The Challenges of Change –

Planning a Midwifery Model of Care

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Certificate of Originality

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as full acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

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Acknowledgements

I have two passions in life. My first passion is being a midwife and having the privilege of being able to share the miracle of childbirth with women and their families. My other passion is the education of people to become midwives in the true sense of the word. Through education of midwifery students I to strive to improve midwifery care by focusing the care on the women and her family. Part of this passion then is the promotion of midwifery care and, therefore, midwifery models of care.

My passionate commitment in pursuing the planning of this midwifery model of care arose from the influence of Dr Maralyn Rowley and Dr Pat Brodie. These wonderful midwives were the first project leaders in New South Wales to plan and implement midwifery models of care in the form of team midwifery at two different hospitals. Both midwives fought many battles to achieve the success with the midwifery models of care that they did. Without their passion for midwifery models of care, this work would not have been started. Much of what they learnt along the planning process was incorporated into the planning of this midwifery model of care.

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Finally, I would like to dedicate this work to Asha, my recently departed cat, who spent endless hours sitting and just being there for me.

Notes on style and language

The headings are presented using different font size. Chapter number is presented as 28 font size, followed by the chapter heading in 26 font size, main heading under this are in then font size 18, with a lesser heading being presented in font size 14.

Throughout this thesis where there are more than three references available to support a point or argument, the references are preceded by 'see for example'. This strategy is to facilitate ease of reading.

The maternity service government reports have been consistently referenced using the name of the chairperson of the review committee, rather than using the title of the report. For example, 'Lumley Report 1990', rather than 'Having a Baby in Victoria 1990'.

There are a number of references that have been removed from the text and reference list in order to protect the anonymity of the hospital in which this study was undertaken and the privacy of the participants. Where these references would appear in the text has been replaced by the words 'Reference removed' in the bracket. These references do not appear on the reference list. The alternative to this action would have been to place an embargo on the thesis.

Direct quotations from any source of data, whether they are from field notes, minutes of meetings or interviews, are written in *italics* without quotations marks.

Glossary of terms and abbreviations

Area refers to the Area Health Service in which the hospital and maternity unit is situated and where the project was being planned.

FN refers to Field Notes, which could be notes made from formal or informal meetings or just as a record of events that unfolded at that time.

M refers to Minutes of meetings, either of the Steering or Management Committee. These were formal notes of the proceedings of the meetings that were then presented to the next meeting for verification as a true recording of the proceedings of the meeting.

MC refers to the Management Committee.

SC refers to the Steering Committee.

I refers to any interview undertaken with key stakeholders.

L refers to a portion of a letter written between key stakeholders.

The date that appears in the brackets following any of the above abbreviation is the date on which the direct quote or statement was made and, therefore, recorded.

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Abstract

This thesis is about the challenge of change in maternity services. It examines the factors that facilitate and hinder the implementation of new models of midwifery care. At the time that the midwifery model of care described in this thesis was being planned, a great deal had been written regarding the problems with Australian maternity services. Such was the level of dissatisfaction with maternity services that government inquiries had been held and reports were produced recommending changes for improvement. Maternity services at the national and local level were in a state of transition, slowly addressing the recommendations from such inquiries and reports. It was in this environment of transition that a midwifery model of care was being planned. The midwifery model of care aimed to provide comprehensive maternity care for women of low risk, who did not hold health insurance and would incorporate childbirth and parenting education and support as well as care throughout the childbearing experience. Midwives would work collaboratively with General Practitioners in the community and provide midwifery led care.

The purpose of the project described in this thesis was to record and analyse the process of change associated with planning and implementing a midwifery model of care. This thesis is as much about effecting organisational change as it is about midwifery and exploring the conditions that are needed to plan and implement new models of midwifery care. This thesis explicates the factors that hindered the planning and implementation of the model, particularly the barriers to shifting boundaries of practice between groups of health professionals.

This thesis draws on Kotter's work on organisational change to describe and analyse the planning process in order to gain a better understanding of what it takes to achieve organisational change. An emerging theme from the data was the interplay between creating a sense of urgency to facilitate change and limiting obstacles to block the vision. These activities revealed the continual struggle that occurred as various strategies were put into place to overcome obstacles and defuse resistance to change.

The conclusion emphasises that while the midwifery model of care was not implemented, change had been achieved through a shuffling rather than a shifting of the professional boundaries between 'key players', namely the midwives, General Practitioners and obstetricians. Changing allegiances, partnerships, relationship and power had changed the status quo. In addition, the midwives had developed professionally leading to an increased capacity to continue the process of achieving the midwifery model of care.

Chapter One

Setting the scene

At the time that the midwifery model of care described in this thesis was being planned, a great deal had been written regarding the problems with Australian maternity services. It was argued that such problems related to the domination of maternity services by obstetrics, an increase in intervention rates, a diminished role for midwives and consumer dissatisfaction with maternity services. Such was the dissatisfaction with maternity services that government inquiries had been held and a number of reports produced recommending changes for improvement. Maternity services were therefore in a state of transition slowly addressing the recommendations from these reports. It was in this transitional environment that this midwifery model of care was being planned.

The purpose of the project described in this thesis was to record and analyse the process of change associated with planning a new midwifery model of care. It is important to note that this midwifery model of care required a shift in professional boundaries to enable the midwives, general practitioners (GPs), and obstetricians to collaboratively care for childbearing women. This thesis is, therefore, as much about midwifery as it is about effecting organisational change in the endeavours to shift boundaries of practice between these health professionals. The aim of the thesis was then to record and analyse the process of change used to plan this midwifery model of care and not the model of care itself.

This chapter provides a synopsis of the thesis by presenting a brief overview of the history of the local maternity services and why it was in a state of transition at the time of the project planning. Following this is a description of the maternity services in Australia, including what constitutes midwifery care, and the role of the obstetrician and the GP in providing maternity care in this country at that time. In addition, a brief background of the organisation of the hospital during the time the project planning occurred, situates the study further. This is followed by what the proposed midwifery model of care was, with a brief overview of the main players in the planning process. The process used to plan the midwifery model of care is then summarised before

providing a summary of each chapter and a few notes on style used throughout this thesis.

It is important to note that the arguments in this thesis unashamedly prioritise midwifery care and advocate for the midwife. This position is evident throughout the history of maternity services and in the literature on various models of care. An examination of obstetric care is therefore not included.

Background

In 1991 when this project was conceived, a vast amount had been written about maternity services, not only in Australia, but also in Britain (see Chapter Two). First, there was much in the literature about the medical domination of maternity services. This domination ultimately resulted in a higher incidence of hospital births and a decline in home births. Higher intervention rates, a diminished role for midwives, and decreased satisfaction of women with maternity services followed (see for example, Black 1994; Donnison 1988; Willis 1989). Midwives were prevented by obstetricians from undertaking that which they were best able to do, that is, ensure the normality of childbearing (Wagner 1994; Reid 2000). In addition, midwives became more like obstetric nurses with much of their practice controlled and regulated by obstetricians (see for example, Hobbs 1993b; Svigos 1991; Waldenstrom 1996).

Increased medicalisation of childbirth resulted in an increased concern about the quality and capacity of maternity services to meet women's needs for emotional and social support as well as for their safety (see for example, Aicken 1997; Cope 1994; Oakley 1986). Consumers in the 1960s also were dissatisfied with maternity services (see for example, Aicken 1997; Oakley 1986; Towler and Bramall 1986). Consequently, consumers put pressure on governments in Australia and Britain for inquiries into maternity services in order to bring about change (see for example, Biggins 1992; Melia, Morgan, Wolfe and Swan 1991; Morris-Thompson 1992). These government reports concluded that there were a number of major issues that needed to be addressed in order to meet the needs of consumers and increase their satisfaction (see for example, Cumberlege Report 1993; Lumley Report 1990; Shearman Report 1989). These issues included long waiting times for antenatal care, over-crowded antenatal clinics, short

consultation times, fragmented care and a focus on physical safety aspects rather than emotional and social support for childbearing women (see for example, Battersby and Thomson 1997; Conroy 1993; Reid 1989). A number of solutions were, therefore, proposed and involved adopting midwifery models of care that would provide woman-centred care with an emphasis on the normal process of childbearing (see for example, Brodie 2003; Cochrane 1995; Murphy-Black 1995). Such midwifery models of care would provide consumers with choice, control, and continuity of care (see for example, Cumberlege Report 1993; Hobbs 1993b; Maternity Coalition AIMS 2002). A further outcome of these midwifery models of care for midwives was reclaiming their role as primary providers of care for low risk women (see for example, Finlayson 1993; Robinson 1989; Street, Gannon and Holt 1991).

In Britain, the consequence of these government reports was increasing agitation for change resulting in the slow introduction of a large number of different types of midwifery models of care (see for example, Cochrane 1995; Flint 1993; Murphy-Black 1995). These included midwives' clinics, birth centres, team midwifery and caseload with a primary midwife. Midwifery models of care were then extensively evaluated. Preliminary results indicated that intervention rates were lower and women's satisfaction with these models of care was high (see for example, Currell 1995; Flint, Poulengeris and Grant 1989; Walton and Hamilton 1995). At the same time in Australia, agitation for change saw little action (Brodie 2002). By the early 1990s only two new models of midwifery care were introduced as a result (Kenny, Brodie, Eckermann and Hall 1994; Rowley, Henseley, Brinsmead and Wlodarczyk 1995).

The innovations that were introduced to maternity services required obstetricians, midwives and GPs to work together and establish ways of complementing each other's skills (Kitzinger 1992). Unfortunately, cooperation more often occurred at the level of rhetoric and policy, rather than in the development of successful models that would combine skills and knowledge and juxtapose public and private sector services. Continued consumer dissatisfaction with maternity services was evident in the published reports of the time. There remained room for improvement with mainstream maternity services (Brodie 2002). Despite efforts to achieve improvement at policy or government level, dissatisfaction continued to be expressed by women because change was not occurring at the rate women required (see for example, Maternity Coalition

AIMS 2002; Robinson Report 1996, Crowley 1999). The need to implement models of midwifery care and how to facilitate and maintain this in an obstetric dominated world remained a challenge. Despite the many recommendations on support for midwifery care an under utilisation of midwifery skills continued (Robinson 1990). Few organisations and midwives had made significant changes in maternity care despite the increasing evidence to do so (Brodie 1992 & 2002). It was in this climate of a continued agitation for changes to maternity services that this midwifery model of care was conceived (more detailed examination of this background will be presented in Chapters Two and Three).

The Australian context

In Australia there are approximately 250,000 births per year, with childbirth the single most important reason for hospitalisation (Maternity Coalition AIMS 2002). Care for around two thirds of childbearing women is provided in the public hospital system using employed midwives (see for example, Heffernan 1993; Homer, Brodie and Leap 2001a; Waldenstrom 1996). These midwives are paid an hourly wage by the hospital and are not able to claim Medicare payments. The majority of women give birth in 'delivery suites' in tertiary institutions that provide a medicalised and highly technological birth environment (Maternity Coalition AIMS 2002). In this environment, midwives undertake the assessment, care and management of women during the antenatal, labour/birth and postnatal periods in collaboration with their medical colleagues. This is described as midwifery care. Women usually receive fragmented care; each time they receive care they are attended by a different midwife or doctor. A midwife will care for a woman attending the antenatal clinic, which may vary each visit, and a different midwife will offer parenthood education classes. Another midwife will attend labour and birth, and a different midwife will manage the postnatal period.

The obstetricians who have visiting rights in the public hospital sector are termed Visiting Medical Officers. In this thesis they will be referred to as obstetricians. In addition, obstetricians have their own private practice, providing antenatal care for women in their rooms. When these women go into labour, a midwife, under the direct supervision of the obstetrician, undertakes the care. The obstetrician may or may not visit the woman during labour and attend the birth. During the hospital postnatal stay, the midwife undertakes the

care of the woman and the obstetrician usually visits. This practice constitutes obstetric or 'specialist' care. Women directly pay the obstetrician for these services through private health insurance and are, therefore, classified as 'insured'.

Non-insured women attend a public hospital antenatal clinic and are cared for by midwives in consultation with obstetricians. In this mode of care, midwives, under the supervision of an obstetrician, undertake the care during labour, birth, and the postnatal period. Midwives can provide much of the care obstetricians provide and do undertake much of the care without the presence of an obstetrician. It must be emphasised, however, that the obstetricians must be involved in the care of women when complications develop during the antenatal, labour, birth and postnatal period. The obstetricians are then 'on call' for non-insured women during labour and birth if complications arise. This means that if obstetric assistance is required for a non-insured woman, the obstetrician who is on call is consulted by phone or may need to come to the hospital to attend to the woman. Mostly women will see an obstetric registrar or resident rather than an obstetrician (Homer and Barclay 1999). A resident is a newly qualified doctor who, after a period of time, may decide to specialise in obstetrics and then becomes known as a registrar. Obstetricians receive a fee from the hospital for the time that they are on call whether they come to the hospital or not. As well, obstetricians are rostered for specific periods for consultation in the public hospital antenatal clinics for these non-insured women. Usually the obstetrician attends within specific periods and undertakes the care for these non-insured women. This practice constitutes 'traditional' or 'standard' care for which the non-insured women do not directly pay. Each person has a certain percentage taken out of their pay packets as tax paid directly to the Commonwealth Government towards covering these health care costs and is called the Medicare system.

Obstetricians are not directly employed by the hospital and only receive sessional payment for the time they are on call for non-insured women. Each individual obstetrician may have visiting rights with a number of hospitals, both private and public. Generally speaking, the obstetricians are independent, with the hospital executing no control over them. This arrangement means obstetricians do as they choose and can exert great control within the hospital, despite the fact that there is no direct relationship between the obstetrician and the hospital. Some hospitals, however, directly employ obstetricians under the category of staff specialist. Non-insured women then receive direct care from this staff specialist who

is consulted and referred to if a problem arises. Staff specialists are indemnified by the hospital which in turn, has greater control over them as a consequence of this relationship. It should be emphasised here that the role of the obstetrician in maternity services is caring for women who develop complications during the childbearing process. Obstetricians, therefore, need to be called in if any complication develops during the pregnancy, labour, birth or postnatal period.

A further model of care provided for women during the childbearing period is termed Antenatal Shared Care with GPs. In this model, GPs continue to care for women during their pregnancy in conjunction with the public hospital antenatal clinic. The antenatal care is shared between the GP in private practice, and the midwives in the hospital antenatal clinic. Women thereby see both groups of practitioners. During labour and birth, the hospital midwife cares for women in consultation with the obstetricians. The hospital midwives either provide postnatal care within the hospital, or under the Early Discharge Program at home. A woman then returns to her GP for her six-week postnatal check.

At the time this research was initiated, midwifery workforce numbers were fairly stable. In addition, there were minimal vacancies in maternity units throughout Sydney and Australia, with midwives staying in their positions (NSW Health Department 1993b; Tracy, Barclay and Brodie 2000b). Midwifery students, on completion of their education, were not readily employed in maternity units. The culture in the maternity unit where this research was undertaken was well established with no hint of change to come.

The change

It was evident from the literature review that there continued to be consumer dissatisfaction with maternity services into the early 90s and more change was needed. Midwifery models of care that provide women with choice, control, and continuity needed to be implemented. The instigation and impetus for implementing a model of continuity of midwifery care came from the recently appointed Professor of Nursing (Prof (N)). This appointment provided an opportunity for the researcher to become involved in setting up a midwifery model in the Area Health Service (Area). The Prof (N) had a desire to achieve improvement in maternity services in the Area and the researcher was very enthusiastic to

obtain a project for doctoral work. Being aware of the literature, the Prof (N) and the researcher, having assessed the maternity services in the Area, came up with a solution. The researchers perceived that collaborating with GPs was the most appropriate way that a midwifery model of care could be implemented within the political and cultural climate of the Area. A midwifery model of care in collaboration with GPs was, therefore, considered as the solution. The researcher aimed to document this process of change in order to gain an insight into the change process.

The midwifery model of care (the change) was aimed at low risk, non-insured women and would incorporate education and support as well as care throughout the childbearing experience. After reviewing the literature and undertaking a consultative process, it was determined that a model where midwives worked collaboratively with GPs in the community be adopted and thus provide midwifery led care to women in this community. An obstetrician would assess the suitability of women to participate in the model and be referred to if any complications develop. Midwives would be employed by the hospital and become, in effect, an outreach service of the hospital for antenatal and postnatal care of women. Each midwife would provide antenatal and postnatal care in the GPs rooms, the women's home or community centre. The GP might share visits with the midwife or just be available if a problem occurred. When a woman went into labour, her midwife would provide care in the hospital and then manage the birth. The essence of this model was a reorientation of a maternity service that was different to, yet built on the work of other projects at the time. There would be four GPs participating with two midwives and a relief midwife. Each midwife would care for four women a month, or 36 per year as recommended by Flint (1993), Leap (1997) and McCourt and Page (1996). This arrangement gave midwives time to undertake antenatal and postnatal care as well as labour and birth care.

In achieving this midwifery model of care, it was necessary for a number of boundaries to be traversed. The different boundaries of the three professional groups, that is, midwives, GPs and obstetricians are as follows:

- The professional boundaries of the midwives differ from those of the GPs and obstetricians;

- The midwives and GPs are the caretakers of normal childbearing; they refer to obstetricians when complications occur. The obstetricians are the caretakers of complicated childbearing;
- Employment of the midwives occurs through the hospital, whereas the GPs and obstetricians are contracted by the hospital to provide sessional care;
- Remuneration of the midwives through the hospital is from State Government funds, as opposed to the GPs and obstetricians who receive a rebate from the Commonwealth Government;
- The midwives receive a salary, whereas the GPs and obstetricians receive a fee for service directly from the women they care for;
- The GPs and obstetricians are independent entrepreneurs, whereas the midwives are employed by the hospital within a distinct hierarchical model;
- The midwives could be considered to work in an acute care hospital setting, whereas the GPs and obstetricians conduct their practices in a community setting.

The purpose of the study described here was to record and analyse the process of change associated with planning and implementing a midwifery model of care that followed the principles of community, continuity and collaboration. Within this process of change, two projects were operating simultaneously. The first was implementing a midwifery model of care and the second, the topic of this thesis, was a study of the change process. This study does not research the midwifery model of care itself, but instead examines the process of implementing the midwifery model of care. In other words, the processes that occurred during the planning of the midwifery model of care and the factors that enhanced or impeded the process of achieving organisational change are the objects of study. By documenting and analysing the process, it became clear what were the impediments to change and what can be learnt from this to make change successful. This enables other researchers to learn what the important factors are to successfully achieve change. The research question was therefore 'what factors are necessary to successfully achieve organisational change in maternity services?'

The hospital context

The maternity unit, in which the midwifery model of care was planned, was located at a district hospital in Sydney and had approximately 900 births in 1992 (NSW Health

Department 1993a). The majority of women attending this hospital for their childbearing experience were non-insured women (90% (Field Notes Management Committee (FN MC): 26.10.93 (date on which this data was recorded)), with a high number from a non-English speaking background (NSW Health Department 1993a). A strength identified for this hospital was its ability to provide culturally sensitive care to the large ethnic community that it served (Shearman Report 1989). Antenatal Shared Care was introduced by the hospital in 1991 as a strategy to more effectively meet the needs of non-English speaking background women (Nunn 1996).

The hospital was situated in an Area in Sydney in which there were three hospitals, two small and one larger providing maternity services. This hospital was one of the two smaller hospitals, termed district hospitals. The larger hospital was a referral hospital to which women from the district hospitals were transferred if problems arose.

Initially, three key people drove the planning of change, the researcher, the Prof (N), and the Area Director of Nursing (Area DON). This was the initial 'guiding coalition' (Kotter 1996; Kotter and Cohen 2002) that aimed to improve maternity services in the Area and research the process of implementing a midwifery model of care. The roles of the three people will be briefly outlined.

The Prof (N) occupied a joint appointment between the Area and the university. This was the first position of its kind within Australia, and other such positions followed. The Prof (N) professional role, in part, was to instigate research that would lead to improvement in maternity services within the Area. The Prof (N) had no authority over service provision except through persuasion and scholarship. As this was the first clinical chair position in Australia, there was an imperative to achieve change and be successful and influential in the position (Donoghue and Jones 1993; Schmied, Creegan, Pelletier, Duffield and Barclay 1992). The perceived role of the Prof (N) was that of a change agent (see Chapter Five).

The Area DON was the manager of nursing services for the entire Area. Her role was to oversee the nursing and community services across the Area. The DON had convinced the Area to instigate the Prof (N) position and, therefore, had a vested interest in the Prof (N)'s success in improving maternity services. The three hospitals in the Area each had a

Director of Nursing (DON) who was answerable to the Area DON in relation to command and resources.

The role of the Area DON in relation to the project was to initially suggest what could realistically be achieved within the Area. She was in a position of leadership and authority in the delivery of midwifery services. In addition, the Area DON had influence in policy making in the Area because of her position on the health service executive team (see Chapter Five).

The researcher was a Senior Lecturer in the Faculty of Nursing and Midwifery, involved in teaching and coordinating the Graduate Diploma in Midwifery, the route for the preparation of midwives to practice. In this role, numerous health professionals in the Area and its maternity units already knew the researcher. The researcher had developed relationships with these people, opening the lines of communication. The driving force for the researcher was a passion to set up a continuity of midwifery care model and to complete her doctorate.

The Prof (N) and the researcher initiated the project and consulted closely. In the planning of the project, the Prof (N) and the researcher worked together as a team, with the Prof (N) leading discussion and seeking permission from the participants for the researcher to take notes as part of the research into the process of change. The researcher was a conduit. The researcher's main responsibility was to collect data on the process of achieving change. A secondary responsibility for the researcher was to organise the various meetings, make appointments, notify relevant people about meetings, to take meeting minutes and distribute accordingly.

These three people, the Prof (N), the Area DON and the researcher, had the vision to improve maternity services in the Area through the implementation of a continuity of midwifery care model. What form and where this innovation would occur was the next step in the planning process.

The process of change

There are many approaches to studying organisational change. Having reviewed the literature on organisational change, it became clear that a common theme existed regarding the components that must be present in order to achieve and sustain change within an organisation (Kotter 1996). These components included such factors as establishing a sense of urgency to change and defusing the resistance to change. Further it became clear from the literature that there was a need for some sort of process in order to implement these components. Action research could provide the process to achieve change (Hyrkas 1997). In fact, Mander, Gomes and Castle (2002) believe that action research is crucial in order to follow the strategies suggested by Kotter (1996). Action research is increasingly being used as an effective strategy for facilitating, learning about and achieving change (East and Robinson 1994; Heywood and Heywood 1992). Flint (1993), for example, used an action research process to set up a midwifery model of care in Britain that was team midwifery. Change, therefore, occurs through involving the people who are part of the situation they wish to change.

With this in mind, an action research group was formed consisting of midwives, GPs, obstetricians and management personnel from the hospital and the Area. Before the action research process was able to start in earnest, however, it was important to assess the feasibility of the project with the GPs and the management of the hospital. The Prof (N) gathered around her supportive people who were in positions of authority, ascertaining from them a commitment for the formation of an action research group and process to plan a midwifery model of care. Following a positive assessment of the feasibility of the project, the action research process commenced. Meetings were held to plan the midwifery model of care and to inform people of the plan and gain their support. A large number of meetings were held in an attempt to engage participants in the plan for change and the implementation of the midwifery model of care. The action research process itself commenced with the collection of data in the form of a record on the process of change. A social system analysis of roles various people played in the planning process formed the basis of this data collection and analysis. It is this collection of data and subsequent analysis that forms the method for this research into the process of change.

In recording the process of introducing change, it became evident that there were

difficulties in engaging some participants in planning the midwifery model of care. The critical first step in planning such a project was to instil a sense of urgency in the participants to plan the change; in this case the midwives, GPs and obstetricians. With the GPs, this sense of urgency to plan was achieved right from the start and continued throughout, diminishing only towards the end. The GPs' diminishing interest had more to do with the fact that planning had gone on for too long. The obstetricians exhibited strong resistance throughout the planning phase. Eventually a somewhat tenuous sense of urgency was achieved, though essentially this was forced onto the obstetricians. Much has been written about the professional tensions between midwifery and obstetrics, specifically the continual struggle between these two groups that has dominated maternity services history. It became evident from the data from this project that these tensions are still very much a part of maternity services today.

The midwifery managers from the labour and postnatal wards, the two main midwives from the maternity unit, were the only constant midwifery participants in the project over the planning period of the project. At times they wavered as barriers were placed in front of them. During the five years that the midwifery model of care was being planned, a vast number of obstacles occurred which blurred the vision for change. These included aspects of midwifery culture itself, such as subordination and professional immaturity that affected their confidence or ability to participate; difficulties encountered when effecting organisational change, such as not involving all of the participants from the start and the researchers imposing the solution on the participants; strong resistance exhibited by obstetricians; organisational instability due to executive changes, threat of closure of the hospital and relocating the hospital to another Area. The effect of these obstacles was to distract the midwives from participating in the planning and resisting the change.

The midwifery managers from the labour and postnatal wards eventually took on an ownership of the project and were prepared to pursue it. The successful change became the change in ownership of the project as well as a shift in the professional boundaries to make it possible. There was, therefore, an improvement in the capacity of these two people to continue the process of achieving change. As Forbes (1992) states, an important by product of the action research process is the ability to lead to an improvement in the capacity of the participants to continue the process of achieving change. The process of action research continues on after the researchers have written up their report and left

(Checkland and Scholes 1991 & 2001; McTaggart 1992). Learning about achieving change becomes incorporated within the process of action research and becomes part of the skills repertoire of the participants (Heywood and Heywood 1992).

