These issues are returned to below when survey 2 results relating to these items are discussed (see page 233).

The four factors quantitatively identified, through factor analysis of midwives' understanding of empowerment, show clear links to the midwifery literature described in chapters 2 and 3. Related to the first factor **Control**, Begley (2002 p316) highlights that within a medicalised model of childbirth, the medical takeover of decision-making for the care of women in normal childbirth negatively affects the education and practice of midwives. This factor reasserts the necessity of control for independent practice and decision-making. Highlighting the importance of the second factor **Support**, the evident lack of and need for support for midwives was identified by Kirkham & Stapleton (2000). The authors called for a generative and nurturing midwifery culture, rather than the blaming and muting culture they identified in their research. The authors also highlight the importance of mutual support for midwives and conclude that if midwives get support then they will be able to support women (p469). More recently Kirkham (2004) again re-emphasises the need for midwives to be mutually supportive of each other. Begley's (1997) study suggested a hierarchical structure within Irish midwifery, which emphasises control more than support. Support for midwives is a key factor if midwives are to support birthing women.

The **Recognition** factor is important to highlight in context of the "medico-politics of clinical childbirth" (Jowitt 1993 p13). In Ireland, the domination of the obstetrician is culturally and legally "firmly entrenched" (Begley 2002 p315). This factor reinforces the discussion above (see page 45) about the importance to midwives of being "recognised" by doctors, related to their current subordinate position. Another component of this factor, advocacy, is espoused nationally (An Bord Altranais 2001).

and internationally (ICM 2003), as a “key midwifery concept” As well as advocating for individual women the ICM also calls for midwives to have a role in advocating with women for a variety of birthing settings This factor emphasizes the role of midwives in their work with individual women and at a social level, securing woman centred services Gould (2002) calls for midwives to become “strong advocates for women” rather than passively perpetuating behavior that does not respect women’s individual needs and aspirations It is from the women with whom they work that midwives derive most satisfaction (Begley 1997, Kirkham 2004) This factor highlights the importance of recognising that work

The **Skills** factor has echoes of Bower’s (2002) notion of professional competence, which incorporates performance (skills etc) and capability (knowledge and understanding of skills and information in context etc), with midwives’ skills being utilised within their scope of practice Begley (2002) highlights the limits that obstetric domination of maternity care places on midwifery practice and the ensuing loss of confidence in midwifery skills Murphy-Lawless (1998 p258), referring to midwifery education in Ireland, describes midwives as having “had to pass through the obstetric net in order to qualify”, due to the medicalised childbirth services in Ireland, thus perpetuating medicalised care This all takes place within the patriarchal practices of demarcation outlined above (page 45) This factor highlights the importance of protecting and promoting the skilled independent practice which midwives espouse

The analysis of the responses of midwives to the *Understanding of Empowerment Scale* suggested the four factors described above However the limitations regarding the skewed nature of the data and the small sample size mean that these findings are suggestive at this stage Furthermore, Hair *et al* (1995 p405) state that results of a single analysis even where the solution looks plausible are not necessarily dependable Thus within the next phase of this research on empowerment in midwifery the psychometric properties of this scale are further tested on a larger sample of practising midwives (See chapter 7 below)

6.2.2.2 Midwives’ perceptions of their levels of empowerment

The findings as measured by the UWO empowerment scales suggest a mixed picture The means on the UWO scales show mid-range scores, suggesting that midwives have

“some” empowerment. On the negative side they report low levels of both formal and informal power, as measured in this survey. In particular regarding informal power, midwives report low levels of collaboration with doctors and other professionals. A reasonable link can be suggested between this low level of collaboration and the medical model as described in chapter 2. However clearly collaboration is a two-way process and the reasons for this lack of collaboration are not directly explored within this survey. The qualitative data provides some further insights with “the medical profession” being cited by many midwives as inhibiting empowerment. This is preceded only by “management” items in terms of most frequently mentioned inhibiting factors. That section of the questionnaire asks “what are the factors that inhibit and enhance empowerment?” Conceivably these responses might not directly relate to respondents’ own subjective experiences. However the emotive language used suggests that these responses are not entirely hypothesising about likely factors. The quotes about bullying cited above (see pages 168 and 170) are examples of this. Concerns about practising within the constraints of the obstetrical model in Ireland were also expressed. All of these findings are consistent with the model of maternity service provision within which midwives practise. They highlight the subordinate position midwives occupy, having little formal and informal power. This reflects a gendered organisational structure. The findings highlight that midwives do link this with the role of the medical profession, who they identify as inhibiting their empowerment.

Midwives also report low levels of support (positive and negative feedback and helpful advice) from their immediate managers. As described above, the qualitative data shows that “management” is highlighted as the factor that inhibits empowerment by most midwives who suggested factors. Authoritarian hierarchical management is discussed by Kuokkanen & Leino-Kilpi (2001) as preventing empowerment. On the other hand, having a supportive manager was seen as crucial/quite important to empowerment by 87.4% (within the *Understanding of Empowerment Scale*). This suggests a wide gap between what is seen as desirable and what is being perceived as happening in practice.

In the context of the current health strategy (DoHC 2001) that calls for innovation in service planning and delivery, midwives’ perceptions about the lack of rewards for innovation in their jobs is of concern. As discussed in chapter 2, Kuokkanen & Leino-Kilpi (2001) explicitly refer to “resistance to innovation” as preventing empowerment,

whereby innovation and creativity comprise the category “future-orientedness” within their analysis Aiken (1990 p73) had warned some time ago in a US context that “nursing cannot afford to turn a deaf ear to the persistent problems that undermine innovation and creativity in hospital nursing practice” The National Council (2003) specifically calls for midwives to work in partnership with women “to help ensure a quality service and a wider choice of care options for women and their families throughout the country” It also calls for midwives to “recognise and overcome the barriers to provide women with alternatives to medicalised care” Innovative approaches appear to be unlikely, given the perceptions regarding innovation of the midwives who participated in this study Unless midwives are supported by the National Council for the Professional Development of Nursing and Midwifery, the Department of Health and Children and, more specifically, their own senior and line managers then innovation is improbable The historical findings of this study show a long range picture of the erosion of midwifery identity and the struggle of midwifery leaders to reassert midwifery’s distinctiveness Without leadership and legislative recognition of midwifery identity, midwives should not be scape-goated for not being innovative, when they themselves are constrained by the maternity care system The need to strike a balance between acknowledging these constraints and providing opportunities for midwives to achieve optimum care for birthing women is a theme that runs through this thesis This is picked up after the findings of survey 2 are also considered

The current context of most midwifery practice in Ireland is within hospital-based consultant-led maternity services Regarding their workplace and its influence on empowerment, the results for the global empowerment items offer interesting insights This is particularly so since both statements explicitly mention the word “empower” in its various forms (while the “empowerment scales” - CWEQ, ORS, JAS - do not) When asked if “your current workplace empowers you” almost half agree, one third disagree and the remainder neither agree nor disagree One third report that their “workplace is an empowering environment” while one third disagree with this statement (with one third neither agreeing nor disagreeing) Apart from the interesting but slight differences in the results for the two items (though they are strongly correlated), these results represent quite a polarised picture of experiences of working within the obstetric model of Irish maternity care It is not possible to establish the basis on which midwives judged their workplace as empowering or not from these data Clearly the precise local

workplace context within which midwives work is key to their experiences of empowerment. Given that almost all of the midwives in the sample work in hospitals, this makes the identification of the local situations which facilitate empowerment more crucial. The polarisation of responses suggest quite variable environments, or at least perceptions of these.

There was strong correlation between both global empowerment items. There were also moderate correlation between the other scales and sub-scales. This supports the validity of the scales and sub-scales, as has been shown in other studies (Laschinger 2006). As shown above in **Table 6.11**, the results also support the internal reliability of the scales.

6.2.3 Discussion of qualitative results

The qualitative data relating to the factors that influence empowerment links with the other survey findings described above. The factors identified were management style, level of education, style and extent of communication, the role of the medical profession, the extent to which one is valued, level of knowledge, level of skills and staffing levels.

Specifically midwives were asked to identify the factors which they perceived enhanced and inhibited empowerment. The factors perceived to enhance empowerment most frequently mentioned by midwives were education, communication, good management, knowledge and skills. These reflect the items deemed to be the most crucial components of empowerment (see pages 151 and 153) as identified in the rating and ranking exercises.

The factors identified by midwives as inhibiting empowerment were lack of support from management, poor management style, the influence of the medical profession, poor communication and not being valued. The latter are among the elements that the literature also identifies as likely to inhibit empowerment (Conger & Kanungo 1988, Fulton 1997 and Kuokkanen & Leino-Kilpi 2001).

Table 6.16 summarises the results relating to the conditions important to empowerment drawn from the quantitative and qualitative data.

Table 6 16• Results relating to the conditions important to empowerment

Rating scale- items judged to be “crucial to empowerment” by the highest number of midwives	Items ranked number 1 by the most midwives	Ranked (anywhere 1-10) by most midwives	Sum of ranking scores of all midwives- top scores	Factors suggested by factor analysis (in order of descending % variance explained)	Factors identified from qualitative data
Skills	Skills	Skills	Effective communication with management	Control control, education, resources	Management
Accountability	Scope of practice	Education	Accountability	Support support, back-up, communication	Education
Scope of practice	Effective communication with management	Scope of practice	Education	Recognition recognition, autonomy, advocacy	Communication
Effective communication with management	Being an advocate for my clients	Effective communication with management	Being able to say no when I judge it necessary	Skills skills, scope of practice	The medical profession/ medical model

The results based on the rating and ranking scores (first four columns) suggests that the conditions which were most important to empowerment, as judged by practising midwives are

- Having the skills to carry out my role
- Knowing what my scope of practice is
- Being adequately educated to perform my role
- Being accountable for my practice
- Having effective communication with management

These items are all reflected in the factors identified quantitatively and qualitatively (columns 5 and 6)

Midwives who included additional comments mostly highlighted issues of concern to them. Based on her nursing survey in the US of work-related stress (n= 1,780), Fletcher (2001) comments about the pessimistic nature of “additional comments” within her responses. As Fletcher observes, criticisms that these additional comments are not representative of all respondents is not relevant in this context, since representativeness is not claimed. It is however appropriate to consider this data as contextualising and supplementing the other data gathered. The motivation to include comments may be stronger when respondents have perceived grievances. Offering respondents this

opportunity to air those grievances has some value in itself in terms of providing a channel for such grievances. The main perceived grievances expressed through these comments related to respondents' lack of autonomy, poor management styles, unmet education needs and unfavourable comparisons between midwifery practice in Ireland and elsewhere. These findings link with the other findings in this current survey and previous research on midwifery discussed in chapter 2.

6.3 Conclusions

This survey explored many aspects of midwives' beliefs and experiences of empowerment. It found that the conditions which midwives perceive as being important for empowerment were related to skills, scope of practice, education, accountability and effective communication. Using existing scales, it also measured midwives' perceptions of their current experiences and found a negative picture overall with little support and resources accessible to midwives and low levels of formal and informal power. These findings are consistent with the analysis of patriarchal medicalised maternity care offered in chapters 2 and 3. The quantitative findings were supported by the qualitative data. The small sample of this study means that these findings must be considered as provisional. Nonetheless they suggest that empowerment is a relevant concept for midwives. Respondents were willing to engage with this study about the conditions important for empowerment and their experiences of empowerment. This provided an impetus to continue the study of empowerment using another cross-sectional survey of practising midwives, aiming for a larger sample and towards the development of a scale to specifically measure the conditions important for empowerment in midwifery. Survey 2 continued to address the objectives of the survey research outlined in chapter 1, namely, to identify the conditions important for empowerment in midwifery and to explore strategies for measuring midwives' perceptions of their levels of these conditions. Chapter 7 reports and discusses the results of survey 2.

CHAPTER 7: SURVEY 2, RESULTS AND DISCUSSION

As indicated in chapter 4, the overall aim of the survey research is to identify the conditions important to empowerment in midwifery and to explore strategies for measuring midwives' perceptions of their own levels of these conditions. Survey 1 began to address these objectives, though a small sample size meant that the findings were tentative. Furthermore, based on the findings of survey 1, further examination of the feasibility and desirability of developing and testing a scale to specifically measure conditions important for empowerment in midwifery appeared to be appropriate. Accordingly, a survey of practising midwives was undertaken in May 2005. The questionnaire used in the survey comprised the following sections:

- A demographic section
- A section comprising measures of empowerment
 - The *Perceptions of the Conditions for Empowerment in Midwifery Scale (PCEMS)*, developed for this study
 - The University of Western Ontario *Work Empowerment Scales*, which measure levels of empowerment, formal power and informal power
- An open *Additional Comments* section, to provide an opportunity for respondents to include additional views on the topic of empowerment

This chapter reports and discusses the results of survey 2. The results are presented in section 7.1 and these results are discussed in section 7.2.

7.1 Results of survey 2

The results of survey 2 are presented as follows:

- Response rate
- Demographic profile of respondents
- Midwives' perceptions of their levels of empowerment
 - Results of *PCEMS*
 - Factor analysis results
 - Results of UWO Work Empowerment Scales
 - Correlations between scales
 - Univariate analysis of variance (ANOVAs)
 - ANOVA Results for *PCEMS* and its sub-scales
 - ANOVA Results for UWO Scales
- Qualitative data: Respondents' additional comments

7.1.1 Response rate

The overall response rate was 49% (n= 970, from a total of 2,000 questionnaires mailed, see page 101 above) Of the 970 responses received, 244 midwives completed questionnaires, representing 12% of the total number in the full sample (n=2,000) It is not possible to estimate the response rate of practising midwives precisely, since the number of practising midwives who had received questionnaires is not known As discussed in chapter 4, it was known *a priori* that only approximately 20% of those on the Midwives' division of the Live Register of An Bord Altranais, the sampling frame for this survey, are in midwifery practice Therefore, it is possible to estimate that approximately 400 questionnaires went to practising midwives (i.e. to 20% of 2,000) A response of 244 questionnaires (from an estimated 400) gives an estimated response rate of 61% It is possible to assume that practising midwives may have been more motivated to respond to the survey than non-midwives, hence the higher response rate for midwives than the overall rate of 49% However, this is based on a best possible estimate, given the lack of available information about the practice status of persons whose names are held on the register

Of those respondents who stated that they were not working in midwifery (n= 726), 426 were working in an area of nursing This includes seven people who completed the questionnaire though they stated that they are in nursing practice (six in general nursing and one in the care of the older person) These questionnaires were not included in the usable returns Three hundred respondents stated that they were not practising either midwifery or nursing This latter group represents 31% of respondents (300 from 970 total replies), a figure higher than the 25% "not in practice" in the 2002 study across nursing and midwifery (Scott *et al* 2003 p28) The majority of those in nursing practice were in general nursing, care of the older person and in community care (see Table 7.1)

There were 18 practice nurses within the "community care" group who did not complete the questionnaire One of those practice nurses said she was involved in ante-natal and post-natal care, but nonetheless did not complete the questionnaire Two "Community RGN/RMs" who said they were involved in postnatal care and breastfeeding did not complete the questionnaire

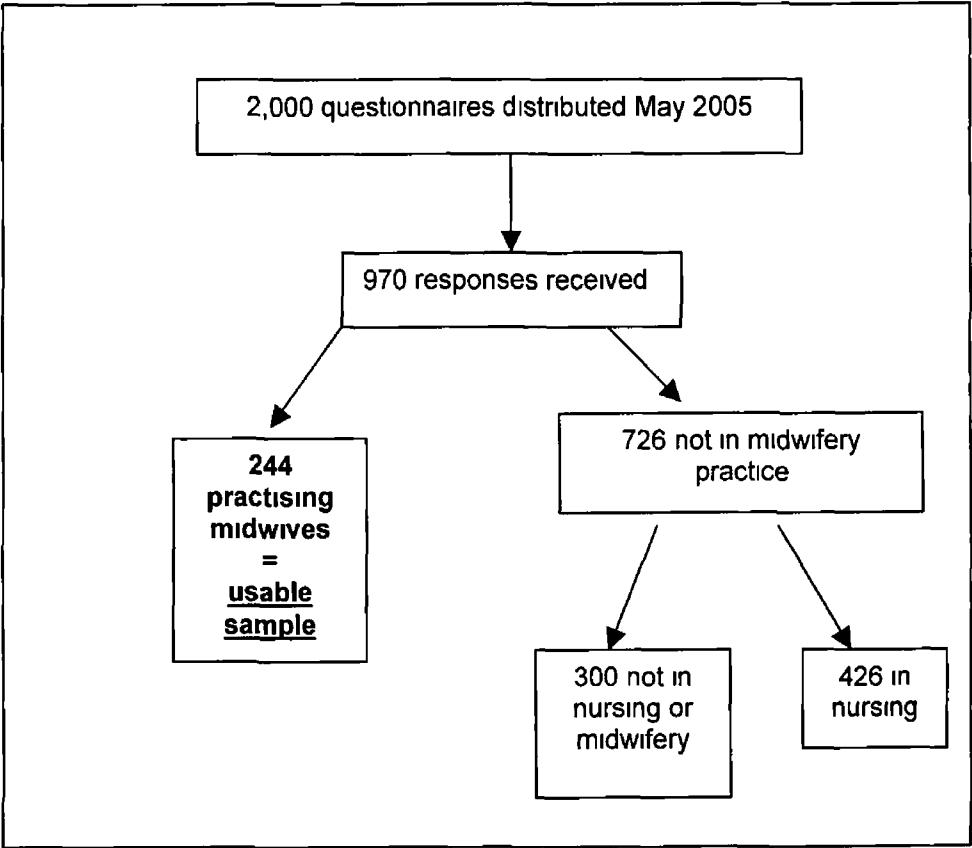
Table 7.1. Area of nursing practice of respondents who were not in midwifery practice

Area of nursing practice	Number
General nursing	226
Care of the older person	119
Community care*	53
Intellectual disability nursing	13
Children’s nursing	5
Other	10
Total	426

* excludes public health nurses as PHN registration was a sampling exclusion criterion

The pattern of responses is shown in **Figure 7 1**

Figure 7.1: Pattern of survey 2 responses



7 1 2 Demographic profile of respondents

Summaries of the demographic characteristics of the sample are shown in Tables 7 2a-7 2d

Table 7.2a: Demographic characteristics of sample, survey 2

		n	Valid %
Age group	20-29	29	11 9
	30-39	79	32 5
	40-49	95	39 2
	50-59	37	15 2
	60 or more	3	1 2
	<i>Missing</i>	<i>1</i>	
	<i>Total</i>	<i>244</i>	<i>100</i>
Grade/Role	Staff midwife	122	52 4
	Senior staff midwife	29	12 4
	CMM1/2/3/Assistant Director	38	16 3
	Clinical Midwife Specialist	7	3 0
	Independent midwife	2	0 9
	Staff nurse/Senior staff nurse	10	4 3
	CNM1/2	13	5 5
	Practice nurse or CNS/CMS General practice	12	5 2
	<i>Missing</i>	<i>11</i>	
	<i>Total</i>	<i>244</i>	<i>100</i>
Years midwifery experience (excluding training)	0-5 years	52	22 0
	6-10 years	55	23 3
	11-15 years	37	15 7
	16-20 years	31	13 1
	21-25 years	36	15 3
	More than 25 years	25	10 6
	<i>Missing</i>	<i>8</i>	
	<i>Total</i>	<i>244</i>	<i>100</i>

Approximately one-third of respondents were within each of the following two age groups 30-39 years (32 5%, n=79) and 40-49 years (39 2%, n=95) Just 11 9% (n=29) were aged under 30 Only 16 4% (n=40) were aged 50 years or more

In summary, almost half (44 4%, n=108) of the participants were aged under 40 years of age Since exact age was not requested, the mean age cannot be calculated

As can be seen in Table 7 2a, almost half (45 3%, n= 107) of the sample had less than ten years midwifery experience (excluding training) Just over one quarter (25 9%, n=61) had 21 years or more experience Just over one third (36 1% n=99) had practised

outside Ireland. Of those who had worked as midwives overseas, 72.0% (n=67) had worked for five years or less.

Table 7.2b Demographic characteristics of sample, survey 2

		n	Valid %
Overseas midwifery experience	Yes	93	38.1
	No	151	61.9
	<i>Missing</i>	-	
	<i>Total</i>	244	100
Duration of overseas practice (if yes to overseas practice)	0-5 years	67	72.0
	6-10 years	16	17.2
	11-20 years	7	7.5
	21 years or more	3	3.3
	<i>Missing</i>	-	
	<i>Total</i>	93	100

More than half the respondents (52.4%, n=122) were at Staff Midwife grade, with a further 12.4% (n=29) at Senior Staff Midwife Grade. Just over sixteen percent (16.3%, n= 38) were at CNM1/2/3 or Assistant Director grade. There were seven Clinical Midwife Specialists (3.0%) and two independent midwives (0.9%). In addition a number of respondents described themselves as Staff nurses (3.4%, n=8), Senior Staff Nurses (0.9%, n=2) and CNM1/2s (5.5%, n=13). These particular respondents were working in neo-natal units though one “staff nurse” was working in a labour ward. By definition all those in this sample have a midwifery qualification. They all identified themselves as working with birthing women and they were thus retained in the sample. In addition, nine practice nurses (3.9%) and three respondents who described themselves as “CNS/CMS General Practice” (1.3%) completed the questionnaire. These GP-practice-based respondents identified that they are involved in the care of women’s ante-natal and post-natal care. They were retained in the sample as they had identified themselves as working with birthing women.

When asked about their area of midwifery practice, almost half (47.1%, n= 114) the respondents stated that they worked across several clinical areas. Most (n=75, 66%) of those who work “across areas” work in former Health Board hospitals, which are all outside the Eastern region. The next largest group worked in labour/delivery (21.1%, n=51). In terms of geographical spread across Ireland, one fifth worked in both the East

(20.4%, n=49) and South-east (20.2%, n=48). Just under one fifth worked in the South (17.9%, n=43) and less than 10% in each of the remaining regions

Table 7.2c Demographic characteristics of sample, survey 2

		n	Valid %
Practice area	Labour/delivery	51	21.1
	Antenatal care	17	7.0
	Postnatal care	21	8.7
	Neonatal care	25	10.3
	Across several areas	114	47.1
	Other	14	5.8
	Missing	2	
	<i>Total</i>	<i>244</i>	<i>100</i>
Geographical work area	North-east	32	13.3
	East	49	20.4
	South-east	48	20.0
	South	43	17.9
	West	20	8.4
	North-west	12	5.0
	Midlands	13	5.4
	Mid-west	23	9.6
	Missing	4	
	<i>Total</i>	<i>244</i>	<i>100</i>

As can be seen from Table 7.2d, most midwives (85.7%, n=209) worked in hospitals, with 5.3% (n=13) working in both community and "other". Nine respondents (3.7%) said that they worked in a hospital and in the community. Of those who worked in hospitals, almost half (46.3%, n=99) worked in hospitals with between 31 and 60 maternity beds, while 38.7% (n=83) worked in hospitals which have more than 70 maternity beds. 15% (n=32) worked in hospitals with fewer than 30 maternity beds.

Almost two-thirds (71.2% n=156) worked in former Health Board hospitals, while 16% (n=35) worked in voluntary hospitals and 8.7% (n=19) worked in private hospitals.

The demographic profile of survey respondents is discussed, and compared to that of survey 1 below (see page 227).

Table 7.2d Demographic characteristics of sample, survey 2

		n	Valid %
Work setting	Hospital	209	85.7
	Hospital and community	9	3.7
	Community	13	5.3
	Other	13	5.3
	<i>Missing</i>	-	
	<i>Total</i>	244	100
Number of maternity beds (if yes to hospital)	More than 70 maternity beds	83	38.7
	Between 31 and 60 maternity beds	99	46.3
	Fewer than 30 maternity beds	32	15.0
	<i>Missing</i>	-	
	<i>Total</i>	214	100
Hospital ownership (if yes to hospital)	Former Health Board hospital	156	71.2
	Voluntary hospital	35	16.0
	Private hospital	19	8.7
	Other hospital	9	4.1
	<i>Missing</i>	-	
	<i>Total</i>	219	100

7.1.3 Midwives' perceptions of their levels of empowerment

In survey 2, two measurement tools were used to measure midwives' perceptions of their own levels of empowerment. These were the *Perceptions of Conditions for Empowerment in Midwifery Scale (PCEMS)* developed during this study, and the UWO Scales (CWEQ, JAS, ORS and two global items). The results for these two measures are presented in the following section.

7.1.3.1 Results of Perceptions of Conditions for Empowerment in Midwifery Scale

As outlined in chapter 4 (see page 107), the *PCEMS* was developed to specifically measure midwives' perceptions of their levels of empowerment. A summary of the descriptive results for this scale is presented in Table 7.3 below.

Table 7.3: Summary results for PCEMS

	Responses (valid % per item)	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	I am valued by my manager	14.7	41.6	22.7	18.5	2.5
2	I am an advocate for birthing women	36.2	44.7	14.5	3.0	1.7
14	I do not know what my scope of practice is	2.1	5.9	7.1	39.3	45.6
3	I am involved in midwife-led practice	10.8	27.7	17.7	29.0	14.7
4	I do not have the skills required to carry out my role	3.0	3.8	5.1	36.3	51.9
5	I have the back-up of my manager	15.3	39.1	28.9	11.9	4.7
6	I am not recognised for my contribution to the care of birthing women by my manager	3.4	15.0	26.6	36.1	18.9
7	I have adequate access to resources for birthing women in my care	6.1	35.2	28.3	26.1	4.3
8	I do not have a supportive manager	4.6	14.3	22.8	38.1	20.3
9	I have effective communication with management	9.4	37.0	28.9	21.7	3.0
10	I am not informed about changes in my organisation that will affect my practice	4.3	25.6	19.7	41.9	8.5
11	I am adequately educated to perform my role	32.4	50.0	9.2	5.9	2.5
12	I have support from my colleagues	35.6	52.7	7.9	2.1	1.7
13	I am able to say no when I judge it to be necessary	34.7	48.5	10.0	5.4	1.3
15	I am accountable for my practice	64.6	33.3	0.4	0	1.7
16	I am recognised as a professional by the medical profession	21.4	48.7	19.3	7.6	2.9
17	I have control over my practice	15.3	37.3	24.6	19.9	3.0
18	I empower birthing women through my practice	20.6	57.9	15.0	6.4	0
19	I do not have adequate access to resources for staff education and training	13.5	23.2	23.2	33.8	6.3
20	I have autonomy in my practice	11.9	35.6	28.0	20.3	4.2
21	I am not listened to by members of the multidisciplinary team	3.4	8.0	23.6	53.6	11.4
22	I am recognised for my contribution to the care of birthing women by the medical profession	8.7	44.1	31.9	12.7	2.6

For ease of interpretation, these categories are collapsed into three groups (“Strongly agree/Agree”, “Neither agree nor disagree” and “Strongly disagree/ Disagree”) These results are shown in Table 7.4

Table 7 4· Summary results for *PCEMS*· Using three response categories

Responses- valid %	Strongly agree/ Agree	Neither agree nor disagree	Strongly disagree/ Disagree
1 I am valued by my manager	56 3	22 7	21
2 I am an advocate for birthing women	80 9	14 5	4 7
3 I am involved in midwife-led practice	38 5	17 7	43 7
4 I do not have the skills required to carry out my role	6 8	5 1	88 2
5 I have the back-up of my manager	54 4	28 9	16 6
6 I am not recognised for my contribution to the care of birthing women by my manager	18 4	26 6	55
7 I have adequate access to resources for birthing women in my care	41 3	28 3	30 4
8 I do not have a supportive manager	18 9	22 8	58 4
9 I have effective communication with management	46 4	28 9	24 7
10 I am not informed about changes in my organisation that will affect my practice	29 9	19 7	50 4
11 I am adequately educated to perform my role	82 4	9 2	8 4
12 I have support from my colleagues	88 3	7 9	3 8
13 I am able to say no when I judge it to be necessary	83 2	10	6 7
14 I do not know what my scope of practice is	8	7 1	84 9
15 I am accountable for my practice	97 9	0 4	1 7
16 I am recognised as a professional by the medical profession	70 1	19 3	10 5
17 I have control over my practice	52 6	24 6	22 9
18 I empower birthing women through my practice	78 5	15	6 4
19 I do not have adequate access to resources for staff education and training	36 7	23 2	40 1
20 I have autonomy in my practice	47 5	28	24 5
21 I am not listened to by members of the multidisciplinary team	11 4	23 6	65
22 I am recognised for my contribution to the care of birthing women by the medical profession	52 8	31 9	15 3

These items can be grouped according to midwives' level of agreement with each item. The groupings are as follows: greater than 80% agreement, between 50% and 80% agreement, and less than 50% agreement. The percentage of midwives who agreed/strongly agreed with the item is shown in parentheses after each item. In the case of negatively worded items, the percentage shown refers to the percentage who disagreed/strongly disagreed with that negatively-worded item.

Items with which more than 80% of midwives agreed/strongly agreed

- I am accountable for my practice (97 9%)
- I have support from my colleagues (88 3%)
- I do **not** have the skills required to carry out my role (88 2% disagreed/strongly disagreed)
- I do **not** know what my scope of practice is (84 9% disagreed/strongly disagreed)
- I am able to say no when I judge it to be necessary (83 2%)
- I am adequately educated to perform my role (82 4%)
- I am an advocate for birthing women (80 9%)

Items with which between 50 and 80% of midwives agreed

- I empower birthing women through my practice (78 5%)
- I am recognised as a professional by the medical profession (70 1%)
- I am **not** listened to by members of the multidisciplinary team (65% disagreed/strongly disagreed)
- I do **not** have a supportive manager (58 4% disagreed/strongly disagreed)
- I am valued by my manager (56 3%)
- I am **not** recognised for my contribution to the care of birthing women by my manager (55% disagreed/strongly disagreed)
- I have the back-up of my manager (54 4%)
- I am recognised for my contribution to the care of birthing women by the medical profession (52 8%)
- I have control over my practice (52 6%)
- I am **not** informed about changes in my organisation that will affect my practice (50 4% disagreed/strongly disagreed)

Items with which less than 50% of midwives agreed/strongly agreed

- I have autonomy in my practice (47 5%)
- I have effective communication with management (46 4%)
- I have adequate access to resources for birthing women in my care (41 3%)
- I do **not** have adequate access to resources for staff education and training (40 1% disagreed/strongly disagreed)
- I am involved in midwife-led care (38 5%)

The items with high levels of agreement suggest interesting positive perceptions of midwives about their levels of accountability, collegial support, skill and education, their knowledge of their scope of practice and their roles in advocacy and in empowering birthing women. More than two-thirds agree that they are recognised as a professional by the medical profession and that they are listened to by the team.

On the other hand the items which received the lowest levels of agreement depict less positive perceptions of midwives regarding their access to resources, their involvement in midwife-led care, and a range of perceptions about the supportiveness of their managers. Of particular note, in terms of midwifery's stated independent identity, just under half agree that they have control over their practice and just over half that they have autonomy on practice.

In order to investigate if the items within the 22 item scale grouped together into coherent clusters, exploratory factor analysis was undertaken on the responses to the scale. The factor analysis on the responses to the Understanding of Empowerment Scale (UES) used in survey 1 is reported in chapter 6. Those factors were based on the midwives' responses pertaining to their beliefs about the meaning of empowerment. The responses to the UES were factor analysed and the factors Control, Management, Recognition and Skills. Due to the small sample obtained in survey 1, these factors were considered provisional and the responses to the PEMS were re-factor analysed. Confirmatory rather than exploratory factor analysis is carried out when an analyst wishes to test a preconceived structure (Hair et al 1995 p367). In this case exploratory factor analysis was again carried out, given the provisional nature of the factor solution of survey 1. The items from the UES that were deemed by midwives to be important to empowerment were included in the PCEMS in survey 2. The PCEMS asked midwives about these items in relation to their perceptions about their own practice and/or practice settings. Therefore the factor analysis is based on midwives' perceptions about their own experiences rather than their beliefs as was the case with the UES in survey 1.

7.1.3.1.1 Factor analysis of responses to the PCEMS

The first issues to consider when undertaking factor analysis are sample size and case variable ratio. There were 22 items in the scale being examined and 244 cases. Thus a case to item ratio of just over 11:1 was achieved which is deemed adequate by most sources (Hair et al 1995, Pett *et al* 2003).

The correlation matrix was visually inspected and a sufficient number of correlations suggested that these data were suitable for factor analysis. There were no items

correlated too strongly which might have suggested duplication. Thus all 22 items from the scale were included in the factor analysis.

To further test the suitability of the data for factor analysis, Bartlett's Test of Sphericity was used and found to be significant at the <0.0001 level. The Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy was 0.838, which is classed as "meritorious" by Kaiser (1974). In addition, the individual MSAs on the Anti-Image Correlation matrix were all >0.7 . Prior to factor analysis, the negatively worded items in the scale were recoded (with value labels 1 to 5 reversed) into different variables, thus preserving the original data while facilitating the use of appropriately recoded variables within factor analysis. The wording in the tables pertaining to the factor analysis reflect the original wording (negatively worded) of relevant items since this was the form in which the respondents had received these items.

The factor analysis procedure followed was similar to that undertaken in survey 1 (see page 158). The method of factor extraction ultimately used was Principal Axis Factoring (see page 109). The method of rotation chosen was oblique (Direct Oblimin), because as stated above (page 110) it could not be assumed that factors would not be correlated. Various factor solutions using different methods of extraction and rotation were carried out and the factors extracted were similar across these methods, suggesting a robust solution. Regarding the number of factors extracted, several options were examined, including an examination of eigenvalues, cumulative variance, variance per factor and an examination of the scree plot, shown in Figure 7.2. Five factors had eigenvalues of greater than 1 (the Kaiser-Guttman rule). The scree plot suggests four or maybe five factors. Solutions with forced four and five factor were extracted and examined. The fourth and fifth factors had low internal reliability and only two items per factor. Based on the examination of the four factor solution, a three factor solution was extracted and ultimately chosen because of the theoretical coherence and acceptable internal reliability of the factors.

As described for survey 1 above (see page 159), since the factors proposed are correlated, it is not accurate to add their attributed explained variance to calculate a total variance. These results are shown in Table 7.5 for illustrative purposes.

Table 7 5: Variance explained by factor solution; survey 2

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5 626	25 572	25 572	5 041	22 911	22 911
2	2 033	9 242	34 814	1 465	6 659	29 571
3	1 693	7 697	42 511	1 039	4 723	34 294

A factor loading cut-off point of ≥ 0.4 was chosen to maximise factor interpretation. The results are shown in the pattern matrix presented in Table 7 6.

Figure 7 2: Scree plot for survey 2 factor solution

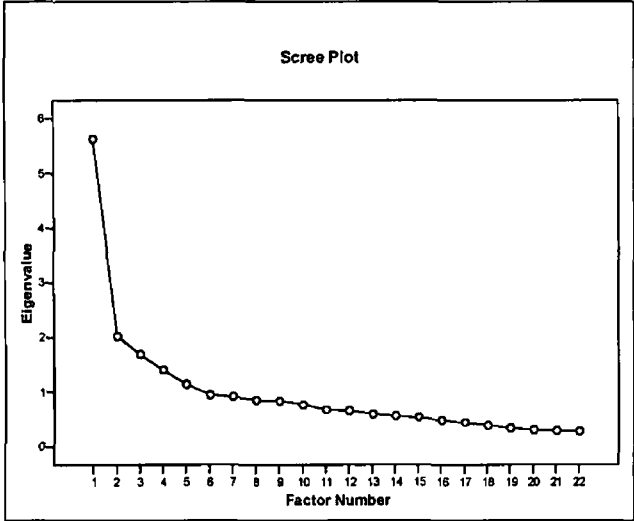


Table 7.6 Pattern matrix (Loadings ≥ 0.4 only shown)

	Factor		
	1	2	3
	Autonomous practice	Effective management	Women-centred practice
I am recognised as a professional by the medical profession	0.73		
I am recognised for my contribution to the care of birthing women by the medical profession	0.71		
I have control over my practice	0.52		
I am not listened to by members of the multidisciplinary team (recoded)	0.43		
I have autonomy in my practice	0.43		
I have adequate access to resources for birthing women in my care	0.42		
I do not have a supportive manager (recoded)		-0.81	
I am valued by my manager		-0.77	
I have the back-up of my manager		-0.65	
I am not recognised for my contribution to the care of birthing women by my manager (recoded)		-0.55	
I am not informed about changes in my organisation that will affect my practice (recoded)		-0.48	
I have effective communication with management		-0.38	
I empower birthing women through my practice			0.62
I am an advocate for my patients/clients			0.55
I am able to say no when I judge it to be necessary			0.49
I am involved in midwife-led practice			0.45
I have support from my colleagues			0.42
I do have the skills required to carry out my role (recoded)			0.37
Internal reliability of factors (Cronbach's alpha)	0.77	0.82	0.66

The factors were named inductively on the basis of their constituent items. The first factor was named **Autonomous practice**. It includes the items relating to being recognised by medical staff, both as a professional and for one's contribution to the care of birthing women. It also includes being listened to by members of the multidisciplinary team. In maternity care, while midwives work most closely with doctors, the team also comprises social workers and physiotherapists among others. The items relating to having autonomy and control over practice are also in this factor. Having adequate access to resources is also included in this factor, linking the issue of having resources with having control and autonomy. This is also linked in this factor with having recognition from fellow professionals.

The second factor, named **Effective management** includes the items which relate to being supported and valued by one's manager, as well as being recognised and having

the manager's back-up. This also includes being informed about changes that affect one's practice, a function most likely to be associated with a manager. This can be linked with the final item in this factor, having effective communication with management.

The third factor is named **Women-centred practice**. It includes the items that relate to midwives' perceptions that they empower birthing women, that they are involved in midwifery-led practice and that they advocate for birthing women. It also includes being able to say no when required. Also linked with this ability to provide women-centred care is the item relating to having the support of colleagues. This suggests that collegial support will assist in facilitating this care. Having the skills required to carry out one's role is also contained in this factor, to facilitate this women-centred practice.

The internal reliability of the scale was confirmed, with a Cronbach alpha score (α) of 0.860 for the full scale comprising the 18 items retained in the factor solution. The internal reliability of each factor was calculated and the results are shown in the bottom row of the pattern matrix in Table 7.6 above. All factors have alphas of 0.7 or more, when rounded to one decimal place, which is deemed as satisfactory (Cronbach 1951).

The summarised distribution of responses are grouped by these factors, in Table 7.7.

Table 7 7• Results of *PCEMS* Items grouped by factors

		Strongly agree/ Agree	Neither agree nor disagree	Strongly disagree/ Disagree
	Factor 1 Autonomous practice			
16	I am recognised as a professional by the medical profession	70 1	19 3	10 5
22	I am recognised for my contribution to the care of birthing women by the medical profession	52 8	31 9	15 3
17	I have control over my practice	52 6	24 6	22 9
21	I am not listened to by members of the multidisciplinary team	11 4	23 6	65
20	I have autonomy in my practice	47 5	28	24 5
7	I have adequate access to resources for birthing women in my care	41 3	28 3	30 4
	Factor 2 Effective management			
8	I do not have a supportive manager	18 9	22 8	58 4
1	I am valued by my manager	56 3	22 7	21
5	I have the back-up of my manager	54 4	28 9	16 6
6	I am not recognised for my contribution to the care of birthing women by my manager	18 4	26 6	55
10	I am not informed about changes in my organisation that will affect my practice	29 9	19 7	50 4
9	I have effective communication with management	46 4	28 9	24 7
	Factor 3 Women-centred practice			
18	I empower birthing women through my practice	78 5	15	6 4
2	I am an advocate for birthing women	80 9	14 5	4 7
3	I am involved in midwife-led practice	38 5	17 7	43 7
13	I am able to say no when I judge it to be necessary	83 2	10	6 7
12	I have support from my colleagues	88 3	7 9	3 8
4	I do not have the skills required to carry out my role	6 8	5 1	88 2

Since an oblique rotation was again performed, a factor correlation matrix is shown below in Table 7 8 This shows that all three factors were correlated with each other, at the 0 3 or “low” level (Pett *et al* 2003 p60) The negative correlation merely reflect the negative loadings in the pattern matrix (an artefact of factor analysis)

Table 7 8• Factor correlation matrix

Factor	Autonomous practice	Effective management	Women-centred practice
Autonomous practice	1 000	-0 370	0 291
Effective management	-0 370	1 000	-0 314
Women-centred practice	0 291	-0 314	1 000

7 1 3 1 2 Scoring system of the PCEMS

Pett *et al* (2003 p221) recommend the generation of scores from summated factor-based scales, that is from the newly-identified sub-scales. This involves calculating the mean score across only those items which now constitute each factor or sub-scale. The mean scores were thus generated for each of the three factors which are now considered as sub-scales. For each sub-scale, this involved summing the score for each item in the sub-scale and dividing by the number of items in the sub-scale (six in each case in *PCEMS*).

This scoring system was not determined before the factors were identified as there was no *a priori* assumption of the nature of the final scale and any constituent sub-scales. This scoring system is based on a division of the possible range of scores into five and their corresponding descriptions as very high, high, moderate, low and very low levels of perceived empowerment according to each scale. While there is an arbitrariness about assigning labels to these categories, they are based on the nature of the Likert option. Thus, for example, very high levels of empowerment will relate to high frequencies of Strongly agree responses to the positively worded statement and Strongly disagree responses to negatively worded statements.

The possible range for sub-scales scores was one to five, with a mid-point of three. Based on the Likert scale which respondents completed, the scores are categorised in Table 7.9 below. The scale ran Strongly agree to Strongly disagree. Thus, the higher the score on the *PCEMS* the lower the level of perceived empowerment, and vice versa.

Table 7.9 Score categories for the sub-scales of *PCEMS*

Mean score on the sub-scales of <i>PCEMS</i>	Corresponding description of level of perceived empowerment
1	Very high perceived empowerment
2	High perceived empowerment
3	Moderate perceived empowerment
4	Low perceived empowerment
5	Very low perceived empowerment

Mean scores were calculated for the sample of practising midwives who participated in survey 2 and the results are shown in Table 7.10.

Table 7.10: Mean scores for the *PCEMS* sub-scales

		Autonomous practice sub-scale	Effective management sub-scale	Women-centred practice sub-scale
N	Valid	239	241	239
	Missing	5	3	5
Mean		2.55	2.58	2.07
(Mean, rounded to integers)		3	3	2
Standard Deviation		0.684	0.786	0.563

Rounding these means scores to the nearest integer, these results show that midwives' scores were lowest on the Women-centred practice sub-scale (reflecting higher perceived empowerment), with moderate perceived empowerment on the Effective management and Autonomous practice sub-scales (as described in Table 7.9)

An overall score for the full *PCEMS* was then calculated by summing the scores on each of the three sub-scales. The possible range for the *PCEMS* was three to 15, with a mid-point of 9. The basis for this is shown in Table 7.11

Table 7.11: Basis for calculation of *PCEMS* score

Sub-scale	Lowest possible mean	Mid-point	Highest possible mean
Autonomous practice	1	3	5
Effective management	1	3	5
Women-centred practice	1	3	5
Overall <i>PCEMS</i> (sum of sub-scale means)	3	9	15

Accordingly the score categories for the full scale are shown in Table 7.12

Table 7.12 Score categories for the *PCEMS*

Mean score on the <i>PCEMS</i>	Corresponding description of level of perceived empowerment
3-5	Very high perceived empowerment
6-8	High perceived empowerment
9	Moderate perceived empowerment
10-12	Low perceived empowerment
13-15	Very low perceived empowerment

As shown in Table 7.13 below, The overall *PCEMS* mean is 7.19 (SD 1.587), which is lower than the mid-point of nine. Based on the categorisations in Table 7.11 this score represents a “high perceived empowerment level”

Table 7.13: Mean score for *PCEMS*

		<i>PCEMS</i> Mean
N	Valid	238
	Missing	6
Mean		7.19
Standard Deviation		1.587

7.1.3.2 Results of UWO Scales

The CWEQ (which includes the opportunity, support, information and resources sub-scales), the Job Activities Scale (measuring formal power), the Organisational Relationships Scale (measuring informal power) and the two global empowerment statement were used in this survey. Table 7.14 presents a summary of the summarised frequencies for the items on the UWO Scales.

Table 7.14: Summary table showing all frequencies of UWO Scales responses

How much of the following do you have in your present job? (Valid %)					
		None	None-some	Some	Some – a lot
1	Challenging work		1 7	27 3	43 8
2	The chance to gain new skills and knowledge on the job	2 5	9 9	43 6	22 7
3	Tasks that use all of your own skills and knowledge	0 8	5 0	25 1	40 2
4	Information about the current state of your organisation-service	2 9	19 1	48 1	8 3
5	Information about the goals of top management	22 5	31 7	32 1	2 9
6	Information about the values of top management	29 5	30 8	29 5	3 4
7	Specific information about things you do well	26 8	26 8	28 0	5 4
8	Specific comments about things you could improve	25 8	27 1	28 8	4 2
9	Helpful hints or problem solving advice	15 8	29 0	28 6	5 8
10	Time available to do necessary paperwork	10 4	33 3	45 0	0 8
11	Time available to accomplish job requirements	5 9	25 5	48 5	1 3
12	Acquiring temporary help when needed	23 0	33 1	31 4	3 3
	In your work setting				
1	The rewards for innovation on the job are	32 2	28 5	28 1	4 1
2	The amount of flexibility in your job is	10 0	23 7	38 6	6 2
3	The amount of visibility of your work-related activities within your organisation/service is	11 0	22 8	47 3	6 8
	In your present job, how much opportunity do you have for these activities?				
1	Collaborating on patient care with doctors	6 2	12 9	30 7	27 4
2	Being sought out by peers for information	4 5	12 4	34 7	19 4
3	Seeking out ideas from professionals other than doctors, e g , Physiotherapists, Occupational Therapists, Dieticians	11 6	16 2	44 4	7 5
		Strongly agree	Agree	Neither agree nor disagree	Disagree
1	Overall, my current work environment empowers me to accomplish my work in an effective manner	5 8	43 2	24 1	2 9
2	Overall, I consider my workplace to be an empowering environment	7 1	31 1	27 0	10 0

As can be seen from Table 7 14, more than 20% of respondents stated that they had “a lot” of only four items. These items were challenging work (43 8%), tasks that use all one’s skill and knowledge (40 2%), collaboration with doctors (27 4%) and the chance to gain new skills and knowledge on the job (22 7%). Three of these four items (excluding collaboration) comprise the Opportunity sub-scale of the CWEQ.

For ease of interpretation these results have been collapsed into 3 categories (“None/None-some”, “Some” and “Some-A lot/A lot”) which are shown in Table 7 15 below.

Table 7.15. UWO Scale results summarised into 3 categories

	How much of the following do you have in your present job? (valid %)	None/ None- some	Some	Some- a lot/ A lot
1	Challenging work	1 7	27 3	71 1
2	The chance to gain new skills and knowledge on the job	12 4	43 6	44 6
3	Tasks that use all of your own skills and knowledge	5 8	25 1	69 1
4	Information about the current state of your organisation-service	22	48 1	29 9
5	Information about the goals of top management	54 2	32 1	13 7
6	Information about the values of top management	60 3	29 5	10 2
7	Specific information about things you do well	53 6	28	18 4
8	Specific comments about things you could improve	52 9	28 8	18 4
9	Helpful hints or problem solving advice	44 8	28 6	26 5
10	Time available to do necessary paperwork	43 7	45	11 2
11	Time available to accomplish job requirements	31 4	48 5	20 1
12	Acquiring temporary help when needed	56 1	31 4	12 5
	In your work setting			
1	The rewards for innovation on the job are	60 7	28 1	11 1
2	The amount of flexibility in your job is	33 7	38 6	27 8
3	The amount of visibility of your work-related activities within your organisation/service is	33 8	47 3	19
	In your present job, how much opportunity do you have for these activities?			
1	Collaborating on patient care with doctors	19 1	30 7	50 2
2	Being sought out by peers for information	16 9	34 7	48 3
3	Seeking out ideas from professionals other than doctors, e.g., Physiotherapists, Occupational Therapists, Dieticians	27 8	44 4	27 8
		Strongly Agree/ Agree	Neither agree nor disagree	Strongly disagree/ agree
1	Overall, my current work environment empowers me to accomplish my work in an effective manner	49	24 1	27
2	Overall, I consider my workplace to be an empowering environment	38 2	27	34 9

On the global empowerment items, 49% (n=120) strongly agreed/agreed that their current environment empowered them to accomplish their work in an effective manner, while 38 2% (n=93) strongly agreed/agreed that they consider their workplace to be an empowering environment

The mean scores for the UWO Scales are shown in Table 7 16

Table 7.16: Survey 2 mean scores on all UWO scales

	Potential range	Mean	Standard Deviation	N	alpha
Condition for Work Effectiveness Questionnaire	4 to 20 (none to a lot)	11 62	2 36	242	0 823
Opportunity sub-scale	1 (none) to 5 (a lot)	3 89	0 76	243	0 705
Information sub-scale	1 (none) to 5 (a lot)	2 60	0 87	242	0 806
Support sub-scale	1 (none) to 5 (a lot)	2 53	0 98	242	0 829
Resources sub-scale	1 (none) to 5 (a lot)	2 60	0 73	242	0 667
Job Activities Scale (formal power)	1 (none) to 5 (a lot)	2 64	0 82	242	0 681
Organisational Relationships Scale (informal power)	1 (none) to 5 (a lot)	3 32	0 88	242	0 702
Global Empowerment item 1	1 to 5 (High to low)	2 75	0 981	241	n/a
Global Empowerment item 2	1 to 5 (High to low)	3 00	1 116	241	n/a

7 1 3 3 Correlations between scales and sub-scales

The relationships between the scales and sub-scales were calculated using Pearson's correlation (r) Specifically the correlation between the *PCEMS* and *CWEQ* was examined to test the concurrent criterion validity of the *PCEMS* against the established *CWEQ* The relevant correlation matrices are provided in Tables 7 17 and 7 18 and the notable correlations are described below It should be noted that the correlations between *PCEMS* sub-scales differ from those presented in the factor correlation matrix (Table 7 8 page 191) Within that matrix all items that loaded on that factor were included, while in this score only the items retained in the factor (loadings $\geq 0 4$) are now included in this correlation

Table 7 17. Correlation matrix of scales, survey 2

		Job Activities sub-scale	Organisational Relationships sub-scale	CWEQ	PEMS
JAS	Pearson Correlation	1			
	Sig (2-tailed)				
	N	242			
ORS	Pearson Correlation	451	1		
	Sig (2-tailed)	000			
	N	242	242		
CWEQ	Pearson Correlation	591	443	1	
	Sig (2-tailed)	000	000		
	N	242	242	242	
PEMS	Pearson Correlation	- 527	- 436	- 552	1
	Sig (2-tailed)	000	000	000	
	N	242	242	242	242