Despite the positive step of a change of ownership, the researchers made the decision to cease the active planning of the project, mainly because of the overwhelming organisational instability. The researchers had come to the realisation that enough energy and resources had been expended. This realisation was heightened when the change in Area boundary occurred, followed soon after by the maternity unit being moved to another site for two years. This resulted in further administrative changes that created a situation where it became more difficult for the researchers to continue the planning of the project. As a consequence, the researchers ceased the project planning and the midwifery model of care was not implemented.

Organisation of thesis

This chapter introduces the thesis by providing a brief overview. **Chapter Two** provides the background to the study through a literature review of the history of maternity services in Britain and Australia. This review reveals a need for change within maternity services and outlines the reasons for such change. Further, the review provides evidence to help explain the organisational change process.

Chapter Three presents the literature that has determined whether midwives and GPs provide safe care for childbearing women. Various models of maternity care are examined. A closer analysis of the literature describing team midwifery and caseload enabled a decision to be made for the midwifery model of care that was to be implemented in this project.

Chapter Four situates the project through a discussion of the theories of organisational change and the conditions that Kotter (1996) outlines that need to be in place in order to achieve change. This is followed by an overview of the methods of action research and soft systems methodology as a change process, and means of data collection and analysis respectively. The purpose of the chapter is to provide a theoretical framework

for implementing and analysing the change process. In addition, methods of data collection and analysis are described.

Chapter Five describes the process and strategies that were used to plan the midwifery model of care. Described in this chapter are the groundwork events before the planning of the model started in earnest. The chapter provides a background to situate where and how the planning occurred and the circumstances of the organisation where the change was to occur. The structural processes that needed to be put into place to assess the feasibility of introducing the model in the Area are included. Finally, an overview of the planning events and summary of the meetings is given from which the data were obtained and analysis occurred.

The first of two chapters reporting on the results of the data analysis from the action research process, through which the implementation of the midwifery model of care was planned, is **Chapter Six**. An emerging theme from the data analysis is the interplay between creating a sense of urgency and permitting obstacles to block the vision to plan the model (Kotter 1996; Kotter and Cohen 2002). These activities reveal the continual struggle that occurred as various strategies were put into place to overcome obstacles and defuse resistance to change. This process was an attempt to empower broad based action and, therefore, increase the sense of urgency.

The various strategies utilised by the researchers to empower broad based action and create a sense of urgency in the action research group participants, is described in **Chapter Seven.** Having identified that many participants were indeed creating obstacles to block the vision, strategies were needed to overcome these. This chapter outlines the strategies that were used to help break down these obstacles to change and therefore facilitate the engagement of the participants to the planning process.

Chapter Eight examines the impact that the environment had on the midwifery model of care planning. A summary of what happened is then followed by explanations as to why this was the case. This includes an examination of why there was such resistance to the project planning. The chapter concludes by outlining the lessons learnt from this process and the way to move forward with organisational change.

This chapter has provided an overview of the thesis by first providing a brief outline of the history of maternity services. An overview of maternity services in Australia was then discussed, followed by a description of the proposed midwifery model of care. The fact that this thesis discusses the process of change used to plan this project and not the project, is then emphasised. A brief background of the organisation of the hospital during the time planning occurred, situates the study further. This section was followed by a brief overview of the main players in the planning process, and the change process used to plan the organisational change.

The next chapter discusses the history of maternity services in detail in order to demonstrate the continual struggle that existed between obstetrics and midwifery. The purpose of this review was to explore the historical factors that have shaped maternity services and identify a midwifery model of care that could address some of these issues. This history, therefore, provided the background to the development of the midwifery model of care and helped provide explanation for what happened during the planning of this model.

Chapter Two

History of maternity services

This chapter describes and analyses the literature on the history of maternity services, and consumer and midwifery perceptions of maternity services. This historical context is predominantly based on British and Australian literature. Australia was originally colonised by Britain and, therefore, followed closely the British system in maternity services. This British influence has continued and, therefore, likeness to the United States of America maternity system is remote. The approach of the United States to maternity care differs dramatically from Britain and Australia.

The purpose of this review is to explore the historical factors that have shaped maternity services and identify a midwifery model of care that could address some of these issues. A wide range of sources was used and included the documented descriptions of problems with maternity services, which appear in state, national, and international government reports (see for example, Shearman Report 1989; Robinson Report 1996; Cumberlege Report 1993). The literature about maternity services provides the background to these various government inquires and reports. Further, the literature provides the research evidence that supported the recommendations of these reports. This literature review identified potential approaches to improve maternity services drawing on the principle of continuity of carer, achieved through an innovative maternity service provided by midwives. The initial purpose of the review was to provide a context from which to examine the position of midwifery care within maternity services and to identify a way forward to develop an innovative midwifery model of care. Further, this literature review provided a basis for exploring what happened in this project. Much of this literature is, therefore, extrapolated in Chapter Eight in order to help explain the obstacles effecting organisational change in this study.

The beginning struggle

It is clear from the literature on the history of midwifery care, that a steady decline in midwifery practice and an increasing struggle between midwives and obstetricians for the control of birthing women has occurred. In most developed countries midwifery

was traditionally considered a lay occupation for women up until the 17th century and remains so in many developing countries today (see for example, Donnison 1988; Russell and Schofield 1986; Willis 1989). The status of the midwife during the 17th century was high with the midwife's skills commanding public respect (Black 1994). Childbearing was not perceived to be a medical responsibility and consequently doctors received no training in midwifery (Thornton 1972; Willis 1989). Doctors were men and women were excluded from medicine. Midwifery was therefore seen as work for women only, with men rigidly excluded (see for example, Loudon 1990; Towler and Bramall 1986; Willis 1989).

The struggle between male and female midwives began in the early 17th century in Britain when the term male midwife first appeared (Willis 1989), later becoming known as obstetricians (Donnison 1988; Towler and Bramall 1986). During the 17th century obstetricians began to be summoned by midwives for complicated labours to mainly perform caesarean sections on dead mothers or to dismember a dead fetus to remove it from the uterus (Russell and Schofield 1986; Towler and Bramall 1986). The popularity of obstetricians increased, in part, through the invention of forceps by the Chamberlens, termed barber surgeons (Cochrane 1995; Towler and Bramall 1986; Willis 1989). As a consequence of forceps being used more frequently, men appeared in the birthing rooms in greater numbers (Donnison 1988; Willis 1989). The use of forceps meant a baby might be born alive when previously either the woman or her baby would have died (Donnison 1988). This development gave men an advantage over midwives who were not permitted to use forceps and were obliged to summon a barber surgeon when faced with an obstructed labour (Donnison 1988; Towler and Bramall 1986).

Men became involved in normal cases of childbirth when it became fashionable among upper class women to employ men, not just when forceps were needed. This change created direct competition with midwives (Donnison 1988; Towler and Bramall 1986). Another contributing factor for the increased popularity of men within maternity services was their higher status. Doctors were seen as superior to midwives because of their gender and education (Donnison 1988; Towler and Bramall 1986). The fact that men generally were paid more than women reinforced this difference. Being able to

afford an obstetrician was an important status symbol of the time (Donnison 1988; Towler and Bramall 1986) and tends to remain so for some women in Australia today.

In the early 17th century, to guarantee being summoned by midwives for difficult births, one of the Chamberlen brothers attempted to gain the support of midwives (Towler and Bramall 1986). This was achieved by not responding to midwives calls for assistance unless the midwife attended his lectures. This brother also wined and dined midwives as bribery for their continued support. Towler and Bramall (1986) do not comment on how successful these strategies were, though it is likely they were fairly successful as the midwives of London presented a petition to the College of Physicians protesting against this unauthorised control over midwives. This move led to an inquiry in 1634 in which the midwives' complaints were upheld (Towler and Bramall 1986). It would appear that the first public confrontation between obstetricians and midwives was the only time that a midwife won the case.

Throughout the 18th and 19th centuries most birthing women were still supported by midwives (Willis 1989). The number of obstetricians increased with more women choosing an obstetrician to attend them during birth rather than a midwife (Donnison 1988; Loudon 1990). Female modesty, which had previously been a barrier to male involvement in childbirth among the upper and middle class women, was disappearing (Towler and Bramall 1986). Male control over childbirth accelerated further with the advent of lying in hospitals in the mid 18th century in London (Willis 1989). These hospitals were initially for women who could not afford a doctor or midwife to assist them to birth at home (Oakley 1986). Very few midwives were employed in hospitals and those that were became subordinate to doctors (Willis 1989). This development was the first attempt to place birth firmly under medical management and away from the home (Willis 1989).

Establishing a place where healthy working class women could birth and obstetricians could manage this process had a number of advantages for obstetricians. The advantages included the availability of subjects in order to gain clinical experience and teaching (Tew 1992), which, in turn, legitimised medical management of childbirth (Willis 1989). Oakley (1986) claims that the emergence of hospitals for birth had significant implications for midwives. Competition from midwives was reduced and

doctors gained control over the preferences of women. Over time obstetric services became more attractive to upper class women who were in a position to pay for them (Willis 1989). Obstetricians further assisted this process by emphasising the dangers of childbirth in order to ensure their attendance (Murphy-Black 1995), a frequent strategy employed throughout the history of childbirth. Doctors, however, began to realise how useful it would be to have a nurse who could care for women during labour and after birth, as they could not manage all this themselves. Consequently, in Britain, ladies' monthly nurse training began in the early 19th century (Towler and Bramall 1986). Ladies' monthly nurses cared for women at home in the month after birth.

The medical domination over childbirth occurred concurrently with British settlement of Australia (Willis 1989). Initially there were very few midwives in Australia. Women were helped to birth by husbands or each other (Donnison 1988). Slowly women began to specialise, having given birth themselves, they assisted other women to birth. Such women were called 'accidental midwives' or handywomen (Thornton 1972). The term accidental was used, as these women were midwives by accident. When a doctor arrived in the area he was available for complications if the midwife needed help. Some doctors refused to assist the midwife. Doctors were also available to provide birthing services for more affluent women (Willis 1989). The doctors of the time held midwives in low regard and referred to them as illegitimate, incompetent and ignorant women and used this designation to gain control of them (Adcock et al 1984). There was a tendency then, as there is now, to exaggerate any occurrences of poor practice by midwives. In Canada, for instance, a midwife was prosecuted following the death of one baby. Whereas, 23 babies died in obstetric care before an inquiry was started (Thomson 1994).

In this early period, Willis (1989) claims there were probably a number of factors that contributed to doctors' motivation to control midwives. Firstly, there was incongruence between doctors' concern for maternal and infant mortality and morbidity, and reality, with doctors instead claiming that midwives were dangerous and ignorant (Willis 1989). A second factor was doctor's fear of competition from midwives who were cheaper and in some cases more popular. Doctors wanted to take over the field of midwifery for their own financial gain (Russell and Schofield 1986). Allowing

midwives to be educated would mean that midwives could take over obstetric practice completely and this was feared by some doctors (Willis 1989).

Doctors' reasons for wanting to be involved with midwifery, however, were not just for economic gain. Loudon (1990) believed there were two other factors, one being the job satisfaction that doctors derived from caring for childbearing women. Most importantly, maternity care was seen as a guaranteed mechanism for establishing a practice, including the care of the children and the whole family (Loudon 1990).

Interestingly, the developing concern for infant welfare stemmed more from the societal preoccupation around the turn of the 20th century with military recruitment (Murphy-Black 1995). There was a concern that not enough healthy men would be available to join the army. During the Boer War recruitment it was realised that the large number of men in poor physical health was a result of poor feeding in infancy and childhood (Murphy-Black 1995; Oakley 1986).

In the mid 19th century 'lying in' hospitals were established in Melbourne and Sydney (Adcock et al 1984; Thornton 1972). Midwives were trained to operate under medical control in these hospitals and were termed ladies monthly nurses, caring for wealthy women after birth (Adcock et al 1984; Willis 1989). Consequently, there was a reduced need for traditional, community-based midwives.

By the late 19th century women began to earn a living as midwives. Some brought women into their homes for childbirth. These homes became known as private maternity hospitals (Adcock et al 1984; Willis 1989). In this period midwifery education became more formalised (Thornton 1972; Willis 1989). Women who were trained as midwives, however, had to be qualified nurses. This requirement enabled doctors to have direct control over midwives through their dominance of all health services (Russell and Schofield 1986). Doctors taught in the very brief midwifery programs with the intention of creating subordinated maternity nurses (Willis 1989). In 1898 the title obstetric nurse replaced the title ladies monthly nurse. The trained obstetric nurse, who worked in the lying in hospitals, replaced the highly respected community based self-employed midwife (Willis 1989).

In 1899 a decision, supported by doctors and nurses, was made to allow only those midwives who were nurses, to work in hospital maternity units (Willlis 1989). This move was supported by nurses because it extended their occupational territory to include childbirth, and was supported by doctors because the incorporation of midwifery into nursing ensured its continued subordination (Willis 1989). Subordination of nurses had already occurred in Britain when Florence Nightingale refused to attend patients unless directed to do so by doctors (Willis 1989). Nightingale also stressed obedience to doctors and that nurses were never to see themselves as colleagues to doctors (Game and Pringle 1983). As nursing and medicine in Australia were strongly linked to Britain through colonial ties, Nightingale's ideas and style of practice were adopted in Australia. Hospital midwives became increasingly subordinate to doctors. The midwives accepted their subordinate role to doctors who in turn supervised their practice (Towler and Bramall 1986). As a consequence, the midwife became an obstetric nurse (Tew 1992). Doctors had gained the competitive advantage and reaffirmed their ascendancy over the midwife.

Other factors contributed to the demise of the independent midwife. Midwives, for instance, were blamed for puerperal fever (Willis 1989). Nightingale advocated for birthing at home with midwives in attendance in order to prevent infections (Wills 1989). In fact affluent women, attended by doctors, were at greater risk of infection than women who were poor and attended by a midwife (Russel and Schofield 1986; Towler and Bramall 1986; Willis 1989). The contributing factors to puerperal infection were believed to be doctors who undertook post mortems followed by vaginal examinations with unwashed, ungloved hands (Towler and Bramall 1986) and also did not wash their hands or change their clothes after each birth (Wills 1989).

Midwives were also blamed for high maternal and infant mortality rates (Willis 1989). Doctors exploited these high mortality rates in order to attack midwives with incompetent practice. Consequently, it was recommended that midwifery be restricted to trained midwifery nurses subject to medical control (Willis 1989) and that childbirth take place in hospitals (Lewis 1990). These practices in turn, increased the status of obstetricians within medicine, further reinforcing the trend for hospital births (Lewis 1990). These developments further contributed to the demise of the independent midwife. A further contribution to this demise was the introduction of a baby bonus to

encourage women to have more babies. The baby bonus allowed women to afford a doctor, resulting in more women birthing in a hospital under the care of a doctor.

In 1915 a Midwives Act was passed in Victoria, which considerably restricted midwifery practice and placed it under medical control (Willis 1989). The Act aimed to prevent unqualified women from practising midwifery and outlined a number of requirements necessary for becoming a midwife. The Midwives Board of Victoria required midwives to be women of good character and to bathe and wash their hair regularly in disinfectant (Willis 1989). The Board, with a strong representation of doctors, had the power to suspend midwives. Midwives were required to pay an annual registration fee to the Board. This registration fee controlled midwives, for those that did not pay could not practice (Black 1994). Women's hospitals in Sydney and Melbourne undertook training programs for midwives to enable them to register. These registered midwives could assist women to birth in hospital or home. The accidental midwives also received education in order to become registered (Adcock et al 1984; Thornton 1972). In contrast, doctors did not have to prove they were of good character, paid no annual fee and had no requirement to regularly bathe before attending births (Willis 1989).

In 1928 a Nurses' Act was passed which further incorporated midwifery into nursing (Willis 1989). This Act aimed to improve midwifery by controlling midwives through the same body that controlled nurses, that is, the Nurses' Board. Only trained nurses could undertake midwifery, which spelled the end of midwifery as an independent occupation (Russell and Schofield 1986). The effect of incorporating midwifery into nursing was to formalise the subordination of midwives to doctors and extend medical dominance (Willis 1989).

At the beginning of the 20th century doctors became more highly skilled and professional, using this image to encourage more women to be attended by them rather than by midwives. Women were further encouraged to birth in hospital, a means of confirming medical control over childbirth (Willis 1989). Women began to find it more practical to birth in the hospital rather than at home which further assisted the trend to hospital birth (Adcock et al 1984). Maternal and infant mortality rates, however, were still high in the 1930s. These high rates were used as an argument for hospital birth

because birth was considered to be a dangerous event. In fact, mortality rates did not decline, despite an increase in medical attendance at births in hospitals (Hayes and Bayliss 1984; Willis 1989). The continued high mortality rate was the result of medical incompetency, in turn, the product of poor education of doctors in the area of obstetrics (Willis 1989). A further reason for high maternal and infant mortality rates was the over use of new medical technology in the area of childbirth (Willis 1989).

By the 1950s most women were choosing to give birth in a hospital. This move was probably due to the increasing awareness of the public for the necessity to be close to such facilities as blood transfusions and antibiotics (Adcock et al 1984). Another contributing factor was the persuasive argument put forward by the obstetricians that hospital births were safer (Cahill 2001). With the increase in medical technology from the 1960s onwards, the midwives' role profoundly changed and midwifery practice became regarded as a nursing speciality (Towler and Bramall 1986). Consequently, more births were attended by doctors and, therefore, were not managed by midwives (Robinson 1990). This medicalisation of childbirth saw a culmination in medical control, which almost caused the demise of midwifery (Murphy-Black 1995). For women, the result was a steady decline in choice, control and satisfaction in the care they received (Cahill 2001).

From the 1970s medical benefits insurance increased in Australia and many more women opted to be a private patient, consulting an obstetrician rather than attending a public hospital clinic (Adcock et al 1984). At the same time, the availability of technical equipment, and intervention in childbirth increased (Adcock et al 1984). The midwife was seen as having little power and followed the obstetrician's instructions, despite knowing the implications for a woman and her baby (Oakley 1980).

More recent times has seen the growth of private hospitals with maternity units that attract women to being cared for by obstetricians in private, prestigious facilities. This expansion has been assisted by government policy making private health insurance affordable. An increased uptake of private health insurance and eligibility for obstetric care has followed (Homer 2002). Placing private hospitals in the grounds of public hospitals has contributed to this diversion of women to obstetric care (Goulston 2002).

Reasons for obstetric domination of maternity

The historical events described in the first part of this chapter established a pattern for medical domination of evolving maternity services. Willis (1989) believes the subordination of midwives by doctors was not a result of advances in childbirth technology. In fact, midwife subordination occurred well before the advances in childbirth practices and is attributed to a number of factors. Subordination was partly due to the low status of midwifery, which, in turn, was the result of a lack of organisation and regulation with minimal support for training and development (Cahill 2001). Another contributing factor to midwifery subordination was gender. The division of labour in health services resembles the domestic division of labour. The male-husband-father-doctor controls the female-wife-mother-nurse in the care of the child-patient. The insinuation here is that midwives became subordinate to doctors because midwives are women and doctors are men (Cochrane 1995; Willis 1989). These gender roles are reaffirmed by Game and Pringle (1983) who claim that doctors exert, not only the power of a father figure, but also direct sexual power over nurses and midwives. Medical dominance is reaffirmed by sexual dominance over nurses and midwives. This subordination reflects a patriarchal division of labour (Willis 1989)

This patriarchal dominance in western society was partially derived from the teaching of the church (Russell and Schofield 1986) in which women were viewed as creatures of nature that bled, gave birth, lactated and lured men with sex. All these activities are characteristic of animal behaviour and devoid, therefore, of that which makes people human. Consequently, women were seen as base, evil and threatening, requiring control and guidance by men. These beliefs enabled men to dominate and control women, a situation that has continued throughout history (Black 1994).

Another factor involved in the subordination of midwives is class. Doctors have increased their status as a profession and consequently demanded higher fees (Willis 1989). On the other hand, midwives' status has declined. Midwives were drawn from the lower class and were paid a minimal fee, thereby preventing them achieving high status (Willis 1989). On the whole, obstetricians originate from the upper class and being male, support these claims about women and midwives being subordinate (Kitzinger, Green and Coupland 1990).

In addition, there is an historical difference in the educational preparation of doctors and midwives. Traditionally, doctors received an education, though women were excluded. Scientific knowledge was characteristically male and superior to caring and empathy, considered inherently female. Academic knowledge held to be superior to experience (Cahill 2001). These ideas were translated into doctors receiving longer and more expensive education than midwives (Hoekelman 1978). In contemporary Australia, for instance, a higher tertiary entrance ranking is required for medicine than for nursing in universities. Education programs for doctors are longer than those for midwives. Those with more education will dominate those with less education, often in overt and subtle ways (Hoekelman 1978; Murphy-Lawless 1998).

Economic factors have contributed to the higher social standing of doctors when compared with midwives. Men in general earn more than women (Hoekelman 1978; Murphy-Lawless 1998). Higher income positively correlates with level of education. Consequently, doctors enjoy a higher social standing within the community in comparison to midwives (Hoekelman 1978; Reiger 2001). In having a high status and nearly all the power, doctors benefit financially (Wagner 1994). In addition, a woman, when pregnant, cannot directly refer herself to a midwife for childbearing care. (Towler and Bramall 1986). The doctor is usually the first point of contact in maternity services, though this arrangement is slowly changing in Britain where women can contact a midwife directly (Cumberlege Report 1993). In New Zealand women and midwives have worked together and managed to change the legislation, resulting in midwives gaining independence from obstetricians and women having the right to contact a midwife directly (Guililand and Pairman 1995).

Medicalisation of childbirth

Maternity services were evolving at the same time as views of childbirth as a medical event was occurring. This did not necessarily have positive consequences for consumers. During the 19th and 20th centuries childbirth become an event seen only as normal in retrospect, with systems of care based on a sickness or doctor-dominated model (see for example, Hobbs 1993b; Lane 2002; Sangala, Dunster, Bohin and Osbourne 1990). Health, on the other hand, is considered to be the absence of illness as opposed to a positive situation in itself. One doctor in this period declared that "... it was rapidly appreciated that

normality in obstetrics is at best retrospective" (Bull 1980: 208). Obstetricians, therefore, perceived childbearing as a disaster waiting to happen and 'cared' for all women accordingly (Kitzinger et al 1990; Klein and Zander 1989). This resulted in the assessment of women being aimed at identifying abnormalities (Cox 1992; Turnbull 1984).

There are a number of reasons speculated as to why childbirth became viewed as a sickness. Firstly, this approach was seen to be a direct consequence of medical education in which doctors are taught about identifying and treating pathology (Zander 1986). Doctors are committed to curing the sick, not improving health (Cahill 2001). According to Schuman and Marteau (1993) the longer obstetricians practiced, the more risky they viewed the process of childbearing. Another factor in this equation was that most obstetricians are also gynaecologists (Cochrane 1995). It would seem irresponsible to combine physiology, that is obstetrics, and pathology, that is gynaecology, in the two separate situations, with the only common dominator being the women. There is a further difference between the medical profession, prepared to 'do' something to deal with a problem, and midwives who watch and wait (Torr 1993). Obstetricians determine if women were of high or low risk, consequently becoming the lead professionals for 'high risk' women, thus strengthening their power base and gaining more control (Cahill 2001).

Consequently, childbearing was perceived as highly dangerous and most appropriately handled by obstetricians (Brodie 1993a; Hastie 1991), with the childbearing process provoking anxiety (Zander 1986). This perception in turn, made women anxious, which Callaghan (1993) believes becomes a self-fulfilling prophecy when problems arise. Viewing childbearing as dangerous became an assumption on the part of professionals and women. All women, therefore, required an obstetrician during childbearing even though most care would be provided by a midwife (Flint 1991; Winterton Report 1992). Oakley (1986) described this view as pathology in childbirth, which facilitates the social control of women and guarantees the continued existence of obstetricians. All women were to be treated medically, which for obstetricians was efficient, predictable and controlled (Bennett 1997). Obstetricians, according to Tew (1992), perpetuated and emphasised the belief that childbearing was essentially dangerous and only 'obstetric control' could reduce this danger. Obstetric attendance was therefore deemed essential (Murphy-Black 1995; Willis 1989). For instance, obstetricians published statements such as: "The significant decline in maternal and perinatal morbidity and mortality during this century reflects the focus of

obstetric care on improvement in these health outcomes" (Bennet and Shearman 1989: 673). Wagner (1994) held that obstetricians were selling themselves as a guarantee of safety. Obstetricians, using power messages of risk and danger, had convinced the public at large that, even though expensive, medical care was safer than the preferred option of midwifery attendance (see for example, Robinson 1990; Towler and Bramall 1986; Wagner 1996). This was despite the limited evidence of medical practice making a difference to maternity care (Wagner 1994). Donnison (1988) argued that obstetricians were, in fact, deliberately frightening women by exaggerating the risks. Women believed obstetric attendance was essential. These messages have recently emerged again with the advocating of centralised maternity units, just in case a disaster occurs (Dahlen 2002).

The result of such powerful constructors was that, in developed societies, women who could afford to pay and were healthy accepted that a normal childbearing experience meant receiving primary care from an obstetrician rather than a midwife (see for example, Brodie 1992; Thomson 1991; Zander 1986). Women were convinced that obstetricians and technology were essential to ensure the birth of a healthy baby (Purkiss 1998). This conviction was fuelled by the 'what if' warning dictating that obstetric care was necessary when something went wrong (Wagner 2001). Women in the early 20th century were themselves campaigning for hospital births and care by obstetricians as opposed to care by midwives (Lewis 1990). As a direct consequence, the role of the midwife has declined (see for example, Robinson 1990; Thomson 1991; Towler and Bramall 1986). No longer was the midwife in control of the situation. This then was the pivotal point in the power struggle between midwives and obstetricians (Flint 1989; Robinson 1990). The pivotal point occurred in a social context of neo-liberal principles and the value of being able to purchase services. Increased medicalisation was, therefore, linked to the secularisation of society and part of the broader social, historical and political processes at the time (Kent 2000). A point needing to be emphasised here, however, is that obstetricians are best placed to care for women when complications occur during childbearing. It is when obstetricians operate outside of this realm of practice that is being contested and the resultant path that follows. That is, when there is no place for midwives in the care of low risk women.