In relation to the scales themselves (*PCEMS*, *CWEQ*, *JAS*, *ORS* and the global empowerment items), there was just one strong correlation ($r \geq 0.7$) between the two global empowerment items ($r = 0.707$, $p < 0.001$). There were moderate ($r \geq 0.5$) correlations between

- *PCEMS* and
 - *JAS* ($r = 0.548$, $p < 0.001$)
 - *ORS* ($r = 0.475$, $p < 0.001$)
 - *CWEQ* ($r = 0.589$, $p < 0.001$)
- *CWEQ* and
 - *JAS* ($r = 0.591$, $p < 0.001$)
 - *ORS* ($r = 0.443$, $p < 0.001$)
- *JAS* and *ORS* ($r = 0.451$, $p < 0.001$)

Table 7.18: Correlation matrix: sub-scales, survey 2

		PCEMS			CWEQ			
		Autonomous practice sub-scale	Effective management sub-scale	Women-centred practice sub-scale	Resources sub-scale mean	Support sub-scale mean	Information sub-scale mean	Opportunity sub-scale mean
Autonomous practice sub-scale	Pearson Correlation	1						
	Sig (2-tailed)							
	N	239						
Effective management sub-scale	Pearson Correlation	449	1					
	Sig (2-tailed)	000						
	N	238	241					
Women-centred practice sub-scale	Pearson Correlation	427	288	1				
	Sig (2-tailed)	000	000					
	N	239	238	239				
Resources sub-scale	Pearson Correlation	- 209	- 301	- 079	1			
	Sig (2-tailed)	001	000	225				
	N	239	241	239	242			
Support sub-scale	Pearson Correlation	- 319	- 373	- 397	222	1		
	Sig (2-tailed)	000	000	000	000			
	N	239	241	239	242	242		
Information sub-scale	Pearson Correlation	- 286	- 326	- 235	196	508	1	
	Sig (2-tailed)	000	000	000	002	000		
	N	239	241	239	242	242	242	
Opportunity sub-scale	Pearson Correlation	- 386	- 272	- 369	145	407	412	1
	Sig (2-tailed)	000	000	000	024	000	000	
	N	239	241	239	242	242	242	243

In relation to the subscales of the *PCEMS* and *CWEQ*, there were several moderate ($r \geq 0.5$) correlations as follows

- Autonomous practice sub-scale and Effective management sub-scales of the *PCEMS* ($r = 0.494$, $p < 0.001$)
- Support and Information sub-scales of *CWEQ* ($r = 0.508$, $p < 0.001$)

There were also many “low” ($r > 0.3$) correlations

- Autonomous Practice sub-scale of *PCEMS* and
 - Women-centred practice sub-scale of *PCEMS* ($r = 0.403$, $p < 0.001$)
 - Support sub-scale of *CWEQ* ($r = -0.319$, $p < 0.001$)
 - Information sub-scale of *CWEQ* ($r = -0.286$, $p < 0.001$)
 - Opportunity sub-scale of *CWEQ* ($r = -0.386$, $p < 0.001$)
- Effective management sub-scale of *PCEMS* and
 - Women-centred practice sub-scale of *PCEMS* ($r = 0.346$, $p < 0.001$)
 - Resources sub-scale of *CWEQ* ($r = -0.325$, $p < 0.001$)
 - Support sub-scale of *CWEQ* ($r = -0.380$, $p < 0.001$)
 - Information sub-scale of *CWEQ* ($r = -0.344$, $p < 0.001$)
 - Opportunity sub-scale of *CWEQ* ($r = -0.280$, $p < 0.001$)
- Women-centred practice sub-scale of *PCEMS* and
 - Support sub-scale of *CWEQ* ($r = -0.372$, $p < 0.001$)
 - Opportunity sub-scale of *CWEQ* ($r = -0.354$, $p < 0.001$)
- Opportunity sub-scale of *CWEQ* and
 - Support sub-scale of *CWEQ* ($r = 0.407$, $p < 0.001$)
 - Information subscale of *CWEQ* ($r = 0.412$, $p < 0.001$)

7.1.3.4 Univariate analysis of variance (ANOVA)

Univariate analysis of variance tests were carried out to examine whether there were significance differences in scores on the *PCEMS* and *CWEQ* for a number of key demographic characteristics. The demographic variables examined were

- Grade
- Years of midwifery experience
- Overseas practice experience
 - If worked overseas Length of overseas practice
- Practice area
- Geographical work area
- Work setting
 - If hospital-based Number of maternity beds and hospital ownership

As far as possible, groups were appropriately combined with the aim of obtaining equal numbers in each group for analysis. In some cases, this was not possible because of the distribution of the data. This was the case for length of overseas practice, since one category (0 to 5 years) constituted 72% of the group. In addition within the work setting variable, 85.7% of the sample were hospital based, which means that groups were unequal. Across all results, where unequal sub-group numbers remain, these results are considered tentative.

Where there were significant differences within groups, Post hoc tests (LSD and Scheffe) were applied if there were three groups or more for comparison. A stringent significance level (<0.001) was used in view of the large number of tests performed, which increases the chance of spurious significant results, or Type I errors. While other Post hoc tests are considered more conservative (for example, Bonferroni), adopting the stringent significance level described above was the favoured approach.

The *PCEMS* score range is from three to 15, from high perceived empowerment to low perceived empowerment, with a mid-point of 9. The *CWEQ* score range is from four to 20, from low perceived empowerment to high perceived empowerment with a mid-point of 12. Thus these scales run in opposite directions. Table 7.19 shows the results for the *PCEMS* and Table 7.23 for *CWEQ*.

7.1.3.4.1 Results for Perceptions of Conditions for Empowerment Midwifery Scale and its sub-scales

As can be seen in Table 7.19, only grade and years of midwifery experience shows significant variation (at <0.000 level) in relation to *PCEMS* scores.

Table 7.19: ANOVA results: *PCEMS*

Variable	Group	<i>PCEMS</i> Score (3-15) high-low	SD	N	df	F ratio	Significance level	LSD* (p <0.0001) (see notes)
Grade	Staff midwife	7.59	1.51	122	2	11.259	0.000	Staff Midwife > Senior Midwife^
	Senior midwife	6.70	1.51	74				
	Nurse	6.71	1.67	33				
	Total	7.17	1.59	229				
Years midwifery experience	10 yrs or less	7.66	1.72	104	2	8.824	.000	10 yrs < 21 or more+
	11-20 years	6.93	1.25	68				
	21 + years	6.62	1.49	59				
	Total	7.18	1.59	231				
Overseas practice	Yes	7.26	1.65	90	1	0.512	.475	n/a
	No	7.15	1.56	148				
	Total	7.19	1.59	238				
Yrs of overseas practice	Up to 5 years	7.30	1.71	64	1	.000	.998	n/a
	6 yrs +	7.18	1.50	26				
	Total	7.26	1.65	90				
Practice area	Labour ward	7.03	1.57	51	2	.265	.265	n/a
	Across areas	7.12	1.57	114				
	Ante/post/ neonatal	7.43	1.62	73				
	Total	7.19	1.59	238				
Geographical area of practice	North-east	6.75	1.16	32	5	2.429	.36	n/a
	East	7.17	1.53	48				
	South-east	7.40	1.48	47				
	South	7.70	1.75	42				
	West/North-west	7.44	1.69	32				
	Midlands/Mid- west	6.66	1.75	34				
	Total	7.22	1.58	235				
Work setting	Hospital	7.33	1.58	205	n/a	n/a	n/a	n/a
	Hosp /community	6.88	1.41	9				
	Community	6.42	1.65	13				
	Other (incl GP surgery n=7)	5.83	0.90	11				
	Total	7.19	1.59	238				
Number of maternity beds	> 70	7.11	1.54	83	2	0.952	.388	n/a
	31-70	7.49	1.54	97				
	<30	7.39	1.52	32				
	Total	7.33	1.54	212				
Hospital ownership	Former health board	7.36	1.55	155	n/a	n/a	n/a	n/a
	Voluntary	6.98	1.59	35				
	Private	7.45	1.83	18				
	Other	6.53	0.70	6				
	Total	7.28	1.57	214				

*results are shown for LSD Post hoc tests only, in those analyses where significant variation was found, this was seen on LSD only and not Scheffe

^ staff midwives had lower levels of perceived empowerment than senior midwives

+ those with 10 years or less had lower levels of perceived empowerment than those with 25 years or more experience .

In the case of grade, staff midwives had the lowest levels of perceived empowerment. There was a significant difference between the scores of staff midwives and senior midwives (which comprised senior staff midwives, CMM1/2/3s, independent midwives and CMSs). As there were not enough in any of these groups to consider them separately, they were thus combined. The “nurse” category contained staff nurses, senior staff nurses, CNMs and practice nurses. It should be pointed out that all of these nurses had contact with birthing women (mostly in a neonatal care setting or practice nurse capacity) and all are qualified midwives. The term “nurse” is to be considered in this light. Their *PCEMS* score lay between the scores of the staff midwives and senior midwives groups, but did not show significant variation with either of those groups. Clearly, separate analysis with adequately large samples of all relevant staff groups would be interesting in future studies and this is proposed in chapter 8.

In relation to years of midwifery experience, the group with the lowest perceived empowerment was the one comprising midwives with 10 years or less experience. Perceived empowerment level rose as years of experience rose. There was a significant difference between the group with ten years or less experience and those with more than 21 years experience.

In relation to all the other demographic variables tested, there were no significant differences in variation. These included overseas practice, length of overseas practice, practice area, geographical area of practice, practice setting, hospital size and hospital ownership. However, there are some interesting points arising from the descriptive statistics (in particular the mean scores) presented in Table 7.19.

Regarding length of overseas practice, while the group that had up to five years experience scored identically to those who had over five years, as observed above, the former group was larger and so this analysis is not robust. There was some variation in mean scores across practice areas, with higher perceived empowerment reported from those working in the labour ward, followed by those working across several areas, and lowest for those who worked in antenatal, postnatal or neonatal areas. Again the sample sizes necessitated these groupings and these differences were not significant.

When geographical location of practice was considered, those working in the Midlands/Mid-west had the highest reported perceived levels of empowerment, followed by the North-east, then the East, the South-east, the West/North-west with the South having the lowest levels

The results regarding work setting must be taken as indicative given the unequal group sizes. They are mentioned here since the highest perceived empowerment is seen within the “other” group, more than half of which relates to working in a GP surgery. The next highest perceived empowerment is seen within the community group, then within the group that work in both hospital and community with the lowest perceived empowerment (highest *PCEMS* score) seen for those who work in hospitals. These suggestive patterns should be tested on larger sub-samples in future studies, as recommended in chapter 8.

For those who do work in hospital, levels of perceived empowerment rise with an increase in the number of maternity beds in the hospital. In other words, those working in hospitals with less than 30 maternity beds report the lowest perceived empowerment. This is not a statistically significant difference. The groups sizes are unequal when hospital ownership is considered, though the data suggest that the lowest level of perceived empowerment is reported by those who work in former Health Board hospitals, followed by private hospitals and then voluntary hospitals. The small ($n=7$) “other” category has the highest perceived empowerment and while four of this group are midwives, the size of the group means that findings cannot be considered to be robust.

ANOVAs were also carried out on the sub-scales of the *PCEMS*. The results are shown in Tables 7.20 – 7.22. Only one demographic variable shows significant variance on one sub-scale, at the stringent <0.001 level. This significant variance was found on the Women-centred practice sub-scale in relation to years of midwifery experience. Using the Post Hoc LSD test there was significant variance between the scores of those with 21 years or more midwifery experience and those with less than 10 years experience, the latter having lower levels of perceived empowerment within this sub-scale. This was

also recorded above as significant in relation to the full *PCEMS*. This same pattern was also found in the other two *PCEMS* sub-scales, but not at a significant level.

The other non-significant results on the sub-scales of *PCEMS* generally follow the patterns described above for the full *PCEMS*. For example, staff nurses on all three sub-scales have the lowest levels of perceived empowerment. There are some differences within the sub-scales results vis-a-vis the results for the full scale, including

- On the Women-centred practice and the Autonomous practice sub-scales, midwives practising in the North-east region have the highest levels of perceived empowerment. The results for the full scale showed that the Mid-west had the highest levels overall, followed by the north-east. This is an interesting distinction given the recent midwifery-led developments in the north-east the outcomes of which are being studied using a randomised trial (The MidU Study).
- In relation to area of practice, those who work “across areas” have the lowest levels of perceived empowerment on the effective management sub-scale. This was not the case for the overall *PCEMS* or for the other two *PCEMS* sub-scales.
- In relation to hospital ownership, those working in private hospitals have lowest levels of empowerment on the Women-centred practice sub-scale and on the Autonomous practice sub-scale. For the Effective management scale those in former health board hospitals had lowest levels of empowerment. As described above, these results are viewed cautiously, as the groups are unequally sized.
- Those with overseas midwifery experience have slightly lower levels of perceived empowerment than those who do not on the Autonomous practice and Effective management sub-scales. On the other hand those without overseas experience have higher levels on the Women-centred practice sub-scale. It should be noted that these differences are very slight.

Table 7.20 Effective management sub-scale of *PCEMS*: ANOVA results

Variable	Group	Score (1-5) high- low	SD	N	df	F ratio	Significance level	LSD (p <0 0001)
Grade	Staff midwife	2 74	0 704	122	2	5 836	0 003	n/a
	Senior midwife	2 39	0 843	74				
	Nurse	2 39	0 840	35				
	Total	2 57	0 788	231				
Years midwifery experience	10 yrs or less	2 73	0 821	106	2	4 093	0 018	n/a
	11-20 years	2 53	0 693	68				
	21 + years	2 37	0 796	59				
	Total	2 58	0 790	233				
Overseas practice	Yes	2 66	0 869	91	1	1 674	0 197	n/a
	No	2 53	0 729	150				
	Total	2 58	0 786	241				
Yrs of overseas practice	Up to 5 years	2 72	0 900	65	1	0 921	0 340	n/a
	6 yrs +	2 53	0 788	26				
	Total	2 66	0 869	91				
Practice area	Labour ward	2 41	0 722	51	2	1 394	0 250	n/a
	Across areas	2 62	0 846	114				
	Ante/post/neonatal	2 60	0 675	75				
	Total	2 57	0 772	240				
Geographical area of practice	North-east	2 41	0 634	32	5	3 007	0 012	n/a
	East	2 39	0 644	49				
	South-east	2 69	0 713	48				
	South	2 82	0 781	42				
	West/North-west	2 82	0 869	32				
	Midlands/Mid-west	2 38	0 984	35				
	Total	2 59	0 786	238				
Work setting	Hospital	2 63	0 760	207	n/ a	n/a	n/a	n/a
	Hosp /community	2 56	0 664	9				
	Community	2 23	0 939	13				
	Other (incl GP surgery n=7)	2 12	0 983	12				
	Total	2 58	0 786	241				
Number of maternity beds	> 70	2 47	0 715	83	2	4 710	0 010	n/a
	31-70	2 79	0 756	99				
	<30	2 53	0 752	32				
	Total	2 63	0 753	214				
Hospital ownership	Former health board	2 69	0 756	156	n/ a	n/a	n/a	n/a
	Voluntary	2 45	0 690	35				
	Private	2 37	0 769	19				
	Other	2 57	1 134	7				
	Total	2 62	0 764	217				

Table 7.21. Autonomous practice sub-scale of *PCEMS*: ANOVA results

Variable	Group	Score (1-5) high- low	SD	N	df	F ratio	Significance level	LSD (p <0.0001)
Grade	Staff midwife	2.69	0.644	122	2	6.280	0.002	n/a
	Senior midwife	2.41	0.679	75				
	Nurse	2.39	0.693	33				
	Total	2.55	0.678	230				
Years midwifery experience	10 yrs or less	2.73	0.738	104	2	7.010	0.001	n/a
	11-20 years	2.46	0.578	68				
	21 + years	2.34	0.643	60				
	Total	2.55	0.688	232				
Overseas practice	Yes	2.57	0.725	91	1	0.114	0.736	n/a
	No	2.54	0.660	150				
	Total	2.55	0.684	241				
Yrs of overseas practice	Up to 5 years	2.54	0.755	65	1	0.364	0.548	n/a
	6 yrs +	2.64	0.651	26				
	Total	2.57	0.725	91				
Practice area	Labour ward	2.55	0.656	51	2	0.845	0.431	n/a
	Across areas	2.50	0.676	114				
	Ante/post/neonatal	2.63	0.717	74				
	Total	2.55	0.684	239				
Geographical area of practice	North-east	2.29	0.587	32	5	1.944	0.088	n/a
	East	2.62	0.650	48				
	South-east	2.65	0.670	47				
	South	2.70	0.754	42				
	West/North-west	2.56	0.679	32				
	Midlands/Mid-west	2.44	0.612	34				
	Total	2.56	0.671	235				
Work setting	Hospital	2.59	0.688	205	n/a	n/a	n/a	n/a
	Hosp /community	2.40	0.797	9				
	Community	2.29	0.598	13				
	Other (incl GP surgery n=7)	2.25	0.539	12				
	Total	2.55	0.684	239				
Number of maternity beds	> 70	2.60	0.720	83	2	0.010	0.990	n/a
	31-70	2.58	0.662	97				
	<30	2.59	0.671	32				
	Total	2.59	0.683	212				
Hospital ownership	Former health board	2.58	0.697	155	n/a	n/a	n/a	n/a
	Voluntary	2.51	0.718	35				
	Private	2.71	0.645	18				
	Other	2.28	0.417	6				
	Total	2.58	0.690	214				

Table 7 22: Women-centred practice sub-scale of *PCEMS* ANOVA results

Variable	Group	Score (1-5) high-low	SD	N	df	F ratio	Significance level	LSD (p < 0.0001)
Grade	Staff midwife	2.16	0.555	122	2	4.434	0.013	n/a
	Senior midwife	1.91	0.534	75				
	Nurse	2.06	0.630	33				
	Total	2.06	0.568	230				
Years midwifery experience	10 yrs or less	2.23	0.589	104	2	9.073	0.000	10 years or less < 21 yrs or more > 10 yrs*
	11-20 years	1.94	0.496	68				
	21+ years	1.92	0.506	60				
	Total	2.07	0.561	232				
Overseas practice	Yes	2.06	0.530	91	1	0.094	0.760	n/a
	No	2.08	0.583	148				
	Total	2.07	0.563	239				
Yrs of overseas practice	Up to 5 years	2.08	0.524	65	1	0.244	0.622	n/a
	6 yrs +	2.02	0.553	26				
	Total	2.06	0.530	91				
Practice area	Labour ward	2.07	0.578	51	2	2.262	0.106	n/a
	Across areas	2.00	0.521	114				
	Ante/post/neonatal	2.18	0.603	74				
	Total	2.07	0.563	239				
Geographical area of practice	North-east	2.05	0.479	32	5	0.997	0.420	n/a
	East	2.15	0.526	48				
	South-east	2.06	0.595	47				
	South	2.18	0.638	42				
	West/North-west	2.06	0.486	32				
	Midlands/Mid-west	1.92	0.604	34				
	Total	2.56	0.562	235				
Work setting	Hospital	2.11	0.572	205	n/a	n/a	n/a	n/a
	Hosp /community	1.91	0.573	9				
	Community	1.90	0.406	13				
	Other (incl GP surgery n=7)	1.78	0.428	12				
	Total	2.07	0.563	239				
Number of maternity beds	> 70	2.04	0.568	83	2	1.926	0.148	n/a
	31-70	2.10	0.531	97				
	<30	2.27	0.623	32				
	Total	2.11	0.562	212				
Hospital ownership	Former health board	2.08	0.558	155	n/a	n/a	n/a	n/a
	Voluntary	2.02	0.537	35				
	Private	2.34	0.715	18				
	Other	2.08	0.418	6				
	Total	2.09	0.568	214				

* those with 10 years or less had lower levels of perceived empowerment than those with 25 years or more experience

7 1 3 4 2 ANOVA Results for *Conditions for Work Effectiveness Questionnaire*

As can be seen in Table 7 23, the demographic variables for which significant variation was found when tested were grade and geographical area of practice. In addition, as with the *PCEMS* results reported above, a number of interesting patterns are seen in relation to other variables, though not statistically significant. The higher the CWEQ score, the higher the level of perceived empowerment, as measured by the CWEQ.

Table 7.23: ANOVA results. CWEQ

Variable	Group	CWEQ Score (4-20) low- high	SD	N	df	F ratio	Significance level	LSD (<0.000)
Grade	Staff midwife	10.96	2.19	122	2	12.269	.000	Staff midwife< senior
	Senior midwife	12.52	2.23	75				
	Nurse	12.13	2.45	35				
	Total	11.64	2.53	232				
Years midwifery experience	10 yrs or less	11.37	2.41	106	2	2.923	.056	N/a
	11-20 years	11.48	2.29	68				
	21 + years	12.26	2.36	60				
	Total	11.63	2.38	234				
Overseas practice	Yes	11.34	2.63	92	1	2.159	.143	N/a
	No	11.80	2.17	150				
	Total	11.62	2.36	242				
Yrs of overseas practice	Up to 5 years	11.54	2.69	66	1	1.414	.237	N/a
	6 yrs +	10.82	2.44	26				
	Total	11.34	2.63	92				
Practice area	Labour ward	11.90	2.19	51	2	0.561	0.571	N/a
	Across areas	11.51	2.30	114				
	Ante/post/neonatal	11.51	2.43	76				
	Total	11.59	2.31	241				
Geographical area of practice	North-east	12.05	1.44	32	5	5.794	.000	South- east < East, Midlands/ Mid-west
	East	12.24	2.45	49				
	South-east	10.34	1.92	48				
	South	11.47	2.56	42				
	West/North-west	11.09	2.17	32				
	Midlands/Mid-west	12.57	2.51	35				
	Total	11.59	2.34	238				
Work setting	Hospital	11.46	2.31	207	3	2.939	0.34	N/a
	Hospital and community	11.83	2.31	9				
	Community	13.09	2.17	13				
	Other (incl GP surgery n=7)	12.65	2.83	13				
	Total	11.62	2.36	242				
Number of maternity beds	> 70	12.07	2.35	83	2	5.242	.006	N/a
	31-70	11.08	2.21	99				
	<30	10.96	2.08	32				
	Total	11.45	2.29	214				
Hospital ownership	Former health board	11.33	2.09	156	3	2.547	.057	N/a
	Voluntary	12.20	2.78	35				
	Private	11.21	2.64	19				
	Other	13.12	4.00	7				
	Total	11.52	2.36	217				

The relationship between grade and perceived level of empowerment as measured by CWEQ was in the same direction as the *PCEMS*. In other words, staff midwives had the lowest level of perceived empowerment and the difference between this and senior midwives' scores was significant. Nurses' scores fell between these two groups, as with *PCEMS*. Post hoc tests showed that only the scores of staff midwives and senior midwives differed significantly.

The other variable which showed significant variation across sub-groups was geographical area of practice. The order of areas from highest perceived empowerment to lowest was as follows: Midlands/Mid-west, East, North-east, South, West/North-west and with the lowest level, the South-east. The order differed slightly with *PCEMS* scores, though the three highest and lowest areas were the same for each set of results.

In addition to these two variables (grade and geographical region), other results are also of interest for various reasons. In contrast to the *PCEMS*, there was not a significant difference between groups with different levels of midwifery experience. As with *PCEMS*, levels of perceived empowerment rose with increased experience but in the case of the CWEQ this was not statistically significant. As with the *PCEMS* there was little difference in score based on whether the midwife had worked overseas or not. For those who had practised overseas, the length of that practice did show some variation unlike the *PCEMS* for which scores were identical. Those who had worked up to 5 years overseas had higher levels of perceived empowerment than those who had worked overseas longer. However this difference was not statistically significant and the groups are of unequal size.

Though not significant, those working on the labour ward had the highest CWEQ scores, as was the case with the *PCEMS*. Similarly to *PCEMS* scores, those working in the community had higher perceived levels of empowerment, though with the unequal groups this is merely suggestive. As with *PCEMS*, the greater the number of maternity beds in the hospital (for those who worked in hospitals), the higher the perceived empowerment levels. This was significant but did not match the stringent criteria used.

Finally, in relation to hospital ownership, the order from highest levels of perceived empowerment was "other", voluntary, former health board and with the lowest level,

private hospitals. The order for *PCEMS* was similar (“other”, voluntary, private, health board), though as discussed above the unequal sized groups mean that these results are suggestive only.

As stated above the only two demographic variables that showed significant variation across sub-groups on *PCEMS* scores were grade and years of experience, with lower perceived empowerment associated with lower grades and less experience. With the *CWEQ*, grade and geographical area of practice varied significantly. Previous empowerment research using *CWEQ* has consistently showed that perceived levels of empowerment rises with increasing grade (Scott *et al* 2003, Laschinger 2006).

Many other interesting findings are suggested within the results that did not show significant variation. Most of these (higher perceived empowerment for labour ward staff, community-based midwives) are theoretically plausible. Further testing of the *PCEMS* with larger numbers within these sub-groups would examine the robustness of these tentative findings (see page 272).

7.1.4 Qualitative data: Respondents’ additional comments

In addition to the three closed questionnaires (demographics, *PCEMS* and *UWO Scales*), respondents were invited to include any additional comments. Eighty-eight (37%) midwives chose to include comments. These data were analysed with the assistance of the *Atlas ti* software package, as described in chapter 4. Codes were assigned to sections of the data, and codes were linked into themes. The data is presented under two themes, which borrow from the words of two of the midwives who made comments in this section. These themes are

- “The powers that are in force”
- “The system is hard work, not midwifery”

7.1.4.1 Theme 1 “The powers that are in force”

Managers were referred to as “the powers that are in force” by one midwife. This expression captures the sense of the comments made about management. There was a recurring message relating to dissatisfaction with senior midwifery management in

particular. One midwife working in a maternity unit of a general hospital expressed this as follows,

Direct line managers are supportive and empowering. Top managers are not approachable and can be disempowering and do not recognise difference in nurse/midwife.

The midwives who wrote about senior management bemoaned the fact that they believed that senior management had little power vis-à-vis other groups, in particular obstetricians. Several midwives stated that their line managers were supportive and the problems were with top midwifery management.

As you can see "manager" is a broad description for the powers that are in force in a hospital environment. It is a pyramid effect – one manager may well be supportive until her manager becomes involved and so on to the very top. Inconsistent support is a huge problem.

Negative feedback relating to management was more commonly reported than positive feedback, with one manager, a Clinical Midwife Manager II herself, saying

I find I'm never told, 'you are doing a good job', from management. So you wonder at times are you doing the job well. You certainly will be told if complaints come in.

Another midwife similarly expressed her emotive response to frustrations which are linked to her perception that,

I worked and trained in England before returning to Dublin. I found that many of the hospital policies are not in keeping with current practices. I find management un-supportive. Management are inflexible and do not offer any encouragement only reprimands. I don't think they know what empowerment means. I am very dissatisfied with my work environment. I am leaving to go somewhere else and perhaps leave midwifery, which is a shame. And I feel I have a lot to offer. I have a BSc. (hons) and eight years experience.

Linked with this quote, formal qualifications were perceived to be of more value by some managers than experience. Another major related concern was about staff shortages and the perceived ineffectiveness of management to deal with this. Midwives perceived that this meant that opportunities for education could not be taken up. The

practical difficulties and the resulting effects on morale were suggested by one midwife who stated that,

Staffing levels are at a minimum on every shift where I work, as a result, this has a huge effect on the overall running of the unit. Managers are constantly trying to 'call in' staff on their time off to replace staff that are sick or depleted. Existing staff are 'worn out' trying to cover shifts. Lack of staff is having a huge effect on the whole morale and atmosphere on the unit in which I work. We are told by management that the issue is being addressed but this is going on for years and years – such a shame!

Lack of resources and poor physical environment were also linked with the lack of effectiveness of midwifery management. Rather than addressing this, managers were perceived to spend too much time in meetings, with their own agendas. One midwife commented that managers are

[N]ot at all concerned with the midwives' opinions on conditions. No communication. And we all feel they have their own agenda for that day and you do not disturb or divert or add to their 'problems' – time spent on meetings. But no real changes on the ground or not much improvement in standard of care at the end of it all in practice. Looks great on paper but resources as in manpower not given to implement change. No evaluation as they have moved onto the next agenda.

Several midwives referred to the increased number of managers but commented that the respective roles of managers were not clear and that the benefits to staff "on the ground" were not apparent. Other midwives working in maternity units in general hospitals stated that this brings some difficulties, as one midwife commented

Midwifery managers are good but we are part of a general hospital & they do not understand MIDWIFERY AS WOMEN CENTRED AND MIDWIFE-LED CARE (emphasis in original, using capital letters)

The necessity for midwifery managers to lead and back-up positive midwifery changes was emphasised by some midwives. One midwife concluded that, because these changes required senior midwifery management backing, which itself was controlled by "male obstetricians", then

[D]evelopments in midwifery such as home birthing, domiciliary care, out reach teams will be very slowly won

The direct effect of management style and manner on midwives' care of birthing women was also highlighted, with one midwife claiming that

I work in a very busy [urban] hospital, there are a lot of protocols there to follow - not always written protocols. Therefore, the sister in charge has a lot to do with the type of advice you give women, e.g. some do not like women having intact membranes and mobilising! This greatly influences your care of these women

The notion of “unwritten protocols” is perhaps oxymoronic, or at best challenging to operationalise in practice. The reference in this context to “intact membranes” implies the preference of some “sisters-in-charge”, for artificial rupture of membranes (ARM). The choice of the uncontroversial “mobilising” alongside that more controversial intervention of ARM implies that outdated and inappropriate practices as well as seemingly discretionary “protocols” are in operation.

Being asked to “act” into a senior position with no recognition was a source of frustration, whereby

Even though you take all the responsibilities for patient care. It's a political & financial saving exercise – can be very frustrating!¹

In conclusion within this theme, even those who viewed their managers positively stated their fears for midwifery,

I have a certain fear for the future of midwifery on two levels. 1. Possible lack of midwives in the future due to changes in nursing education & Medico-legal hassles can be off-putting. 2. Medicalisation of childbirth – I worry that we will become obs/gyn nurses with current trends. As things stand now I feel very empowered in my job with good line management backing.

7.1.4.2 Theme 2 “The ‘system’ is hard work, not midwifery”

This theme relates to various constraints that midwives raised, while asserting that they still valued and enjoyed midwifery practice. In relation to constraints, several midwives spoke of their frustrations in not being autonomous practitioners within a medicalised environment. Some link those with the “medical profession”, others with hospital policy.

at the organisational level, and others with the “system” Some acknowledged the limits of their “training” and experience In that context, they wrote of the difficulties they would have in being able to deliver “midwifery-led care” Others identified the lack of visibility of the midwife’s role within the maternity care system One hospital-based staff midwife who had 18 years experience and who had worked overseas illustrated many of the issues raised by others and she is quoted at length here,

Many women are private patients of obstetric consultants so the consultant has the control much of the time It is not midwifery-led care but obstetric-led care The midwife is not empowered to make decisions i.e. induction/ ARM/ analgesia/ birthing positions- women are (see themselves) under the care of the obstetrician and takes direction from them Some even still say ‘Oh - can you deliver a baby’ Otherwise our role is developing slowly Midwifery I believe should be separate from nursing with its own midwifery governing body Normal midwifery is still controlled too much by medical- obstetricians There are few rewards in midwifery Staff in the delivery suite should be CNM2s as in A&E Highly litigious area to work in

In her comments, this midwife covered private obstetrics, medicalisation generally and litigation which she linked with the invisibility of the midwifery role She was the only midwife who mentioned the regulatory system in this open section She highlights the challenges facing delivery suite midwives in particular, and their lack of adequate recognition in terms of grading and associated financial “reward” or remuneration She describes the need for “CNMs” (Clinical Nurse Managers) rather than “CMM” (Clinical Midwife Manager) grade This use of nursing language was also reflected in other midwives’ comments For example, a midwife commented that

We need more care assistants and to shed a lot of non-nursing duties

Another midwife who highlighted the lack of public knowledge about the distinctiveness between nurses and midwives called for school children to be educated about this distinction so that it can be addressed early

While many midwives spoke about the medicalised system of childbirth, one midwife made the distinction between the “system” and medicine, as follows,

I do believe if staffing numbers were not an issue a midwife could be more empowered to provide midwifery-led care on a one-to-one basis in the labour ward. We have the knowledge and experience to practice autonomously but this is not practised due to the conveyor type labour wards. This is not a reflection on medical staff as I do appreciate numbers must be catered for.

This is interesting in that references to the “system” often implicate the medical profession as controlling this system. In general, those who raised issues relating to medicalisation presented them as being difficult to overcome. For example one midwife said

[I] find the medicalisation of midwifery very frustrating. There is a long way to go to achieve autonomy in midwifery practice in Ireland!

Another said

Midwives in Ireland are not recognised or given recognition as practitioners, midwifery is still very doctor/ obstetrician led in many ways and will be difficult to change the thinking unfortunately.

One midwife described her experience of having moved from a larger maternity hospital to a smaller maternity unit of a rural hospital as follows,

I found that my contribution to the care of birthing women was more recognised when I was working in a Dublin maternity hospital. Having recently moved to a rural hospital I feel that it is the doctors’ opinions that mattered. This was a shock for me because I would have been more accustomed to my opinion taking precedence. However as I’ve said I’ve only recently moved, I have noticed that more experienced (more than 15 years) staff are highly valued by the medical team.

On the other hand another midwife said that

Our hospital is obstetrically-led as opposed to midwifery led but [we] do voice our opinions and stand up and be counted.

This “standing up” was seen by another midwife as having repercussions for the midwife. She also identifies this as a wider social issue,

Since returning to Ireland it still annoys me the lack of control/power women have in their own birthing experience. In a lot of cases if a midwife makes an

issue she is regarded as troublesome The women and men of Ireland need to take pregnancy and childbirth back into their own control''

Private care was linked to medicalisation by several midwives One midwife stated that she had,

[T]rained and staffed in the U K worked with midwifery-led/ partnership approach to care, find that Ireland has medicalised approach to pregnancy & birth I do wonder how much private care has to do with this paternalistic approach

Another midwife was more forceful on this issue, saying

I feel the private obstetric machine will always hinder the development of midwives' practice in Ireland as it is too lucrative for obstetricians to return control of normal birth to midwives

A midwife who worked in a private hospital said that as

There are no nursing managers on the night shift so I speak with the consultant and abide by their decision

The choice of language here is interesting, "abiding by decisions", is a negative portrayal of the relationship between midwives and obstetricians On the other hand a midwife working in the public sector who was describing the constraints of a medicalised system saw night duty as a covert away of achieving her aims

Working in a medicalised unit can mean (for me) that when trying to empower women about preparing for the birth of their baby, you are often over-ruled either directly or indirectly, 'the doctor said ' As a midwife I feel my practice is more autonomous on the night shift There are fewer doctors around You get to practice true midwifery

Another midwife acknowledged the impact of medicalisation but highlighted that with individual women, she acts as best she can in the interests of the woman,

Most decisions are made by the consultants but when looking after a normal labour I consider myself to be a full advocate for women and will do my utmost to help them have a good experience

Underlying the negative comments about management, medicalisation and staff shortages there was a positive current relating to satisfaction about “being a midwife” and the enjoyment of midwifery despite the constraints. One midwife who had worked overseas articulated her concerns about the constraints she felt but finished on a positive note.

Sometimes I feel I was able to work more as a practitioner in the UK where I trained. Even the public had more recognition for the midwife there and we were constantly encouraged to update existing skills and gain new skills. Here in Ireland we are expected to update our skills and attend study days – but in our off duty time, which I do not think is acceptable. On the whole I love my midwifery and enjoy my job.

Another midwife who had worked in the UK and Australia and had a midwifery degree concluded that

The system is hard work not midwifery.

This phrase encapsulates many of the views presented by midwives and was accordingly chosen to describe this theme. Another midwife stated that “on the whole I love my midwifery and enjoy my job”. Another expressed her enjoyment of midwifery, while also stating the constraints on practice,

Although I enjoy my work, a hospital environment is not always conducive to my practice (e.g. short staffed, huge birth rate) particularly working in Ireland.

All of those who had worked overseas who included comments referred to their more positive autonomous experiences of midwifery outside Ireland. Running through most of the comments in general was a concern for the quality of the maternity services and the impact of that for birthing women. Only one practice nurse who is involved in antenatal and postnatal care mentioned advocacy. She saw herself as an advocate to assist women in having as good a birth experience as possible. Several midwives complained that paperwork and computers were taking them away from their work with birthing women.

The next section discusses the quantitative and qualitative findings presented above

7.2 Discussion of results of survey 2

Empowerment is a reciprocal concept and until midwives are themselves empowered to practice it is difficult to empower women
(Senior Staff Midwife, respondent of survey 2)

As the above quote suggests, the midwives in this study recognised the importance of empowering midwives for the benefit of the women with whom they work. Therefore the findings of this survey of a national sample of practising midwives are significant for midwives and birthing women. The previous section has outlined those findings. They are discussed in this section as follows:

- Response rate
- Demographic profile of respondents
- Midwives' perceptions of their levels of empowerment
 - *PCEMS* results
 - UWO Scales results
 - Correlations between scales
 - Analysis of variance results
- Qualitative data: Respondents' additional comments

7.2.1 Response rate

The response rate for survey 2 was 49% (n=970). Of this number, 244 were practising midwives. The decision about the size of the target sample (2,000) was made in the knowledge that the use of the Midwives division of An Bord Altranais Live Register was likely to retrieve people who were not in midwifery practice. It was known that only one fifth of those on the Midwives' division are in midwifery practice. More than three quarters of those who responded to the survey indicated that they were not in midwifery practice (n=726) and this bears out that estimate.

More than half of those who were not in midwifery practice were in nursing practice (n=426). They were mostly in general nursing or in care of the older person, the two largest areas of nursing practice. Those who were also on the public health nursing division had been excluded from the sample. This was the sampling strategy adopted.

because it was known that all those on the public health nursing division necessarily had a midwifery qualification. In a two-staged extraction, those who were on the public health nursing division were firstly excluded and then a random sample was extracted from those remaining (see page 101)

The information about the current area of nursing practice of those who received questionnaires is useful in examining strategies to attract those with a midwifery qualification back to midwifery. Several maternity hospitals currently offer back-to-midwifery courses and these offer a means of recruiting those with midwifery qualifications back to midwifery practice. An Bord Altranais (2006) has recently published a document which outlines the competency-based approach with which all return to midwifery practice courses starting after 1 February 2006 must comply. Several survey respondents who were not practising midwifery at the time enquired about the availability of such courses. These competency-based guidelines will assist in ensuring the quality of such programmes and are welcome in the context of current midwifery shortages.

Many maternity services also offer flexible hours and shift patterns in order to suit those with family commitments and in response to equality legislation. This is not to assume that all those with a midwifery qualification will necessarily wish to return to midwifery practice. Hunt & Symonds (1995 p25) comment that a midwifery qualification was sometimes viewed in the "nature of a trophy which need not be used" and this equally applies to Ireland. In some cases a midwifery qualification was obtained for some other indirect purpose. Those who seek permanent jobs in general hospitals which have maternity units in Ireland are obliged to have a midwifery qualification. Though excluded from this sample, those working in public health nursing were required to have a midwifery qualification, though not necessarily intending to practice midwifery within the maternity services. The high number of people with a midwifery qualification nonetheless represents what might be described as a "latent midwifery resource"- in other words people with a midwifery qualification not currently practising midwifery. Work to explore and quantify reasons for undertaking midwifery and the possibility to enhance recruitment and retention has taken place over the last few years in Ireland (McCarthy *et al* 2002, Pitman 2004). Further research on midwifery recruitment is recommended in chapter 8.

7.2.2 Demographic profile

Respondents to survey 2 (n=244) were drawn from across all geographical regions, hospital/community practice settings, areas of midwifery practice and hospital types. In addition, the sample comprised a range of grades, experience levels and those with and without overseas midwifery practice. Notwithstanding the larger sample size obtained in survey 2, the demographic patterns across most variables were similar to those of survey 1. This was the case in relation to age group, grade, years of midwifery experience, work setting (hospital), and hospital ownership/employer. There were only slightly different patterns for two variables, namely geographical region and experience of overseas midwifery practice, and these are discussed below.

The age profile of respondents suggests a relatively young practising midwifery resource, with almost half of respondents less than 40 years of age. The majority of respondents were aged between 30 and 49 years (71.7%), with 11.9% aged under 30 and 16.4% aged 50 years or more. This suggests a pattern whereby those over 50 leave midwifery. Related to this, almost half of the sample had less than 10 years midwifery experience, while one quarter had 21 years or more experience. This suggests a polarised group in terms of experience, with a relatively large inexperienced group and a smaller highly experienced group. One midwife in survey 2 commented that midwives with more than 15 years experience are more respected by doctors, an anecdotal comment that seems plausible. The challenge is in retaining midwives within the less experienced group and ensuring that more experienced midwives are not overburdened with responsibility.

Just over one third of survey 2 respondents had practised midwifery overseas. In survey 1, just over half (51%, n=48) had done so. The age and experience profiles of both samples were similar. This may suggest changing patterns during the time period between the two surveys (three years). Possible interpretations include that either fewer midwives who work overseas are returning to Ireland, or that fewer are leaving Ireland in the first place (and hence there are fewer to potentially return). It is not possible to establish which, if either, of these interpretations is more accurate. The issues of retention of midwives in Ireland and the attraction to Ireland of those working overseas are critical in context of the current shortage of midwives (Pitman 2004). The patterns

suggested in this study merit further examination and this is highlighted below as a useful focus of future research (see page 275)

There was a low number (seven) of Clinical Midwife Specialists (CMSs) in the sample. This reflects the low number of CMSs nationally, with only 43 in post by February 2006 (National Council for the Professional Development of Nursing and Midwifery 2006). This contrasts with 1,698 Clinical Nurse Specialists (CNSs). Most CNSs are in general nursing (1,036) with a further 662 across the branches of nursing (National Council for the Professional Development of Nursing and Midwifery 2006). There are no Advanced Midwife Practitioners (AMPs) in Ireland, hence their absence from the survey sample. By contrast again, there are 32 approved Advanced Nurse Practitioner (ANP) posts and 25 accredited ANPs by February 2006 (National Council for the Professional Development of Nursing and Midwifery 2006).

The low number of CMSs and the absence of AMPs reflect broader issues for midwifery. One of the key recommendations of the Commission on Nursing related to the creation of clinical career pathways for nurses and midwives. The proposed pathway comprised three levels: Staff nurse/Staff midwife, Clinical Nurse Specialist/Clinical Midwife Specialist and Advanced Nurse Practitioner/Advanced Midwife Practitioner. The National Council for the Professional Development of Nursing and Midwifery has overseen the implementation of this recommendation. As suggested by the survey sample profile, both the specialist and advanced levels of the pathway have proved to be problematic for midwifery. It is argued by midwives that there is an inherent difficulty with the notion of a specialist role in a holistic profession such as midwifery. This is acknowledged in the National Council's report on the *Evaluation of the Effectiveness of the Clinical Nurse/Midwife Specialist* (National Council for the Professional Development of Nursing and Midwifery 2004 p45). This report notes that

Some midwives are of the view that specialisation may lead to fragmentation of care and that creating sub-specialties in midwifery in order to provide promotional opportunities is detrimental to professional development.

The report acknowledges that these debates have influenced the low numbers of CMS posts. It states that some midwives believe that the term "enhanced practice" is more in keeping with the holistic philosophy of midwifery. It continues that "notwithstanding

this valid perspective”, 31 CMS posts had been created by the time of the report. That is followed by information about the specialist areas of these posts and suggested areas for future development. The rest of that evaluation report uses “nurse and midwives” or “CNS/CMS” together and with the exception of the recommendations section, does not distinguish between nursing and midwifery.

Related arguments are offered in opposition to the appropriateness of the Advanced Practitioner role for midwifery. The core concepts of ANP/AMP are autonomy in clinical practice (with a specific caseload), pioneering professional and clinical leadership, expert practitioner and researcher (National Council for the Professional Development of Nursing and Midwifery 2006). As mentioned above, there are no AMPs though there are two ANPs in neonatal care (National Council for the Professional Development of Nursing and Midwifery 2005). The argument is that the elements of the AMP role would be fulfilled if midwives were fulfilling their midwifery role. This certainly applies to the issue of caseload, though clinical leadership, expert practice and research are not fulfilled by all midwives and so this issue needs more consideration by midwives. These issues relating to specialist and advanced practice roles in midwifery are central to the identity of the midwifery profession and cannot be dismissed as not conforming to the model set out by the Commission on Nursing and implemented by the National Council. The fact that the Commission dealt with both nursing and midwifery, albeit separately at times, contributed to their similar treatment in areas like the clinical career pathway. The model appears to fit nursing, where specialist and advanced practice roles have been welcomed by the profession. While midwives articulated their reservations about the CMS role initially, alternatives were not pursued. This suggests a lack of effectiveness of midwifery leaders to effect change or resist change that is detrimental to midwifery. This has echoes of Irish midwifery history explored in this study (see chapter 5 above). Conviction and strong feelings need to be translated into effective political involvement in and influence over policy-making. The recent consultation day held at Trinity College Dublin heralds the emergence of constructive developments in this area. This has involved the identification of key themes within the areas of supervision, site preparation, clinical experience, role and organisational links (O’Boyle 2006). These developments usefully build on overseas experience with advanced midwifery practice roles. Further research to address this issue is recommended in chapter 8 (see page 276).

Almost one tenth of the sample described their grade as “nurses”, although all those in this sample had a midwifery qualification. Most in this “nurses” group were working in neonatal care, or in the community as practice nurses. By their own definition, they were working with birthing women when they completed the survey. While these respondents have a midwifery qualification, in settings such as neonatal ICU, they need not necessarily have one. For example, a children’s nurse with neonatal care experience and an appropriate neonatal care qualification might work along side those with a midwifery qualification in the neonatal unit of a maternity hospital. This is supported by Pitman’s (2004) study of the Dublin maternity hospitals, in which 13.7% (n=24) of his stratified survey sample (n=175, 64% response rate) were nurses. The issue of nurses working in maternity hospitals is not necessarily posed here as a problem. However there may be interesting questions relating to the identity of those working in maternity services who see themselves as nurses. Further study of those who work as “nurses” and midwives within maternity hospitals would shed light on this and is recommended in chapter 8 (see page 276).

Regarding area of practice, almost half of respondents worked across several areas of maternity care, for example across antenatal and postnatal care. Just over two-thirds of this group worked in former Health Board hospitals. Within maternity units of acute Health Board hospitals, there may be a greater tendency to move midwives across areas. This was reported in Scott *et al* (2003). Within maternity hospitals, there has been a traditional practice of remaining in one maternity “area” (e.g. postnatal ward, paediatric outpatient clinic) for a long time, even decades. There is a tension between midwives keeping their skills updated in all midwifery areas and on the other hand feeling perhaps more comfortable when remaining in one area, with unchanged colleagues and practices. Clearly the notion of continuity of midwifery care suggests that the midwife should follow the woman through the stages of her care and should be equipped to care during all these stages. This does not happen in the majority of maternity services (apart from within DOMINO and midwifery-led services). Rotation around midwifery areas (labour ward, antenatal care) is a justifiable goal, if it is accompanied by support, proper planning and involvement of midwives. Midwives may view being up-to-date and competent in all midwifery areas as more relevant now than was the case in the past, in the context of the current increase in DOMINO and midwifery-led practice.

opportunities While there may be resistance to changes to established practices, being competent in all aspects of midwifery permits the holistic care which midwives claim as a value

Most midwives in the sample worked in hospitals, consistent with national patterns of hospital-based care Just over one third worked in hospitals which have more than 70 maternity beds, of which there were only four in the country at the time of the survey, the three Dublin maternity hospitals and the Regional Maternity Hospital in Limerick (Department of Health and Children 2003a, Cuidiu 1999) (The Cork University Hospital with a 150 maternity bed capacity is scheduled to open in mid 2006) There is a wide geographical spread, across the country, which allows for cross-regional comparisons In the absence of national data on the population of practising midwives, it is not possible to confirm that a nationally representative sample was obtained in survey 2 However, as described, the pattern on all relevant demographic variables is consistent with the information which is available

These demographic data in themselves raise interesting debates and issues within midwifery practice, such as those relating to specialist and advanced practice Furthermore, the collection of relevant demographic data enabled the analysis of the influence of these variables on midwives' perceptions of their levels of empowerment (see page 253)

7 2 3 Midwives' perceptions of their levels of conditions for empowerment

Midwives perceptions about their levels of the conditions important for empowerment were measured using the newly developed *PCEMS* and the UWO Work Empowerment Scales These results are discussed in turn

7 2 3 1 PCEMS results

The *PCEMS* was developed and psychometrically evaluated in this survey Factor analysis was carried out on the responses to the *PCEMS*, suggesting three factors **Autonomous practice, Effective management and Women-centred practice** These factors and their constituent items are considered alongside the factors underlying empowerment which were identified qualitatively and quantitatively in survey 1 (see Table 7 24)

This comparison suggests that the three factors identified in survey 2 encompass and supplement those identified both qualitatively and quantitatively in survey 1. Accordingly, these three factors are suggested as comprising the three “domains of empowerment in midwifery”. The *PCEMS* measures perceptions of empowerment, as encapsulated within these domains. The domains were identified as important by midwives and thus the *PCEMS* is a contextually-sensitive instrument for measuring empowerment in midwifery.

Table 7.24. Comparison of conditions underlying empowerment in midwifery

Survey 2: Factors identified through factor analysis of <i>PCEMS</i> responses	Survey 1: Factors identified through factor analysis of <i>UES</i> responses	Survey 1: Qualitative data. Factors influencing empowerment
Autonomous practice Recognition from medical profession Control over practice Listened to by team Autonomy in practice Access to resources for birthing women	Control Recognition	The role of the medical profession
Effective management Supportive manager Valued by manager Back-up of manager Recognition from manager Informed about organisational changes Effective communication with manager	Management	Communication style and extent Being valued Staffing levels Management style
Women-centred practice Empowering birthing women Advocating for birthing women Ability to say no when necessary Involved in midwife-led practice Support from colleagues Adequately skilled for practice	Skills	Level of skills Level of education Level of knowledge

The remaining results pertaining to the *PCEMS* are discussed under its three constituent domains/sub-scales: Autonomous practice, Effective management and Women-centred practice. This involves a discussion of the items within these domains individually and collectively. Following this, the composite mean scores on *PCEMS* and its subscales are discussed.