The effect of technology

The medicialisation of childbearing had negative effects on the social and emotional care of women (Murphy-Black 1995). Obstetricians initiated hospital birth in 1927 in Britain as a solution to high maternal and neonatal mortality rates (Lewis 1990). There has, however, been no research undertaken to support the conviction that obstetric care in hospitals is a safer option (see for example, Fedrick and Butler 1978; Tew 1992; Tew and Damstra-Wijmenga 1991). Obstetricians, of course, work in hospitals where the necessary technology was provided to guarantee a safe birth (Tew and Damstra-Wijmenga 1991). When tested, results indicated that much of the technology was not as useful as it was claimed to be, or as safe (Purkiss 1998; Tew 1992). An example of this is the use of electronic fetal monitoring, which has been demonstrated to be linked to many unnecessary interventions (Hillan 1991; Thacker, Stroup and Peterson 2002). Nevertheless, women accepted that being cared for by an obstetrician in a hospital was the best option (Brodie 1992). Hospitals were deemed safe because the necessary staff and equipment were on hand in case something went wrong (Cox 1992). In addition there was a false assumption that faster action was possible in the hospital than in the home (Wagner 2001). These assumptions resulted in more and more women birthing in hospitals and fewer births occurring in the home (Tew 1992; Towler and Bramall 1986). This state of affairs was perpetuated when a woman was taken from home to hospital for birth, her ability to use her own resources to cope with childbirth was lost and use of technology was inevitable (Murphy-Black 1995). In increasing the number of hospital births, hospitals became centres of teaching and research for obstetricians who, in turn, required more hospital births. Medical men supported the hospital system in order to provide a regular supply of subjects to advance their knowledge (Murpy-Black 1995; Tew 1992; Willis 1989). The trend towards centralisation of maternity services resulted in making expensive technology more accessible (see for example, Cope 1994; Parboosingh, Keirse and Enkin 1989; Robinson 1990). Centralising of maternity services for clinical 'material' has recently resurfaced (Goulston 2002; Dahlen 2002). Initially, only women with complications were seen in these hospitals, contributing to a lack of experience in the care of normal childbirth. All women were perceived to need an expert (Murpy-Black 1995; Tew 1992; Towler and Bramall 1986). As a consequence, medical interventions and the medicalisation of the birthing process became prevalent from 1930s, increasing steadily up to the 1960s (Aicken 1997; Willis 1989), reaching unprecedented peaks by the 1970s (Reiger 2001; Towler and

Bramall 1986), and an all time high by 2000s (Dahlen 2002; Reiger 2001). For women, these developments meant less choice and increasing fragmentation of midwifery care (see for example, Hundley et al 1994; Murphy-Black 1995; Robinson 1990).

Medicalisation of childbirth reached a point where many midwives believed women received unnecessary interventions during childbirth (Kitzinger 1983; Rooks, Weatherby and Ernst 1992a). This outcome was an extension of the idea in the 18th century when women were first attracted to forceps as a means of shortening their labours (Towler and Bramall 1986). Since the end of World War II childbirth has become increasingly medicalised (Kitzinger 1983; Towler and Bramall 1986). For instance, regardless of whether a woman was considered high or low risk she was subjected to the same protocols in labour management, including continuous fetal monitoring and augmentation of labour (Towler and Bramall 1986; Walsh 1989). This management illustrates a flow on effect from interventions aimed at high-risk women to include women of low risk (Reid, Carroll, Ruderman and Murray 1989), resulting in all women being treated the same. Shearman (1989) speculated that the reason for these escalating intervention rates was either a result of inflexible hospital practices or because of the practices of individual health professionals. Wagner (1994) believes there was more to this issue and suggests a number of other reasons. The first of these is the fact that the majority of low risk childbearing women in Australia have an obstetrician as the primary carer rather then a midwife or that their care is provided by a midwife under obstetric management (Wagner 1994). Very few obstetricians in other countries spend as much time with low risk childbearing women as those in Australia. This situation can partly be explained by Australia having the highest ratio of obstetricians to women in the world, in other words, there is an excess of obstetricians (Wagner 1994). As a direct consequence of obstetric education aimed at identifying and treating pathology, too many women are over diagnosed and labelled at risk (Roberts, Tracey and Peat 2000; Zander 1986), resulting in unnecessary intervention (Wagner 1994). As a result, midwives are unable to fulfil their role, further contributing to high intervention rates.

High intervention rates can also be attributed to the tendency for one intervention to lead to another (Wagner 1994), described as a 'cascade of interventions' (Hundley et al 1994; Wagner 1994) or a 'package deal' (Kitzinger 1983). This is the case whether the women is experiencing her first or subsequent birth. An induction, for example, has been

demonstrated to lead to a cascade of subsequent interventions, that is, one intervention resulting in further interventions and so on (Dunn 1976; Wagner 1994; Winterton Report 1992). Fetal monitoring is another such example leading to a cascade of subsequent interventions (Hundley et al 1994). There is in addition, a statistically significant relationship between the use of epidural and an outcome of caesarean section (Butler, Abrams, Parker, Roberts and Laros 1993). These findings have been confirmed more recently by Roberts, Tracey and Peat (2000) who found an increasing use of interventions accumulated during the management of labour and birth. The interesting point here is that there is no evidence to suggest that higher intervention rates occurring over the last 20 years have resulted in better outcomes for the mother or her baby (see for example, King 1993; Reid et al 1989; Roberts et al 2000). For example, the rapid increase in the number of caesarean births in the last ten years has resulted in a minimal improvement in the perinatal mortality rate (Tracy and Dahlen 2002).

There is, however, a growing body of evidence that supports the view that the use of interventions, dissatisfaction with antenatal care and the presence of unwanted people at birth, is more likely to result in postnatal depression (Astbury, Brown, Lumley and Small 1994). There is further evidence that indicates that obstetric interventions are a predictor of a negative birth experience (Brown and Lumley 1994; Creedy, Scochet and Horsfall 2000). As well, women who have experienced an instrumental birth have a higher morbidity, both short and long term, compared to women who birth normally (Johanson et al 1993). The long-term sequela of the consequences of the use of interventions on women has never really been fully examined. Work undertaken by Creedy (1999), however, suggests that the long-term sequela for these women is a critical issue. There is no doubt that morbidity is expensive for women and the health care system (Tracey, Barclay and Brodie 2000a).

Added to this argument, privately insured women have much higher intervention rates than women who are not insured privately (see for example, Butler et al 1993; Roberts et al 2000; Wagner 1994). For example, in a retrospective analysis of labour outcomes of 3,000 low risk women, those who were privately insured had lower rates of spontaneous vaginal birth and higher rates of instrumental and caesarean delivery (Cary 1992). Caesarean section and instrumental delivery rates were found to be double for privately insured compared to non-insured women in Australia and Britain (Bennett 1997; King 1993).

These findings have been confirmed in a more recent analysis by Roberts and colleagues (2000) and Crowley (1999). Privately insured women, however, are much healthier, attend more antenatal checks with their obstetrician and are less likely to need interventions (see for example, King 1993; Tew 1992; Thomson 1991). It is women in the lower socio economic group who are at greater risk of morbidity and mortality, and require interventions (see for example, Brodie 1992; Lumley Report 1990; Wagner 1994). These women have less access to unnecessary care with resultant lower intervention rates (Wagner 1994). It could be argued that women who pay private insurance could in fact expect more service for their money. Wagner (1994: 8) states " ... the underlying cause of operative birth in Australia is money." This conclusion is made not just because operative births provide a higher reimbursement for the obstetrician and the hospital, though personal reimbursement is a further factor in the equation. Women who are privately insured are perceived to be more likely to sue and, therefore, more likely to demand interventions such as epidural pain relief, forceps births or caesarean sections (Wagner 1994). A further factor is that women having regular antenatal care with an obstetrician are more likely to have the normal physiological process of pregnancy converted to a pathological process (Tew 1992).

One of the consequences of all of the above is that interventions have become routine or normal obstetric care (see for example, Barclay, Andrae and Glover 1989; Kitzinger et al 1990; Purkiss 1998). For example, the high rates of repeat caesarean sections illustrate the undertaking of an intervention that has traditionally been done despite evidence to the contrary (Wagner 1994). The convenience of undertaking a planned operation during working hours rather than at any time is further noted. Emergency caesareans tend to occur more often before 5.30 pm, arguably a time that is more convenient to obstetricians (Bennett 1997; Wagner 1994). Cahill (2001) believes that as the caesarean rates are twice the recommended rate, non-medical factors are influencing the decision. Dunn (1976:791) believes strongly that "convenience is a poor excuse for interfering with an event" such as childbirth. Kaufman (1993) holds that the basis for such interventions is for the obstetricians to control labour and birth.

The defence by medicine for the use of technology is based on a successful outcome for childbirth, known as the 'perfect baby syndrome' (see for example, Cope 1994; MacLennan 1993a; Tew 1992). An outcome according to the medical model is

predominantly measured by mortality rates (Callaghan 1993). Some authors go as far to say that the mortality rate is the only measure of obstetric outcome (Marsh and Channing 1989; Young 1987). Garrett, House and Lowe (1987:490), however, believe that " ... mortality rate alone is not a sensitive indicator of quality of maternity care." Morbidity rates are therefore considered to a lesser extent when in fact they should be considered in assessing birth outcomes. Another point to be considered is that women have a very different definition of success in childbirth compared to the definition of obstetricians (Lewis 1990). Women take a live baby for granted, however, and are searching for other outcomes of success (Barclay et al 1989). Success for women is more about satisfaction with childbirth. Further with rising rates of medical litigation (see for example, Butler et al 1993; Svigos 1991; MacLennan 1993a) comes the risk of defensive obstetric practice (Feldman and Freiman 1985; Purkiss 1998). Defensive obstetrics occurs when an obstetrician intervenes because of a fear of being sued. This practise is said to provide a legitimate excuse for high intervention rates (Wagner 1994). When analysing intervention rates over decades, Wagner (1994) noted that the increased rate of caesarean sections was accompanied by an increasing litigation rate. It would appear, therefore, that the increase in intervention rates was not necessarily the solution to the problem of litigation. Tew (1992) argues that obstetric interventions do much more harm then good. The use of electronic fetal monitoring which increases the incidence of caesarean is one such example (Thacker et al 2002) and the link between instrumental births and increased pelvic dysfunction, is another (MacLennan, Taylor, Wilson and Wilson 2000). As a result of fetal monitoring and instrumental birth in these instances, women experience morbidity.

It has been argued that the desire for the perfect baby was instrumental in the 1970s in Britain for the increase in the perinatal mortality rate. The response in the form of health policy, was that women should birth in larger units, homebirths be phased out, delivery units should be regarded as an intensive care area, and women should be cared for by obstetricians (Cochrane 1995). It was claimed that only then could a healthy baby be guaranteed. The consequence of these policies was an emphasis on physical care to the detriment of emotional and psychological care (Murphy-Black 1995). This policy was criticised given the fact that the perinatal mortality rate declined least during the period of increased hospitalisation (Tew 1992; Winterton Report 1992). Ironically, mortality rates declined most noticeably during World War II when medical care was scarce for civilians because most doctors were involved in the war effort (Cahill 2001; Tew 1992; Towler and

Bramall 1986). The fall in mortality rates was attributed to the success of antenatal care at the beginning of the 19th century and not as a direct result of improvements in socio-economic status and environment (Cahill 2001; Robinson 1990; Thomson 1991). Obstetricians refused to believe that poverty was the cause of high maternal mortality rates and saw hospital as the only answer (Lewis 1990). Even so, it was the improvements in public health that brought about improved mortality rates (Wagner 1996), together with women having fewer babies (Maternity Coalition AIMS 2002). It would follow from these developments that countries with high intervention rates would have the lowest mortality rates when the converse is, in fact, the case (Enkin et al 2000).

Improved training of midwives was a further contributing factor to the improved mortality rates (Purkiss 1998; Willis 1989). Countries with low mortality rates, in comparison with Britain, have midwives as the main birth attendants (Zander 1986). Parboosingh and colleagues (1989) acknowledge the influence of these factors, adding that the contribution of obstetricians to the fall in mortality rates has, however, been immensely important. Conversely, Lowe, House and Garrett (1987) believe that the extent to which obstetric practice contributed to lower mortality rates is unclear. Dunn (1976) comments that it must not be forgotten that the perinatal mortality rate had been falling steadily for decades. Towler and Bramall (1986) commented that the only significant decrease in mortality rate occurred in the 1950s with the advent of antibiotics.

The effect of medicalisation on midwifery

Midwives have expressed concern about a lack of job satisfaction in a role developed as a direct consequence of the obstetric domination of midwives (see for example, Brodie 2002; Frohlich and Edwards 1989; Robinson 1993). Prior to the era of hospitalised births, midwives practised the art of midwifery and offered continuity of care (Aicken 1997). The majority of midwives (80%) now work in a hospital setting in Australia (see for example, Brodie 1992; Heffernan 1993; Waldenstrom 1996) and Britain (Cochrane 1995). The hospital hierarchy places the doctor in a senior position to midwives (Cochrane 1995; Kitzinger et al 1990). Midwives in hospitals have had to follow policies laid down by doctors promoting active management of labour and birth, even when they believed such policies were against the interests of the women for whom they cared (see for example, Kitzinger et al 1990; Lane 2002; Walker 1976). For example, policies were developed as

to when to rupture the membranes, or when to perform vaginal examinations (Robinson 1990; Walsh 1989). Midwifery decision-making skills were undermined, as midwives had no choice but to abide by the policies, even though efficacy of these policies had not been demonstrated (Robinson 1990). Midwives consequently became more like nurses, with less confidence and trust in their own abilities (Robinson 1989). These policies were seen as rigid, aggressive and limited the midwives' freedom to work as a midwife (Kitzinger et al 1990). When midwives fulfilled their role in the care of childbearing women, their influence was eroded by obstetricians (Rider 1984). This effect is clearly identified in the duplication that occurs when the obstetrician undertakes the same antenatal assessment previously undertaken by the midwife (Robinson 1989; Towler and Bramall 1986). This is an example of a lack of recognition of midwives' skills by obstetricians, with midwifery practice and policy governed by obstetric knowledge as opposed to midwifery knowledge (Allison 1992; Reid 1989). In addition, midwives have been used for trivial work in hospitals, not fulfilling their role as midwives. In other words, a medical model of maternity services dominated, with midwives becoming obstetricians' handmaidens (see for example, Morris-Thompson 1992; Waldenstrom 1996; Zander 1986) or 'chaperones' (see for example, Robinson 1990; Tew 1992; Turnbull 1984). Midwives, for instance, were given the tasks of testing urine and weighing women (Robinson 1990).

The advent of hospitalised births also resulted in midwives no longer practising all components of midwifery practice because maternity units adopted a model of fragmented care (see for example, Lane 2002; Murphy-Black 1995; Towler and Bramall 1986). The rotation of midwives, initially introduced to encourage efficiency, and because obstetricians demanded that experienced midwives work in labour wards, was discouraged. Consequently, midwives became specialised in either antenatal, intrapartum or postnatal care. By the 1980s in Britain, for instance, the majority of midwives worked in only one area of care (Robinson 1989). Brodie (1996) believed that midwives more recently chose to become specialised in one area of midwifery.

A further issue with hospital midwifery care was that often midwives cared for more then one woman during labour because of low staffing levels (Cox 1992; Kenny et al 1994). This requirement decreased the ability of a midwife to accurately assess the progress and wellbeing of woman and her baby as she was unable to remain with the woman at all times. This practice resulted in women spending periods of time during labour alone

(Kenny et al 1994; Klaus, Kennell, Roberston and Sosa 1986). Women left alone during labour have a heightened fear of pain and labour, with a subsequent increase in interventions (Lederman, Lederman, Work and McCann 1978). Added to this, obstetricians, not surprisingly, believed that complications during labour occurred without warning. The reality is that not many obstetricians remain with women during labour and are only contacted when a complication occurs. Obstetricians then perceive such complications to occur suddenly (Rooks 1990). This perception justifies the need for a 'constant medical alert' for all women in labour (Feinbloom 1986). Birth is perceived as a medical crisis (Kitzinger 1983; Kitzinger 1989).

To add to this, Svigos (1991) believed that midwifery education in Australia was at the level of the obstetric nurse. It could be argued that midwifery education is still lacking in producing autonomous midwives (see for example, Brodie 2002; England and Jones1998; Leap, Sheehan, Barclay, Tracey and Brodie 2002b). Autonomous in this sense refers to midwives practising in the true sense of the word midwife. Most midwives in Australia become qualified nurses before undertaking midwifery. These midwives are, therefore, more likely to work within an illness model of childbearing and act more as nurses then midwives (Walker 1976). Hobbs (1993b) believed that many midwives prefer a traditional nursing mentality and shield themselves behind obstetricians. This choice often resulted from a lack of confidence that occurred as a consequence of former professional conflicts with obstetricians (Cochrane 1995). There is safety in the medical model rather than the midwifery model when challenged. A further issue, according to Waldenstrom (1996), was that midwives were too dependent on obstetricians for managing labour/birth care, even when the process was normal. Fenwick (1995) believed that midwives' perceptions of birth could be distorted when faced with an obstetric catastrophe. The midwife then seeks consolation in the hospital safety net and her role as obstetric handmaiden. As a consequence of the disparity in the views on childbearing, with midwives viewing the process as normal, and obstetricians viewing the process as risky, the care provided for childbearing women has the potential to be misjudged (Schuman and Marteau 1993). The differing views of childbearing could result in conflicts regarding the significant events, thereby adversely affecting communication and decision making (Brodie 1996) and further contributing to the job dissatisfaction of midwives.

Professional indemnity issues and industrial relations structures are recent constraints impacting on midwives for operating in new directions (Reid 2000). Professional indemnity has been an ongoing issue for midwifery practice (Reid 2000) and has worsened in recent times with midwives currently not able to gain insurance (Dahlen 2001). Consequently, independently practising midwives are either not practising or are continuing to practice without insurance. Obstetricians are having similar difficulties in relation to indemnity and are leaving the area of maternity care (Maternity Coalition AIMS 2002; Reibel 2003).

In addition, industrial relations, as a professional issue for midwives, revolve around an annualised salary versus a standard award. Working within standard award is restricting and has resulted in inadequate remuneration; inflexible work practices and contributed to a lack of control (Bower 1993; Kenny et al 1994). This lack of control has in turn contributed to burnout, with midwives reluctant to work within midwifery models of care (Allison 1992).

It is therefore not surprising that midwives have only in the last few years become strong enough to overcome obstetric domination and develop new models of midwifery care (Brodie 2002; Robinson 1993). Obstetric domination has continued to make the development of midwifery models of care difficult and impede their acceptance.

Consumers' response to medicalisation

From the early 1960s in Britain, consumer organisations (see for example, Morris-Thompson 1992; Towler and Bramall 1986; Zander 1986), women's groups and health professionals were concerned that maternity services neglected important emotional and social aspects of the childbearing experience (see for example, Brodie 2002; Bennett and Shearman 1989; Lane 2002). Women complained about separation from family during birth and a lack of involvement in decision-making (Campbell et al 1981). None doubted the improved ability to monitor and manage the physiological risks and complications of pregnancy and childbirth during this time. Some groups, however, considered this monitoring and managing in childbearing had gone too far. There was a call from childbirth advocacy groups all over the world for the acknowledgment of the childbearing experience as a normal event (Battersby and Thomson 1997). The 1960s, according to

Aicken (1997), were considered the dark ages of obstetrics and it was from this time onwards that women sought to change maternity services. Contributing factors were the feminist movement and the mobilisation of women to articulate their health needs in the 1960s in America and early 1970s in Australia (Oakley 1986). At that time, there was an increased concern about the quality and capacity of maternity services to meet women's needs for emotional and social support as well as those for safety. Women complained about feeling alienated and marginalised and being treated as objects on a conveyer belt or a number. As a result, a growing number of women chose homebirth as an alternative to the over medicalised birth in hospitals (see for example, Cope 1994; Rooks 1990; Soderstron, Stewart, Kaitell and Chamberlain 1990). This shift occurred in the later 1970s in Australia (Campbell et al 1981; Torr 1993) and 1960s in Britain (Towler and Bramall 1986). Obstetricians became apprehensive about the renewed interest in homebirths and responded by renewing their calls for women to have, " ... trust in the powers of obstetric management to achieve a superior outcome" (Tew 1992:10). With more women opting for homebirths, in 1980 a policy was circulated to New South Wales maternity units to redress consumer dissatisfaction (Shearman Report 1989). Recommendations were made for changes to hospital practices in the form of the promotion of a more homelike atmosphere in order to decrease the demand for homebirths. Birth centres were also considered to be a safe alternative and attracted couples who originally wanted a homebirth (Campbell et al 1981; Torr 1993). At the same time, there was an insistence that interventions be monitored, hospital practices changed to promote a more homelike atmosphere, doctors and midwives were given a broader education, and women were kept informed in order to participate in decision making about their childbearing experience (Shearman Report 1989). These recommendations resulted in significant change, though hospitals were slow to instigate change (Cope 1994). According to Shearman (1989), the recommendations were inconsistently adopted over the next decade. It became evident that more work was still needed, as consumers continued to complain about inflexible practices and the overuse of technology (Campbell et al 1981; Fenwick 1995).

There were other concerns, evident in the literature, about the inflexibility of maternity services in Australia and Britain. These concerns included the long waiting times for antenatal care that women experienced (see for example, Battersby and Thomson 1997; Reid 1989; Turnbull 1984), over crowded antenatal clinics (Conroy 1993; Street, Gannon and Holt 1991), short consultation times (see for example, Brodie 1993a; Rooks 1990;

Tew 1992), problems of access, lack of information about childbearing (Turnbull 1984) and the fact that each woman met different people every encounter during her childbearing experience (see for example, Cochrane 1995; Parsons 1991; Zander 1986). More seriously, fragmented care is dangerous for a woman for a number of reasons (Kitzinger 1992). First, because the woman is seen by a different health professional at each visit, there is a possibility that important changes can be missed because the woman and her carer do not know each other (Cox 1992), the woman may not feel comfortable about discussing her concerns (Robinson 1989) and care becomes impersonal (Battersby and Thomson 1997). Fragmented care is also inefficient and results in deskilling of midwives (Aicken 1997). Another issue is that because large numbers of women attend these antenatal clinics, each woman is seen for only a short period of time. This practice results in a superficial consultation, which could only detect gross abnormalities (Tew 1992). The result is less then adequate care with the clinic visit for many women being far from reassuring (Zander 1986). Tew (1992) believed that for many women the clinic experience was upsetting and did not encourage them to keep appointments. An interesting indictment of the state of antenatal care surfaced in recent times with research advocating for psychosocial assessment and care of women (Forster et al 2004; Mollart and Bullard 2004). This is an area that should be a routine part of antenatal care and not exceptional.

All these factors have contributed to consumer dissatisfaction with maternity services, resulting in consumer groups becoming active in attempting to influence women's health services (Melia et al 1992; Biggins 1992). Pressure from consumer groups resulted in a number of government reports being written on birthing services in Australia (see for example, Lumley Report 1990; Robinson Report 1996; Shearman Report 1989) and Britain (Cumberlege Report 1993; Winterton Report 1992). These reports reflected consumer advocacy and recommended that significant changes occur in maternity services. Such government inquiries into maternity services in both Britain and Australia were an attempt to bring about change. Many recommendations were made but few changes occurred until the Cumberlege Report (1993) in Britain. The implementation of the report's recommendations as policy saw the introduction of midwifery led models of care in both Britain and Australia and was a great stimulus for change. Consumer dissatisfaction with maternity services was eventually successful in instigating change, though very slowly (Cochrane 1995; Murphy-Black 1995).

Despite the subordination of midwives by obstetricians and the resistance of obstetricians to change, midwifery models of care slowly evolved and, in some instances, have survived. Obstetricians for so long had promoted the danger of childbirth that could only be reduced by obstetric care (Murphy-Black 1995). This had to be disproved, however, if midwifery models were to become mainstream.

Government responses

Government inquiries into maternity services in Britain and Australia provided an opportunity to examine some of the issues identified earlier in this chapter. In turn this examination provided a further opportunity to evaluate existing services and make specific recommendations for improvement. It was usual for such reviews of maternity services to include consultation with a broad spectrum of people, including consumers and health professionals (Bennett and Shearman 1989). The findings and recommendations of relevant major reviews are briefly examined here. Only those recommendations pertinent to this research project are mentioned here.

All the issues raised in the literature were identified in the government reports following the evaluation of existing maternity services. These evaluations formed the basis for recommendations. The Shearman Report (1989) made a number of recommendations pertaining to the improvement of maternity services for women in New South Wales (NSW). These recommendations include the need to promote collaboration and cooperation between health professionals; that all women whether high or low risk, should have continuity of care; and that care should be community based. The Shearman Report (1989) also suggested the introduction of models of care where general practitioners (GP) and/or midwives undertake antenatal care with obstetric support for low risk women. Further, the report recommends that continuity of antenatal care and childbirth support models should be extensively piloted and that there should be community based midwives caring for low risk women during pregnancy and childbirth (Bennett and Shearman 1989). It was also evident that there was a need to provide family centred childbirth for women and above all, a choice in service delivery.

Seven years later, the Trickett Report (1996) was published in NSW and reaffirmed the recommendations made in the Shearman Report (1989). The Trickett Report (1996) was

specifically established to examine workforce participation, midwifery practice and midwifery education. The report recommended that the Department of Health support the principles of primary health, the implementation of midwifery care projects, and the development of midwifery services occurring in collaboration with GPs.

Other states in Australia have released similar reports, such as the Lumley Report (1990) in Victoria, identifying many of the same issues and concerns about maternity services. The recommendations were that a collaborative network of health professionals should operate; midwives and GPs should be supported to play a much greater role in the care of low risk women; models of care should be appropriate to the level of need; options of care should be available to the maximum possible extent for women; women should have informed choice; and continuity of care should be an objective of maternity services. These recommendations mirror what had been presented in NSW and were a common theme throughout the maternity services inquiries.

In the same year, Western Australia published the Michael Report (1990), which identified the same issues and concerns about maternity services as previously identified. Pertinent recommendations were that women should have an informed choice regarding options of care; that a greater involvement of GPs and midwives should be encouraged in the provision of antenatal care for women with low risk pregnancies; and a pilot project be funded to trial team midwifery. The majority of recommendations in this report were very specific about the structural changes that needed to occur within maternity services, such as more home like atmosphere for labour wards.

Despite all of the evidence and the review of maternity services in three states in Australia (Lumley Report 1990; Michael Report 1990; Shearman Report 1989), there continued to be dissatisfaction with maternity services (Robinson Report 1996) and little action. This dissatisfaction resulted from the fact that little change had occurred despite the reviews of maternity services. There had been some innovations, with a minority of women being given more choice, but more system wide change was needed. Consumers continued to exert pressure (Robinson Report 1996) to expand innovative services with the aim to improve the range of options for maternity services. Consequently, in 1991 the Australian Women's Health Committee suggested the formation of a working party to explore options for effective care in childbearing (Aicken 1997). The draft report was produced in 1994

with the final report being handed down in 1996 (Robinson Report). Needless to say, continuity of care continued to be high on the agenda for maternity services change. The pertinent recommendations were very familiar. It was recommended that women have informed choice regarding options of care; continuity of care and carer should be promoted; midwives should play a greater role in the care of low risk women; and links should be developed between midwives and GPs.

Yet there was still little action and continued dissatisfaction despite the many recommendations that had been made. Crowley (1999) believed that it was, therefore, time for national leadership on the issue. The suggestion was that an Australia wide review of maternity services would be more effective in making recommendations across the country. With this, yet another inquiry occurred, this time a Senate Inquiry, including recommendations. The Senate Inquiry report (Crowley 1999), however, went deeper and further then previous reports in that it dealt with the medicalisation of childbirth. The report included discussion on the increased intervention rates and consequent morbidity; the fact that intervention rates were highest with privately insured women, in tertiary hospitals attended by obstetricians and influenced by the threat of litigation; the fact that funding arrangements increased fragmented care for women; and the fact that many practices were based on custom as opposed to evidence (Crowley 1999). The recommendations followed a familiar theme, that is, that women receive information about options of care and that previous recommendations regarding continuity of care, and shared care, should be implemented (Crowley 1999).

At the same time as these inquiries were occurring in Australia, similar inquiries were happening in Britain. The Winterton Report (1992) in Britain, however, was somewhat different. For example, the Winterton Report (1992) emphasised in its introduction that childbearing is a normal process and not an illness and placed the women at the centre of maternity services. This stance was acknowledged as the starting point and focus of the inquiry. The psychosocial aspects of childbirth and the need to balance the issues of health and safety were continually emphased (Winterton Report 1992). This emphasis was a radical perspective to take at the time (Page 1993).

As part of the investigation into maternity services in Britain, women were asked to comment about their needs in relation to maternity care (Winterton Report 1992). Three

common themes emerged: the need for continuity of care; desire for choice of care and place of birth; and the right of women to control their own bodies at all stages of pregnancy and birth (Winterton Report 1992). These findings mirrored Australian findings. The women in the Winterton Report (1992) also supported the notion of community-based models of care. Developing supportive networks antenatally was seen to assist women immensely with postnatal support at a time when this support was needed most. Community based models of care, therefore, facilitated this process.

The Winterton Report (1992) also identified the need to reassess the midwives' role in order to achieve flexibility and be responsive to women's needs. The report further recommended that midwives should have their own caseload and their status as professionals acknowledged. The principle of continuity of care should be applied equally to high-risk women and those with normal pregnancies. More attention was to be given particularly with postnatal care for continuity of care models. These recommendations reflected the principles of full utilisation of midwifery skills; birth in hospital can no longer be justified on grounds of safety; there should be development of midwifery-managed units; and that there should be improved continuity and community based care.

The response of the British Government to the Winterton Report (1992) was to ask Cumberlege, the Minister for Health, to set up a taskforce to review maternity services and to make further recommendations. Representatives from user groups and professionals were included in this taskforce. The Cumberlege Report (1993) went one step further than other reports, holding that women and their families should be at the centre of maternity services, both in the planning and provision. Key components of the maternity service included that women be given the name of a midwife who can be directly contacted as the lead professional in care; antenatal care should be based in the community; labour and birth care should be provided by a midwife known to the women; and GPs and midwives should work in a complementary way. The report then identified the key principles of continuity, choice and control, which must then underlie effective women centred services. Ten key indicators of success were then outlined, which if achieved, would mean that the recommendations in the report had been adopted and all women would have choice, continuity and control. The Cumberlege Report became policy for maternity services in Britain and started a wave of fundamental reform (Page 1995b).

As a direct result of these government reviews (see for example, Cumberlege Report 1993; Robinson Report 1996; Shearman Report 1989) attempts to improve maternity services through system change and innovations have been instigated in Britain and more recently in Australia (Aicken 1997). These reports have been the impetus for new midwifery models of care and greater choice for women (Brown and Lumley 1994). In Australia, this process has included birth centres (see for example, Biro and Lumley 1991; Rowley and Kostrzewa 1994; Stern et al 1992), team midwifery (see for example, Aicken 1997; Parsons 1991; Rowley et al 1995) and caseload models (Bowman, Hunter and Wotley 1997; Kelly 1998). These innovations required obstetricians, midwives and GPs to begin to work together in complementing each other's skills (Kitzinger 1992). Unfortunately, cooperation has more often occurred at the level of rhetoric and policy, rather than through the development of successful models that combine skills and knowledge and juxtapose public and private sector services. Opportunities for the participation of women in these innovations have frequently been limited to clients who are well educated and fluent in English (see for example, Brodie 1993a; Hastie 1991; Parsons 1991). These innovations have occurred predominantly in tertiary hospitals and involve women of low risk (see for example, Adams 1997; Kenny et al 1994; O'Donnell 1992). In addition these innovations have often remained alongside conventional services, rather than achieving system level change for all clients (see for example, Heffernan 1993; Kostrzewa and Rowley 1992; Hambly 1997). The need to reorient innovations within the existing maternity services has been recently recognised (Fasano, Kelly and Queen 1998; Johnson, Stewart, Langdon, Kelly and Young 2003).

Despite considerable rhetoric and policy activity there remained room for improvement within mainstream maternity services in Australia. Consumer dissatisfaction with obstetrical services is still evident (Crowley 1999; Robinson Report 1996). Under utilisation of midwifery skills continues, despite developments in maternity services (Robinson 1990). Few organisations and midwives have made significant changes in maternity care despite the evidence for change (Brodie 1996). It is, therefore, imperative that midwives grasp the opportunities to improve maternity services.

It has become clear from these reports that women want control, choice and continuity of carer. These conditions must, therefore, become the underlying principles of any innovation in maternity care (Hobbs 1993b). Despite all the efforts to achieve

improvement at policy or government level, these needs continue to be voiced by women. Changes have not occurred at the rate women expect. There is still a need for change in maternity services despite the number of reports that have been produced. Insufficient change has been achieved. Despite the recommendations from these reports regarding the implementation of midwifery models of care, there continues to be a dominance of the medical model of care, with an obstetrician as the lead professional (Maternity Coalition AIMS 2002; Reibel 2003). There remains a need to implement models of midwifery care and to rethink how these could be implemented and maintained in a maternity service system dominated by obstetrics. In addition, agitation for change in maternity services has continued despite the many recommendations that have been made in the various reports.

A common theme in all of the reports was the appropriateness of midwives to provide care to childbearing women in collaboration with medical colleagues. Midwives need to work collaboratively with the medical profession in some form, with the GP being a viable option. The proposed change to be implemented in this research project was a midwifery model of care in collaboration with GPs. The purpose of the study described in this thesis was to record and analyse the process of change associated with planning and implementing a midwifery model of care to enable a better understanding of organisational change. More evaluation of the maternity services literature was first required to assess the most appropriate form the midwifery model would take.

It is clear from the literature presented in this chapter that, since the 18th and 19th centuries there has been a steady decline in the role of the midwife that has only been recently redressed. The history of maternity services outlines the continual struggle that has occurred between midwives and obstetricians for the control of birthing women. Further this struggle has resulted in increased medicalisation of childbirth and subsequent increased use of technology. As a result, women expressed dissatisfaction with maternity services and pushed for reform through government inquiries. Despite all efforts to achieve improvement, the need for change continues to be expressed by women.

The literature presented in this chapter has been used to justify introducing a midwifery model of care in collaboration with GPs. Further, the literature provides an insight into the reasons this model was not successfully implemented. Much of this literature is, therefore,

extrapolated in Chapter Eight in order to help explain the obstacles effecting organisational change in this study.

The next chapter examines the literature on a number of evaluations undertaken on midwifery models of care in order to set the context for the model studied in this thesis. An examination of the literature on team midwifery and caseload follows in order to ascertain the most appropriate model. The next chapter will also examine the evaluations on GP care in order to ascertain if GPs were the most appropriate collaborators for a midwifery model of care at the time this study was proposed. This further justifies introducing midwifery GP shared model of care for low risk childbearing women.

Chapter Three

Models of maternity care

The previous chapter describes and analyses the literature of the history of maternity services in order to justify introducing a midwifery model of care in collaboration with general practitioners (GPs). A common recommendation from the literature was the appropriateness of midwives to provide care to childbearing women in collaboration with GP. This chapter takes the recommended collaboration further through an examination of the literature evaluating midwifery and GP models of care in order to confirm this collaboration and ascertain the most appropriate model to implement. In addition, this examination of the literature explores in detail the topics of team midwifery and caseload in order to confirm the most appropriate model. It should be emphasised here that the decision to implement a midwifery model of care in collaboration with GPs was based on available evidence in the early 1990s. The literature that reports on evaluations of the range of midwifery models and midwifery care during the 1980s and early 1990s indicated that positive outcomes could be achieved for women and their infants through midwifery led care models. This literature is discussed and these findings are than placed in the context of the more recent literature analyses. The later literature appears to be somewhat equivocal in terms of outcomes such as reduced perinatal mortality rates and reduced caesarean section rates.

It is clear from the literature on the history of midwifery care, that a long history of obstetric domination of midwives has and continues to occur. On these grounds a midwifery model of care in collaboration with obstetricians was not pursued and an evaluation of obstetric care was, therefore, not undertaken.

Evaluation of midwifery care

In Britain and Australia, care for most childbearing women is provided in the public hospital system with employed midwives (see for example, Brodie 1992; Cochrane 1995; Heffernan 1993). This practice has reduced the midwives' role, resulting in minimal impact on maternity services development (Morris-Thompson 1992). Midwives have been prevented, by controls over practice and regulation, from doing

what they are best able to do, that is, ensure to the greatest extent possible the normality of childbearing (Wagner 1994; Reid 2000). These controls have derived from increased medicalisation of childbirth. Midwives have recently sought to reclaim their role as primary carer of low risk women (Finlayson 1993) and rejuvenate the midwifery profession (Brodie 1998). This is the practice for which midwives are educated (Robinson 1989; Street et al 1991) and government reports have advocated (see for example, Cumberlege Report 1993; Robinson Report 1996; Shearman Report 1989). For example, the Shearman Report (1989) supported the role of the midwife in caring for low risk women to ameliorate congestion and problems of fragmented care identified in antenatal clinics. The report noted that a failure to effectively utilise the skills of midwives and GPs in antenatal care for low risk women, had occurred. Further, British midwives have reported their belief that midwifery led care improves outcomes for women and their babies (Winterton Report 1992).

Despite the recommendations in support of midwifery care, change has been slow. Robinson (1993) believed that only in the last ten years the midwifery profession had become strong enough to challenge the status quo and develop new models of care. Such midwifery models of care have been evaluated and indicated that midwifery care is a justifiable option. The literature outlining these evaluations will now be reviewed (see Appendix One for more details). Before beginning this discussion, it is important to emphasise that, although this is about midwifery led models of care, obstetricians are still potentially involved. The midwife would always need to refer the women to an obstetrician if complications occurred at any stage during the childbearing process.

Some of the earliest work evaluating midwifery led care tended to focus on the role of the midwife in providing antenatal care and domiciliary postnatal care. Evaluations of antenatal clinics in Britain and Australia demonstrate that women are more satisfied with midwife care compared to midwife/obstetric care (see for example, Giles, Collins, Ong and MacDonald 1992; Craveley and Littlefield 1992; Reid 1989). These evaluations were predominantly undertaken as a cohort study, with one randomised control trial (Giles et al 1992). The number of participants in these studies ranged from 89 to 396, predominantly low risk women. The results of these evaluations indicated a lower perinatal mortality rate (De Costa et al 1991), or no difference in other outcome measures when compared to traditional care (Craveley and Littlefield 1992; Giles et al

1992). Caution needs to be exercised in interpreting these results as large sample sizes are needed to determine changes in rates or mortality and caesarean section rates. Further outcomes in many studies were demonstrated decreased costs (Craveley and Littlefield 1992; Giles et al 1992) and increased maternal satisfaction (Concoy 1993; De Costa et al 1991; Reid 1989) when compared to traditional care. Such increased satisfaction, identified by women, is reported because midwives have more time to give comprehensive information. Further, the lack of bustle and tension in the midwives' clinic, the midwife being able to stop and listen to women (Reid 1989) and to show an interest in her concerns and questions, contributed to this satisfaction (McCourt and Percival 2000). The midwife, therefore, provided more personalised, supportive, responsive and continuous care (Conroy 1993; McCourt and Percival 2000). These findings can explain why women choose to attend antenatal care with midwife care more often when compared with midwife/obstetric care (Thomson 1991).

Evidence indicates, therefore, that midwives' clinics (midwives providing antenatal care) provide safe and effective care, at lower costs because of lower salary expenses (Fagin 1982; Giles et al 1992; Craveley and Littlefield 1992). Higher productivity has also been demonstrated in midwives' clinics (Craveley and Littlefield 1992) as well as greater midwife satisfaction (Conroy 1993).

Similarly domiciliary postnatal care or early discharge was evaluated in the late 1980s and early 1990s demonstrating a positive impact for women. Domiciliary postnatal care refers to women and their infant being discharged from hospital 12 hours after birth and having home visits from the hospital midwife. The evaluations of this care were predominantly undertaken as a cohort study, with one randomised control trial (Carty and Bradley 1990). The number of participants in these studies ranged from 42 to 710 women. The results of one evaluation indicated a lower maternal and infant morbidity, with more women fully breastfeeding by one month and were more satisfied, with the hospital group scoring higher depression scores and lower on scores of confidence in being a mother (Carty and Bradley 1990). Being better adjusted as a mother was also reported in the evaluation undertaken by James et al (1987). On the whole, the evaluations reported that there was no difference in infant and maternal morbidity between the two groups (see for example, James et al 1987; Lemmer 1987; Scott et al 1992), concluding that early discharge is safe and cost effective (Berryman and Rhodes

1991). Though Scott and colleagues (1992) reported that early discharge actually cost more.

Earlier evaluations of midwifery led care in Britain and America attempted to compare midwife with obstetric intrapartum care. The findings of these studies indicate that midwife care is a serious option (Blanchette 1995; Oakley et al 1995; Tew and Damstra-Wijmenga 1991). These evaluations were predominantly undertaken as a cohort studies, with one randomised control trial (Hundley et al 1994). The number of participants in these studies ranged from 1,107 to 184,554 women of all risk categories. The results of these evaluations indication that women receiving midwifery care had less continuous fetal monitoring, fetal distress, analgesic use and episiotomy rates when compared with obstetric care (Blanchette 1995; Hundley et al 1994; Oakley et al 1995). Women receiving obstetric care were more likely to have an intravenous infusion, oxytocics, artificial rupture of membranes, no fluids or food during labour, instrumental births, caesarean section and less educational and psychosocial intrapartum care (see for example, Blanchette 1995; Hundley et al 1994; Oakley et al 1995). There was no difference in perinatal mortality, however, when comparing midwifery to obstetric intrapartum care (Blanchette 1995; Hundley et al 1994). In contrast, Tew and Damstra-Wijmenga (1991) in their examination of 184,554 women of all risk categories demonstrated a 12 times lower perinatal mortality rate for midwifery care when compared with obstetric care.

Birth centre care (where low risk women are cared for by midwives during pregnancy, birthing and immediate postnatal period) is another form of midwifery care that was positively evaluated in the 1980s and early 1990s. Studies in America have compared birth centre care with labour ward care (Chambliss et al 1992; Stern et al 1992) and with national intervention rates (Rooks et al 1992a; Rooks et al 1989). These evaluations have involved cohort studies with no randomised control trials. The number of participants in these studies ranged from 951 to 11,814, predominantly low risk women. In Australia, birth centres have been evaluated indicating that care provided to women and babies has not been compromised (see for example, Biro and Lumley 1991; Rowley and Kostrzewa 1994; Stern et al 1992). Rooks and his colleagues (Rooks et al 1992b) concluded that birth centre care in fact resulted in decreased perinatal mortality when compared to traditional care. These evaluations took into account the risk status of

women birthing in traditional care compared to birth centre care. Overall the evaluations indicate that women receiving birth centre care are less likely to use analgesia, have continuous fetal monitoring, be augmented/induced (Rooks et al 1992a and 1992b), and have lower caesarean section and episiotomy rates (see for example, Chambliss et al 1992; Hodnett 2002a; Rooks et al 1992a). Birth centre care for high-risk women has been found to be safe (see for example, Chapman 1993; Kostrzewa and Rowley 1992; Rowley and Kostrzewa 1994) and to be more satisfying for all women (Rooks et al 1992a & 1992b; Hodnett 2002a). Further, birth centres have been shown to save costs (Rooks et al 1989) with midwives more satisfied when compared to labour ward midwives (see for example, Biro and Lumley 1991; Chapman 1993; Kostrzewa and Rowley 1992).

More recently, the development of continuity of care and carer models has occurred. Continuity of care is not well defined. The term is used to describe a philosophy of care provided by a team of known midwives (see for example, Flint 1991; Homer et al 2001a; Green, Renfrew and Curtis 2000). Continuity of carer, on the other hand, is total childbearing care provided by a specific midwife (Walton and Hamilton 1995). The appropriate health professional to provide continuity of care or carer is the midwife who is present at all stages of childbearing (Flint 1991; Lawson 1992), and educated in the clinical and advisory aspects of childbearing (Robinson 1989). Rowley and Saxton (1992) believe that a midwifery philosophy maintains childbearing to be normal no matter whether care is undertaken in a hospital, the community or at home.

Evaluations of team midwifery based in hospitals, in the community or across the hospital and community have been undertaken (Currell 1993; Walton and Hamilton 1995). These evaluations have been either descriptive exploratory (Aicken 1997), cohort studies (Morris-Thompson 1992; Smethurst 1997; Ward and Frohlich 1994) or randomised control trials (see for example, Flint et al 1989; Homer et al 2001a; Kenney et al 1994). The sample size in these evaluations ranged from 34 to 1,089 women, of all risk categories. Randomised control trials in Australia and Britain have demonstrated that women were better prepared for labour and parenting, had less interventions (augmentation, analgesia, episiotomy, instrumental) (see for example, Biro, Waldenstrom and Pannifex 2000; Flint et al 1989; Waldenstrom and Turnbull 1998) and less antenatal and neonatal admissions of care with team midwifery care compared to

traditional care (Kenny et al 1994; Rowley et al 1995). Evidence in support of reduced caesarean section rates, however, is inconclusive (Homer et al 2001a). A systematic review undertaken by Waldenstrom and Turnbull (1998) indicated that caesarean section rates were not reduced with team midwifery care. Biro and colleagues (2000) concurred with these results. The outcomes of these evaluations have indicated either no difference in perinatal mortality (see for example, Biro et al 2000; Flint et al 1989; Kenny et al 1994) or slightly less perinatal mortality (Homer et al 2001b) when comparing team midwifery with traditional care.

Women participating in team midwifery projects have been satisfied with their care and overwhelmingly in favour of team midwifery (see for example, Aicken 1997; Olssen, Jansson and Norberg 2000; Page 2000). A number of factors contributing to this increased satisfaction compared to traditional care have been identified; they include women's improved experiences of care (see for example, Homer el al 2001b; Kenny et al 1994; Rowley et al 1995) and their higher participation in decision-making (Turnbull et al 1996). It appears women's experience of team midwifery can result in better long-term health outcomes for them and their babies. This partially relates to the growing evidence indicating the negative effect that obstetric interventions can have on a women's childbirth experience, particularly in terms of their psychosocial and emotional health (see for example, Creedy et al 2000; Brown and Lumley 1994; Gamble and Creedy 2004). The costs of such outcomes have not been investigated.

In Australia and Britain, team midwifery has been identified as an approach to care that provides a more rational and satisfying use of midwifery skills. Further, it increases midwives' learning opportunities, with the midwife able to evaluate the care provided as the woman is followed through the process of childbearing (Flint 1993; Rowley et al 1995). For example, the midwife can discuss with the woman the decisions made regarding appropriate pain management after the birth. Midwives were satisfied because they were able to fulfil their role and had better opportunities to develop a relationship with women and their families (see for example, Adams 1997; Black 1992; Morris-Thompson 1992).

Continuity of care models provide women with the social support of a midwife during pregnancy and labour. Research indicates that provision of such support may be one of

the key mechanisms for improved outcomes. Support during pregnancy influences a number of pregnancy outcomes when compared to traditional care, including decreased antenatal hypertension (Turnbull et al 1996), an increase in spontaneous vaginal births, a decrease in epidural use, healthier babies and women (Oakley, Rajian and Grant 1990) and increased satisfaction of women to antenatal care (Waldenstrom et al 2000).

Similarly support of a midwife during labour can improve labour outcomes. Women birthing in hospitals rarely have continuous supportive midwifery care during labour, with health professionals in and out of the room (see for example, Kaufman 1993; Keirse, Enkin and Lumley 1989; Kenny et al 1994). A growing body of research indicates, however, that good physical and psychological care during labour decreases the need for analgesia, the length of labour and interventions, and improves fetal outcome (see for example, Butler et al 1993; Hodnett 2002b; Klaus et al 1986). It appears that being alone increases anxiety, fear and pain leading to the process of labour slowing with resultant interventions (Lederman et al 1978). Further, women report they value continuity of carer in labour and being cared for by a midwife they have met (McCourt, Page and Hewison 1998; Walsh 1999). This finding has been challenged recently, however, with women reporting that they would prefer to be cared for by a competent, caring midwife during labour over one that they knew (Green et al 2000). Waldenstrom (1998) attributed this preference to the shared philosophy and attitudes of midwives working in midwifery models, that presents all midwives as the same. The confounding factor with this argument is the past experience of women and how that determines their response. If women were asked to choose between a competent and caring midwife and a known midwife, they would naturally select the former (Page, Cooke and Percival 2000). Homer and colleagues (2001a) speculate that women would value a known midwife more if they could have both these options.

Continuity of carer midwifery models are termed caseload or one-to-one. Considerable confusion about what is meant by a caseload model of care is evident in the literature (Hutton 1995). This confusion is apparent when caseload has been used to refer to teams (see for example, Fawcett and LaCumber 1995; Lewis 1995a-d; Stimson 1995).

The characteristics of a caseload model are described in the following definition.

> When a midwife carries a caseload she is the primary provider of midwifery care during pregnancy, birth and the early postnatal days for an agreed number of women. She may be providing care to women wherever they are ... she has responsibility for the planning and monitoring of care throughout for the women on her list (Hutton 1995: 396).

The evaluations that have been undertaken to compare caseload midwifery to traditional care have not included any randomised control trials. Between 73 to 1,403 women of all risk categories have been involved in these evaluations. Evaluations of caseload midwifery care compared to traditional care demonstrated lower induction rates (Sandall, Davies and Warwick 2001); higher rates of normal vaginal birth, less use of analgesia, fewer episiotomies, smaller proportion of low birth weight babies (see for example, Hambly 1997; Page, McCourt, Beake and Hewison 1999; Sandall et al 2001); lower rates of epidurals (see for example, Benjamin, Walsh and Taub 2001; McCourt and Page 1996; Sandall et al 2001); decreased caesarean section rate (Leap 1997); higher breastfeeding rates at birth (Sandall et al 2001); women more positive and confident about their maternity care, birth and parenting compared to women receiving conventional care (McCourt and Page 1996); and achievement of high levels of continuity (Sandall et al 2001). The perinatal mortality rate in these caseload midwifery care evaluations was found to be either similar to (McCourt and Page 1996) or lower (Guilland 1999) when compared to traditional care. Women participating in caseload midwifery care were satisfied with the care they received compared to traditional care (see for example, Hambly 1997; McCourt and Page 1996; Sandall et al 2001).