Power is about politics, not just in the formal sense but more broadly, about the politics of everyday life (Clegg 1989 p149)

The first domain, **Autonomous practice**, covers the following items (in order of descending loading on this factor)

- being recognised by the medical profession as a professional
- being recognised by the medical profession for one's contribution to the care of birthing women
- control over practice
- being listened to by the members of the multidisciplinary team
- autonomy in practice and
- access to resources for birthing women

This domain centres around the role of midwives within the maternity care system the subordinate position of midwifery within this system is the inescapable backdrop to these findings The first two items asked about midwives' perceptions of their level of recognition by the medical profession These items were discussed above (see page 174) in relation to midwives' views about their importance to midwifery empowerment Within this survey, almost three quarters (70.1%) agreed that they were recognised as a professional by the medical profession Just over half (52.8%) agreed that they are recognised by the medical profession for their contribution to the care of birthing women Responses to these two items were moderately correlated (0.644, $p < 0.001$) The level of perceived recognition as a professional is perhaps higher than expected, given midwives' complaints about their lack of professional identity and their perceptions of dominance by the medical profession It could be suggested also that the level of perceived recognition of midwives for their contribution to the care of birthing women is lower than expected, given the reliance of doctors on midwives for the day-to-day care of birthing women In other words, it would be plausible to suggest that midwives perceive that doctors recognise midwives for their care of birthing women but do not recognise them as professionals However these findings indicate the opposite Further interpretation of these two items is required

Midwives' high level of perceived recognition as professionals by the medical profession, while apparently positive, is interesting in light of the patriarchal obstetric-

led model of care dominant in Irish maternity care and midwifery's inter-professional historical legacy, as illustrated in chapter 5. Apart from within the fully midwife-led pilot schemes described above (see page 11), the very structure of the maternity system itself does not acknowledge the professional identity and role of the midwife, in fact it undermines and devalues it. In particular, the registration of all women with an obstetric team illustrates a lack of recognition of the appropriateness of the midwife as lead care provider of first resort for all birthing women, as the WHO recommends (see page 18). Within this structural configuration, inter-professional relations between medicine and midwifery have been all the more tested. The historical analysis provided in chapter 5 illustrates that even advocacy for the recognition of midwives, by the medical profession, takes place within a patriarchal context within which it is taken-for-granted that medicine would demarcate the scope of midwifery practice (see page 131). In the Irish case, the maternity care structure reinforces the adoption of the lead care role by obstetricians. Increasingly, within midwifery-led care initiatives, midwives are being recognised as their professional definition entitles, as independent, continuous holistic carers of women in the maternity period. The results for this item suggest that midwives perceive that they are recognised as professionals, even within the current system.

The second item related to recognition, refers to the recognition of midwives' contribution to the care of birthing women. Fewer midwives perceived that they were recognised for this contribution, than as professionals. The distinction between these two items may suggest that midwives perceive that they are not acknowledged for this contribution, in terms of being valued and receiving positive feedback. Located somewhere between these two items is Pitman's (2004) finding, discussed above (see page 31). This has showed that two-thirds of midwives working at the Dublin maternity hospitals surveyed felt that doctors respected their midwifery skills. There is again a distinction between this and the two items asked in this survey. However, Pitman's findings are also more positive than can be expected, given midwives' history, the organisational maternity care context and its domination by medicine, and stated lack of professional midwifery identity. Not being recognised for your contribution to care implies not being valued for that care, which, as described above, is less valued than technical and interventionist medical care. Nonetheless as the professionals who spend most time with birthing women, that midwives do not perceive that they are recognised for what takes place within this care, is dispiriting.

Related to the two items about recognition by the medical profession is the item about being listened to by members of the multidisciplinary team. That team comprises mainly doctors and midwives, but also physiotherapists, social workers, radiographers and others. Almost two-thirds perceived that they are listened to by members of the multidisciplinary team. This is very positive and contrasts with the results on the item relating to being recognised for one's contribution to care, with which just over half agreed. Perceiving that one is listened to by multidisciplinary team members might suggest that one's contribution to care is recognised by the medical profession, the most prominent other profession in the multidisciplinary team. These two items are moderately correlated ($r = 0.4$) and so there is an association between them. It may be that the direct reference to the medical profession influenced a more negative response than reference to members of the multidisciplinary team. This may reflect a perception that others like social workers and physiotherapists listen to midwives more than doctors. Further ethnographic research which explores the interactions of those in maternity care is suggested below to clarify and illuminate these issues.

Also within this Autonomous practice factor are the items relating to having control over practice and having autonomy in practice. As described in chapter 2, these are central to the identity of midwifery. The literature reviewed in chapter 2 also suggested that within medicalised, patriarchal childbirth contexts, autonomous practice is difficult to achieve. Just over half of the sample perceived they had control over their practice and just under half that they had autonomy in their practice. These findings appear to support midwives' complaints that they are not fulfilling their role. They are of concern, though perhaps not unsurprising in the structural context within which midwives work. Within that context, midwifery autonomy and control is necessarily limited by the obstetrician-led care structure, except in those midwife-led areas.

Clearly at a micro level midwives have control over certain aspects of care, related to their own behaviour and relationship-building. This is argued by those who are critical of the focus on the macro structures described above (see page 62). It is necessary to explore the extent to which midwives are pushing the boundaries of these structural limits at an individual level. They may be using covert strategies to support women within a model that they perceive not to be women-centred, as the literature suggests.

(see page 23) However, there may be limits of the extent to which covert action can improve the practice environment for both midwives and birthing women, since it does not openly challenge it. However, in an environment of perceived lack of support, open challenge may carry with it personal risk, or at least perceptions of such risks (such as barriers to career development, promotion, lack of other opportunities). Against this backdrop midwives may feel that acting covertly is the only option open to them. Further research to elucidate the area of covert practice is indicated and is proposed in chapter 8 (see page 274).

The final item in this Autonomous practice domain (and sub-scale of *PCEMS*) relates to having adequate access to resources for birthing women. Less than half of midwives perceived that they had adequate access to resources for birthing women. The level of access to resources players in an organisation have reflect the level of power they have, and for some, resources define power (see page 48 above). This findings reflects the broader lack of power that midwives perceive they have. As described above, as well as one's behaviour, control is considered to include the successful manipulation of environmental variables and physical resources (see page 160). This item therefore links to the discussion above about control. Using a term such as "resources" may have been interpreted by midwives as physical and environmental resources and also in terms of time and human resources. Other data in this study highlight that staff shortages are a major concern for midwives. It is not possible to establish over which resources for birthing women, midwives seek control and this topic merits further research. This is returned to in chapter 8 (see page 276).

In summary, within this Autonomous practice domain of empowerment in midwifery, midwives are reporting a mixed picture. Midwives have relatively positive perceptions about the extent to which they are recognised as professionals by the medical profession and the extent to which they are listened to by the multidisciplinary team. However these findings must be interpreted in terms of the subordinate position of midwifery vis-à-vis medicine in the current system of maternity services. On the other hand, there are negative perceptions in relation to a perceived lack of autonomy in, and control over, their practice, lack of recognition for their contribution to the care of birthing women and inadequate access to resources for birthing women. Some of the findings suggest that it is not only the direct relationships with the medical profession which reduce

midwifery autonomy. This is consistent with characterizing the system as patriarchal at the social level rather than at the individual level. Underlying the maternity service structure is a medical dominance over midwifery, as evidenced in the examination of the patriarchal nature of maternity care and the historical analysis carried out in this study (see chapters 3 and 5). This reflects that fact that the influences of medicalisation and the patriarchal nature of birth are insidious and covert and requires analysis at the social rather than individual or interpersonal level only.

Within this domain of Autonomous practice, it is necessary to highlight a sense of the overarching power of the system of policy-making, within which the influence of political power is seen. This affects the control and autonomy allowed to midwives, as this is set out in policy, which is influenced by politics, at various levels, both formal and informal. The term “political power” is not only used to relate to the formal political system, but all those informal alliances and influences on the formal policy-making process. Formal politics take place within national and local political spheres, manifested ultimately by Ministerial and governmental decisions. Thus it is the policy-making system or macro level organisation of maternity care within which midwives’ autonomy in practice is influenced. Informal politics concern those sets of relations that try to influence the formal political system, overtly and subtly. Traditionally elite groups such as the medical profession have influencing power, exemplified in the Mother and Child debacle (Barrington 1987). In the case of the Central Midwives Board, they had limited power, when it was exercised on behalf of midwives. Medicine’s indirect influence on the overall configuration of Irish maternity services and the more direct problematic issues that midwives identify in the interactions with doctors (for example, their lack of recognition for their care of birthing women) presents a negative picture within this domain. This highlights a need for midwives to be politically effective in order to influence the macro level policies that affect their practice. Being politically aware of the structural contexts within which they work is the first step for midwives. Midwifery leaders, educators and researchers have critical roles to play in the analysis of those contexts and in facilitating midwives’ political effectiveness. This is returned to within the recommendations offered at the end of this study (see page 270).

Power in organisations is essentially about the hierarchical structure of offices and their relation to each other (Clegg 1989 p189)

The second domain of empowerment in midwifery identified in this study, **Effective management**, relates to midwives' perceptions of their managers. It is a particularly cohesive factor in that all items relate specifically to management. It includes the following items

- being supported by one's manager
- being valued by one's manager
- having the back-up of one's manager
- being recognised by one's manager for your contribution to the care of birthing women
- being informed about organisational changes which affect one's practice
- having effective communication with management

The results pertaining to all these items are quite negative, in that just between 46% and 58% agreed with these statements (or disagreed with negatively worded statements). Having a supportive manager had the highest positive response (58.4%), while having effective communication with management had the lowest (46.4%), the others falling in between. Again, some interesting distinctions are suggested by these data. Slightly more midwives perceived that they have a supportive manager than perceived they were valued, backed-up or were recognised by their managers. There is therefore an implied distinction between a general feeling of being supported and a feeling of being backed-up. The latter might imply a more active role on the part of the manager, though this distinction is subtle. Having a perception of back-up is critical to midwives who wish to be innovative and creative. However, since the levels of perceived support themselves are low, the overall negative picture regarding management is of more importance than these minor implied distinctions. In relation to midwives' perceptions of their recognition, slightly more midwives perceived that managers recognised them for their contribution to the care of birthing women (55%) than did doctors (52.8%), though both levels are reasonably low. The consequences of this perceived lack of recognition for their contribution to care from both managers and doctors can only be discouraging for midwives who feel stretched and stressed by the staff shortages they report within the qualitative data in both surveys.

In particular, management support is identified in the literature as critical to enable effective midwifery practice (see page 25). This literature suggests that if midwives are to support women and each other, then they need to be supported themselves by their managers. The qualitative data of survey 1 identified poor management as a key factor inhibiting midwifery empowerment. Other studies have suggested problems with hierarchical midwifery management, particularly at the senior level (see page 32). The data from this survey equally suggest deficits in perceived support from managers. The qualitative data allows us to be clearer about the level of management which midwives perceive as most problematic, since these findings suggest that higher midwifery management is perceived as being most ineffective and least supportive.

The critical perspective on power suggests that these indications of poor management might reflect horizontal violence, whereby those who perceive themselves to have little control at their level in medically-dominated institutions take this out on their subordinates (Freire 1993). In the context of the patriarchal maternity services, this tendency might be even more expected. In an Irish midwifery context, Begley (1997) has agreed with this characterisation. She portrayed midwifery management as having hierarchical structure and autocratic style. The findings of this study suggest that this is still the case.

Two items in this domain relate to communication, a factor identified in survey 1 as key to enhancing empowerment. These data suggest perceptions about poor communication generally and particularly in relation to being informed about organisational changes that affect one's practice. Not being informed about such changes is just one end of the spectrum in the process of decision-making. Arguably involvement in decision-making extends from being "informed", through being consulted, participating in decision-making, to having decision-making responsibility that affects one's practice. If so few are informed, then fewer again might feasibly have responsibility for such decision-making. Clearly there are appropriate levels of decision-making within organisations. However midwives might expect to be kept informed at least about those decisions which directly affect midwives and their practice.

Programmes such as *Leading an Empowered Organisation* (LEO) have been rolled out

for midwifery and nursing managers across the country over the past number of years, with the support of the National Council for the Professional Development of Nursing and Midwifery in Ireland. The aim of the LEO programme is to support organisational and cultural change by “developing healthy relationships, skilled problem solvers and confident risk takers” (Lynch 2006). The findings of this study would suggest that the approach promoted by the LEO programme is still badly needed in midwifery management. An evaluation of the LEO programme carried out for the Management Development Sub-Committee of the Steering Group on the Empowerment of Nurses and Midwives (Office for Health Management 2003a) reported that the LEO programme was valuable in its contribution to management development, but that it could only be part of a deeper and broader approach. The Office for Health Management (2003b, 2003c) also invested heavily in identifying the development needs of senior and middle-level nursing and midwifery managers and the responses to those needs. The Nursing and Midwifery Planning and Development Units across the country responded to these initiatives by funding the uptake of various management development programmes. Despite these initiatives, the persistence of such low levels of perceived support from management in survey 2 suggest that positive change within midwifery management has not yet been readily perceived by midwives. It may be that within certain localised or regional areas there has been an effect related to the high uptake of these initiatives. For example, this might be the case in those regional areas within which midwives’ perceptions of their levels of empowerment were highest in this study. However further study of midwifery management is recommended below to identify which initiatives are most effective and why (see chapter 8).

These findings are presented within the context of the opportunities offered by the recent advent of midwifery-led initiatives in Ireland. Pending the results of the randomised trial in the North-east region, midwifery-led developments across the country may be modest. They might involve the extension of DOMINO and early-discharge services. All attempts to reassert the holistic and lead care role to the midwife, in the absence of complications, are significant in terms of the continuity of care they offer women and the increased fulfilment of the midwifery role and satisfaction of midwives. During these changes midwives must be supported through education provision and the back-up of their managers.

Overall, the items in this domain relate to the organisational context of midwifery practice and are influenced by those who manage the organisation. This domain relates to the organisational perspective explained in the literature review. This perspective emphasises the structural nature of power and empowerment (Kanter 1979, 1993, Laschinger 1996). Organisational structures and relations affect communication style, participation in organisational decision-making and the responses to the needs of employees, for support, recognition, to feel valued and that they have managers' back-up. The effects of structural power are shown in this study to be quite negatively perceived by midwives. The findings on the UWO Workplace Empowerment Scales, developed from this perspective, provide further evidence of the critical unmet needs for organisational support that midwives perceive (see page 251). This is all the more serious in light of the current midwifery-led service developments and the integration of midwifery education into the third level sector. While these developments are welcome, they also involve challenges to midwives, through which they must be supported if change is to happen. These issues facing maternity service providers and midwifery managers, and some recommendations to address them, are discussed in chapter 8.

7 2 3 1 3

Women-centred practice

The third and final domain of empowerment in midwifery identified in this study is

Women-centred practice This domain comprises items relating to

- empowering birthing women
- being an advocate for birthing women
- being involved in midwife-led care
- saying no when judged necessary
- having the support of colleagues
- being adequately skilled for practice

Around four-fifths of the midwives surveyed report that they perceive that their practice involves empowering women (78.5%), advocating for birthing women (80.9%) and being able to say no when they judge it necessary (83.2%). This portrays a very positive picture of how midwives perceive their own practice and their relationships with birthing women. It must be acknowledged that as with all studies in which participants know they are being studied, there may be an element of social desirability. Nonetheless, these results require further interpretation. The three related items referred to above imply assertiveness and confidence to defend one's own decisions and those of

birthing women. This picture is interesting and somewhat difficult to reconcile with the context of the midwifery practice environment and the findings within the Autonomous Practice domain discussed above. There, in particular, midwives reported a perceived lack of control and autonomy in practice. Those findings were more consistent with the context of midwifery practice in Ireland. One must question the extent to which midwives without control or autonomy in practice can go about empowering birthing women. There may be an element of social desirability about these responses but they also require further exploration. As discussed in chapter 2, there are serious limitations on midwives' practice, especially within a hospital-based organisation. Medicalised, patriarchal, institutionalised services place limits on the extent to which midwives can provide women-centred care, particularly in relation to contested concepts such as advocacy and empowering birthing women. This relates to structural attributes of the maternity system. For example, there is a lack of continuity of midwifery care within most maternity services, the exception being those of independent midwives and midwife-led care. There is therefore a strong likelihood that a woman entering an Irish maternity unit or hospital will not have previously met the midwives who are with her in labour and post-natally. This, as highlighted by Vague (2001, see page 19), makes meaningful communication and trust very difficult, despite the best intentions on the part of individual midwives to empower and advocate for women. Equally, assertiveness is at best difficult within the current midwifery culture, where, as discussed above, management style is perceived as unsupportive. Begley (1997) also highlighted that midwives, who previously trained as nurses, were socialised into a subservient role within nursing which carries into their midwifery education and practice. This is further entrenched within maternity services which appoint doctors as the dominant carers. These aspects of women-centred care are not central to medicalised maternity care systems which are characterised as industrial and within which there is a process completing a time-bound process, as within the active management of labour described above (see page 14).

Within these maternity care structural constraints, midwives may 'do their best' for individual women and for birthing women collectively. Therefore their notion of what advocacy involves may be interpreted within the limits which they acknowledge and accept. In the same way, midwives may believe that empowering women relates to what they *can* do, within the given contextually-determined limits. Thus midwives'

expectations of what midwifery practice which empowers and advocates for women might entail may be curtailed within the context of their practice environments. As Hunt & Symonds (1995 p107) highlight, women's expectations may also be low in the current system. On a positive note, interpreting these findings using a Foucauldian view of power (see page 67), suggests that midwives acknowledge and are able to exercise their power to practice as best they can at an individual level. Consistent with Foucault's views, this does not deny that there are dominant powers at play (e.g. obstetricians, senior midwife managers). However, it sees the possibilities of the productive exercise of power at a local level. This domain is linked to the professional power of midwives. It challenges the notion that midwives are powerless in the face of a dominant force which is referred to as the "medical model" or "the system". It is not possible from this study to establish whether midwives are using their power in this way. Again the findings of Begley (1997) and Pitman (2004) convey a different picture. Begley's student midwife participants reported levels of bullying of women, suggesting the uncaring traits listed by Too (1996a, 1996b) and others. In other research, it was found that midwives perceived that birthing women are too demanding (Pitman 2004 p31). This was presented alongside the idea that midwives believed that they provided adequate care for women. Elsewhere Pitman reported that midwives stated that the care they deliver lacks continuity and meaningful relationships. These apparent contradictions within midwives' perceptions of their care and how birthing women perceive that care needs further study and this is recommended in chapter 8.

Another contradiction is suggested in this and other studies, between how midwives perceive they are practising themselves and the "system" they see as being outside them. Begley (2002 p315) commented on the "strict hierarchy that appears to be perpetuating itself continuously". Within Giddens's (1984) structuration theory (see page 64) it is suggested that it is agents who reproduce the structural properties of systems. Therefore positive midwifery practice would be reflected in the "system", rather than being in opposition to it. Giddens's theory emphasises that structures are reproduced by agents through repetition and routinisation. Midwives complain about the routinised nature of maternity care within the "industrial model", as defined by Begley (1997), although some routines have been abandoned (such as routine perineal shaves and enemas on admission to the labour ward). As discussed above, it is also necessary to take account of midwives relative ability to enact their agency, based on subordinate

position within the maternity care system. Midwives need support and guidance on how to reproduce their type of women-centred care across the current system and educators and leaders need to provide this. This whole area of the interaction of midwives with their environment needs further exploration with midwives and birthing women, as recommended in chapter 8 (see page 274). In particular how midwives identify with the system and their part in shaping it should be examined.

Also within this domain, approximately two-fifths of midwives stated that they practise midwifery-led care. Interpretation as to what “midwifery-led care” entails was open to the respondents and they may have interpreted this in various ways. This could range from conducting deliveries themselves, albeit under medical-led care, to fully independent midwifery practice. In between, there are many possibilities. Given that there are very limited, though increasing, opportunities for full midwifery-led care, this finding is perhaps positive, in that midwives are identifying their practice as midwife-led, even within the constraints discussed above. This is positive in terms of midwifery identity within that environment, but negative since the limits of practice are accepted. Further study of the extent to which midwives can and do push the boundaries which they perceive as constraining their practice would elucidate these issues.

Another item within this domain relates to collegial support. The perceptions of high levels of collegial support are consistent with Pitman’s (2004) findings on this item. The inclusion of the item relating to collegial support in the Women-centred practice domain highlights the role that this support plays in enabling midwives to practice in this way. However as Begley’s (2001b) findings about student-staff hierarchies suggest, this support may be less inclusive than might ideally be the case. Similarly Daski’s (2004) findings (see page 60 above) suggest that nurses “eating their young” applies to both students and new staff who had trained and gained experience elsewhere. Hunt & Symonds (1995 p67) describe the importance of the production of a collective identity, whereby “individuals entering the labour ward from other practice areas learned what is preferred, what is tolerated and what is frowned upon”. Clearly there is pressure to “fit in”. This may be more difficult for those who trained abroad. This was described in the comment of a midwife who responded to survey 1 above (see page 170). On the whole, though, the positive nature and extent of collegial support offers an optimistic perspective, within the current context of change and development in midwifery. The

recent findings of the Inquiry into the Lourdes Hospital mentioned at the start of this thesis highlights the real need for support and a willingness to back colleagues up when necessary. This needs to extend to those who are “new” to the particular setting, those who trained overseas, and to students. This may be a challenge given the divide-and-conquer (Freire 1970) approach of those who dominate subordinate groups. This could apply to midwives’ treatment by both those outside the profession such as doctors and also within, such as senior and other managers. In such a climate within which support is not offered, self-protection might seem more of a priority than collegial support. The need for unity and collective support, and the need to value these, is a challenge that can be facilitated through leadership and education and this is returned to below (see page 270).

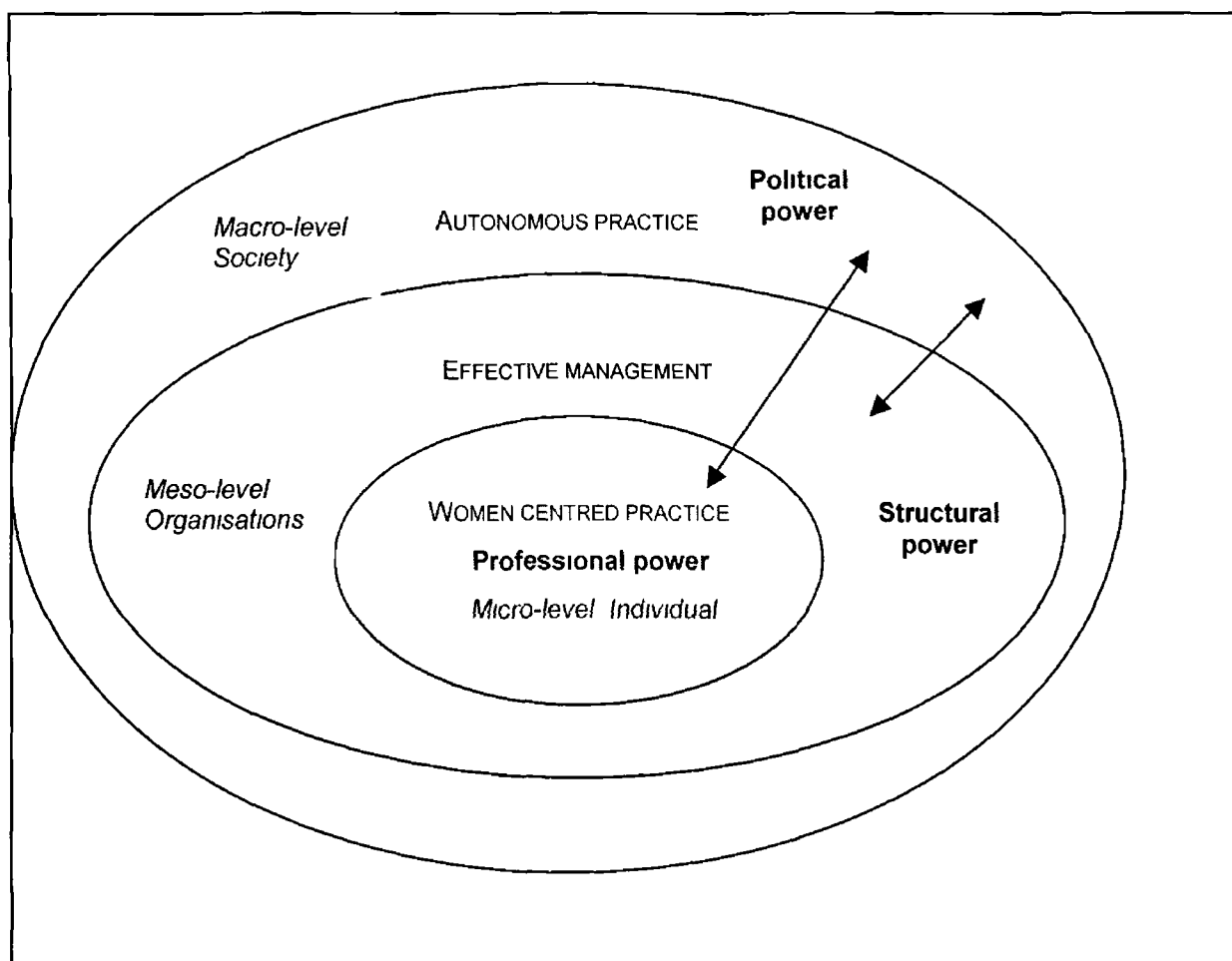
The final item in this domain relates to having adequate skills for practice. In survey 1 the item relating to skills was rated as crucial to empowerment by the highest percentage of midwives (84.9%) and it was also the highest ranked item. In survey 2, most midwives reported that they perceived that they are adequately skilled (88.2%). Linked with this, though not retained within this factor solution, they also perceive themselves to be adequately educated for practice (82.4%). The comments relating to education in the additional comments section of the questionnaire mostly referred to problems with accessing study days because of staff shortages. This issue was cast as one which reflected managers’ inability and unwillingness to respond appropriately. In addition, just over one third felt that they did not have adequate access to resources for staff training and education. This suggests a picture whereby although midwives feel that they are adequately skilled and educated for practice, there are some problems with accessing the resources to undertake further training and education. At one level this may appear contradictory, although it may also link with midwives’ acknowledgement that they must continuously update their skills and knowledge. Midwives may also be judging their levels in relation to the limited use of those skills within the current service delivery model. It has been highlighted that in order to take up the challenges afforded by recent developments in midwifery-led care, midwives need to expand their skill and education level (Commission on Nursing 1998, Expert Group on Midwifery and Children’s Education 2004). With the integration of midwifery education into the third level sector, further education and research opportunities will be presented to midwives. If backed-up by the provision of adequate resources and support, these

should continue to enhance midwives' capacities to take on new challenges. Again, these midwifery skills need to be valued by midwives and others so midwives can play their optimum role in maternity care.