When caseload midwifery care was compared with team midwifery care, it was demonstrated that women receiving caseload care had fewer labour interventions, more normal births, experienced much higher levels of continuity and were more likely to decide on early discharge than women receiving team midwifery care (Benjamin et al 2001).

Added to this there is acknowledgment (see for example, Kitzinger 1992; Morris-Thompson 1992; Shearman Report 1989) of the need for innovations to extend outside the hospital to the community. The literature refutes the notion that the most appropriate place for birth is hospital, especially for low risk women (see for example, Kitzinger 1992; Olsen and Jewell 2002; Olsen 1997). The Winterton Report (1992) claims that a community

setting for antenatal care should be recognised as socially and practically important for women. The community setting will 'sow the seeds' for the vital postnatal support for women and their babies. Antenatal care, therefore, should be community based (Giles et al 1992; Lawson 1992), offered, for example, in early childhood centres (Homer et al 2001b). In Britain the advantages of community based maternity care for women include improved accessibility, greater attendance, reduction in waiting times, improved satisfaction and better pregnancy outcomes (Ladford 1995; Wood 1991). In addition, little time is wasted in travelling for women and the fact that community based maternity care facilitates contact with other local people (Zander 1986). The financial and personal cost for women experiencing community care was found by Thomas, Draper, Field and Hare (1987) to be much less then equivalent hospital care. These authors also discovered that the incidence of hypertension in women attending care in the community was lower then for those attending hospital care. This could relate back to the advantages discussed earlier for community based maternity care.

A number of evaluations comparing women who had midwives assess them in early labour at home with women who contacted the labour ward have been undertaken (see for example, Klein, Lloyd, Redman, Bull and Turnbull 1983a; Lauzon and Hodnett 2002; McNivan, Williams, Hodnett, Kaufman and Hannah 1998). Women assessed at home had fewer inductions, less analgesia, fetal distress and forceps births. These outcomes were attributed to the fact that women who contact the labour ward were usually asked to come into hospital to be assessed. Sometimes these women were in false labour and were sent home or they were in very early labour. The risk of these women being in hospital is that often, obstetricians want to start intervening by augmenting the labour. This practice contributed substantially to the cost of care (Flint 1993; Walsh 1989).

The table in Appendix One summarises the evaluations used in this section clarifying that midwifery care is a safe option.

There is no evidence to support the notion that midwifery care is dangerous (see for example, Thomson 1994; Waldenstrom 1996; Walker, Moore and Eaton 2004). A lot of the evidence in fact supports the fact that the perinatal mortality rate is similar (see for example, Giles et al 1992; Hundley et al 1994; Biro et al 2000) or reduced (see for

example, De Costa et al 1991; Homer et al 2001b; Tew and Damstra-Wijmenga 1991) when comparing midwifery care to traditional care. In Britain, women are recognising that a midwife is the best person to care for them during childbearing, specifically through continuity of care and carer models (Winterton Report 1992; Zander 1986). Studies in Britain have asked women who they would prefer to care for them during childbearing, with the majority choosing a midwife if obstetric care was not required (see for example, Chamberlain, Soderstrom, Kaitall and Stewart 1991; Davies and Evans 1991; Flint 1991). The consequence of this preference by women for midwives has, according to Flint (1993), resulted in women putting pressure on the health care system in Britain to provide them with continuity of care by their midwife. While this is not so evident in Australia, there are suggestions of similar trends emerging (Fenwick 1995; Reid 2000). Positive midwifery outcomes can partly be explained by the midwives' orientation to non intervention (Zander 1986). This ability of midwives to avoid interventions follows from their beliefs and values about women and labour being normal (Kaufman 1993; Lane 2002). Midwives are, therefore, the appropriate carers of low risk childbearing women and their families (Glover 1992).

In the previous chapter, the examination of literature identified that women want choice, control and continuity. At the time of starting this project, the midwifery models that best provided continuity of carer were team midwifery and caseload midwifery care. In order to determine the most appropriate midwifery model to implement for this project, a brief description of each model follows and the differences critically examined. The different forms that both models take will be incorporated into the discussion in order to provide an overview of current practice.

Team midwifery

In Australia, team midwifery projects cater for low risk (see for example, Aicken 1997; Heffernan 1993; Walker et al 2004), high risk (Farrell and Everitt 1997; Walker et al 2004) or all women (see for example, Kenny et al 1994; Parsons 1991; Rowley et al 1995). Some team midwifery projects include privately insured women (see for example, Carey 1992; Farrell and Everitt 1997; Parsons 1991). The number of midwives on each team is five or six, caring for 250 to 300 women per year. There is an account of one team with only four midwives caring for 200 high-risk pregnancies. The reasons for this are that care is

provided in collaboration with obstetricians, the women are usually induced and the midwives do not work nights (Farrell and Everitt 1997). Team midwifery projects in Australia have been evaluated by randomised controlled trials (see for example, Biro et al 2000; Rowley et al 1995; Waldenstrom, Brown, McLachlan, Forster and Brennecke 2000).

Team midwives provide care predominantly from the first visit to the early postnatal period. There is an account of one team midwifery project where the midwives provided antenatal, labour and birth care only (Rowley et al 1995). Midwives did however, provide a labour and birth debriefing with the women for whom they cared.

Predominantly, team midwifery projects have been based in hospitals with antenatal care provided at the hospital or in the woman's home (Paynter 1998). Recently antenatal care has been provided in the community (Homer et al 2001b). During pregnancy women were required to see the hospital obstetrician once (Aicken 1997; Parsons 1991) or up to three times (Carey 1992; Rowley et al 1995). Women admitted to hospital antenatally if complications arose had the team midwife as the primary midwife, visiting daily to undertake care (Parsons 1991). A midwife was rostered to work in the high-risk pregnancy unit for the morning and afternoon shifts (Farrell 1998). To increase the chance of women being cared for by a known midwife during childbirth, they met all the team midwives antenatally (Homer et al 2001b; Kenny et al 1994). Despite these efforts not all women were guaranteed to have a known midwife care for them during childbirth (see for example, Brayer 1998; Homer et al 2001b; Kenny et al 1994). The level of continuity of carer, therefore, was variable and not as high as with caseload care (see for example, Kenney et al 1994; Homer et al 2001b; Rowley et al 1995), though higher levels (80%) of continuity have been reported (Biro et al 2000). Antenatal education sessions were either formal and structured (Aicken 1997; Carey 1992) or two weekly drop-in sessions for education and support (Kenny et al 1994).

When in labour, women contacted the midwife on call (Kenny et al 1994). There is no mention about whether women were assessed at home or hospital. Early labour care may be conducted at home (Paynter 1998). Women gave birth in the labour ward or birth centre (Rowley et al 1995). Women were offered options for postnatal care. If women elected to stay in hospital, then a team midwife visited daily (see for example, Heffernan 1993; Homer et al 2001b; Kenny et al 1994). If women elected to go home postnatally, a team

midwife would visit daily until day four (see for example, Carey 1992; Heffernan 1993; Kenny et al 1994).

Midwives were not necessarily available over 24 hours for women (see for example, Dwyer and Eaton 1998; Homer et al 2001b; Paynter 1998), some teams do not have midwives available at night (Heffernan 1993; Farrell and Everitt 1997) or they are on call (Heffernan 1993). Other team midwifery projects had a roster with first and second midwife on call (Kenny et al 1994; Rowley et al 1995). Regular meetings occurred between the team midwives, an important component for review and support (Brayer 1998).

In Britain, team midwifery projects cater for low risk women (Fleissig, Kroll and McCarthy 1996; Flint et al 1989) or all women (see for example, Fawcett and LaCumber 1995; Heseltine and Watkins 1991; Smethurst 1997). Caring for high and low risk women together was identified as a problem because high-risk women needed more time (Fleissig et al 1996). A recommendation was made, therefore, that women with high-risk pregnancies should be cared for separately (Fleissig et al 1996; Lewis 1995c), which has recently been implemented (Yeadon et al 2001). Teams consisted of six midwives, with one team having four (Flint et al 1989) and another having eight midwives caring for 200 to 300 women per year (Fleissig et al 1996). Flint and colleagues (1989) recommended five or six midwives rather than four to allow a second midwife to be on call. Team midwives provided care from booking to 28 days postnatal. Randomised controlled trials of team midwifery projects have also been undertaken in Britain (Flint 1993; Turnbull et al 1996).

The team midwifery projects were based in hospital (see for example, Flint et al 1989; Lewis 1995a; Morris-Thompson 1992) or community (see for example, Fleissig et al 1996; Stimson 1995; Smethurst 1997). Antenatal care was provided in women's homes (Flint 1993; Smethurst 1997) or community clinics (Fleissig et al 1996; Stimson 1995). Women birthed in hospital with provision being made for women to elect a home birth. During pregnancy women were required to see the hospital obstetrician once (Flint 1993; Smethurst 1997) or up to three times (Heseltine and Watkins 1991). Antenatally women met all the team midwives through the visits or education sessions, in order to increase the chance of women being cared for by a known midwife during childbirth. Despite these

efforts, not all women were guaranteed to have a known midwife care for them during childbirth, because of organisational difficulties in having women meet all midwives (Stimson 1995).

When in labour, women contacted the midwife on call, who undertook a home assessment. Women would either stay at home or be transferred to hospital for continued labour care and birth. Following the birth, women were offered options for postnatal care. Women staying in hospital would have a team midwife visit her daily. If women elected early discharge, they would have a team midwife visit daily at home for ten days and then every four to seven days until 28 days (Flint 1993).

Team midwives were available to women over 24 hours, with a second midwife being on call for labour and birth. Lewis (1995a) discussed the use of seven floating midwives being available for sick, maternity or study leave. Midwives kept a record of the hours they worked and, if necessary, adjustments were made by doing extra shifts if they were under their hours (Flint 1993). Regular meetings occurred between the team midwives (Flint 1993), seen as an important factor in team building.

Walton and Hamilton (1995) report that in Britain the average size of teams is between 11 and 13 midwives. Benjamin and colleagues (2001) describe a team with 25 midwives. The work practice of large teams tends to result in fragmentation of care, poor continuity and midwives not acting as team players (see for example, Hall 1996; Lewis 1995a; Walton and Hamilton 1995). The issue of women being cared for by an unknown midwife during childbirth was addressed by Hall (1996), who suggested that teams be no larger than six. Bower (1993), however, questions whether a team of six midwives could effectively provide continuity of carer. Further, Kenny and colleagues (1994) reported that where team midwives met all women antenatally, women saw more carers than women receiving conventional care. It is clear that team midwifery may provide continuity of care but does not guarantee continuity of carer (Cumberlege 1993; Stock 1993). Some teams hold that continuity is not important as long as there is a common team philosophy (Hobbs 1993b). Stock (1993) believes that even if continuity is not achieved, at least women will receive overall improvement in quality of care. It is unclear, however, if improved outcomes are a consequence of improved continuity, midwife led care or other factors (Sandall 1997b).

A problem that has been highlighted in regards continuity with team midwifery is the postnatal care of women who stay in hospital. Team midwives usually only undertake daily visits and then when they can. This visiting pattern leads to difficult working relationships between ward and team midwives, resulting in tension and communication problems (Hall 1996). Postnatal care continues to be evaluated poorly with women complaining of inconsistent advice, lack of support and follow up from midwives (Homer et al 2001b). Homer and colleagues (2001b) attributed this result, in part, to women being cared for by team midwives over eight-hour shifts as opposed to 24 hours.

In Britain, team midwifery projects have been widely adopted, with over 40% of hospitals implementing team midwifery (Cumberlege 1993; Hall 1996). In contrast, Australian midwives have been slow to embrace team midwifery (Brodie 1997). Team midwifery in Britain, however, appears to be problematic with many team midwifery schemes not continuing (Brodie 1997; Page 1995a). Reasons for their termination include criticism and lack of collaboration and support (Brodie 1996). A further factor was the midwives' allegiance to women rather than to the institution and their colleagues to undertake tasks, which often resulted in conflict between the team midwives and the maternity unit midwives (Brodie 1997). Midwives are also reporting a decreased job satisfaction in team midwifery projects because of the lack of continuity of care (Watson, Potter and Donohue 1999). Flint (1993) speculates, however, that the demise of team midwifery in Britain was more due to professional sabotage from the obstetricians. Other factors attributed to the demise of team midwifery include burnout and a sense of elitism leading to conflict among midwives (Adams 1997). Burnout results from a number of factors: the constant emotional pressure arising from prolonged and intense involvement with women; lack of control in decision making and the work pattern required of midwives; the effects of unsocial hours; and a reduction in satisfaction levels as midwives strive to develop a relationship with many women, resulting in intolerable workloads. (Bowman 1986; Sandall 1997b).

A further issue for team midwifery is the demand placed on midwives to work in more flexible ways. This requirement is perceived as leading to unpredictable work patterns, which not all midwives are prepared to commit themselves to (Bower 1993; Stock 1993). Other negative responses from midwives to team midwifery include the sometimes long and unsociable hours, being on call, inadequate remuneration and feelings of isolation from their colleagues (see for example, Bower 1993; Currell 1993; Leap 1994a). In

addition, it is reported that there is decreased sick leave within team midwifery as midwives are reluctant to place an added burden onto their colleagues as a consequence of them being off sick (Stock 1993). As a consequence of the problems identified with team midwifery, many believe it is time to move onto caseload midwifery (Cumberlege 1993; Hall 1996).

Caseload midwifery

Caseload midwifery models have been adopted in Britain (see for example, Flint 1993; Page et al 1999; Sandall et al 2001), New Zealand (Guililand 1999) and Australia (see for example, Bowman et al 1997; Kelly 1998; King 1998). Women participating in caseload can be of low risk (Hambly 1997; Flint 1993), moderate risk (Fasano et al 1998), high risk (Forster 1998) or all women (Thiele and Thorogood 1997; Benjamin et al 2001). A caseload midwife cares for four women per month with a partner also caring for four women (see for example, Crowe et al 1994; Flint 1993; Hutton 1995). The aim is to have one woman birthing each week for each midwife (Fasano et al 1998). Each midwife is a backup midwife for four women as well as being the primary midwife for four other women per month. Each midwife, therefore, cares from 35 to 40 women per year, including a three-month holiday (see for example, Benjamin et al 2001; McCourt and Page 1996; Sandall et al 2001). Women get to know both midwives antenatally in case the primary midwife is unavailable during labour. To achieve this, the women alternate their visits between the midwives (Leap 1994b) or meet both midwives when attending the education sessions (Flint 1992). Sandall and colleagues (2001) report that 89% of women had their primary midwife in attendance at birth, with Johnson and colleagues (2003) more recently reporting 93%. Each pair of midwives works within a larger group practice usually made up of six midwives that provide support, peer review and backup (see for example, Guililand 1999; Hutton 1995; Page 1995b). Each midwife is on call for 24 hours, anticipating not being called more than once per week (see for example, Fasano et al 1998; Flint 1992; Sandall et al 2001) and, on average, working 37.9 hours per week (McCourt 1998). The result is an intense experience for the midwife with a profound sense of responsibility for the women in her care (Page 1995b; Sandall et al 2001).

Caseload models are based in the community rather than the hospital, with women having antenatal care in their home or community centre (see for example, Flint 1993; Hunter

1998; Sandall et al 2001) or both (Fasano et al 1998). Some independently practising midwives function in a caseload with women paying midwives directly for their care (Flint 1993; King 1998) or care is provided through the health care system that employs midwives (see for example, Hunter 1998; Kelly 1998; Page 1995b).

With caseload, women usually carry their own notes and are given information packages covering a wide range of issues. After reading these packages, women discuss them further with the midwife, being encouraged to make their own decisions regarding care (Bowman et al 1997). The midwife provides antenatal care with obstetric involvement only as necessary (Page 1995b), or women are required to have one obstetric visit (Fasano et al 1998) or two (Hambly 1997) or three (Forster 1998) or share care with the GP (Sandall et al 2001). The midwife facilitates support group sessions where women discuss their issues, aimed at developing the women's support network and independence from the midwife (Leap 1997; Sandall et al 2001). Women may have the choice of attending unstructured or structured antenatal sessions (Fasano et al 1998).

When in labour, the woman calls the primary midwife who undertakes an assessment and labour care in her home, with women being transferred to hospital for birth (Hambly 1997; Leap 1997). Women may elect to have a homebirth, a decision made during pregnancy or when women are in labour (Leap 1997; Sandall et al 2001). Women may be assessed by telephone, with labour and birth occurring at hospital (Fasano et al 1998). Twenty-four hours after birth, women are encouraged to leave hospital with the primary midwife visiting for up to three weeks, tailored to individual women (Bowman et al 1997; Hambly 1997). Women may choose to stay in hospital and be cared for by hospital midwives with their primary midwife visiting (Fasano et al 1998).

Recently in Australia, some modification of caseload midwifery has occurred where one primary midwife has two to three partners. This arrangement aimed to decrease the time on call for each midwife, perceived to be unsustainable with fewer partners (Fasano et al 1998; King 1998). Forster (1998) discusses two further variations where two midwives between them care for 13 to 14 women per month or where one midwife cares for one to six women per year with an allocated back up for each case. A further variation to case load recently reported on involved two midwifery educators directly supervising

midwifery students caring for women as part of their postgraduate course requirements (Jones, Deken and Stewart-Krstitch 2002).

For the midwife, the advantages of caseload compared to team midwifery include the ability to organise work patterns around family commitments and simultaneous flexibility to respond to needs of women in their care (Sandall 1995a). Further, caseload midwives are more able to get to know women antenatally (Leap 1997). Caseload developed from team midwifery in a further attempt for the women to receive childbirth care by a known midwife, therefore, providing continuity of carer (Flint 1993; Forster 1998). Continuity of carer is more readily achieved with caseload when compared to team midwifery, especially postnatally. Consequently, caseload midwives feel less stressed about being on call compared to team midwives. Overall, caseload midwives have more control over how they work, more autonomy, are more able to develop meaningful relationships with women and, therefore, less at risk of burnout (Sandal 1997b).

It is clear from this literature review that the caseload model is favoured over team midwifery because women receive continuity of carer throughout childbearing. Caseload provides better job satisfaction for midwives who describe more control and flexibility over working conditions, more autonomy and are more able to develop a relationship with women. These outcomes place midwives at a lower risk for burnout.

General Practitioners' role in maternity services

As previously identified, there is a need for midwives to collaborate with medical colleagues. It is clear from the literature that GPs are potential collaborators for midwives. This next section will explore this aspect in detail by first examining the role of GPs in the care of childbearing women and then evaluating GP care to ascertain appropriateness. Again, it needs to be emphasised that women would be referred to an obstetrician if any complication occurred. The literature evaluating the feasibility of GP involvement in maternity care originates from Britain. Comparable literature does not exist in Australia. The only evaluations undertaken in Australia on the GP role in maternity care are those related to antenatal shared care.

In Australia, GPs play an important role in the primary health of the community. It is recognised they could expand this role and improve their links with other primary health care professionals (Macklin Report 1992). One solution suggested by the Macklin Report (1992) is the strengthening of links between GPs, hospitals and patients through the implementation of models for delivering primary health care services in women's health and midwifery.

There has been a decreasing involvement of GPs in maternity care in Australia and Britain (see for example, Bull 1981; Feinbloom 1986; Smith 1992; Waldenstrom 1996). In some rural areas in Australia, GPs continue to provide maternity care including birthing services (Homer and Barclay 1999; Jones 1998). The reasons for this decline include the disruptive nature of maternity care to general practice and life (Feinbloom 1986); increased specialisation; medical education in obstetrics is limited and focused more on risks and hazards rather than normal aspects of childbearing; an increased use of technology (Klein and Zander 1989; Bull 1981); and the fact that the scope and standards of practice in other aspects of primary health care have rapidly changed with GPs not having time or energy to reclaim maternity care (Loudon 1980).

It has been suggested in Australia that maternity care is an area of potential expansion for GPs and should be encouraged (Allen 1994; Macklin Report 1992; Shearman Report 1989; Svigos 1991). Those GPs that are involved in maternity care, however, attend to few women making it difficult to maintain their skills (Feinbloom 1986; Stewart and Beresford 1988). Further, it is difficult for GPs to provide care throughout childbearing (Flint 1993), not being involved in intrapartum care (Lewis 1995d; Loudon 1990; Waters 1997). One solution to these problems is joint care with midwives of low risk women (Cavenagh 1996; Robinson 1996; Stewart and Beresford 1988). Such a partnership would permit GPs' continued involvement in maternity care (Stewart and Beresford 1988) and enable maternity care to become more feasible for GPs (see for example, Feinbloom 1986; Flint 1993; Lumley 1997; Svigos 1991). The implication of this proposal is that GPs who choose not to undertake intrapartum or total maternity care, could retain their life cycle continuity of care as the family GP, while supporting women through childbearing in conjunction with midwives (Finlayson 1993; Flint 1993).

There are a number of reasons why this collaboration would be successful. GPs will have already established a relationship with women and their families, resulting in better communication and more appropriate care during childbearing (Klein and Zander 1989). Midwives and GPs have similar primary health care philosophies (Rooks 1990) and are uncomfortable with technology and its effect on women and childbearing (Hueston and Rudy 1993; Klein and Zander 1989). Midwives and GPs could, therefore, collaboratively care for childbearing women, acknowledging their individual contributions and be colleagues (Lewis 1995d). Waldenstrom (1997:17) believes that

> " ... high quality maternity care will always depend on a close collaboration between midwives and doctors. Midwives' isolation from the medical profession will never be in the childbearing women's interest".

Evaluation of General Practitioner care

Over the years, GP involvement in maternity care has taken different forms. In Britain maternity care is provided by GPs in general practice maternity units, which have been compared with obstetric care (see for example, Bull 1980; Lowe et al 1987; Taylor, Edgar, Taylor and Neal 1980). A number of evaluations have been undertaken, with cohort study participants ranging from 252 to 14,415, predominantly low risk women. The GP operative delivery rate was found to be half that of obstetricians in some evaluation (see for example, Klein, Lloyd, Redman, Bull and Turnbull 1983b; Reid et al 1989). Operative delivery rates for GPs were found to be generally low (Prentice and Walton 1989; Young 1987). In contrast, Walsh (1989) and Lowe and colleagues (1987) reported that operative rates were very similar between the two groups. A number of other studies (see for example, Lowe et al 1987; Reid et al 1989; Walsh 1989) have demonstrated higher levels of interventions in the obstetric group. These interventions include fetal monitoring with a tendency to diagnose more fetal distress, augmentation and inductions. Women cared for by obstetricians were more likely to be admitted in early labour, and this could explain the higher use of interventions (Flint 1993; Walsh 1989), leading to shorter first stage labours (Lowe et al 1987). Further, there was a higher use of analgesia in the obstetric group (see for example, Taylor et al 1980; Reid et al 1989; Walsh 1989) that has been attributed to an increased use of induction and augmentation by this group (Walsh 1989). The perinatal mortality rate in general

practice units was demonstrated to be either acceptably low (see for example, Banwell and Hamilton 1970; Cavenagh, Phillips, Sheridan and Williams 1984; Owen 1981), or there was no difference (see for example, Klein et al 1983; Lowe et al 1987; Taylor et al 1980), even when including women transferred out when problems arose (Garrett et al 1989).

In Britain, it is difficult to ascertain the effectiveness of GP childbearing care as midwives working with GPs provide the care, or it is shared care (Battersby and Thomson 1997; Klein and Zander 1989). For example, general practice units are staffed by midwives and GPs (Lowe et al 1987), much like midwives and obstetricians staff obstetric units. Midwives undertake varying amounts of care during childbearing depending on circumstances, concentrating their care during childbirth (Klein et al 1983a). With obstetric care, midwives are the primary carer (Hundley et al 1995). Any comparison of GP and obstetric care, therefore, includes the midwife on both accounts. Even though midwives provide most of the care in both circumstances, it is GPs or obstetricians who manage or control the midwife in caring for women. The GP or obstetrician, therefore, delegates the care to midwives (Robinson 1990).

Klein and Zander (1989) argue in their literature review that GP birth outcomes are better than those of obstetricians, due to the decreased interventions and lower perinatal mortality rate (identified above). Others (Klein et al 1983a; Taylor et al 1980) did not go as far, instead stating that GP birth outcomes are as safe as obstetric care. Care provided by GPs, however, has been identified as being qualitatively different from that provided by obstetricians (Zander 1986). Tew (1992) found that women consequently preferred GPs who were more accessible, more efficient and with whom they felt more comfortable. Ratcliffe, Ryan and Tucker (1997) commented that routine antenatal care with GPs costs less for women when compared with obstetric care due to decreased costs for staffing, investigations and interventions. When compared with midwifery care, however, GP care was not cost effective (Hobbs 1993b).

One of the many recommendations of the Shearman Report (1989) was that Antenatal Shared Care between GPs and midwives be introduced. Antenatal Shared Care aims to provide a community based continuity of GP care for non-insured low risk women (Halloran, Gunn and Young 1992). In this model, the GPs undertake antenatal care with

screening, tests and occasional visits being attended to at the hospital antenatal clinic. Women birth under the care of the hospital midwifery and obstetric staff, then return to the GP for the six-week check. Antenatal Shared Care utilises the skills of GPs and midwives more effectively and promotes community rather than institutional care (Halloran et al 1992). Access is improved and, inevitably, antenatal care attendance is increased with Antenatal Shared Care.

According to Tew (1992), Antenatal Shared Care in Britain was introduced in the late 1980s because too many women were attending antenatal clinics. Obstetricians did not, therefore, have enough time for these large clinics and found them overwhelming (Thomson 1991). Further, the majority of women attending these clinics were healthy, with obstetricians finding the work to be tedious (Tew 1992). Consequently, obstetricians delegated low risk women to Antenatal Shared Care with GPs. In turn the obstetrician was consulted by GPs if problems occurred, thus ensuring their seniority in the team of those providing care. The midwife could have equally provided antenatal care but this was not an option obstetricians favoured. This shared care model developed between the two medical groups, yet it is midwives who are specifically educated to provide care for low risk women (Robinson 1989; Robinson 1990). Antenatal Shared Care programs have increased steadily in Australia, in some cases due to down sizing of hospital services (Small, Lumley, Yellard and Rice 1998). Many women in Australia have chosen to have Antenatal Shared Care (Holzl 1996).

In Australia, Antenatal Shared Care has been found to have certain advantages, including continuity of life cycle care, reduced travel and waiting time for women, better access to local community resources, an increased capacity for GPs to undertake more health education and preventative care (Macklin Report 1992); convenience of appointment times (Del Mar, Siskind, Acworth, Lutz and Wyatt 1991); and a more personal approach (Webster et al 1995). Overall, there is substantial cost saving as it is three times more expensive for women to attend hospital antenatal clinics than to visit a GP (Thomas, Draper, Field and Hare 1983).

In Britain, Antenatal Shared Care demonstrates positive perinatal and maternal outcomes (Halloran et al 1992). Further, there is an indication of better communication between health professionals and women, and higher satisfaction with Antenatal Shared

Care (Halloran et al 1992). Similar results have been found with shared care programs in Australia (Lumley Report 1990).

A major disadvantage with Antenatal Shared Care occurs if the two providers do not communicate directly (Halloran et al 1992; Zander 1986). Shared care relies heavily on good communication to function effectively (Del Mar et al 1991; Thomas et al 1983). Thomas and colleagues (1983) demonstrated that protocol for shared care was ill defined and results in women having more visits than necessary. Further, there is a risk of women receiving duplication of services when attending GP and antenatal clinics (Homer and Barclay 1999). Antenatal Shared Care can, therefore, be fragmented and inefficient, and not necessarily meet the needs of women (Winterton Report 1992).

On examining the literature regarding GP involvement in intrapartum care in Britain and Australia, it is apparent that some GPs want to be involved while others do not (Flint 1993; Halloran et al 1992; Smith and Jewell 1991). Other authors have concluded that a minority of GPs wanted to undertake births and that GPs could not be persuaded to do so (Loudon 1990; Waters 1997). It would appear that the number of GPs involved in intrapartum care is in fact decreasing (Lewis, Tipton and Sloper 1978; Prentice and Walton 1989; Young 1987). Justification given by GPs for not wanting to be involved in intrapartum care largely relates to impracticality due to time and inconvenience (see for example, Halloran et al 1992; Flint 1993; Waters 1997), safety and fear of litigation (Waters 1997); and that GPs did not feel they were appropriately renumerated to attend a birth (Bull 1981). For these reasons, Taylor and colleagues (1980) recommended GPs should be advised against undertaking intrapartum care. Marsh and Channing (1989), however, hold it is imperative for GPs to visit women during labour and be present at the birth for psychological and clinical support reasons.

Comparing midwife and General Practitioner care

Evaluations that compare the care given to women antenatally by a midwife and a GP have found that care provided by midwives is more comprehensive (Buhler, Glick and Sheps 1988). Women were, therefore, more satisfied with midwife care than GP care. A British randomised control trial by Turnbull and colleagues (1996), on 1,299 low risk women, compared midwife led care with shared care. The results indicated that women

receiving midwife care were less likely to be induced, have episiotomies or hypertension antenatally then those receiving GP care. These findings were attributed to the different style of antenatal care provided by midwives, with an emphasis on individual care, continuity and a more relaxed atmosphere. These factors appear to have a valuable biological effect (Wagner 1996).

In Britain, Hueston and Rudy (1993) directly compared midwife with GP intrapartum care. The results indicated that GPs had higher caesarean section and episiotomy rates compared to midwives. Butler and colleagues (1993) undertook a similar study in America on 4,607 women, demonstrating that as well as a higher caesarean section rate, women cared for by GPs had a higher fetal distress and epidural rates. These findings reiterate the effects of support during labour, as women in the midwife group had one to one support, which appeared not to be the case with women cared for by GPs. Slome and colleagues (1976) compared midwife with physician care for 438 low risk women, finding that physicians had a higher use of forceps. No such studies have been undertaken in Australia.

Midwives working with General Practitioners

Good outcomes have been reported mostly from Britain and some from United States, of maternity services that have involved GPs working with midwives in a complementary way (Rooks 1990; Street et al 1991; Zander 1986). Problems with GPs collaborating with midwives in maternity care, however, have been raised in Britain. Kitzinger (1992) points out that a more flexible way of organising maternity services is needed to avoid what could be considered a duplication of effort between midwives and GPs. Duplication of services arising from current Antenatal Shared Care, for instance, should be abandoned (Winterton Report 1992). Midwives and GPs take on different roles when caring for women, midwives focusing on caring rather then curing (Salisbury and Tettersell 1988). Midwives, therefore, have been found to contribute to health promotion and were better at listening, explaining, understanding and to be generally easier to talk with than GPs. Another way of viewing this is, that GPs are less crucial to the outcome than the midwife in the care of low risk women who do not need to be cured (Salisbury and Tettersell 1988; Winterton Report 1992). This reduces the potential overlapping of services.

There have been a number of projects where midwives and GPs collaborate in the care of childbearing women in Britain (Frohlich and Edwards 1989; Ward and Frohlich 1994) and in Australia (Fenwick 1995; Key and Reibel 1998; Thiele and Thorogood 1997). The role of the GP is not always clear in these projects. Women may see a specific GP (Bower 1993; Ward and Frohlich 1994) or any GP (Fenwick 1995; Thiele and Thorogood 1997). In another project, a team of six midwives undertook the majority of midwifery care for all women booked from three surgeries (Bower 1993; Frohlich and Edwards 1989; Ward and Frohlich 1994), including those women who developed complications (Frohlich and Edwards 1989; Marsh 1985). Women with special needs were also included (Thiele and Thorogood 1997). Ward and Frohlich (1994) later developed a caseload model with two midwives allocated to each GP surgery. Fenwick (1994 & 1995) developed a caseload model of care. Women saw a GP or midwife (Bower 1993; Marsh 1985; Street et al 1991), either in the GP's surgery (Bower 1993), hospital clinic (Ward and Frohlich 1994; Thiele and Thorogood 1997) or at home (Fenwick 1995; Key and Reibel 1998). At the end of each antenatal session the midwife and GP would discuss the case (Marsh 1985). Education was provided at visits (Marsh 1985) or during weekly sharing sessions, combining antenatal and postnatal women with midwives as facilitators (Fenwick 1994; 1995). In early labour, midwives undertake home visits (Bower 1993), with intrapartum care being provided in hospital by GPs or midwives, or GPs may nominate a hospital midwife (Street et al 1991). In one project, as there was no on call midwife, after a ten-hour shift in labour ward the women's continued care would be undertaken by a hospital midwife (Frohlich and Edwards 1989; Ward and Frohlich 1994). Midwives may be on call for 24 hours, undertaking labour and birth care at home or hospital (Key and Reibel 1998; Thiele and Thorogood 1997). Women were discharged after 48 hours (Street et al 1991) with midwives visiting daily (Fenwick 1995; Frohlich and Edwards 1989; Thiele and Thorogood 1997) or twice daily (Bower 1993) for three to four days (Thiele and Thorogood 1997). Street and colleagues (1991) indicated that midwifery GP shared care was safe in relation to birthing outcomes with a decreased perinatal mortality rate. Further, Fenwick (1994 & 1995) found there was less intervention and analgesic use compared with standard maternity care, with women being satisfied. Recommendations were made in this report that midwives need to converse with GPs on an equal footing, use first names and that midwives inform GPs about what they want to do (Fenwick

1995). These practises would then enhance the relationship between the GPs and midwives.

Complementary roles played by GPs and midwives within a practice have been demonstrated locally. There are suggestions from limited local experience that there could be an increase in the number of referrals from a midwife to GP (Barclay, Sebastian, Mills, Jones and Schmied 1993). The threat to the income generating businesses of GPs has not been realised by a strengthened collaboration of GPs with salaried health staff, such as Women's Health Nurses or midwives (Thiele and Thorogood 1997). General practitioners may therefore gain more consultations overall if antenatal visits are shared through referrals from midwives, for example, when a child in the family is sick. Further, GPs have been found to attract more women to their practice, because of their support for midwifery led care (Thiele and Thorogood 1997).

In addition, the numbers of specialist obstetricians are declining to the extent that some of the largest metropolitan hospitals are having difficulties recruiting obstetricians (see for example, Finlayson 1993; Halloran et al 1992; Kenny et al 1994). This issue continues to be a concern for maternity services (Goulston 2002; Reibel 2003). Further, obstetricians are seeking new ways to practice because of concerns about inconvenient hours, fear of litigation and an increasing cost of insurance (Waldenstrom 1996). These developments provide opportunities for midwives and GPs to work together and fill this deficit.

The table in Appendix Two summarises the evaluations used in this section clarifying that GP care is a safe option.

It is clear from the literature outlined in Chapter Two there was need for further change in maternity care that incorporated the principles of control, choice and continuity of carer. Women expect care to be continuously provided throughout childbearing by a health professional with whom they can form a relationship (Melia et al 1991). An important factor that is recognised as making this type of care successful is the flexibility of midwives who are able to work in hospital and community settings or anywhere women need her. Further, with GPs collaborating with midwives the advantages are that GPs remain closely involved with families, which continues after the midwives' role is

completed. Therefore, it appeared feasible for midwives and GPs to develop a complementary system of working together without duplication of effort. Further, there is support in the literature for this collaboration.

From the literature examined in this chapter, it was evident that caseload midwifery is favoured over team midwifery because women receive continuity of carer throughout childbearing. In addition, caseload midwifery provides better job satisfaction for midwives because they have more control and flexibility over working conditions, more autonomy and are more able to develop a relationship with women.

Combining the above conclusions from the review of the literature, it became clear what format the midwifery model of care to be planned in this project would take. The midwifery model of care to be implemented in this study was, therefore, midwives having a caseload, collaborating with GPs, based in the community caring for low risk childbearing women.

As noted in the preface of this thesis, the period when this midwifery model of care was to be implemented was in the early 1990s. Thus this midwifery model of care was to be implemented in the early days of midwifery model development in Australia. At the time it was, therefore, deemed pragmatically the best way to proceed with a midwifery model of care. The way forward was for midwives to work collaboratively with GPs. There was, however, strong support in the literature and in practice, for this notion. If this model was to be instigated in the current climate, when many more midwifery models were in existence, it is hard to say whether the model selected for this project would have been different.

Having decided on this model of care for the research project, the next step was to plan and implement it. The aim was to achieve change and to document the organisational change process. There was, therefore, a need to identify the components of achieving change in organisations and a process to achieve that change. By recording and analysing the change process, it becomes clear as to what can facilitate change and what the impediments to change are, and what can be learnt from these in order to make change happen. This process and its outcomes enable others to recognise and understand the

factors important to successfully introduce and sustain change. The next chapter provides a theoretical framework for implementing and analysing the change process.

Chapter Four

Achieving organisational change

The purpose of this chapter is to provide a theoretical framework for implementing and analysing the change process. As indicated previously, a caseload midwifery model of care in collaboration with general practitioners (GPs) was the change to be implemented. The research project aimed to achieve change in maternity services while concurrently documenting and analysing the process of achieving change. In recording and analysing the change process, the impediments to change and what can be learnt from these to make change happen, become clear. These outcomes enable others to learn what the important factors are in successfully achieving change.

The chapter begins with a discussion of organisational change and the different approaches that have been proposed, highlighting what needs to be in place in order to achieve organisational change. The next section then describes the use of action research as a process for achieving organisational change and soft systems methodology as a means of data collection and analysis. Inherent in all sections of this chapter is justification of the entire research process. Finally, this chapter presents the application of the method to the research project, in particular, data collection and analysis.

Organisational change

Organisational change can be defined as transforming an organisation from its current state to one that is improved and more desirable (Ragsdell 2000). Over the last 20 years the study of organisational change has increased in magnitude, particularly the number of conceptual approaches available (Coram and Burnes 2001). These approaches can be categorised as planned and emergent. The planned approach originated with Lewin's (1951) work, which describes three phases of organisational change. Phase one is about unfreezing past behaviours and attitudes in order to heighten awareness for the need to change. Moving is the second phase and involves making the changes that takes the organisation to its new state. The final phase is refreezing or securing the change. Senior

(1997) criticised the refreezing phase as ignoring the increasingly turbulent environment of an organisation and the need for ongoing change.

Hendry (1996) believes most organisational change has followed these stages in some form or another. Lewin's (1951) work, termed soft systems model of change (Senior 1997), became the central focus of organisational development and action research in the 1960s (Chapman 2002; Dunford 1997). An organisational development approach cares about people who are crucial as both drivers and participants of change (French and Bell 1995). Change is achieved with organisational development through processes of facilitation that moves an organisation from one state to a new state through a set of activities (Senior 1997). It is a collaborative process directed to change through developing problem awareness and problem solving skills among people in the organisation (Dunford 1997). The process involves collecting data and making a diagnosis, followed by discussion of these by the group who, in turn, develop action plans for implementation. An evaluation is carried out, followed by more action and subsequent evaluation, and action, and so forth. These processes involve an ongoing, interactive process as change occurs in incremental steps as opposed to a sudden event. Organisational development then becomes the action research approach.

Dunford (1997) refutes the effectiveness of organisational development as a change strategy. This criticism is based on the assumption that participation and incremental change are not always appropriate. Further, Dunford (1997) believed that organisational development neglects the significance of power. In addition, Senior (1997) maintained that organisational development neglects to face up to the harsh realities of change and, therefore, has limited scope. Consequently, organisational development is appropriate for transformational change, which results in significant alterations to an organisation (Connor and Lake 1994).

Planned change, in general, was developed for a top down, rigid, autocratic organisation. This has been strongly criticised in an increasingly more chaotic and turbulent organisational world (Coram and Burnes 2001). A top down approach neglects the professional development of the employees through which change can occur more readily (Clarke and Meldrum 1998). There is also an assumption with planned change

that one method suffices for all organisation, situations and times (Dunphy and Stace 1993). The focus is primarily on individual or group level interventions, which supports gradual or incremental organisational change (Chapman 2002).

As a consequence of the increasing criticism of a planned approach to organisational change, the emergent approach came about (Coram and Burnes 2001). The emergent approach was seen as being more appropriate for dynamic and unpredictable organisations. In such organisations, continuous change was the focus in order to procure organisational transformation. The emergent approach was based on certain assumptions, that is, organisations operate in a dynamic, turbulent and unpredictable environment with organisations needing to appropriately response (Coran and Burnes 2001). In summary, the emergent approach was an open ended, bottom up and continuous process. An example of an emergent approach is that developed by Kotter (1996), discussed later.

The emergent approach is not without its criticisms, although these are really not substantial. Coran and Burnes (2001) believe that the emergent approach is not suitable in organisations operating in stable environments or where major change is required through rapid, coercive measures. Further, the emergent approach has been criticised for over emphasising politics and culture in change process (Hendry 1996). Certainly with this study, politics and culture were a major contributing factor to issues that developed during its planning. Over emphasising politics was therefore not a valid criticism in this circumstance.

What can be surmised from this brief overview of organisational change literature is that approaches vary. Further, there is no one best, all embracing, universally accepted way to achieve organisational change (Dunphy 1996). It could be argued that this is appropriate as there are many different situations that require change and many different types of organisations. Therefore, whichever method is used needs to be tailored to the individual organisation (Crom and Bertels 1999). Further, the organisational change approach needs to balance technical aspects with human factors (Bovey and Hede 2001). In other words, there is no one best way to achieve change and, in fact, Coran and

Burnes (2001) suggest that a combination may be appropriate in some situations. Certainly, with this research project, a combination was the most appropriate.

What certainly becomes clear from reading the organisational change literature and examining how change was achieved, is that any change process goes through a series of stages. These stages of organisational change have been identified by a number of authors (see for example, Beer, Eisenstat and Spector 1990; 1994; Schein 1985; Stevenson 1985). Each of these lists of stages or strategies suggested to achieve organisational change clearly over lap in content and intent with each other and to those identified by Kotter (1996). The work by Kotter (1996) was developed from an examination of situations where organisational change did not occur and why this was the case. Kotter (1996) than turned these reasons for not achieving organisational change into how organisational change could be achieved. These stages identified by Kotter (1996) provided an excellent, clear framework on which to analyse the data in this project. There were also other reasons, identified below, that made the framework developed by Kotter (1996) as more than suitable to document and analyse what happened with the planning of this project.

The collection of forces, which underpins behaviour in organisations is so formidable that, it is surprising that any change ever manages to be planned, let alone implemented (Mangham 1979). As Flint (1993) notes, change in maternity care is both hard to initiate and hard to live through. Senior (1997) considers that it is too risky to blindly follow a change recipe in the hope that it will work. For change to be successful, the path has to be appropriate for the situation in hand. A health service, as with any complex institution, finds change difficult for many reasons. This includes the fact that the situations are often complex, involving deep-seated, systems problems, which are embedded with complex social systems (Braithwaite, Hindle, Iedema and Westbrook 2002). What is required, therefore, is a process that incorporates these complexities. The sort of change that this project proposed was not a simple change; in fact, it was far from simple. It was, in fact, considered to be messy and chaotic. As the story of the project unfolded, it was evident that the organisation was dynamic, turbulent and unpredictable, and required a continuous approach to achieve transformational change. It also became clear that there was a need to incorporate political and cultural aspects of

the organisation in the process. For these reasons the framework described by Kotter (1996), an emergent approach to organisational change, was deemed appropriate for this project.

A framework for implementing change

Initially, Kotter (1996) examined numerous initiatives aimed at producing organisational change over some 25 years and analysed why transformational change failed in these circumstances. More recent work follows the same principles of analysis of organisational change (Kotter and Cohen 2002). The result was a list of common errors and reasons why change does not easily happen and may fail. This list was useful in assisting leaders of change to understand specific instances of resistance to change in order to develop approaches relevant for a particular situation (Senior 1997). Kotter (1996; Kotter and Cohen 2002) turned this list of errors around, resulting in identifying eight stages that must be present for achieving major change. Each stage was associated with one of the fundamental errors preventing transformational change. These eight stages are likened to strategies that are about unfreezing the participants to plan the change, aiming to embed the change in the organisational culture. The eight steps do not necessarily need to be followed step by step. Kotter (1996; Kotter and Cohen 2002) believes, however, that they need to be in place. This framework is useful for indicating where organizations err in the attempt to achieve change. Senior (1997) described Kotter's change framework as being more directive and all encompassing than other change process and is more adaptive, therefore, to individual circumstances. For all these reasons, the eight phases presented by Kotter (1996; Kotter and Cohen 2002) were deemed appropriate for this project.

Other organisational change authors refer to frameworks very similar to that of Kotter (1996), describing what is necessary to succeed with change (Dunford 1997; Eccles 1994; Senior (1997). The framework provided in this thesis uses predominantly Kotter's (1996) work with some input from the other authors, such as Dunford (1997), Eccles (1994) and Senior (1997), to add to or clarify that developed by Kotter (1996). What follows is an overview of the elements of the framework presented by Kotter (1996).

Creating a sense of urgency

Achieving change within an organisation involves people stepping outside of their normal role and comfort zones, to have initiative and a willingness to make sacrifices. Further, achieving change requires great cooperation from colleagues (Kotter 1996; Kotter and Cohen 2002). This cooperation can be achieved by creating a sense of urgency to achieve change. Without a sense of urgency people are not interested in planning to change or to form a group to gain enough power and credibility to guide the planning. This sense of urgency is achieved by believing that what exists is unacceptable and, therefore, needs changing (Kotter 1996; Kotter and Cohen 2002), thereby creating the pressure to change (Eccles 1994). To increase the sense of urgency, removing or minimising the sources of complacency is necessary (Kotter 1996). People then become motivated to plan for change.

Empowering broad based action

Empowering broad based action is about empowering people to have a sense of urgency by removing as many obstacles to change as possible (Kotter 1996; Kotter and Cohen 2002). With the introduction of any change there is an expectation that certain obstacles to change will occur in an attempt to undermine and obstruct the change. People are moved outside their comfort zone with the advent of change and creating obstacles is often a consequence of this resistance. It is, therefore, important to remove as many obstacles as possible to empower broad based action and thereby create a sense of urgency. According to Kotter (1996) ways that these obstacles can be removed include communicating the change, making structures suitable, providing training opportunities and confronting people. Other stages of the framework further assist with this process of removing obstacles.

It is important to note, however, that it is impossible to remove every barrier from all individuals who are required to change. Consequently, not all people will support the change entirely or consistently. It is important, therefore, that researchers, as change agents, first identify the participants and their reasons for creating obstacles and work around them (Kotter 1996; Kotter and Cohen 2002).

Developing a vision and strategy

Having a vision for how something could be in the future, is the first step in achieving change (see for example, Clarke and Meldrum 1998; Kotter 1996; Kotter and Cohen 2002). Senge and colleagues (1999) argue that leadership is indeed critical in achieving change. Leadership, then, is about having a vision about which one is passionate and the ability to motivate others to bring about that vision. An effective change agent, in being a leader, is able to achieve a vision for change. Having a good and clear vision ensures a number of important purposes to the change process. The purposes in having a vision means the direction of change is clarified, others are motivated towards the change and coordination of other's actions is assisted in order to be fast and efficient (Kotter 1996; Kotter and Cohen 2002). Managing change is necessary, but leadership is crucial (Dunford 1997; Eccles 1994; Kotter 1996).

The characteristics necessary to be a successful leader are also relevant for leaders of change (Dunford 1997; Eccles 1994). Eccles (1994) believes that different styles of leadership may be suited to different types of change. There is little in the literature, Eccles adds, to recommend which style of leadership is most suited for which type of change, with one exception. There is evidence to suggest that transformational leadership is ideal for leading transformational change (Eccles 1994; Senge et al 1999). Transformational leadership concerns challenging the status quo and encouraging others to do the same, resulting in a motivated workforce that adapts well to the effects of change (Dunford 1997). Transformational change results in significant alterations to an organisation (Connor and Lake 1994), an apt description for this research project. With transformational change every person affected by the change become change agents (Chapman 2002). Dunford (1997) adds, however, that achieving change requires more than the qualities of transformational leadership. The change agent needs also to have position power, expertise, credibility and leadership (Dunford 1997; Eccles 1994; Kotter 1996).

Creating the guiding coalition

It is important for change agents to align themselves with powerful others. This group of powerful people then become a guiding coalition. The alignment with others further

facilitates development of support from key stakeholders. The guiding coalition needs a vision and ability to motivate others to accept that vision and, therefore, are leaders themselves with the necessary characteristics. By working together and presenting a united front, the guiding coalition is able to lead and sustain the change process. It is vital that the guiding coalition is not only united, but is seen to be united and committed to implement change (Dunford 1997; Eccles 1994; Kotter 1996).

Communicating the change

Part of identifying change is to communicate that change to as many people as possible, and not just through a top down approach. Mander and colleagues (2002) believe that communication is vital in organisational change. Using different forms of communication frequently, is important in encouraging others to share the vision, support it and be motivated to change (Kotter 1996; Kotter and Cohen 2002). Further, communication is about listening to other's opinions and feelings about change and ascertaining whether they understand it or not (Eccles 1994). Effective communication needs to be in a manner that will increase receptiveness of the information and not create barriers (Dunford 1997). Identifying the range of acceptable points of discussion and presenting this information in a non-threatening manner can therefore, achieve good communication. It is important to have an understanding of what it is that motivates different people and not assume it will be the same as one's own motivation. Communication needs to facilitate a two-way discussion to allow people to voice their concerns and be responded to in order to allay their concerns and break down barriers (Kotter 1996; Kotter and Cohen 2002).

Generating gains

Kotter (1996) defines generating gains as achieving short-term gains that are visible and unambiguous, which serve as a reward and motivation to continue. These gains are about rewarding commitment and success regarding the change (Eccles 1994). Short term gains help undermine those who resist, making it more difficult for those opposed to change to block it. Further, gains can help move people, who may have been previously neutral about the change, into active supporters. Short-term gains do a lot to reassure and motivate the change agent/s to push ahead with change as they are rewarded for pursuing the appropriate goal. Achieving short-term gains gives positive feedback to the change agent

about the viability of the change (Kotter 1996; Kotter and Cohen 2002). These gains also demonstrate to the researchers that the planning is progressing.

Consolidating gains and producing more change

Even when gains have been achieved, it is important not to let the momentum go, keeping the pressure on by continuing to lead the change. Further, it is important to continue to make adjustments as necessary and move forward to achieve more gains (Kotter 1996; Kotter and Cohen 2002). This process of continually making adjustments to the plan makes the progress of change slow, steady but continuous (Eccles 1994). Part of the planning process is learning from the unintended consequences of planning and adjusting accordingly. If the momentum is not kept going the change process may regress, making rebuilding of the momentum difficult and potentially allowing resistors to gain a foothold (Kotter 1996; Kotter and Cohen 2002).

Anchoring new approaches in the organisational culture

Embedding the change into the organisational culture is crucial to achieving change (Kotter 1996; Kotter and Cohen 2002). This involves anchoring the change into the organisation's norms and values so that it becomes so much a part of the organization that it is the organisation. The reason for this is that the culture of the organisation plays a dominant role in trying to achieve substantial change (Senior 1997).