In summary, within this domain, midwives perceive that they are practising according to the values that they espouse, in terms of delivering skilled women-centred care. Establishing whether or not they are delivering this care is beyond the scope of this research. However, this is important in terms of the outcomes for birthing women and requires further study. Further research which explores birthing women's perspectives in addition to midwives' perspectives would supplement these findings. Another aspect that needs further exploration relates to the meaning to midwives and birthing women of some of the items in this domain, for example *empowering birthing women* and *advocating for birthing women*. These issues are further discussed in Chapter 8.

Three domains of empowerment in midwifery have been shown in the above discussion to be linked with three types of power: political, structural and professional power, operating at macro, meso and micro levels respectively. This is illustrated in Figure 7.3 overleaf.

Figure 7.3· A graphical representation of the conditions important for empowerment in midwifery



This representation highlights that midwives in their everyday practice exercise their own professional power. At the organisational level there is an emphasis on the role and effectiveness of managers, based in structural power relations. There is also a need for an awareness and engagement with political and patriarchal power, which ultimately manifests in the policies that influence the scope of midwifery practice. This portrayal of the levels of power operating for midwives draws on Farrell's (2001 p27) advice about the consideration of the interconnectedness of these three levels of analysis (interpersonal, organisational and macro levels). Farrell suggests that focusing on this interaction rather than just on one level proves more useful in explaining the complexity of workplace interactions. This is particularly relevant for the study of empowerment. This analysis builds on the analysis of the debates about the interaction of structure and agency and the ecology of empowerment in chapter 3. There, it was argued that

ultimately power is exercised through the individual and/or collective agency of persons, since only people and not structures can act, decide and reflect. Within this analysis, therefore, the power of midwives as professionals is exercised through their practice on an interpersonal level and it must extend beyond this to affect the structures and policies which shape that practice, hence the two-way arrows in the figure of the graphical representation. If midwives are seeking the recognition of their professional identity, then their own power to influence such recognition needs to take place at the organisation and social levels, as well at the interpersonal level. The subordinate position of women and midwifery at social and organisational levels means that this is not easy to achieve and support and leadership is required (see page 270). Figure 7.3 encapsulates the domains of empowerment in midwifery as identified by midwives and links these to the wider debates about power and empowerment. These domains also comprise the *PCEMS* and the results for this scale are discussed in the following section.

7.2.3.1.4 Levels of perceived empowerment using PCEMS

The three domains of empowerment discussed above also comprise the three sub-scales of the *PCEMS*. The *PCEMS* scale thus comprises 18 items, with 6 in each sub-scale. Within the scoring system developed for this study (see Table 7.12 page 198) there is a possible range of scores between three and 15, with a mid-point of nine. A low *PCEMS* score (of six or lower) signifies high perceived empowerment and vice versa, with a high score (of 11 or higher) representing low perceived empowerment. Accordingly, analysis of responses to this scale suggested “high” levels of empowerment, with a mean score of 7.20. This is lower than the midpoint (nine), suggesting higher than mid-point empowerment. This summary statistic of central tendency, while of interest, conceals the varied and complex pattern of responses to individual items and to groups of items within the three domains discussed above, as measured with the *PCEMS* sub-scales.

Mean scores were also presented for the sub-scales. The possible range of scores on each of the sub-scales is one to five with a mid-point of three. Again, a lower score indicates a higher level of perceived empowerment. The results show that midwives had highest levels of perceived empowerment within the Women-centred practice domain/sub-scale (Mean of 2.07, SD 0.563), the lowest level of perceived

empowerment within the Effective Management domain/sub-scale (mean of 2.58, SD 0.786). The mean score on the Autonomous Practice sub-scale (2.55, SD 0.684) indicates just slightly higher perceived empowerment in that domain than in the Effective management domain. These scores reflect the results for individual items and the domains discussed above. In other words the higher levels of agreement with the items in the Women-centred sub-scale is reflected in the higher level of perceived empowerment in this domain. This links with the discussion of the domains and their constituent items above. The scoring mechanism offers a means to summarise the overall results.

7.2.3.2 UWO Scales Results

The UWO Workplace Empowerment Scales comprise the Conditions for Work Effectiveness Questionnaire (CWEQ) (whose sub-scales cover access to opportunities, resources, information and support), the Organisational Relationships Scale (ORS) which measures informal power and the Job Activities Scale (JAS) which measures formal power.

The overall picture gained within the results of the CWEQ in survey 2 is quite negative. There were very low levels of perceived support from managers. For example, within the Support sub-scale, just 5.4% (n=13) reported that they received “a lot” of specific information about the things they do well. Within the Resources sub-scale, fewer than 1% (0.8%, n=2) of respondents said that they had “a lot” of time for paperwork, and only 3.3% (n=8) said they acquired “a lot” of temporary help when needed. Midwives reported that they had low levels of information about their organisations, which suggests a lack of involvement in organisational matters. Opportunity sub-scale scores were slightly higher than the other three sub-scales scores. The items within the Opportunity sub-scale (relating to challenge, learning new things) suggest why this might be so. Midwifery is seen as a challenging profession in which chances are offered to do new tasks and learn new things, a positive attribute. Within such an environment of learning, growth and change, support is all the more critical, as discussed above. The overall negativity of the findings on management support in this study must be borne in mind in ensuring that midwives continue to take up new tasks and learning opportunities. This need is reflected in the recommendations made in Chapter 8 (see page 271).

Within the ORS, there were low levels of perceived rewards for innovation, little perceived flexibility in the job and low job visibility. Within the JAS, there was an only slightly brighter picture, with just over one quarter having “a lot” of collaboration with doctors. Therefore, just under three-quarters of midwives perceive that they do not collaborate a lot with doctors. This is not so promising, since inter-professional collaboration is essential to the very basis of midwifery’s scope of practice. Collaboration implies mutual respect and recognition. These results link with the others findings on the *PCEMS*. There, midwives reported their perceptions of low levels of recognition for their contribution to care and the extent to which they are listened to by team members.

Within the two global empowerment items, the negative picture continues, with just half agreeing that “overall, my current work environment empowers me to accomplish my work in an effective manner” and one third that “Overall, I consider my workplace to be an empowering environment”. While they are strongly correlated, the results for these two items suggests that midwives made some distinction between them. The more positive response to the first global item suggests that midwives may have been responding to the part which refers to their capacity to “accomplish their work in an effective manner”. Linked with social desirability, midwives may be less willing to imply that they are not achieving their work effectively. They might tend to portray more negatively their perceptions about the item that refers to their “environment” but not to them or their work directly. It is not possible to ascertain this from the data, and as stated above, both results, which are in any case strongly correlated, are quite negative which is perhaps the more important point.

Overall the UWO results depict a rather bleak picture, with the absence of many conditions considered critical for empowerment. For example, positive feedback is a key motivating factor for empowerment (Conger & Kanungo 1988). Its absence appears to reflect a culture where blame rather than praise is the norm. Kirkham (2004) recently highlighted this issue and called for the expression of deserved praise to become part of midwifery culture.

Equally, resource issues affect morale and a sense of control over one's work. These findings link with those in the *PCEMS* about resources, in which midwives reported low levels of access to resources for birthing women. Further research is needed into the resources over which midwives seek control and why they do not perceive that they have access to these resources (see page 276).

7.2.3.2.1 *Comparing UWO Scales results in surveys 1 and 2*

The UWO Work empowerment scales were used in both surveys. The results from the two surveys are similar both in the levels of empowerment recorded on all of the scales and in the patterns within the scales. The survey 2 mean scores on CWEQ are compared with the scores from survey 1 in Table 7.25. The lower sample size in survey 1 is acknowledged in this context. As with survey 1 in 2002, the mean score for the opportunity sub-scale was higher than the other three CWEQ sub-scales, support, information and resources. However these differences are almost negligible.

Table 7.25. Mean scores for CWEQ Scales: comparison between surveys 1 and 2

	Sub-scale		CWEQ	Opportunity	Information	Support	Resources
	Scale options		4 to 20 low to high	1 to 5 none to a lot	1 to 5 none to a lot	1 to 5 none to a lot	1 to 5 none to a lot
Survey 2		N	242	243	242	242	242
		Missing	2	1	2	2	2
	Mean		11.62	3.89	2.60	2.53	2.60
	Standard Deviation		2.36	0.76	0.87	0.98	0.73
Survey 1		N	95	95	95	95	95
		Missing	0	0	0	0	0
	Mean		11.33	3.74	2.58	2.48	2.53
	Standard deviation		2.98	0.815	1.11	1.10	0.85

The mean scores on the JAS and ORS are also slightly higher in survey 2 than survey 1 (see Table 7.26). In both surveys the ORS score is higher than the JAS scores. This reflects the pattern in many nursing studies which have used these scales (Laschinger 2006).

Table 7.26. Mean scores for JAS and ORS Scales: comparison between surveys 1 and 2

			Job Activities Scale	Organisational Relationships Scale
		Possible range	1 to 5 none to a lot	1 to 5 none to a lot
Survey 2	N	Valid	242	242
		Missing	2	2
	Mean		2.64	3.32
	Std. Deviation		0.82	0.88
Survey 1		Valid n	87	95
		Missing	8	0
		Mean	2.59	3.18
		Standard deviation	0.95	0.92

The same distinction was made between the two global items in both surveys, whereby more midwives agreed with the first global item (“Overall, my current work environment empowers me to accomplish my work in an effective manner”), 49.5% in both surveys 1 and 2, than with the second item (“Overall, I consider my workplace to be an empowering environment”), to which 31.2% agreed in survey 1 and 33% in survey 2. As discussed above, the possible distinction between these two items might be linked to the external nature of the latter one.

The results on the UWO Scales (CWEQ, JAS, ORS, global items) are remarkably consistent over the two surveys conducted in this study. These results are also consistent with almost all nursing studies that have used these scales (Laschinger 2006). This consistency was discussed above in terms of previous research which had used these tools (see page 53). One interpretation offered is that these conditions themselves were similar across time and place, hence respondents’ consistent reported perceptions. It could be suggested that, for example, low levels of management support were consistent across nursing, regardless of geographical or clinical setting. This is proposed as a plausible interpretation, given nursing’s traditionally hierarchical, autocratic management style. This proposition can be even more readily applied to midwifery in an Irish context, given the literature on midwifery management (Begley 1997, Pitman 2004). Begley (1997) suggests that it would appear from the statements of the students

in her study that bullying is an even greater problem in midwifery in Ireland than in nursing which may be due to the even more hierarchical nature of the midwifery profession. Therefore, within this example regarding management, consistency over time is conceivable.

7.2.3.3 Analysis of variance results

Mean scores on the *PCEMS* and *CWEQ* were tested for variance according to key demographic variables. On both *PCEMS* and *CWEQ*, grade showed significant variance: higher grades were linked with higher perceived empowerment. In relation to *CWEQ*, this is consistent with the results of other studies (Laschinger 2006). Higher grade is associated with greater experience. The *PCEMS* scores also varied by years of midwifery experience. The *CWEQ* also showed higher perceived empowerment with greater experience, but not at a significant level. Experience offers a midwife a more confident base for decision-making and practice generally. Experienced role models will enhance midwifery care. While this is positive, it also highlights the need to be aware of the needs of less experienced staff, particularly in the context of the retention issues identified by Pitman (2004). The need for support and professional development in particular are suggested by the other findings of this study.

The *CWEQ* results also showed significant variance by geographical location of practice. This showed an order of decreasing perceived empowerment as follows: Midlands/Mid-west, East, North-east, South, West/North-west and, finally, with the lowest levels of perceived empowerment, the South-east. Similar patterns were seen with the *PCEMS* scores. There are no obvious reasons for this pattern and it warrants further study. The maternity services in the Midlands/Mid-west are provided in one maternity hospital and two maternity units in general hospitals. A mix of settings is therefore reflected in the result for those regions. Further examination of local practices in these sites might offer useful ways of enhancing midwifery practice elsewhere. In the north-east and east there are developing opportunities for midwifery-led care but this is also the case in the South-east with the integrated service offered by Waterford Regional Hospital. Without further local knowledge and research it is not possible to ascertain from these data why these patterns exist. Research using *PCEMS* with adequate samples focusing on particular regions with the reported high and low levels of perceived empowerment might elucidate this suggested pattern (see page 272 below).

7 2 3 4 Psychometric evaluation of the *PCEMS*

Complemented by the findings using the *PCEMS*, the UWO results offer insights into particular structural conditions which have been demonstrated to contribute to empowerment. The CWEQ and *PCEMS* mean scores correlate at a moderate level. This suggests concurrent criterion validity for the *PCEMS*. Further, the *PCEMS* provides a means to collect data that is specific to midwifery and which captures midwives' perceptions of specific aspects of their role with birthing women. The scale and its three sub-scales are internally reliable and theoretically coherent. The analysis of variance of *PCEMS* scores according to key demographic variables suggests that the scale is sensitive to differences in groups. Irvine *et al* (1999 p92) suggest that the "ability to discriminate between sub-groups is an important psychometric property of an instrument", especially when being used to evaluate organisational change.

The specific purpose of the sampling strategy adopted in survey 2 was to gain results from a national sample of practising midwives. Further testing of the suggestive findings relating to work setting and hospital as well as particular groups, such as CMSs, would appear to be useful. These could be carried out in order to test differences within such areas and also to further psychometrically test the *PCEMS* itself. This scale was newly developed and psychometrically evaluated in this study and as with any new scale, further testing is required with new samples. While these factors are proposed as theoretically and psychometrically sound on the basis of the findings reported above, further studies would confirm the psychometric properties of the scale (see page 272).

7 2 4 *Qualitative data Respondents' additional comments*

The analysis of the qualitative data collected in survey 2 highlights several pertinent issues which link directly with the other study findings. These data contribute to the completeness and validity of the quantitative measures used, as the issues raised are covered by the measures adopted. In addition, they link with the findings of the historical research, for example, in relation to the limited visibility of midwifery and midwifery's weak identity. Overall, additional comments offered by midwives were generally negative. The themes under which the data were presented related to perceptions of poor management and the constraints of the maternity system. These issues have also surfaced throughout the rest of the findings of this study. For example,

within these qualitative data, there was an acknowledgement of the complex “system” surrounding maternity care, as well as the more well-rehearsed expression of the “medical model” Invoking the perils of the “medical model” belies the complex processes and relations that underlie maternity and midwifery policy-making In particular the patriarchal nature of the state as discussed in chapter 3 provides a fuller and broader explanation for midwives’ subordination The historical data presented in chapter 5 illustrate this clearly, whereby the role of medicine was seen to be a more covert influence on midwifery policy and direction than that of the Department of Health’s successive Ministers and civil servants The apparent lack of midwifery identity and lack of state recognition and awareness about midwifery around the time of the 1959 Act sets the context for explicit government maternity policy which supported medicalisation of maternity care from the 1970s (see page 11) While the notion of a “system” is also an amorphous entity, this term gives an impression of complex connections and networks not conveyed in the “medical model” characterisation This model may indeed be reflected in Irish maternity care provision, but the complex system which upholds it is a more appropriate focus of attention This study’s findings illustrate and emphasise this complexity

The qualitative data also facilitate the expression of the emotive and compelling voices of some midwives who feel disillusioned with the system in which they work Negative perceptions about ineffective senior midwifery management links with Pitman’s (2004) findings relating to the three Dublin maternity hospitals As in Pitman’s study, staff shortages were seen as a major concern and managers’ inability to address this was criticised When education was mentioned, it was only in relation to the difficulties faced in accessing what was available because of staff shortages They nonetheless saw themselves as highly educated and skilled for practice There is little doubt that continuous education is important to midwives’ ongoing professional development In a nursing context, Erbin-Roesemann & Simms (1997 p183) highlight the organisational responsibilities for education They state that “empowerment, personal and group, reaches full potential in enabling environments that are designed to nurture continuous learning by all workers” This emphasises the structural conditions important for education, through which an individual’s motivation for further education is facilitated It also finds echoes in the importance, for empowerment, of an enabling environment found in Scott *et al* (2003) Midwives in both surveys emphasised the structural rather

than individual barriers to continuing education and up-skilling. However, although support and facilitation are important, clearly self-motivation for learning, self-direction and a desire for continuous education are also critical influences on the extent to which midwives engage in continuous education. An emphasis on external factors can be influenced by low morale and other intrinsic elements of work-based satisfaction, such as feelings of being valued and recognised. When these are absent, then there can be an emphasis on extrinsic aspects of work such as pay, conditions and study time. More interestingly, midwives reported within *PCEMS* that they are skilled and educated for practice. This raises questions as to what their unfulfilled education and training needs are. This may be a need for continuous education, consistent with good practice. Further research would elucidate the extent and nature of barriers to education, should they exist. This is further discussed in chapter 8.

Midwives also expressed their concerns about their limited visibility and the lack of public awareness of the midwife's role in society. While complaining about their lack of identity, some midwives in both surveys refer to themselves as nurses. Symonds & Hunt (1996 p206) similarly state that the public image of the midwife is confused. This includes midwives being called nurses. The issue of the title "midwife" was central within the historical findings of this study presented in chapter 5. Central to the concerns of the Central Midwives Board members was the proposed abandonment of the term midwife in the 1950 Nurses Act. Once this issue was highlighted in the 1949 Nurses Bill, they focused their attentions on saving the term, and the very identity, of the midwife. Within the Oireachtas debates, Minister Browne referred to this as merely a matter of nomenclature, though clearly it was much more than this. If the term midwife had been abandoned at that stage, then given the longevity of these matters (such as the "nurse includes midwife" clause), there might be no "midwives" in Ireland. However, even those who resoundly defended midwives' distinct identity sometimes used the term nurse instead of midwife. This discussion is not just about a name or title, it is about identity and visibility in terms of external recognition of that identity. It is also about self-identity and the recognition, articulation and demonstration by midwives of their distinctiveness. Traditionally midwives have been eager to describe themselves as "practitioners in their own right". Hunt & Symonds (1995 p29) highlight the need to unpack this phrase which is "so often taken for granted". The phrase is repeated by one of the midwives in this study in her additional comments in survey 1 (page 169). For

this to be meaningful for midwives and women, midwives must demonstrate that this is what they are, through their practice. If they are not, then this phrase becomes hollow. This is illustrated in Jowitt's (1993 p163) cartoon which shows a midwife declaring "yes - I'm a practitioner in my own right". A new mother then asks "could I go home please?", to which the midwife replies "you'll have to ask the doctor - it's up to him". The cartoon clearly incorporates the gendered nature of these power relations, with a male doctor rather than the female "autonomous" midwife having decision-making power over the woman. Midwives have complained about not being able to "discharge" women post-natally (Commission on Nursing 1998, An Bord Altranais 1999). However, recognising that one's claim of independent practitioner status is not borne out in reality either means abandoning that claim or seeking to make it happen. It could be argued that the notion of this practice is a legacy from the past that does not fit with the modern organisation of maternity care and doctor-led modern health services generally. The findings of this study suggest that midwives still identify with the stated values of midwifery, in terms of women-centred midwife-led care. They must work to achieve this, while acknowledging that the historical and structural contexts of their practice make this a challenging goal. Hunt & Symonds (1995 p30) also highlight the strong socialisation of midwifery recruits relating to the use of phrases such as "practitioners in our own right". In order to lay claim to having a distinct identity to nursing, midwives must practise in a way that distinguishes them from nurses. This distinctiveness is reputed to be related to being able to practise "without a doctor", as the Central Midwives Board members, especially Dr Falkiner, repeatedly pointed out (see chapter 5). Until the recent midwife-led initiatives, this was not a reality for midwives practising in Ireland in the latter half of the twentieth century. Now midwifery-led practice is a reality, for those practising within these services. Those involved in the ongoing midwifery-led developments can also provide leadership to the midwives who work in consultant-led services. Midwives can enhance their own practice and the experience of birthing women by the effective exercise of their professional, organisational and political power.

7.3 Conclusions

Taken together, the findings of both surveys undertaken within this study offer a comprehensive picture of midwives' perceptions of their practice and practice environment. This research has highlighted the domains of empowerment in midwifery.

as Autonomous practice, Effective management and Women-centred practice

These domains also constitute the three sub-scales of a tool developed to specifically measure midwives' perceptions of their own levels of empowerment, the *PCEMS*. This tool was developed and psychometrically evaluated within this study and offers a way of assessing the impact of future practice and educational development in midwifery in Ireland and elsewhere.

The structural and historical contexts also described in this study allow these findings and those of other studies to be more fully and contextually interpreted. Many of the perceived constraints on midwifery practice are linked with the historical legacy of midwifery's lack of identity, in Ireland in the twentieth century. The historical analysis in chapter 5 points to midwives' unsuccessful attempts to play a central role in decision-making about the future directions for midwifery in Ireland. Recent delays with enacting the Nurse and Midwives Act suggest that this may be ongoing. On the other hand, several recent key developments within midwifery in Ireland suggest a more optimistic future. Specifically, these include the integration of midwifery education into the third level sector, the midwifery-led initiative and research programme in the North-east and the other midwifery-led care initiatives across the country. Within the context of such developments, these research findings offer a way of highlighting midwives' perceptions of their practice and practice environments, viewed through the lens of empowerment. This can enable midwives, educators and policy-makers to build on existing strengths and address identified weakness.

These survey findings are analysed within a framework which draws from various theoretical perspectives. The postmodern views of dispersed power highlights the power that midwives exercise in their relationships with women and other professionals. This is consistent with Giddens's theory of structuration which emphasises the role that midwives themselves play in the reproduction of structures and systems within which they practice, while also being aware of the gendered nature of these systems and structures. This underlines the opportunities which rest with midwives to enhance practice environments for women and for their own workplace experiences but also the need to facilitate the enactment of this agency by supporting and providing leadership to midwives. Recommendations from this research and suggested topics for future research are outlined in Chapter 8.

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

Prefer what is positive and multiple,
difference over uniformity,
flows over unities,
mobile arrangements over systems

(Foucault 2001 p109)

This is an exciting time for midwifery in Ireland, with many unique practice and education opportunities on offer. These include the development of evidence-based midwifery-led services and the integration of midwifery education into the third level sector. This research provides a picture of the past and present in Irish midwifery, which sets the context for the current welcome developments. With greater awareness, understanding and action relating to issues of power and empowerment, midwives can better take up the current and future challenges and fully contribute to the evolving Irish maternity care system. This concluding chapter highlights the key findings and conclusions of the study, which contribute to a greater understanding about power and empowerment in midwifery. Key recommendations based on these findings, point the way to the future. Areas requiring future research are highlighted.

8.1 Key findings

The key findings of the study will be highlighted using the framework of the domains of empowerment identified in this research: Autonomous practice, Effective management and Women-centred practice.

8.1.1 *Reclaiming autonomous practice: the need to be politically effective*

The first domain, **Autonomous practice**, encompasses items related to being recognised by the medical profession, having autonomy, having control over practice and having access to resources for birthing women. This takes place at the macro or social level. It involves political power, in the sense of informal and formal politics. This shapes the scope and nature of midwifery practice, since it defines by whom and how maternity care will be delivered at the macro level. Within this first domain, midwives reported both positive and negative perceptions. In particular, they perceive

high levels of recognition as professionals by doctors. On the other hand, midwives perceive that they have low levels of autonomy and control over their practice and that they do not have adequate access to resources for birthing women (see page 188). These deficits are linked with the very context of midwifery practice within hospital-based maternity care. A blanket policy of obstetrician-led care means that midwifery autonomy, as defined internationally, has been necessarily limited. Within this overall context, midwives may experience control over practice differently. For example, night-duty was given as an example which enhances the midwife's ability to practice autonomously, given the reduced number of doctors and managers around. This was echoed in the findings of Hunt & Symonds (1995). Nonetheless there are significant problems raised by these findings in terms of midwifery role fulfilment and identity.