This summary of Kotter's framework has identified eight components that must be present in order to achieve and sustain organisational change (Kotter 1996; Kotter and Cohen 2002). Application of this framework, however, needs some process in order to implement it. The components of the framework, for instance, do not show how to establish a sense of urgency, diffuse resistance or keep the momentum going. These activities are made possible through action research providing a process through which organisational change can be achieved. Mander and colleagues (2002) believe that action research is, in fact, crucial for the implementation of the strategies suggested by Kotter that can minimise resistance and achieve organisational change. Action research is increasingly being used as an effective strategy for facilitating, achieving and learning about organisational change (see for example, East and Robinson 1994; Heywood and Heywood 1992; Hyrkas 1997).

Flint (1993), for example, used an action research process to set up a team midwifery project. It is well established that it is easier to adjust to change of one's own making than to impose change (Perkins 1997). Action research facilitates this process of collaboratively planning change. An overview of action research and what it is, including the elements of the process of action research, follows.

Action research

Most writers agree that action research was first described by social psychologist Kurt Lewin, and developed from the planned approach to organisational change (see for example, Allcock 1996; Checkland 1992; Susman and Evered 1978). Lewin (1946:42) described action research as preceding "... in a spiral of steps each of which is composed of a circle of planning, action, fact-finding about the result of the action". While this description has been criticised subsequently for insufficiently explaining the process of action research (Abraham 1994; Hart and Bond 1995a), it provided a beginning point from which the method evolved. Lewin's description formed the basis of many subsequent definitions, which in itself reflects the lack of clarity Lewin's definition provided in the first place (Abraham 1994; Meyer 1993). A concise definition of action research is still lacking, with no consensus on a set of principles that researchers should follow (see for example, Abraham 1994; Checkland 1992; Grundy and Kemmis 1981). It is only from reading other action researchers' work that a comprehensive definition and guiding principle of action research as conceived by Lewin, can be obtained (see later).

Many reasons are proposed in the literature as to why a precise definition of action research does not exist. A description of Lewin's method was never produced in the first instance possibly due to his premature death (Abraham 1994). Though Holter and Schwartz-Barcott (1993) attributed this lack to the fact that action research, as a concept, does not lend itself to a definition. This conclusion stems from the fact that action research is more of a strategy for change than a research method (Hyrkas 1997). Meyer (2000) believed that action research is more a style of research than a method and, therefore, not easily defined.

Abraham (1994) holds that, as a research method, action research is in fact still emerging. This position is clearly seen in the many interpretations of how action research should be undertaken, with researchers using the process in different ways (Holter and Schwartz-Barcott 1993; Kerr 1996). For example, many years ago Taba and Noel (1957) interpreted the use of action research in their work as a linear process. This approach contrasted with more recent users of action research who interpreted it as being cyclical in nature (see for example, Abraham 1994; Dick 1992; Kemmis and McTaggart 1990b).

Further, unlike the conduct of a randomised control trial, there are no rules for undertaking an action research project. It could be argued that this lack of rules is because action research is more a philosophical approach to research than an established research method (see for example, Hayes 1996; Johns and Kingston 1990; Morton-Cooper 2000). Action research, however, is situational and unique to each project making it impossible to suggest general rules regarding its application (Avison, Baskerville and Myers 2001). Very few writers have given details of the process they used so that others are able to develop a deeper understanding of the action research process. In addition, the challenges, success or pitfalls in using action research have not been explicated and definitions have not necessarily given a clear description of what action research is (Hult and Lennung 1980). This situation would certainly contribute to the variety of ways that researchers have conducted action research (Cruickshank 1996). It would also contribute to the differing ideas that researchers have as to what constitutes action research (Abraham 1994). The individual researcher is, therefore, left to interpret action research. The nursing literature, however, in contrast to the more general literature on action research has made some attempt to outline the process for undertaking action research (see for example Hart and Bond 1995a, Kerr 1996 and McGarvey 1993).

In an attempt to define action research Hult and Lennung (1980) examined descriptions of action research in the literature and from that identified the essential elements. These elements were then integrated to form a new all encompassing definition:

> Action research simultaneously assists in practical problem solving and expands scientific knowledge, as well as enhances the competencies of the respective

actors, being performed collaboratively in an immediate situation using data feedback in a cyclical process aiming at an increased understanding of a given social situation, primarily applicable for the understanding of change processes in social systems and undertaken within a mutually acceptable ethical framework (Hult and Lennung 1980:247).

Descriptions of action research

The process of action research can be likened to that which practitioners do in their day-to-day practice to help them critically reflect on their work practices (Morton-Cooper 2000). The difference being, as Kemmis and McTaggart (1990b) point out, that with action research the process of planning, acting, observing and reflecting is more carefully, systematically, and rigorously undertaken than in every day practice. Action research encourages practitioners to undertake research by reflecting on their everyday practice (Meyer 1993). This reflection is a process whereby participants question the familiar and explore the unfamiliar in their lives (Carr and Kemmis 1986; Stark 1994). As Kemmis (2001) described more recently, action research is research practitioners do, as opposed to research done on or to them.

Action research has further been described as a collaborative approach that ensures the participation of key stakeholders, in the process of change. This approach enables the resolution of problems that could not be achieved through other methods (Kemmis and McTaggart 1990b). Through the process of action research, practical problems are effectively solved (Abraham 1994).

Kemmis and McTaggart's (1990b) description of action research as a cycle, is probably the most common description of action research in current literature. This cycle (see Figure 4.1) outlines a series of steps; to plan, act, observe and reflect, leading to the next stage of planning, and so forth

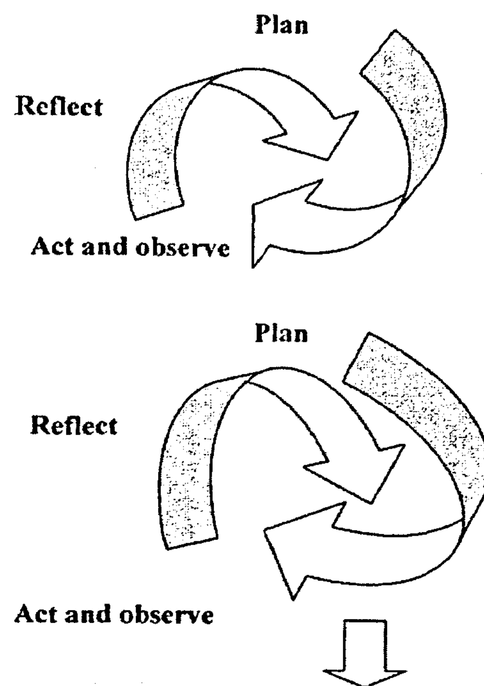

Figure 4.1 Action research process from Kemmis and McTaggart (1990b: 11).

In practice the action research process begins with an imperfectly understood concern (McTaggart 1992; Morton-Cooper 2000), a general idea (Lewin 1946), or an imprecise, 'fuzzy' or very general question (Dick 1992). Further, the action research group needs to have a yearning to improve or change this concern and work together to do so. The problem is then examined through an exploratory, fact-finding phase. The imprecise question may then lead to a 'fuzzy' methodology. From this initial cycle, 'fuzzy' answers are generated, followed by development of a plan of action. The answers to these questions can then be used to refine both question and methodology, with modifications being made. This in turn refines the answers generated. At each step, the information available is used to determine the next step, and so on. The process continues, therefore, as the question, methodology and answers to these questions become successfully more refined at each cycle (Dick 1992; Hart and Bond 1995a) (see Figure 4.2). This approach contrasts with more conventional research approaches that emphasise the importance of precise questions about known events.

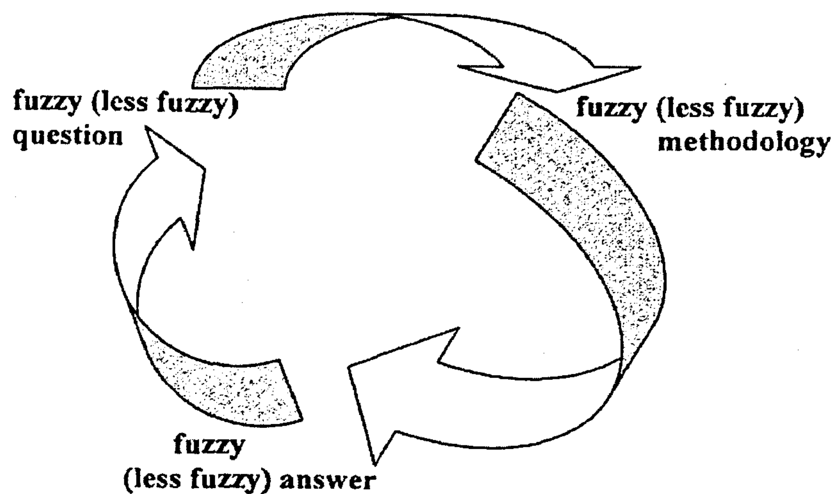

Figure 4.2 Action research process from Dick (1992:432)

The actions necessary to understand and resolve the problem require a focus on the process as well as the outcome of change (Hart and Bond 1995a; McTaggart 1992). Action research, therefore, has the potential to enable change to be achieved while learning how this has occurred (McTaggart 1992).

Key and constant elements of this methodology (see Figures 4.1 and 4.2) include the continuous notion of the cyclical process. This cycle continues as questions, methodology and answers become ever clearer, but never become completely clear or resolved. Action research must, therefore, be flexible and able to adjust as more is learnt about the issues (Waterman 1995). The challenge is that there is an element of unpredictability about action research that must be understood and managed. Nevertheless, action research as a strategy is able to achieve social change while at the same time generating and testing theory (see for example, Breda et al 1997; East and Robinson 1994; Greenwood 1994b).

Forbes (1992) believes that action research never provides a final answer or resolution but instead creates an ongoing process of improvement. Dick's (1992) use of the term 'fuzzy' captures this concept well and is an apt description. A number of authors on action research (see for example Checkland and Scholes 1991 & 2001; Forbes 1992) argue the process never finishes, continuing after the researchers have moved to the next project. The remaining participants or stakeholders, therefore, continue their own cycles.

Characteristics of action research

Action and research

Action research can be viewed as having two main consequences, that is, action and research (see for example, Dick 1992; Greenwood 1994; Senior 1997). These essential features are accentuated by the linking of the terms, action research (Kemmis and McTaggart 1990b). Dick (1992) describes action as an intervention methodology, the key function being to engender future change by involving people most affected by the change in order to secure their commitment. It is characterised, therefore, as a collaborative process involving researchers and people most affected by the change. This group of people become immersed in planning action after identifying what change needs to occur; implementing these plans through their own action; and evaluating these actions as a basis for further planning and action. This process continues on through a self-reflective spiral.

Research, then, provides the analysis and explanation added to the action process by producing research outcomes. These outcomes appear from analysing the interpretation of action and generating explanations (Dick 1992). Data are generated in a way that illuminates and interprets the action. Dick (1993) describes this as action that informs understanding, in turn, assisting action. Kemmis and McTaggart (1990b), however, appear to emphasise the process of action rather than complex, contextual analysis.

The combination and weighting of action and research in a project varies depending on the nature of the project. Further variations occur according to interests and skills of the researcher, and the nature and goals of the research. Some projects have an emphasis on action, with research being a fringe benefit. The outcome of these projects would be change, with research taking the form of increased understanding of those involved. In contrast, projects emphasising research with less focus on action, involve more attention to the research design, sources of data, data collection and a variety of modes of analysis. Projects generally sit somewhere between these two extremes (Dick 1993).

Whatever the combination, Rapoport (1970) argued; good action research must combine action and research. It is not research that is followed by action, according to Street and Robinson (1995). **Instead, action research is action that is researched, changed and researched again.** Foster (1972), however, believed that combining action and research in

planning organisational change was not always easy, with the appropriate balance not always achieved. Avison and colleagues (2001) cautions, however, that there are difficulties regarding control of projects when combining action and research. Those involved in organisational change during the 1970s, either did research with minimal action or action with minimal research (Foster 1972).

The project described in this thesis aimed for a balance of action and research. The action sought to involve the people most affected by the change, in the planning process, in order to gain their commitment. Added to this action was a desire to analyse and explain the process of planning organisational change.

The action research cycle

The action research cycle, or spiral, achieves the dual goals of action and research. Conventional research is usually not cyclical in nature, instead following steps in a linear manner. Further, there is no inclusion of reflection in conventional research or notion that the problem can be revisited following further learning or exploration in which another research cycle occurs (Dick 1993). This spiral illustrates the ongoing exploration of the problem (Street and Robinson 1995).

Responsiveness and rigour is achieved through the spiral. Rigour is achieved through reflection on earlier cycles, and analysis. This reflection is then used to determine the conduction of further cycles, in turn being reflected upon and used to develop later cycles, and so on. Reflection and analysis thus informs each step (Dick 1993). Further, the spiral enables obstacles to be overcome, as reflection illuminates potential solutions (Heywood and Heywood 1992). With progression of action research, cycles evolve and new characteristics of the problem and solutions emerge as a result (Abraham 1994). This process allows for a flexible strategy to achieve change (Hyrkas 1997).

Being responsive facilitates the researcher's improvement of research and action outcomes through a process of iteration. When dealing with the implementation of change, responsiveness is an important quality. A cyclic process enhances responsiveness (Dick, Passfield and Wildman 1993). The deliberate overlapping of action and reflection in Lewin's version of action research specifically allowed for change of action, or flexibility

and responsiveness (McTaggart 1992). Heywood and Heywood (1992) point out that research then becomes directed by reality not by the methodology.

This cyclical characteristic was considered by Lewin (1952) to be a fundamental feature of action research. It is interesting that some early writers on action research, however, did not acknowledge the cyclical nature of action research in their own work (see for example, Chein, Cook and Harding 1948; Susman and Evered 1978). This omission may reflect the lack of a clear and agreed definition for action research, or these researchers' lack of emphasis on cycles.

Participation and collaboration

Collaboration of participants is an essential ingredient for action research (see for example, Cruickshank 1996; Hult and Lennung 1990; Meyer 2000). Without collaboratively working through problems in a participatory environment, action research cannot exist (Abraham 1994). Action research is active co-research that is applied with and for the participants rather than on them (Badger 2000). The level of collaboration varies from total dependence on the researcher as facilitator, to the participants working independently, while the researcher acts more as a resource person. Collaboration and participation should occur throughout the research process (Greenwood 1994a). This collaborative approach of action research is important as it ensures participation of those who are going to change in the change process (Chein et al 1948; Hodgkinson 1957; Shumsky 1956). The process, therefore, allows those affected by the planned change to have primary responsibility for deciding on courses of critically informed action and evaluating the results of strategies employed. Change is more likely to be achieved if those who are about to be changed are involved in the planning of that change (Mander et al 2002). Through the process of action research, participants appreciate the value of potential change and become committed to achieve the necessary action (Corey 1949; Hodgkinson 1957; Kemmis and McTaggart 1990a; Shumsky 1956). In the action research process, the researcher checks the interpretation of events with the participants, allowing consensus and ensuring reliability (see for example, Greenwood 1994b; McGarvey 1993; Meyer 2000). Through this collaborative approach, action research reduces resistance to change (Mander et al 2002).

Many years ago Chein and colleagues (1948) critiqued the collaborative process of action research, challenging whether laypersons had the ability to participate fully in the research process. Some later writers, however, (see for example Forbes 1992; Heywood and Heywood 1992), identified a learning process that occurred through action research, that resulted in development of the participants. Kemmis and McTaggart (1990b) describe action research as belonging in the critical social paradigm by empowering participants to achieve change. The critical social paradigm is about facilitating liberation from constraining social, political and economic circumstances in the quest for human potential to be realised. The aim of critical social theory is to focus on the fundamental structures and ideologies of social systems that limit the concrete alternatives open to people and maximise the life opportunities of some groups by minimising those of others. Through the use of critical social theory, individuals can be inspired to identify the environmental problems with which they struggle, collectively examine their experiences, plan appropriate action and overcome their oppression (Stevens 1989). Using action research, therefore, results in development of the participants to achieve change. This educative, enlightening, empowering and emancipatory aspects of action research is important for nurses who are considered to be undervalued in the workplace (Bellman, Bywood and Dale 2003; Rasmussen 1997). This collaborative aspect of action research, however, does potentially present an ethical dilemma, however, because the outcome cannot be clearly defined (Avison et al 2001).

Further, participation in action research projects has dynamic qualities. For example, as the action research project develops, the expectation is that the circle of people involved in the process become wider and wider (Grundy and Kemmis 1981). Added to this Barrett (1993) suggested that the action research group constantly evolves as people depart and new people join with the progression of the project. Kemmis and McTaggart (1990b) consider this to be one of the underlying principles of action research.

Writers differ on just how participatory successful action research has to be (Dick et al 1993). McTaggart (1992) believed the researcher and participants should contribute equally to the project. This level of involvement is important considering the comment made by Chein and colleagues (1948), questioning the ability of participants to always be able to contribute to the research process. Later work has also questioned this ability of

participants (Abraham 1994; Reason and Bradbury 2001). Rapoport (1970) answered this dilemma by suggesting a division of labour amongst participants and researcher, depending upon the skills and experience. Meyer (2000) adds that the participants should be seen as equals with the researcher facilitating the change.

Problem focus

The principal aim of action research is to improve a practical situation or conditions in social situations (see for example, Nichols, Meyer, Batehup and Waterman 1997; Stark 1994; Titchen and Binnie 1994). According to the situation and setting, the problem is identified, focusing locally (McGarvey 1993). Action research, however, does not outline a specific data collection method to help identify the problem (Holter and Schwartz-Barcott 1993). Instead, authors discuss a range of possible approaches to data collection, including the use of observation (see for example, Bellman et al 2003; Kerr 1996; Titchen and Binnie 1994); interviewing (Wilson- Barnett, Corner and DeCarle 1990); combination of observation, interview and questionnaire (Webb 1989); focus groups, case studies, documentary and policy analysis (Morton-Cooper 2000); checklist (Nolan and Grant 1993); meetings (Bellman et al 2003); or review of literature (Bellman et al 2003; Kerr 1996). Methods of data collection in this study are described later in this chapter.

Action research involves the introduction of change owned by, and for, the benefit of those involved (Kemmis 2001). In order for successful change to occur, the process of change must be motivated by a community or group need (Avison et al 2001; Heywood and Heywood 1992). If external researcher/s try to force the process by pushing their own needs, an imbalance may occur in the relationship between the researcher/s and participants. As a result of this power imbalance and lack of shared goals, action research is more likely to fail. It would, after all, be unreasonable to expect the community to change because the researchers decided that change was warranted, not the community or group (Avison et al 2001; Chein et al 1948; McNiff 2002). Taba and Noel (1957) argue that unless participants are working on a problem they have identified, their affiliation with the problem is weak resulting in their unwillingness to be involved in the research (Bensimon, Polkinghorne, Bauman and Vallejo 2004; McNiff 2002).

There are two ways that participants can be affiliated with a problem. Firstly, the process of change can emerge from a general concern from the community, members of which become the researchers (Heywood and Heywood 1992). Termed client initiated, this represents the classic process of action research (Avison et al 2001). Secondly, the process of change can be initiated by certain people within an organisation who perceive the need for improvement and seek out researchers to help (see for example, Forbes 1992; Heywood and Heywood 1992; Taba and Noel 1957). This perceived need for improvement can flow from a community need, but is not necessarily connected. The group then work through the possible solutions to the problem. Change resulting from this latter process tends to be more lasting. The change tends to be connected to the people involved, however, and may not continue if these people leave or new people join (Holter and Schwartz-Barcott 1993). Successful action research results from the group initiated process, with organisations employing researchers to illuminate and participate in resolving problem situations (Whyte 1991; Reason and Bradbury 2001). More recent work reports on researcher initiated projects where the researcher seeks out an organisation to undertake an action research project, almost like a field experiment (Avison et al 2001).

Role of the researcher

The role and identity of action researchers has been discussed at length in the literature (see for example, Abraham 1994; Eccles 1994; Kemmis 2001). This discussion revolves around whether the researcher should be part of the organisation to be researched (insider) or a professional researcher outside of the organisation (outsider) (Titchen and Binnie 1993a). The insider is the person who initiates an action research project and becomes, therefore, a researcher. This person is part of what is being researched and changed, and has the authority to make the process of action research run more smoothly than the outside researcher. There can, however, be problems of objectivity, personal cost and burnout with an insider approach. The action research that has been undertaken in education appears to have been predominantly carried out by internal researchers. According to Titchen and Binnie (1994), action research undertaken in nursing appears to be adopting this approach.

On the other hand, the outsider is the person appointed to carry out the research, having no authority to initiate or implement the change. There is a real danger in this case, that the

change is not owned by the participants, who could revert back to previous ways once the researcher leaves. It may also be difficult for an outsider to get access to necessary insider knowledge. The possibility of conflict and tensions between the researcher and the participants is also high. This is partly due to the fact that an outside researcher must gain the participants' trust (Meyer 2000). Outsiders do have the advantage of not being indoctrinated or immobilised by the organisation's existing mindset. This objectivity enables the outsider to ask questions that an insider could not and to coax, cajole and jostle people to achieve change (Eccles 1994). Action research that has been undertaken in order to achieve organisational change appears to have been predominantly carried out by an external researcher (Titches and Binnie 1994).

In nursing, action research studies using inside researchers are more successful than studies that employ outsiders, in achieving the desired change (Titchen and Binnie 1993a). Titchen and Binnie (1993a) suggest this outcome is because the insider mode overcomes some of the tensions inherent in the outsider mode. The issue as to whether the role of the researcher should be internal or external needs to be considered and the resulting impact on the research carefully analysed.

One solution to the dilemma of whether to use an inside or outside person suggested by Titchen and Binnie (1993a) is the use of a double-act. This approach involves an outside person or facilitator, and an insider or change agent working collaboratively as researchers. The research is planned together and the analysis of the findings undertaken by both researchers. Titchen and Binnie (1993a) commented on the potential for a perception of imbalance within this partnership, which could create tensions, resulting in an ineffective collaboration. This perception of an imbalance could be resolved through open communication.

The issue of insider and outsider researchers within nursing and midwifery action research projects is not necessarily straightforward because nursing is not an homogenous category (Williams 1995). For example, a researcher may be considered an insider because they are a nurse, concurrently being considered an outsider if they belong to a different category of nurse to the participants. This difference is particularly relevant when the participants are clinicians and the researcher an academic. Webb (1989) sought to overcome this issue of

being an outside researcher by working in the ward at a clinical level prior to working with participants. In this instance, the nurses accepted the researcher as a team member rather than as an outsider.

A further point to this discussion is the nature of the relationship between the researcher and participants (Meyer 1993). Collaboration implies that there is an equal relationship between the researcher and participants. Researchers try hard to maintain an equal relationship between themselves and participants in order to facilitate a successful action research process. This relationship, according to Meyer (1993), is affected by the fact that researchers are more than likely to be outsiders and academics. These factors may influence the relationship, with researchers being seen as powerful and participants as vulnerable, which may in turn negatively affect the action research process. Williams (1995) points out, however, that action research cannot be truly collaborative because researchers have to manage the research agenda.

Another consideration to the role of researchers relates to the actual process of action research and what needs to be achieved. Not only does the researcher have to scrutinise the situation under study, but also the relevant literature to assist with problem solving (Hyrkas 1997). Further, researchers have to assist participants to view the problem with renewed consciousness in order that they can identify the problem, and work through the process. To assist this action research process, researchers become facilitators and technical resource persons (Rains and Ray 1995). This researcher facilitation role includes team building with participants. Further assistance to the action research process is achieved through researchers taking an interest in participants as people and helping them with everyday problems (Kerr 1996).

The personal characteristics, style and skills of researchers have been identified as being important in the success of action research projects. Greenwood (1994a), for example, identified a number of characteristics, including a deep respect for participants; a high tolerance of uncertainty; an ability to let go, when appropriate; and a real commitment to change. Morton-Cooper (2000) more recently added stamina, patience, determination, and ability to motivate and communicate. Action researchers also require a range of research

skills that enable them to apply both quantitative and qualitative approaches to method and data (see for example, Hart and Bond 1995a; Kerr 1996; Nichols 1995).

Limitations of action research

A number of limitations to the use of action research have been identified. For example, action research based in a small community, such as a ward, has limited potential for generalisation (see for example, Avison et al 2001; Wilson-Barnett 1990; McKibbin and Castle 1996). Greenwood (1994), however, argued against this, adding that some findings will be generalisable to other similar situations. Further, Meyer (1993) believed action research generates principles and guides for dealing with different situations and does not, therefore, need to produce generalisable results. The lack of generalisability was supported by Hart and Bond (1995a), but for different reasons. These authors hold that the focus of action research is the improvement in practice and learning how this is done. Hart and Bond (1995a) do stress, however, that the generalisability of action research findings may be limited. This position is supported by Hayes (1996), concluding that it is the documentation of the change process that is helpful for others with similar problems. **The tendency in action research projects, however, is to focus on the outcomes rather than on reporting the process that occurred** (McKibbin and Castle 1996).

The literature identifies a concern regarding the capacity of action research participants to fully participate in the problem solving process (see for example, Abraham 1994; Reason and Bradbury 2001 McKibbin and Castle 1996). This concern refers to the participants' lack of authority, power or prestige to secure change, the proposed change and nature of the collaborative relationship as threatening, inequality in the research process, issues of confidentiality and anonymity, pressure of external events and tolerance of participants. Further, a number of authors raise concerns regarding the difficulty for participants in giving informed consent when the nature of the proposed change has not been fully identified (see for example, McKibbin and Castle 1996; Meyer 1993; Williams 1995). Consequently, action research has the potential to exploit the participants (Williams 1995). Added to this is the concern raised by Johns and Kingston (1990) regarding the issue of dependency of the participants on the researchers. These authors realised that if they withdrew from the project, change would not happen. It would appear, in this instance, that the researchers had given participants a lot of direction and the process, therefore, was

not truly collaborative. True collaboration is difficult to achieve in circumstances where staff turn over is very high (Meyer 1993).