The Autonomous practice domain links directly with the midwifery recent history as analysed in chapter 5. The extent, nature and effects of patriarchal medical involvement in midwifery regulation were clarified by this historical research. It is unsurprising that medical men controlled the Central Midwives Board, given the prevailing cultural and social norms. Undoubtedly, this was seen by medical men and prominent midwives as the only option at the time, since a midwife-controlled profession was unthinkable at that point in history. The medical men who were associated with the Central Midwives Board defended the independent status of midwives, while also defending their right to regulate them, within a strategy of demarcation of maternity care. Internationally, as well as in Ireland, the subsuming of midwifery into nursing regulatory bodies has been lamented by midwives (Donnison 1988, Van der Kooy 1998). This historical research highlights the tensions that existed historically between those who are involved in the regulation of midwifery and of nursing, and the control of medicine over both of them (see page 138).

At the political level, this study suggests that unless midwives are united, visible, vocal and form useful alliances, their causes will go unheard. The historical developments described in chapter 5 both reflect and perpetuate midwifery's lack of visibility in the past. While the particular historical circumstances no longer prevail, the overall nature of the system remains scarcely changed and midwives remain subordinate in a patriarchal system. Lessons learnt from examining that past can still be useful. By highlighting the unintentional influences and outcomes of policy-making and

implementation, the inevitability of current arrangements can be challenged. When the proposal to abolish the Central Midwives Board was being discussed, one Board member asked if they (the Central Midwives Board) could not go to “the midwives”. Dr Falkner had replied that “there was no Midwives’ Institute in Ireland”. The Midwives’ Section of the INO is the most visible face of midwifery in Ireland currently. It is not suggested that this body is deliberately harmful to midwifery, but that arguably a nursing trade union cannot serve to highlight the separateness and distinctiveness of midwifery in the way a dedicated midwifery body could. Because of the predominance of nursing and medicine over midwifery, illustrated in these findings, the visibility of midwifery leadership has been understandably limited. As with the historical developments described above, this is a self-perpetuating cycle whereby existing invisibility is both reflected and reproduced by policy changes that do not take account of midwifery’s distinctiveness. However what the analysis of the maternity structures and of the history of midwifery also shows is that positive change for midwifery is possible. In the past this was shown when the term “midwife” itself was retained at the last minute (see page 124). More recently midwifery-led initiatives show the possibilities for very positive though seemingly difficult change to occur.

Critically, midwives need to address particular aspects of the Irish maternity care system such as the extent and effects of private obstetric practice. Women’s choice of private care, for reasons of accommodation and continuity amongst others, needs to be acknowledged and alternatives pursued by midwives with birthing women. Midwives individually and collectively need to tackle the issues that down-play midwives’ roles. For example, continuity of midwifery care is being made possible through the various midwifery-led initiatives currently in place. The fact that midwives are embracing these changes where they are happening is positive and can be built upon. This is consistent with the midwives’ positive perceptions of their own practice found in this study.

The historical findings of this study provide a greater understanding of the broader social and political contexts from within which current midwifery practice has evolved, both in terms of midwifery’s professional identity and its structural conditions. It highlights the complex and contingent power relations and processes involved in specific episodes within midwifery’s history. It also highlights the need for midwives to be politically aware and involved, while acknowledging the difficulties that this

involves, given its historical legacy. These findings also highlight the powerlessness of midwifery leaders (even medical men) to control the destiny of midwifery regulation, and therefore the future direction of midwifery. In one sense, the involvement of the medical profession seems a less overtly important factor in midwifery's powerlessness during the episodes outlined, than does the role of the civil servants responsible for drafting legislation that would bring about the abolition of the Central Midwives Board. However, the role of the midwife had been in decline since the eighteenth century, due to the emergence of men-midwives, later obstetricians (see page 43). It is this long-range historical perspective that needs to be borne in mind. Nonetheless, the episodes during the twentieth century, analysed within this research, illustrate the more recent manifestations of the demise of visibility of the midwife and midwifery.

The two episodes which were the focus of this historical research relate to efforts of Central Midwives Board members to retain the power to regulate midwives, and, when unsuccessful, their subsequent efforts to regain that power. The nature of regulation is critical to a professional group and indeed it was considered a defining "trait" of a profession (Johnson 1972). However, the events described are also significant in a wider sense. The lack of consultation with midwives, evident in the background to the Nurses Act 1950, point to a lack of acknowledgement of midwifery's distinctiveness. It also suggests a lack of recognition of the ability and appropriateness of its leaders, at that time the members of the Central Midwives Board, to contribute towards decisions about the future of midwifery. What is clear is that midwifery's identity was not strong enough to withstand competing interests. It does not appear to be appropriate to ascribe blame for the lack of midwifery visibility to the abolition of the Central Midwives Board. Rather, it appears that midwifery's lack of visibility prior to its abolition influenced the way in which events relating to its abolition unfolded. The Central Midwives Board also fell foul of the broader public health plans of the Department and successive Ministers for Health, which were noble in themselves. The particular historical circumstances were of critical importance to the way the events played out. These included Ireland's political transition from colonial status and the plans for a national health service in the UK. Ireland missed out on the "nationalisation of care for women in childbirth" (Hunt & Symonds 1995 p15) which the establishment of the National Health Service brought about in the UK.

The nature of the role of politics in midwifery regulation and the unintended consequences of policy in one area on another was illustrated within the episodes described. There are also important lessons that can be learnt about the contingent nature of policy-making, when for example, with the assistance of Senator Bigger, the son of the first Chairman of the Central Midwives Board, the very title “midwife” was saved from abolition at a very late stage in the legislative debate process (see page 124). By engaging in informal and formal politics, midwives can enhance their identity and enhance midwifery practice and maternity care. Experience from other countries shows that women and midwives working together for positive change to the maternity services are likely to be more effective than either group working alone. The need to embrace this shared effort is a key challenge facing midwives in Ireland.

8.1.2 Effectively managing midwives: the need for support

The second domain in the model of empowerment in midwifery is **Effective management**. This covers items relating to being supported, valued and backed-up by management, having effective communication and being informed about organisational changes which affect practice. This domain relates to the “meso” or organisational level of analysis (Farrell 2001). The focus within this domain is on structural power or the power that is exercised by those in positions of formal power within organisations. This focus is emphasised within the organisational or structural perspective on power and empowerment in organisations that was supported by Kanter (1977, 1993) and the subsequent work by Professor Laschinger and her teams in their empowerment programme (see page 52). This perspective was explicitly used in this study, through the use of the UWO Workplace Empowerment scales in both surveys. It is found in the *PCEMS* in this domain of Effective management. While the *PCEMS* includes this perspective, it also encompasses other domains, thereby offering a more multifaceted perspective on empowerment, consistent with the nature of empowerment as discussed in chapter 2.

This study highlights the lack of, and the need for, a supportive work environment for midwives. This is consistent with the Scott *et al.*'s (2003) model which stresses the role of both individuals and of a supportive environment. Within this domain, this research suggests that there are some critical unmet needs, particularly in relation to low levels of access to adequate support, resources and information. For example, just over half of

midwives perceived that they have supportive managers. Midwives also perceive that there is a lack of reward for innovation, a propensity towards negative feedback and that managers are ineffectively managing midwifery retention. These findings were echoed in both the quantitative and qualitative data.

The picture of generally poor perceptions of managers portrayed by these findings is discouraging. The literature reviewed in chapter 2 suggests that midwives must be supported if they are to support birthing women (see page 25). If midwives are to be supportive, creative and innovative in their care of birthing women, then they need the back-up of managers. Midwives currently perceive that this back-up and support is limited. Identifying and implementing ways of doing things differently - to enhance quality and value for money - are the cornerstones of the current health strategy (Department of Health and Children 2001) and the current health service reform agenda (Department of Health and Children 2006). A culture of innovation will foster the creativity of midwives, as has been evidenced where change has taken place in relation to the development of midwifery-led and community-based services. These results suggest that there is a need to extend the support for innovation to those practice areas where it is currently stifled.

8.1.3 Reaffirming midwifery as women-centred practice

The third domain, **Women-centred practice**, includes empowering and advocating for birthing women, being able to say no when required, being involved in midwife-led practice, being skilled for practice and having collegial support. This domain is based on the interpersonal or micro level (Farrell 2001) within which midwives exercise their professional power, or the power that is based on their professional role. This assertion or exercise of power by midwives interconnects with the meso and macro levels, since it is midwifery action and power, based on midwifery goals and values, that can bring about changes for midwives and women at the other levels.

Midwives in this study perceive that they are delivering women-centred care, as expressed in the Women-centred practice domain described above. They perceive that they have high levels of most of the items in this sub-scale, including empowering birthing women, being an advocate for birthing women and having collegial support (see page 188). These findings provide a reaffirmation of midwifery values and goals, in

that midwives are identifying with these aspects of practice, for example, autonomy and empowerment of birthing women. Despite the constraints they identify, midwives appear to still intrinsically derive satisfaction from their work with birthing women. This is consistent with the findings of other recent research (Pitman 2004).

Focusing on the productive power that midwives do exercise, rather than on that which they are said not to have, creates greater potential for positive change. This is not to deny that there are clear organisational and political issues which need to be addressed. Rather, it emphasises the local, diffused situations within which opportunities are presented for various reasons and from which can flow far-reaching positive developments. The case of the changing maternity services configuration in the north-east of Ireland illustrates this potential. While change might not always come about directly because of planned rational policy, the opportunities offered by particular circumstances can be seized enthusiastically by midwives and birthing women where they suit their purposes.

8.1.4 *Conclusions about the PCEMS*

Mean scores on the *PCEMS* were calculated and these suggested “high” or just above mid-range perceptions of empowerment. The scores on the three factors, or for the three domains, were quite similar, with women-centred practice scores slightly higher than the other two domains. The results across these domains provides a comprehensive picture of how midwives perceive their practice and practice environments. The *PCEMS* and its sub-scales were found to be internally reliable (see page 194). The scale captures the aspects of empowerment which midwives themselves had identified as important. The scale shows concurrent criterion validity, being moderately correlated with the *CWEQ* (see page 203). The *PCEMS* is the first instrument that is specific to midwifery and is based on midwives’ views on what constitutes empowerment for them. It encompasses spheres covered by other workplace empowerment measurement scales, such as the *UWO Scales* (i.e. information, support, information, resources, interaction with other professionals). However its additional strength is that it also covers areas of specific interest and importance to midwifery, such as their relationships with birthing women, collegial support and their level of practice-based skills. For future studies, the *PCEMS* offers a means to measure midwives’ perceptions within a changing midwifery and maternity care landscape.

8.2 Key conclusions

The unique contribution of this study relates to the identification of the conditions important for empowerment in midwifery and the development and psychometric evaluation of a scale to measure midwives' perceptions of their own levels of those conditions, the *PCEMS*. The historical research stands as an account in itself of a critical period in midwifery history and also provides a rich political and historical context for the survey findings.

The **key conclusions** of this study, centred around issues of power and empowerment, are as follows:

- To achieve **autonomous practice** there is a need for midwives to engage effectively with informal and formal politics in order to influence the policy-making that directly affects their practice.
- Within the current changing maternity service and educational context, there is a need for more **effective management** of midwives, within which the support provided to midwives must be enhanced.
- **Women-centred practice** is affirmed by midwives as being important to them and highlights the power that midwives can and do exercise.

The **central thesis** of this research is that there is value in articulating a contextual, empirically-grounded conception of empowerment in midwifery and this has been achieved within this research. This research highlights the merits of studying midwives' perceptions of their own practice and practice environments, through the lens of empowerment, facilitated by the *PCEMS* developed in this study.

8.3 Study limitations

This study has a number of limitations which have been highlighted throughout this thesis. The survey method was appropriately used to gather empirical data, since the aim of this study was to generate generalisable and quantifiable national findings on midwives' perceptions about empowerment. The survey method has some intrinsic and anticipated limitations, relating mainly to its non-interactive nature. The collection of some qualitative data in both surveys allowed for the confirmability and more complete interpretation of the predominantly quantitative data. Nonetheless the limitations of the

survey method and some of its associated problems are outlined below

8.3.1 *Survey sample sizes*

The sample within survey 1 is acknowledged as being small. This was addressed by the larger sample obtained in survey 2. It is not possible to compare the sample profile with a national profile of practising midwives since the latter is not available. Sample size is important in particular for factor analysis and an acceptable 1:1 case:variable ratio was achieved in survey 2.

8.3.2 *Reliability of the PCEMS*

While the internal reliability of the PCEMS and its subscales was established in this study, due to constraints of time, reliability over time was not established for this tool. Further studies using the tool should use test-retest measures of the stability of the tool over time.

8.3.3 *Survey response rates*

The overall response rates to both surveys was almost 50%. For postal surveys this rate is deemed usual and acceptable. The use of the Live Register of An Bord Altranais, the only available sampling frame of practising midwives, had some disadvantages, as non-practising individuals are inadvertently targeted. However this represented the best option in the absence of an alternative national sampling frame which would allow for anonymity and random sample extraction.

Related to this point is a limitation to the extent to which the findings of the surveys are generalisable. As shown in Figure 7.1 above, of the 2,000 questionnaires disseminated, ultimately only 244 were completed by practising midwives. This is linked with the imprecision of the sampling frame used and the lack of an alternative. Improved strategies to target practising midwives more efficiently need to be explored in future studies of midwifery, including those using the PCEMS.

8.3.4 *Scale item generation*

The PCEMS was developed and evaluated as a scale that is specific to midwifery. However as described above (see page 107), the original list of 24 items related to empowerment which were included in the *Understanding of Empowerment Scale (UES)*

in survey 1 were drawn from focus groups which comprised both midwives and nurses. In the focus groups, midwifery and midwives were discussed separately to nursing and nurses by participants. Many of the same issues arose in relation to both midwifery and nursing, such as the role of advocacy and the need for management support. Subsequent to the focus group phase of that study, only midwives' survey responses have influenced the development of the *PCEMS*. Survey 1 provided a means of validating their relevance to midwives, by using the UES. Those results provided the basis for the *PCEMS*, which was further developed and psychometrically evaluated in survey 2.

8.3.5 *Social desirability effects*

All studies in which participants know they are being studied include the possibility of social desirability effects to responses. Only studies which involve deception can claim to rule out these effects. Arguably the anonymity guaranteed in this study might be considered to be a factor that would reduce those effects. On the other hand, there may be a natural human tendency to present oneself in the best light. This is particularly so when the items relate to one's own behaviour and actions. These effects therefore cannot be discounted. Items that relate to others' behaviours or actions or to the "system" may prompt a tendency to present a less socially desirable face. Equally this might tend towards an over-negative portrayal. Therefore, these findings must be taken at face value in acknowledgement that the data sought related explicitly to midwives' perceptions.

Finally, the findings of this study raised many interesting questions and issues which could not be addressed in this study. These merit further study in themselves and are described below in the section which outlines the recommendations for future research (see page 272).

8.4 **Recommendations**

The findings of this study have implications for midwifery and maternity policy, midwifery education, maternity service provision and research.

8.4.1 *Maternity and midwifery policy*

This study highlights the need to enact the awaited Nurses and Midwives Act if, as

anticipated, this re-instates separate statutory recognition to midwifery which was lost in the 1950 Nurses Act. The importance of the effects of legislation on midwifery identity was demonstrated in chapter 5, during the in-depth analysis of the background to and impact of that Act. The Commission on Nursing recommended that amending legislation insert the word “midwife” alongside “nurse” throughout the legislation and that future legislation be entitled Nurses and Midwives Act. The delay in enacting this, notwithstanding the competing legislative pressures on civil servants and government and the recent radical health reform agenda, is symptomatic of the relative powerlessness of the midwifery (and nursing) lobby. This delay affects nursing and midwifery since this legislation is to also cover other aspects of nursing and midwifery regulation such as the composition of An Bord Altranais. It appears critical that the awaited legislation should be enacted at the earliest opportunity. This legislative framework would mark the beginning of the revival of official recognition of the distinctiveness of midwifery, which will then require promotion and celebration, internally, within midwifery, and externally, within society generally.

It is anticipated that the awaited legislation will also re-instate the Statutory Midwives Committee (An Bord Altranais 2003). This study has shown how limited the powers of that Committee were in the past, certainly as judged by former Central Midwives Board members. However, it does involve separate statutory recognition for midwifery, absent since the 1950 Act. As a step, it therefore represents progress, in tandem with the other recent developments in education and midwifery-led care. As stated above, An Bord Altranais has already re-instated a Midwifery Committee, pending statutory recognition for the Committee. To call for a Midwives Board would appear unrealistic, though experience internationally, such as in New Zealand, deems it not impossible. This is perhaps a further and future step in midwifery’s claiming of its place in Irish society.

Related to this, there is a Chief Nursing Officer and a Nursing Policy Division within the Department of Health and Children in Ireland since 1998. The establishment of this division evolved from a recommendation of the Commission on Nursing for an increase in professional input into nursing and health policy-making (Department of Health and Children 2003b). This was welcome for nursing, since prior to that, nursing policy making received little direct professional formal input from nurses. There is a midwifery adviser, alongside advisers for each of the branches of nursing. These

midwifery advisers have been drawn from midwifery leaders and their input is undoubtedly valuable. Ideally a Midwifery Division should be established to highlight and promote midwifery as distinct from nursing. This would link in with the other current developments in midwifery services and education and the proposed legislation to recognise midwifery separately. The lack of such a division perpetuates the subsuming of midwifery within nursing. If this recommendation cannot be implemented then at least renaming the current division as the Nursing and Midwifery Division would highlight the two professions.

8.4.2 Education

These findings are presented at a time of significant midwifery educational change and development. The integration of midwifery education into the third level sector offers a welcome opportunity for enhancing midwifery practice, education and research. This also brings challenges, as new educational qualifications and methods may feel threatening to those who trained and practised as midwives in the older “school”. There, little critical analysis of practice was tolerated, much less promoted (Begley 1997). This research highlights certain problems within midwifery such as a lack of perceived reward for innovation and little management support and back-up. Within this culture, change is not necessarily positively received. Management of the changing education delivery and orientation has been facilitated by the partnerships between hospital-based midwifery schools and third level institutions to date. These relationships and those between clinical and education partners need to be fostered, supported and evaluated within the evolving midwifery education configuration. Some of the lessons learnt during the integration of nurse education into the third level sector since 2002 will assist with the midwifery transition (Expert Group on Children’s Nursing and Midwifery Education 2004).

The need to prepare and support midwives so that they can enact their agency and can promote and provide the women-based approach endorsed in this study places an onus on educators to provide education in style and content that takes account of the gendered and medicalised contexts in which midwives practice. The integration of midwifery education into the third level sector adds impetus to this need and provides the opportunity to provide the critical and reflective teaching and learning associated with third level scholarship and research. The pre-registration midwifery degree which

begins in 2006 provides an opportunity to prepare for practice midwives who do not come with the baggage of medicalised general nursing and health services. Thus the values of women-centred care can be situated centrally in midwifery education. In acknowledgment of the strong socialisation forces of maternity services as they currently operate, approaches to learning that are based on the dialogical, transformative or “liberatory model of education” (Freire 1993 p60) and not on the “banking concept of education” which involves the transfer of information should be promoted. Enquiry and problem-based learning approach will develop the cognitive and solution-focused capacities of individuals to equip them for real-life situations. Specific focus on communication and interpersonal skills will equip midwives in their professional practice. Additionally focusing on theoretical and practical learning within the areas of sociology, gender, politics and policy-making can address the social level at which midwives also need to be active in order to influence system-wide changes. These areas and styles of education need also to be central to the further education and professional development of qualified midwives to assist them in dealing with the current changes in education and opportunities for practice development.

8.4.3 *Maternity service provision*

There are clear implications from this research for those who manage the maternity service organisations within which midwives practice. Notwithstanding the macro maternity policy which guides service provision, there are clearly also organisational level issues to be addressed. The most compelling issues relate to perceived problems with management, which mirrors the findings of other research (Begley 1997, Pitman 2004). This study offers national quantitative data which supplements those other studies’ more focused designs. There were particularly negative perceptions about senior midwifery management. Within the medicalised maternity care system, midwifery managers may feel powerless themselves. In historical terms, midwifery leadership has proven limited in its effectiveness, as shown in chapter 5.

Effective managers provide leadership to midwives, though the evidence of this study would suggest that ineffective management is more common and is unlikely to provide leadership or role-modelling. Midwives also related problems such as staff shortages to ineffective midwifery management. Managers need to be aware of and transparent about their own limits (for example, staffing levels), which may be set by external constraints,

and also to challenge these limits. There is a clear need to continue to provide management development initiatives so that managers can in turn support midwives.

8.4.4 *Recommendations for future research*

This study has contributed towards greater understanding of how power and empowerment can be understood in a midwifery context. It has also raised many issues which could not be explored by this study. The integration of midwifery education into third level institutions should enhance midwives' research awareness, capacity and opportunities. Areas requiring further research highlighted by this study relate to future use of the *PCEMS*, research into various aspects of midwifery practice, and historical research.

8.4.4.1 Further studies using the *Perceptions of Conditions for Empowerment in Midwifery Scale*

The *PCEMS* was developed and psychometrically evaluated in this study. This study supports its theoretical and psychometric validity and reliability. Further testing of the scale is required, as with any newly developed scale. In particular, research in other countries, including comparative research, would be valuable. In addition, as identified above, further studies should test the scale on larger appropriate sub-groups, especially where this study has suggested tentative relationships. Groups on which a focus would be interesting might include Clinical Midwife Specialists, community-based midwives and larger samples from various geographical regions. Comparative analysis could be carried out, ensuring adequate sub-group sample sizes using power calculations. Equally pre and post intervention studies could be carried out, where a particular practice-related change is planned and carried out. Measuring changes in midwives' perceptions of their practice and practice environments using the *PCEMS* offers a useful means of analysing the effects of such change. The final scale for future use is presented in Appendix E.

8.4.4.2 Further studies of aspects of midwifery practice

Some of the findings relating to various aspects of midwifery practice need to be explored further. The empirical data were collected by surveys, which measured beliefs and perceptions about empowerment. As discussed in chapter 4, perceptions shape how we react to the world and they therefore constitute a valid and valuable means of

gathering information about the focus of our studies. However, perceptions are evidently subjective and therefore can be supplemented using other means and foci of research. The main group of related issues that require further study are those which relate to midwives' perceptions about their practice, within the three domains identified as important to empowerment. These findings suggest that midwives perceive that they have little control over their practice, little support from management but still perceive that they practise midwifery in a woman-centred way.

What is required to supplement the findings of this study is an ethnographic study of midwifery practice within the broad maternity care *milieu*. The aim of the study would be to describe and explain the day-to-day practice of midwifery, using observation and in-depth interviews. The purpose of ethnography is "to show a familiar world from a different angle in order to make us question taken-for-granted assumptions and beliefs" (Hunt & Symonds 1995 p1). It also allows the study of what midwives do as well as what they say they do. This links with Giddens' theory of structuration in terms of practical (routines, habits) and discursive (explanations) levels of consciousness, respectively. Ethnography studies activities, processes and interactions in the context in which they take place (Hunt & Symonds 1995).

The importance of studying the culture of maternity care environments, reproduced by its actors (consistent with Giddens's (1984) theory of structuration), including midwives, means that ethnographic study is appropriate. Linked clearly with the backdrop of this current research, Hunt & Symonds (1995 p138) highlight that hospitalisation and midwifery's professionalising project are the two key factors which

have been significant in setting and informing the composition of a working culture which daily reinforces and recreates an individual and collective occupational identity. For it is through culture with its beliefs, attitudes and actions that each generation learns what it means to be a midwife.

The role of the hospital setting and the issues relating to midwifery's professionalisation and professional identity have permeated this research and this quote highlights the centrality of the structural and historical backdrop to the ongoing development and practice of midwifery.

The manifest or apparent focus of such future study relate to the domains of empowerment identified in this study, and how they are played out in everyday midwifery practice. For example observing the relationships of midwives with doctors, managers, birthing women and other midwives are central to the three domains identified in this research. However, notwithstanding these identified areas of interest, the study of the culture(s) means that a broad canvas is required. The proposed research would focus on midwifery and maternity service cultures, practice and interactions, drawing on the perspectives of midwives, birthing women, managers and doctors. This would yield data to supplement that of this study and further contribute to the enhancement of midwifery practice and maternity care. To a largely symbolic extent, the labour ward forms the nexus of maternity care- it is where things happen and this appears to be a fruitful site of study. However there are also valid reasons for studying other areas of maternity care, away from the perhaps most obvious site of activity. Hunt & Symonds (1995 p134) emphasise the tendency for haste within the labour ward to “wash and ward” women who have given birth. The labour ward encapsulates a special but brief encounter with birthing women. Brief encounters are also likely in the antenatal and postnatal clinics, while this is not necessarily the case in postnatal and (especially) antenatal wards. Studying midwifery in these sites would allow greater scope encompassing midwifery activity across these areas.

Within this broad area for further research- which essentially covers all of midwifery practice- there are some discrete questions which would most likely form part of the broad canvas sketched above, but could also be studied separately, including

- To what extent do midwives push the boundaries of the constraints they perceive as limiting their practice? How do they gain control within an overall system which does not recognise their autonomy? Also, related to Giddens’s structuration theory, it would be valuable to study the extent to which midwives believe they identify with, reproduce and shape the systems in which they work (see pages 64, 243)
- What do midwives understand as being involved in “midwife-led care”? This study identified that there may be quite varied interpretations of this term. In order to build on current initiatives, clarification is required
- How is advocacy understood by both birthing women and midwives? The

findings of this research show that midwives perceive that they act as advocates for birthing women. This is despite the fact that the literature shows how problematic the exercise of advocacy is. Further exploration is required into the “agony of advocacy” described by Hunt and Symonds (1995 p128), capturing the “considerable emotional strength” required by midwives to practice this

- What do midwives and birthing women understand by “empowering birthing women”? Again, midwives perceived that they were empowering birthing women but this study did not elicit what they meant by that term

Besides these linked questions, there are other questions which have been raised by this study and they require further research. They include the following

- This study’s findings suggest that fewer numbers of midwives who have practised midwifery overseas are currently practising in Ireland, than was the case in the early 2000s. In the context of midwifery shortages, further research should examine the patterns of movement overseas of those who qualify as midwives here. It would be useful to explore the motivations behind decisions to both practise midwifery overseas and to return to midwifery practice in Ireland

Furthermore there were no significant differences in levels of perceived empowerment between those who have practised overseas and those who have not. The qualitative data from both surveys suggest that midwives returning from overseas practice find it difficult to practise again in Ireland. A study of the adjustment process of those who return would be valuable in terms of how to embrace practice that was viewed more positively by the midwife in question and how to influence her/his new setting positively

- To address the problem of midwifery shortages which were described in this study, the survey 2 questionnaire response pattern confirmed that there is a large latent midwifery resource comprising those with a midwifery qualification who are not currently practising midwifery. It was acknowledged earlier that there are many reasons for undertaking midwifery training, such as it being part of the route into public health nursing (see page 226). Further research on what would

attract these people back to midwifery would assist in addressing the staff shortages causing stress to those currently practising. This research would build on the recent work of McCarthy *et al* (2002) and Pitman (2004) but should focus specifically on those with a midwifery qualification.

- The demographic profile of this study shows that nurses and midwives work alongside each other in maternity hospitals. Given the problems with midwifery identity discussed throughout this study, it would be valuable to study the interaction between those who identify themselves as nurses and midwives respectively.
- As described above, there are very few Clinical Midwife Specialists and no Advanced Midwife Practitioners in Ireland. Midwives have judged both roles as inappropriate for midwives, because of the espoused holistic and autonomous nature of midwifery care. Midwives have responded to these levels of their specified clinical career pathways by simply not filling these positions, in some sense ignoring them, rather than seeking appropriate alternatives. The underlying issue in this is the treatment of midwifery as a sub-section of nursing. Hence the Commission recommended the same clinical career pathway structure for nursing and midwifery, while at the same time acknowledging and supporting midwives' calls for the recognition of the distinct identity of midwifery. Welcome developments to explore the AMP role at Trinity College Dublin will address the current apparent impasse and future developments (see page 229). Future developments in CMS and AMP should be evaluated to optimally fulfil these roles.
- Midwives in this study identified that they lack adequate resources for birthing women and for staff training and education. Both of these areas are interesting in different ways. Midwives working predominantly in maternity hospitals identified that they lack access to resources for birthing women. As discussed above this could relate to human resources constraints and shortfalls, though also material or environmental resources. It suggests unmet needs, for which resources are required. This is also the case relating to the lack of perceived

access to resources for staff training and education. Resources such as time off to attend courses was also mentioned within the qualitative data. Nonetheless midwives perceive themselves to be highly skilled and educated. There is clearly a need for continuous professional education and this may be the need being identified by midwives. Within the context of growing midwifery-led DOMINO and community midwifery services there will be further needs to support midwives clinically and psychologically. Further study about the issue of resources is therefore required, with a particular focus on resources for birthing women and midwives' educational needs.

- The findings of this study included midwives' negative perceptions of management. This is despite the investment in management development over the past five years in particular, with the work of the Steering Group on Empowerment in Nursing and Midwifery (see *Final Report*, Department of Health and Children 2004b), the National Council for the Professional Development of Nursing and Midwifery and the Office for Health Management Research with managers into their perceptions of their own empowerment and their support needs would assist in identifying why this situation has not improved more than appears to be the case and which initiatives have been successful and why? The proposed ethnographic study described above would assist in studying in a more in-depth manner the interactions between midwives and managers and in exploring both midwives', managers' and others' (including birthing women's) perspectives on these.
- As described in chapter 2, the integration of midwifery education into the third level sector brings considerable potential benefits to midwifery practice, research and education. However it also challenges those both educated and practising under a more traditional model. The change process and the adjustment to this new model of education, with its effects on practice and research, will require careful management and review. Studies of the experiences of students, clinical and educational staff should assist in this process.

8.4.4.3 Further historical research

Within the historical part of this study, the minutes of the Central Midwives Board and other regulatory bodies were demonstrated to be an invaluable primary historical resource. Their use in this study provided a means to study the complex and imprecise art of policy-making which has such far-reaching effects. There are many other interesting aspects of midwifery history that could constitute the foci of future studies. These include the history of midwifery education, of “penal case” procedures and of the influences of the UK and Europe on midwifery education and practice. These issues weave their way through the minutes which were consulted for this study. The Central Midwives Board minutes offer valuable primary sources of data relating to various aspects of midwifery development. The captivating detail of these minutes are only glimpsed within the findings of this study. They constitute a fascinating and valuable record of many aspects of midwifery history which can illuminate current arrangements and future possibilities. They are currently under-used as a resource and this study demonstrates their value. Unfortunately the curtailment since July 2005 of access to An Bord’s library services, due to accommodation problems, extends to access to the minutes within these archives (O’ Flynn 2005). It is hoped that this is resolved soon, though there is no indication of the time frame involved. In fact, the movement of part of An Bord Altranais’s library collection to the Irish Nurses Organisation library (An Bord Altranais 2006 p16) suggests that this might not be resolved too soon. However, with proposals under review to make the archive available and more secure through microfilm or other methods, it is hoped that this will not prove to be a barrier to future valuable research.

Other primary sources such as the Oireachtas debates, now readily available in an electronic format, offer valuable historical and political perspectives on midwifery policy-making. They demonstrate the value of having accessible primary sources which facilitate and encourage historical research through their ease of use.

8.5 Conclusions

In conclusion, this research provides valuable insights into issues of power and empowerment in midwifery, from past and present perspectives. It identifies the conditions important for empowerment in midwifery and a scale with which to measure them, the *PCEMS*. It also provides a greater understanding of the power relations and

processes that are part of the wider historical and social contexts of current midwifery practice

This research can contribute towards the development of the positive identity of midwifery. The stages through which professional identity is developed include historical analyses, connection and self-belief, ending in political action (Roberts 2000). The historical research findings can enhance midwives' awareness of their complex past and its contingent nature, opening possibilities for the future. The survey research re-asserts the self-belief and values of midwifery, as supported by the midwives who participated in this research.

This study highlights the political, structural and individual levels within which midwives can and do exercise their power in order to be effective. These findings are offered as a means to enhance midwifery's contribution to the changing landscape of the Irish maternity system, bringing the past and present pictures presented in this study, into the future.

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RESEARCH DISSEMINATION

Publications

Matthews, A , Scott, P A , Gallagher, P , Corbally, M A 2006 An exploratory study of the conditions important in facilitating the empowerment of midwives *Midwifery* [Available online from 15 December 2005 at [http //www.sciencedirect.com/science/journal/02666138](http://www.sciencedirect.com/science/journal/02666138)]

Peer-reviewed conference presentations

Matthews, A , Scott, P A , Gallagher, P , Corbally, M 2006 Undertaking factor analysis decisions, decisions *Royal College of Nursing International Research Conference* York, England 21- 24 March

Matthews, A , Scott, P A , Corbally, M A 2005 Is empowerment measurable? Plenary speaker at *International Philosophy of Nursing Conference*, Leeds, 7-9 September

Matthews, A , Scott, P A , Corbally, M A 2005 Overcoming empowerment fatigue in the nursing literature Workshop presentation at the *International Philosophy of Nursing Conference*, Leeds, 7-9 September

Matthews, A and Scott, P A 2005 Between a rock and a hard place? Locating recent midwifery research findings in their historical and structural contexts *27th Triennial Conference of International Confederation of Midwives*, Brisbane Australia, 24-28 July 2005

Matthews, A and Scott, P A 2005 "Mind the gap"- empowerment research to bridge the rhetoric-reality gap in midwifery practice in Ireland *Royal College of Midwives Annual Conference* Harrogate, UK, 10-12 May 2005

Matthews, A and Scott P A and Corbally, M A 2005 "Desperately seeking nurses and midwives"- using the Irish Nursing/Midwifery Register as a sampling frame for a national survey on empowerment Poster presentation *Royal College of Nursing Annual International Nursing Research Conference* Belfast, Northern Ireland, 8-11 March

Matthews, A and Duffy M 2004 Contested citizenship- the local and global contexts of childbirth *4th Interdisciplinary Conference in the Humanities and Social Sciences* DCU, Dublin September

Matthews, A and Scott, P A 2004 Families, midwives and social policy In search of the secret agents Annual Conference *Irish Social Policy Association ISPA* Dublin 16-17 September

Matthews, A and Scott, P A 2004 Advocacy and empowerment in midwifery in Ireland findings of a national survey *Royal College of Surgeons in Ireland Faculty of Nursing and Midwifery 23rd Annual Nursing and Midwifery Research Conference*, Dublin 26-27 February

Matthews, A and Scott, P A 2003 A composite model of empowerment for midwifery in Ireland- poster presentation *RCM-NI/INO Joint Annual Conference*, Armagh November

Other presentations

Matthews, A and Scott, P A 2006 The politics of midwifery regulation The background to and impact on midwifery of the 1950 Nurses Act *The Nursing and Midwifery History Association of Ireland* 26 January

Matthews, A and Scott, P A 2003 Midwives' understanding and experiences of empowerment *Midwifery Conference* Coombe Hospital November

Matthews, A and Scott, P A 2003 Empowerment of midwives in Ireland Provisional survey findings *Research seminar, Glasgow Caledonian University, Scotland* February

Matthews A and Scott, P A 2002 Empowerment and team-building in midwifery *INO Study day, Drogheda* April

Appendix A:
Cover letter, survey 1
(1 page)

2 January 2002

Dear Colleague,

A research team at the School of Nursing, Dublin City University is conducting a study of **Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland**. This study was commissioned by the *Steering Group on the Empowerment of Nurses and Midwives*, set up by the Minister for Health and Children following the Final Report of the Commission on Nursing. We will be submitting our final report to the Steering Group next summer.

This study commenced in April 2001 with a series of group interviews with nurses and midwives throughout Ireland. Your name has been randomly chosen from the Register of An Bord Altranais to invite you to take part in the next part of the study, which is a national survey of nurses and midwives. We hope to find out what you understand by "empowerment" along with your experiences of empowerment in your area of nursing or midwifery practice.

We know that your time is very precious and would really appreciate it if you would complete this questionnaire. It will take approximately 20 minutes to complete the questionnaire. Because your name has been randomly selected as a representative of nurses and midwives in Ireland, it is therefore very important that we hear from you so that your views are counted. There are no right or wrong answers to the questions, it is your views that are important to us. This questionnaire is completely anonymous.

Please complete the questionnaire and return it in the PRE-PAID envelope provided. We would really appreciate it if you would return this as soon as possible, **but before Wednesday 23 January 2002** so that your views are included in the study.

If you are not currently in clinical practice (i.e. you do not currently have direct patient/client contact), there is no need to complete this questionnaire. However it is really important that you indicate this by ticking the box below and returning this page only to us in the PRE-PAID envelope.

I am not currently in nursing/midwifery clinical practice (i.e. I do not currently have direct patient/client contact) ☐

May we thank you sincerely in advance for your time and your valuable contribution to this research.

Yours sincerely

Anne Matthews
Research Fellow, Empowerment Study

Telephone 7008957
Email Anne.Matthews@dcu.ie

Appendix B:
Questionnaire, survey 1
(5 pages)

**Nurses' and Midwives' Understanding and Experiences
of Empowerment in Ireland**

Questionnaire

**Please complete this questionnaire and return in the
enclosed PRE-PAID envelope as soon as possible**

Many thanks

School of Nursing

Dublin City University

Please answer all of the following questions.

1 Sex

Female

☐

Male

☐

2 Nationality

Irish

☐

Other (please specify)

☐

3 Age Group

20-29

☐

30-39

☐

40-49

☐

50-59

☐

60+

☐

4 On which divisions of the An Bord Altranais register are you registered and in what year did you register? (tick and fill in the year for as many as required)

Division

RGN

RSCN

RM

RPN

RMHN

PHN

RNT

Year of Registration

5 What further educational qualifications do you have?

None

Certificate

Pre-registration Nursing Diploma

Other Diploma

Higher Diploma

Degree

Master's Degree

Other (please specify below)

6 How many years of nursing/midwifery experience (including your training) do you have?

yrs (to the nearest year)

7 Where do you work?

A hospital

The community

A hospital and the community

Residential home

Nursing home

Other (please specify)

Please go to Q 7a

7a Does the hospital you work in have

Greater than 300 Beds

Less Than 300 Beds

Not applicable

8 In what geographical area of Ireland do you practice?

North-East

East

South-East

South

West

North-West

Midlands

Mid-West

9 Which of the following grades are you?

Staff Nurse/Midwife

Senior Staff Nurse/Midwife

Public Health Nurse

CNM1

CNM2

CNM3

Assistant Director of Nursing

Director of Nursing

Other

10 What is your current role?

Staff nurse/midwife

Senior Staff Nurse/Midwife

Clinical Nurse Specialist

Advanced Nurse Practitioner

Manager

Public Health Nurse

11 How long have you been in your current post?

yrs (to the nearest year)

12 What is your current area of practice?

General

Psychiatry

Paediatrics

Midwifery

Public Health

Mental Handicap

Other (please specify)

13 How many years of experience in your current area of practice do you have?

yrs (to the nearest year)

14 Do you work in a specialist area?

Yes

No

If yes, please specify

15 Is your job

Full- Time

Part time

16 Is your job

Permanent

Temporary

17 Is your work setting?

Urban

Rural

Both

18 Are you employed by

Health Board/Area Health Board

A Voluntary Hospital

Voluntary Services

A Private Sector Institution

A University

Other (please specify)

19. Have you practised as a nurse/midwife outside Ireland?

Yes

No

If yes, please specify length of time

yrs (to the nearest year)

Your Understanding of Empowerment

The following items have been reported to be important to the meaning of empowerment. In this part of the questionnaire we are trying to identify what you consider to be the core elements of empowerment and those elements which are not quite so important.

1. Please fill out the scale by circling the relevant number for each of the 24 items listed below to indicate how important to empowerment the following items are. If you do not think that the item is related to empowerment please circle n/a (not appli

PLEASE SEE BELOW: Rank order (1-10) of top 10 most important items		Crucially important to empower- ment	Quite important	Important	Somewhat important	A little important	I don't think that this item is related to empower- ment
☐	1 Being valued by my manager	1	2	3	4	5	n/a
☐	2 Being an advocate for my patients/clients	1	2	3	4	5	n/a
☐	3 Knowing what my scope of practice is	1	2	3	4	5	n/a
☐	4 Having the skills to carry out my role	1	2	3	4	5	n/a
☐	5 Being recognised for my contribution to patient care by my manager	1	2	3	4	5	n/a
☐	6 Having access to resources for patients	1	2	3	4	5	n/a
☐	7 Delegating non-nursing tasks to auxiliary staff	1	2	3	4	5	n/a
☐	8 Having a supportive manager	1	2	3	4	5	n/a
☐	9 Having support from my colleagues	1	2	3	4	5	n/a
☐	10 Having effective communication with management	1	2	3	4	5	n/a
☐	11 Being listened to by members of the multidisciplinary team	1	2	3	4	5	n/a
☐	12 Being informed about changes in my organisation that will affect my practice	1	2	3	4	5	n/a
☐	13 Having control over my practice	1	2	3	4	5	n/a
☐	14 Being adequately educated to perform my role	1	2	3	4	5	n/a
☐	15 Performing tasks that were previously performed by doctors and other professionals	1	2	3	4	5	n/a
☐	16 Being able to say no when I judge it to be necessary	1	2	3	4	5	n/a
☐	17 Being accountable for my practice	1	2	3	4	5	n/a
☐	18 Being recognised as a professional by the medical profession	1	2	3	4	5	n/a
☐	19 Being involved in nurse/midwife-led practice	1	2	3	4	5	n/a
☐	20 Empowering my patients/clients	1	2	3	4	5	n/a
☐	21 Having access to resources for staff education and training	1	2	3	4	5	n/a
☐	22 Having autonomy in my practice	1	2	3	4	5	n/a
☐	23 Having the back-up of my manager	1	2	3	4	5	n/a
☐	24 Being recognised for my contribution to patient care by the medical profession	1	2	3	4	5	n/a

2. Now please rank the 10 items that you consider to be most important to the meaning of empowerment, from 1 to 10, where 1 is the most important, 2 is the second most important etc. by placing the numbers 1 to 10 in the relevant boxes to the left of the

Please add anything relating to your understanding of the term empowerment that you feel has not been covered by the above:

Your Experience of Empowerment

In this section we are interested in your experience of empowerment in your current workplace

Please circle the number which best describes your response to the following

How much of the following do you have in your present job?

	None		Some		A Lot
1 Challenging work	1	2	3	4	5
2 The chance to gain new skills and knowledge on the job	1	2	3	4	5
3 Tasks that use all of your own skills and knowledge	1	2	3	4	5
4 Information about the current state of your organisation/service	1	2	3	4	5
5 Information about the goals of top management	1	2	3	4	5
6 Information about the values of top management	1	2	3	4	5
7 Specific information about things you do well	1	2	3	4	5
8 Specific comments about things you could improve	1	2	3	4	5
9 Helpful hints or problem solving advice	1	2	3	4	5
10 Time available to do necessary paperwork	1	2	3	4	5
11 Time available to accomplish job requirements	1	2	3	4	5
12 Acquiring temporary help when needed	1	2	3	4	5

In your work setting

	None		Some		A Lot
1 The rewards for innovation on the job are	1	2	3	4	5
2 The amount of flexibility in your job is	1	2	3	4	5
3 The amount of visibility of your work-related activities within your organisation/service is	1	2	3	4	5

In your present job, how much opportunity do you have for these activities?

	None		Some		A Lot
1 Collaborating on patient care with doctors	1	2	3	4	5
2 Being sought out by peers for information	1	2	3	4	5
3 Seeking out ideas from professionals other than doctors, e g , Physiotherapists, Occupational Therapists, Dieticians	1	2	3	4	5

Please circle the number which best describes your response to the following

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
1 Overall, my current work environment empowers me to accomplish my work in an effective manner	1	2	3	4	5
2 Overall, I consider my workplace to be an empowering environment	1	2	3	4	5

There may be factors that you feel enhance and inhibit empowerment in the workplace. Please describe these below in your own words.

What factors do you think enhance empowerment?

What factors do you think inhibit empowerment?

If you have any other comments about this questionnaire, please add these below.

Appendix C:
Cover letter, survey 2
(1 page)

(date) March 2005

Dear colleague

I wish to invite you to participate in a study on empowerment in midwifery in Ireland. I am undertaking this study for my PhD degree at Dublin City University. My supervisor is Professor P. Anne Scott.

For this study of empowerment in midwifery I am carrying out a national survey of practising midwives. Your name has been randomly chosen from the Midwives' Division of the Live Register of An Bord Altranais to invite you to take part in the survey. In accordance with An Bord Altranais's policies on Surveys and Statistics (An Bord Altranais *News* (Summer) 2004 7) the Bord does not release the names and addresses of midwives to researchers. Therefore I am not aware of the identity of recipients of this questionnaire and your responses are completely anonymous.

I would really appreciate it if you would complete this questionnaire. It will take approximately 10 minutes to complete the questionnaire. Please complete the questionnaire and return it in the **PRE-PAID envelope** provided. We would really appreciate it if you would return this as soon as possible, **but before (date) 2005** so that your views are included in the study findings. Of course your participation is completely voluntary.

If you are not currently in midwifery clinical practice (i.e. you do not currently have direct contact with birthing women), there is no need to complete this questionnaire. However it would be very helpful if you could indicate this by ticking the box below and returning this page only to us in the PRE-PAID envelope.

I am not currently in midwifery clinical practice (i.e. I do not currently have direct contact with birthing women) ☐

I am currently in practice in an area of nursing ☐ Please specify area _____

I wish to thank you sincerely in advance for your time and your contribution to this research. If you have any queries relating to this study or this questionnaire please contact me in confidence below.

Yours sincerely

Anne Matthews
Lecturer in Nursing and Health Policy
School of Nursing, Dublin City University

Telephone 7008957
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Appendix D:
Questionnaire, survey 2
(5 pages)

Empowerment in midwifery in Ireland

Questionnaire

Please complete this questionnaire and
return in the enclosed PRE-PAID envelope
before [date] 2005

Many thanks

Anne Matthews
School of Nursing
Dublin City University

1 Within which age group are you?

20-29	☐
30-39	☐
40-49	☐
50-59	☐
60 or more	☐

3 How many years of midwifery experience (excluding training) do you have? _____

5 Within what area of midwifery practice do you work?

Labour/Delivery	☐
Antenatal	☐
Postnatal	☐
Caseload/Full care	☐
Neonates	☐
Other _____	☐

7 Where do you work? A hospital ☐
A hospital and the community ☐
The community ☐
Other _____ (Please specify)

8 Does the hospital you work in have

More than 70 maternity beds	☐
Between 31and 70 maternity beds	☐
Less than 30 maternity beds	☐
Not applicable	☐

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Please circle the number which best describes your response to the following:

How much of the following do you have in your present job?

	None		Some		A Lot
1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge	1	2	3	4	5
4. Information about the current state of your organisation/service	1	2	3	4	5
5. Information about the goals of top management	1	2	3	4	5
6. Information about the values of top management	1	2	3	4	5
7. Specific information about things you do well	1	2	3	4	5
8. Specific comments about things you could improve	1	2	3	4	5
9. Helpful hints or problem solving advice	1	2	3	4	5
10. Time available to do necessary paperwork	1	2	3	4	5
11. Time available to accomplish job requirements	1	2	3	4	5
12. Acquiring temporary help when needed	1	2	3	4	5

In your work setting:

	None		Some		A Lot
1. The rewards for innovation on the job are	1	2	3	4	5
2. The amount of flexibility in your job is	1	2	3	4	5
3. The amount of visibility of your work-related activities within your organisation/service is	1	2	3	4	5

In your present job, how much opportunity do you have for these activities?

	None		Some		A Lot
1. Collaborating on patient care with doctors	1	2	3	4	5
2. Being sought out by peers for information	1	2	3	4	5
3. Seeking out ideas from professionals other than doctors, e.g., Physiotherapists, Occupational Therapists, Dieticians	1	2	3	4	5

Please circle the number which best describes your response to the following:

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
1. Overall, my current work environment empowers me to accomplish my work in an effective manner	1	2	3	4	5
2. Overall, I consider my workplace to be an empowering environment	1	2	3	4	5

Please tick the option that best describes your response to the following:

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	I am valued by my manager					
2	I am an advocate for birthing women					
3	I am involved in midwife-led practice					
4	I do not have the skills required to carry out my role					
5	I have the back-up of my manager					
6	I am not recognised for my contribution to the care of birthing women by my manager					
7	I have adequate access to resources for birthing women					
8	I do not have a supportive manager					
9	I have effective communication with management					
10	I am not informed about changes in my organisation that will affect my practice					
11	I am adequately educated to perform my role					
12	I have support from my colleagues					
13	I am able to say no when I judge it to be necessary					
14	I do not know what my scope of practice is					
15	I am accountable for my practice					
16	I am recognised as a professional by the medical profession					
17	I have control over my practice					
18	I empower birthing women through my practice					
19	I do not have adequate access to resources for staff education and training					
20	I have autonomy in my practice					
21	I am not listened to by members of the multidisciplinary team					
22	I am recognised for my contribution to the care of birthing women by the medical profession					

Many thanks for completing this questionnaire. If you wish to add anything, please do so below (or attach a separate page):

Appendix E:

The *Perceptions of Conditions for Empowerment in Midwifery Scale*

(1 page)

Please circle the number which best describes your response to the following statements	Strongly agree	Agree	Neither agree nor disagree	disagree	Strongly disagree
<i>Autonomous practice sub-scale</i>					
I am recognised as a professional by the medical profession	1	2	3	4	5
I am recognised for my contribution to the care of birthing women by the medical profession	1	2	3	4	5
I have control over my practice	1	2	3	4	5
I am not listened to by members of the multidisciplinary team	1	2	3	4	5
I have autonomy in my practice	1	2	3	4	5
I have adequate access to resources for birthing women in my care	1	2	3	4	5
<i>Effective management sub-scale</i>					
I do not have a supportive manager	1	2	3	4	5
I am valued by my manager	1	2	3	4	5
I have the back-up of my manager	1	2	3	4	5
I am not recognised for my contribution to the care of birthing women by my manager	1	2	3	4	5
I am not informed about changes in my organisation that will affect my practice	1	2	3	4	5
I have effective communication with management	1	2	3	4	5
<i>Women-centred practice sub-scale</i>					
I empower birthing women through my practice	1	2	3	4	5
I am an advocate for my patients/clients	1	2	3	4	5
I am able to say no when I judge it to be necessary	1	2	3	4	5
I am involved in midwife-led practice	1	2	3	4	5
I have support from my colleagues	1	2	3	4	5
I do have the skills required to carry out my role	1	2	3	4	5