Action research success appears to be researcher dependent for a number of reasons. For example, action research is prone to errors as a result of researcher prejudices, biases and anxieties. Further errors may occur as a consequence of group pressures for conformity (McKibbin and Castle 1996; McGarvey 1993). These outcomes are compounded by the fact that action research has no end point and projects may take longer than first anticipated. The process may be unfinished when the report has to be written or the thesis finished (see for example, Kerr 1996; McKibbin and Castle 1996; Meyer 1993). This concern could alter the process of action research and inhibit the change. It is, however, important that the change occurs slowly in order for staff to have time to adjust. Achieving this balance, therefore, can be difficult (Kerr 1996). Further, action research can be very demanding for researchers (Hyrkas 1997) and the effort involved in undertaking action research may outweigh the benefits (McGarvey 1993). Not every researcher is able to undertake action research, as not all researchers possess group process skills (Lewin 1946).

A further problem identified relates to the difficulty in defining action research, making it confusing and difficult to apply. Added to this is the fact that there is no specific data collection method outlined for identifying the problem in action research (Holter and Schwartz-Barcott 1993). Further, there are no guidelines as to how problem identification can occur. This state of affairs could result in the problem not being fully identified and, therefore, the action may not be suitable. Certainly, this would be the case where problems are of a more complex nature.

In fact, action research only suits particular types of problems. According to McGarvey (1993), action research can only deal with local and individual problems. This then results in small rather than system change or change at policy level. Such small changes are, therefore, not able to achieve major change in strategy, structure, processes or people, necessary components to achieve change on a bigger scale (Senior 1997). Added to this, Waterman, Webb and Williams (1995) criticised action research for being a process that does not recognise when the problem is related but dissimilar in some aspects.

Part of the reason why action research is only suitable for local problems is because it does not take into account culture, power and politics of an organisation or the context in which it operates. The concepts of culture, power and politics have come to embrace much of what is included in the hidden part of the organisation. This arrangement is part of the informal organisation and can act powerfully to influence organisational activity (Senior 1997). It is therefore important to examine the extent to which this impinges upon the organisation's ability to deal with change. Regardless of how well change might be planned in terms of the more formal organisational characteristics, it is the hidden, informal aspects of organisational life that will act to help or hinder it (Senior 1997). Action research does not allow these perspectives to be incorporated.

Abraham (1994) argues there has been considerable discussion regarding the scientific basis of action research since it first was used. Criticism has been levelled at action research for its failure to meet a scientific criterion, and subsequently, it is considered methodologically weak (Hodgkinson 1957). The action research process has been described as being more personal and interpersonal than methodological, because the process relies more on personal skills of researchers than the methodology itself (Meyer 1993). Checkland (1992) suggested a major blemish in action research methodology was a lack of scientific rigour and a pre-declared intellectual framework. One such framework has been developed by Checkland (1981a), is termed soft systems methodology.

Further, criticisms have been made that action research is more a process for achieving change than a means of analysis (Kemmis and McTaggart 1990b). It appears this is a legitimate criticism to level at action research in that the process of achieving change without providing significant analysis or explanation of how such change occurs is emphasised. After all, action research is a critical social process designed to achieve change, but lacking any form or description of how analysis might be conducted.

There are certain concerns regarding action research that apply to the problem situation addressed in this thesis, which have highlighted the need for an approach other than action research. These concerns include the fact that action research can only deal with local problems resulting in small change and not at the level of system or policy. It is difficult to

identify the perspectives of culture, power and politics in action research, unless the appropriate questions are asked and appropriate data, therefore, collected. Once such data is collected, there is no process by which an analysis can be undertaken. Identifying culture, power and politics in the organisation is necessary in order to defuse resistors to change and be able to embed the change within the culture of the organization (Kotter 1996; Kotter and Cohen 2002). Lastly, action research has been criticised because it lacks scientific rigour and an intellectual framework.

In this thesis, the problem to be addressed was not local or individual and became extremely complex. There was a need to thoroughly investigate the problem situation as it became more complex with increasing knowledge and a rapidly changing political and professional environment. Culture, power and politics within the particular organisation acted very powerfully and influenced organisational activity immensely. The broader social context of the problem, taking into consideration all aspects of the situation, was not addressed within a conventional action research approach. Change on a grander level of organisation is considered the most difficult problem because it is so complex. For these reasons action research on its own was deemed insufficient for working through the problem situation and at the same time record and analyse that which was occurring.

Action research is a research paradigm from which developed a number of specific established methods, one of these being soft systems methodology. Soft systems methodology was developed from action research and is considered an extension of it, developing within management to deal with issues of organisational change. Soft systems methodology is useful because it provides a technique for data collection and analysis through the use of models or systems that enables sense to be made of the data (Dick 1992; Prevost 1970). Soft systems methodology therefore, combines the action research process with the means of analysis (Senior 1997).

It was therefore appropriate to employ soft systems methodology in the research. It is acknowledged that health systems are typically 'messy' and therefore particularly suited to the use of soft systems methodology (Lehaney and Paul 1994). In addition, soft systems methodology lends itself to problems within health system because of the holistic approach encapsulated in systems thinking. Soft systems methodology, using systems

concepts, helps to tease out some of the complexity of reality in its richness (Checkland 1981a). Through the use of soft systems methodology to inform the action research process, the researchers became better informed about the organisation, the people within it and the context. For example, the barriers to change became more clear through the use of soft systems methodology, providing the analytical process for studying the process of change. Further, it is hard to embed change within the organisational culture if the culture has not first been identified through the use of soft systems methodology. Soft systems methodology was, therefore, included for all of these reasons. A more detailed description of soft systems methodology follows.

Soft systems methodology

Soft systems methodology was developed in the 1970s by Checkland, and grew out of the inability of hard systems approach to make sense of unstructured problems (see for example, Checkland and Scholes 1991 & 2001; Checkland 1999; Ingram 2000). It incorporated systems concepts derived from Bertalanffy (1968) with action research strategies to describe, analyse and act on problem situations. This provides a technique for data derived from this process to be analysed using systems theory, allowing sense to be made of that data (Dick 1993). Checkland's work combined conceptual frameworks and hard systems thinking with an action research process to investigate and resolve real world problems (see for example, Checkland 1978; Checkland and Jenkins 1974; Wilson 1974). The aim was to combine systems concepts to describe soft or structured problems of the real world to enable improvement or change to occur (Checkland and Wilson 1980). The change is facilitated by bouncing to and fro different ideas (Checkland 1999). Added to this, systems thinking enables consideration of the context beyond the problem situation to be incorporated into problem solving using conceptual models (Checkland 1981a). This approach, which takes a broad view of the problem, and incorporates analytic and process elements, focuses on the interaction between different parts of the problem (Checkland 1981a). Soft systems methodology, therefore, was specifically designed for analysing and designing change within organisations (Senior 1997).

A number of definitions of soft systems methodology have been developed (see for example, Burlow 1989; Checkland and Scholes 1990; Dick 1993). The following one most aptly describes what soft systems methodology is.

> *Methodology* meaning a structured approach with a set of ordered activities, *Systems* implying that the approach is holistic, studying systems and their wider context, *Soft* connoting fuzzy, ill-defined situations where there will be differing perceptions and views (Mingers and Taylor 1992:327).

Soft systems methodology, therefore, is a process of analysis that uses the concept of a human activity system as a means of moving from finding out about the situation to taking action to improve it. This means the activities associated with different worldviews of a variety of participants can be understood and incorporated (Checkland 1981a). Soft systems methodology has a cyclical process of problem solving much like action research does (Atkinson and Checkland 1988; Brocklesby 1995).

The crux of the methodology is the use of systems models to debate a problem situation (Checkland 1987). This approach allows the problem situation to be viewed in a new light by the people concerned, enabling them to see and take action (Davies and Ledington 1988; Ingram 2000). The process is systemic and structured around a comparison of a real world problem with systems thinking, leading to decisions on action incorporating the what and how of change (Checkland 1992; Checkland and Scholes 1991 & 2001). This creates a never-ending learning cycle for the people involved in the situation (Burlow 1989). Systems' thinking enables the process to be highly defined and described, but flexible and broad in scope (Checkland and Scholes 1991 & 2001) and comprehensive (Braithwaite et al 2002). This enables problem situations to be tackled in all their richness and in a way that leads to decisions on action at the what/how level that is not achievable with action research.

Further, the proponents of soft systems methodology claim it is able to incorporate multiple and conflicting values and objectives that exist in soft, unstructured problems. This can be achieved descriptively to make sense of complex situations, or prescriptively to control chaos (Checkland and Scholes 1991 & 2001). Soft systems methodology is

able, therefore, to combine a process of change with analysis that incorporates the complexity of the problem. Action research process, of itself, is unable to achieve this analytic process and suffers in its capacity to achieve complex organisational change as a result. This appears to be because action research is unable to incorporate the broad view, or as Lyytinen (1988) terms it, the larger environment of the problem situation.

Before discussing soft systems methodology in more detail, it is necessary to clarify the language and processes described in the methodology by defining **'system'** and **'soft'** as Checkland (1981a) uses these terms.

System

Bertalanffy is credited as the creator of general systems laws in biology in the 1920s (Checkland 1988a; Mingers 1980). This stemmed from his interest in viewing the organism as a whole rather than its constituted parts (Checkland and Scholes 1991 & 2001). Bertalanffy's initial theory, based on work in biology, was applied to engineering in the 1940s (Checkland 1981b) and, by 1968, was seen as part of everyday thinking (Bertalanffy 1971).

Many definitions of systems have developed from this seminal work (Bertalanffy 1971). One of the most quoted definitions is "... the whole is greater than the sum of the parts" (Kelleher and Cole 1989:55). This reflects Bertalanffy's original concept of a system as he defined it, insinuating that all parts are affected by being a component of a system and are changed if they leave it. Further, the parts in the system are assembled to achieve something, or transfer some input into output. These parts only form a system where the relations between the parts are such that there are no isolated subgroups (de Leeuw 1972).

Further, a system can be defined as the name given to an abstract intellectual concept, which requires certain relationships to exist between the various elements that make the system (Checkland 1988b: 40). The term system can be used to describe and make sense of a problem situation that needs analysis and resolution (see for example, Checkland 1987; Ingram 2000; Woodburn 1988). System in this context is not just a label that is attached to something in the world, a name of the same kind as tree or cat, for example; it is an epistemological device. System, then, in this sense is a way of thinking and not a

body of knowledge (Checkland and Jenkins 1974). Using the word system only as a label limits the system thinking that follows (Checkland 1987).

It follows, therefore, that a systems approach enables a problem to be analysed in its broader social context by focusing on the larger environment within which the problem occurs (Checkland 1981b; Lyytinen 1988). The problem can be structured, stated coherently and hence solved, using a systems approach (see for example, Checkland and Davies 1986; Jenkins 1983; Mingers and Taylor 1992). The aim of the analysis process is to take all aspects of the situation and interactions involved in various parts of the problem into account (Checkland 1978; Ingram 2000). Complex problems, by definition, are multi-faceted and contain many relationships, such as those real-world problems encountered within organisational hierarchies. There is a need to be able to acknowledge "the rich fabric of social ties and expectations involved in any problematic situation" (Lyytinen 1988:75), and an intellectual integration is needed to facilitate the problem solving process (Checkland and Jenkins 1974). It is, therefore, necessary to somehow embrace the whole problem in order to improve it (Checkland 1972). This is made possible by using a systems approach. In effect, the systems concepts, utilised as an epistemological device, facilitates understanding of the problem situation to improve it (Brocklesby 1995).

Soft

Soft are different from hard systems. Hard in this sense, refers to research which deals with problems in which an objective or end result can be projected (Checkland 1981a; Naughton 1979) and the problem is well defined (Naughton 1981; Patel 1995). Through this approach, a solution is engineered to achieve the stated objective (Checkland 1981a; de Leeuw 1972). The research is characterised by hard boundaries and rules, requiring the problem to be well defined (Checkland and Wilson 1980). Hard systems are an efficient means of achieving a known and defined end. This is the nature of hard systems thinking, and constitutes the means-end model (Checkland 1978). Soft systems refers to those related to human activity (Ingram 2000; Checkland 1981a; Patel 1995), or as Ragsdell (2000: 104) aptly summarises it, " ... people-related skills to cope with the cultural aspects of the change."

In contrast, soft problems could be termed fuzzy or ill defined, complex problems, such as those frequently faced by social science researchers working in organisations. These are problems for which the desirable end cannot be predicted or is necessarily known (Checkland 1981a; Naughton 1979). Soft systems methodology enables such problems to be examined in a systematic way (Davies and Ledington 1988). Table 4.1 provides a summary of the differences between hard and soft systems thinking.

Characteristics of 'hard' systems thinking	Characteristics of 'soft' systems thinking
• assumes the world contains systems which can be engineered • language of problems and solutions • well defined/structured problem • goal seeking system • easy to define objectives • clearly defined decision taking procedures • hard boundaries and rules • quantitative measures of performance • human behaviour is goal seeking • assumes systems models to be models of the world (ontology's)	• assumes the world is problematical but can be explored by using systems • language of issues and accommodations • ill defined/unstructured problem • appreciative system • objectives hard to define • decision taking is uncertain • no boundaries or rules • qualitative measures of performance • human behaviour is irrational • assumes systems models to be intellectual constructs (epistemologies)

Table 4.1 Adapted from the work of Checkland (1972; 1978; 1981a; 1985)

Soft systems developed from the inability of hard systems methodology to research soft or ill-defined problems (see for example, Checkland 1972; Jackson 1982; Naughton 1979). Checkland originally attempted to apply hard systems thinking to soft problem situations using action research, as illustrated in Figure 4.3 (Checkland 1972; Wilson 1974).

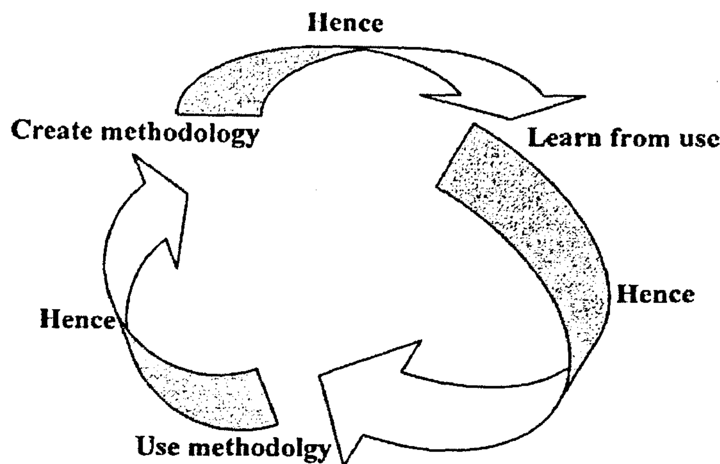

Figure 4.3 Action research cycle used to develop soft systems methodology (Checkland 1981b: 7).

Checkland (Checkland and Scholes 1991 & 2001) used action research, which requires the researcher to be involved in the problem situation. This involvement then becomes part of the research, in turn reflected upon, analysed and results in lessons being learnt simultaneously by the researcher and those being researched (Susman and Evered 1978). Systems thinking provided a conceptual framework that could be used to make sense of both, the situation and involvement of the researcher. Action research provided the process to develop a methodology to tackle real world situations considered as problematic or complex (Checkland and Scholes 1991 & 2001). Warmington (1980:38) commented that "where change is involved, then systems ideas and ... systems approaches are often the most appropriate vehicles for analysis." In other words, a systems approach may be required for action research to be effective (Warmington 1980). The process of working with people and problems are those of action research (Checkland 1978). Using systems then provides a comprehensive means of analysing complex problems (Checkland 1978) and consequently, leads to superior analysis (Jones 1978). Naughton (1981) refers to soft systems methodology as a system based action research. Soft systems methodology could also be described as a specialised type of action research (Brocklesby 1995).

Application

In practice, soft system methodology has its beginnings with a situation in everyday life perceived to be a problem by at least one person (see for example, Checkland and Scholes 1991 & 2001; Checkland and Davies 1986; Patel 1995). As with action research, this person feels that the perceived problem can be managed in a way to bring about improvement. What that improvement is and how it occurs needs to be established. The situation has to be first, closely examined, as it is a product of a particular history, having more then one account or interpretation. If the improvement is to be successful, this history must be outlined and reflected on. The situation needs to be examined to see beyond the superficial logic of it to reveal any unique features. This is necessary to enable action to be taken in the full idiosyncratic context of the situation (Checkland and Scholes 1991 & 2001; Patel 1995). Action research is similar, except that soft systems methodology goes one step further and formalises the process of analysing the problem, requiring multiple perspectives to be elicited and described.

Lyytinen (1988:75) describes some of the features of soft systems methodology as being of "... cyclical nature ... focus on problem situation instead of well defined problem ... and the application of a set of criteria to derive and analyse problem perceptions." Woodburn (1991) added that the constant communication between the researcher and participants in the organisation is necessary to ensure this occurs in a manner that achieves change.

Checkland (1972) developed soft systems methodology so that it can be, paradoxically, both precise and vague. The methodology is precise in that ideas can be used to initiate and guide change. At the same time soft systems methodology is vague in that it must not be seen to be, or become, a recipe. Being vague allows the methodology to remain problem oriented and helps avoid distorting the problem with a structure that provides a recipe to solve it (Checkland 1972; Jenkins 1983). Mathiassen and Nielson (1989) support this notion of soft systems methodology, adding that it is a framework for reflection and action. Schregenberger (1982) and Kreher (1994) believed soft systems methodology to be transparent and understood through common sense. This is supported by Patel (1995), stating that soft systems methodology is simple to use and, at the same time, comprehensive.

After a period of some seventeen years of applying soft systems methodology, Checkland (1988a) reflected upon this wealth of experience. This resulted in a much refined and modified soft systems methodology, as illustrated in Figure 4.4.

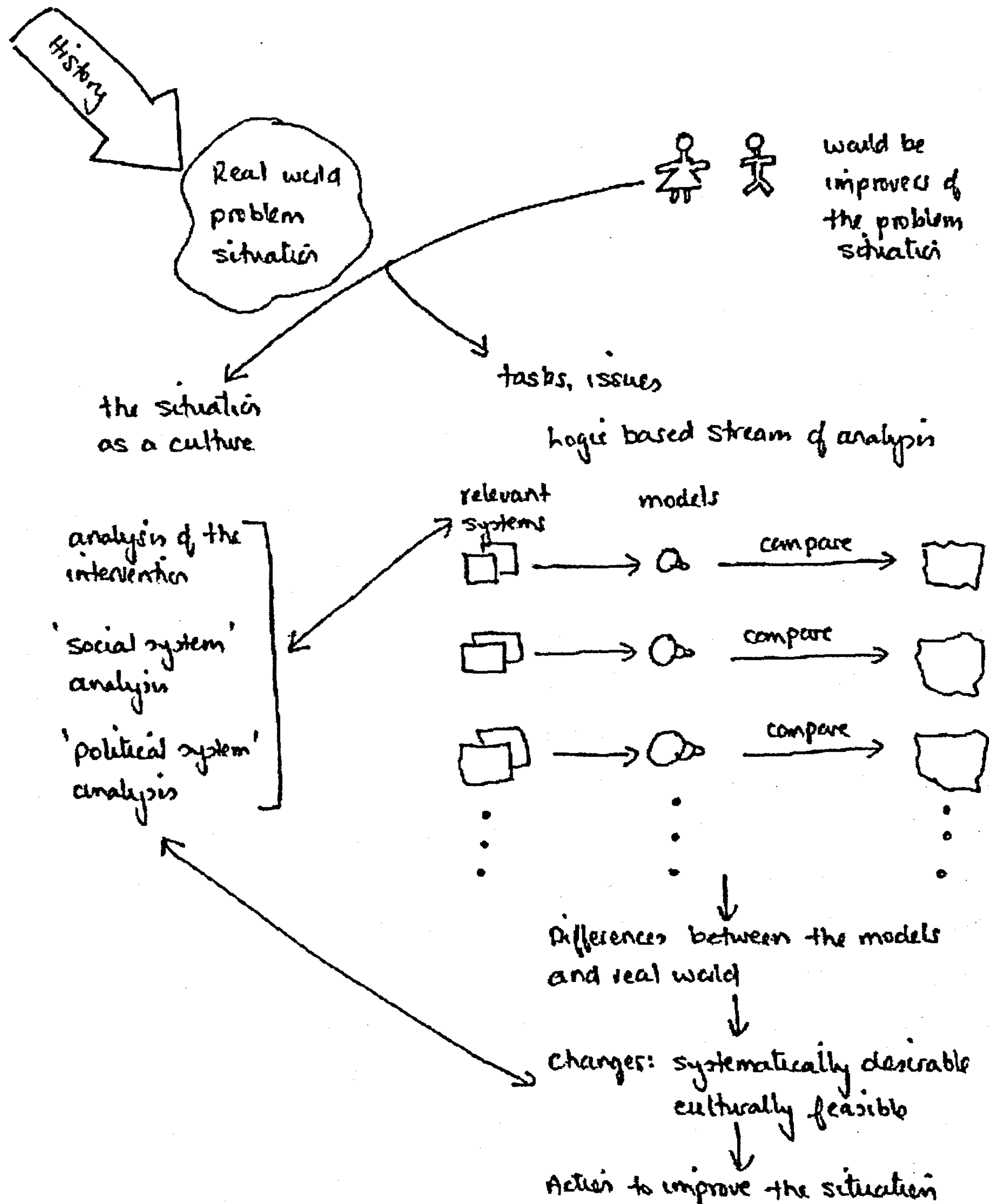

Figure 4.4 The process of soft systems methodology (Checkland and Scholes 1991:29)

On the right hand side of Figure 4.4 is soft systems methodology as Checkland (1981a) first conceived it. This is the logic-driven stream of enquiry that provides the basis on which change can occur. Checkland (1988a) subsequently realised, however, that for this approach to engage the realities of human beings, a second stream was necessary to explore the human and social aspects of the situation. This is what now appears on the left hand side of the diagram as the cultural stream. It became evident that every problem situation has a history dictating perceptions, which needs to be discussed and absorbed. Secondly, the dynamics of people, or social situations, need to be analysed. Finally, the political aspects of the situation need to be taken into consideration (Checkland 1988a). These elements do not appear in a conventional action research approach and enable a broader exploration and analysis of the problem, which action research is unable to. Checkland and Scholes (1991 & 2001), therefore, added the cultural stream, which interacts with the logic driven stream, each informing the other. A more detailed description of these three added aspects follows.

History

The history of the problem explores the real world situation to reveal what is perceived to be a problem and what makes it so (see for example, Finegan 1992; Naughton 1981; Smyth and Checkland 1976). Problems do not exist in isolation, but within a number of environments or backgrounds, all of which need to be analysed (Checkland 1972). Hence, it is not the problem that is explored, but rather the situation in which there is perceived to be a problem (see for example, Checkland 1981b; Jackson 1982; Naughton 1981). This expressive stage aims to develop an appreciation of the problem and the situation in which the problem exists (Atkinson 1986; Wilson 1979). People perceive problems differently (Woodburn 1991) and it is, therefore, important to gather as many perceptions as possible from a wide range of sources, both quantitative and qualitative information (Kelleher and Cole 1989). The purpose of gathering multiple perceptions is to enable better selection of viewpoint/s that will be developed further in seeking solutions (Checkland 1981a). There may only be a temporary or arbitrary completion of this process, with the analysis continuing as the researcher moves from cycle to cycle.

For example, in the project discussed in this thesis, information about the problem situation of maternity services was gathered from multiple sources of literature. This

included various government reports as well as research articles and general articles. The collection of this literature continued throughout the project to gain more information and perspectives in order the build the richest possible picture of the problem situation with maternity services.

The stream of cultural inquiry

Checkland (1988a) realised that for soft systems methodology to adequately engage the realities of human beings, a cultural stream was necessary to explore the human and social aspects of the situation. This stream of cultural inquiry has been described as " ... finding out about the culture in which the work is being done ... " (Checkland and Scholes 1991:44). Analysing the culture is crucial to the success of this approach and continues throughout the project (Checkland and Scholes 1991 & 2001). The cultural inquiry involves the analysis of two aspects.

- **Social systems analysis**

The social system analysis examines the dynamics of the people in the situation. This process studies the continually changing interaction between the elements of roles, norms and values (Checkland and Scholes 1991 & 2001). These elements determine how a person sees and values various situations (Jackson 1982), "... the process by which human beings continually balance factual judgements against value judgements" (Naughton 1979:71). The nature of the social system emerges by reviewing the unfolding of events, making inference as to what the roles, norms and values are. Part of the history of the problem situation "... has led to the development of beliefs about what are meaningful roles, values and norms" (Davies and Ledington 1991:40) and need to be taken into consideration. It is important to recognise that the account of the social system that results from this analysis, however, is never either complete or static (Checkland and Scholes 1991 & 2001).

The assumption that underpins this step is that all players take on particular roles in the situation, resulting in role related behaviour. Roles are, therefore, the expectations of behaviour and socially formed, resulting from perceptions of what behaviour ought to be associated with that particular circumstance. It is a social position that is recognised by the people in the problem situation as being significant (Checkland and Scholes 1991 &

2001). Roles can, however, be ambiguous and therefore misinterpreted in part (Davies and Ledington 1991). Further, a role is value laden, bearing hidden assumptions regarding what is right or wrong. These beliefs are not always obvious. This is the value that helps form the role by indicating the correct behaviour. Values, then, are expectations that are individually or professionally developed regarding the salience of different forms of expression of social behaviour within the role (Davies and Ledington 1991). Norms are the expected behaviours that are socially negotiated and become the moral standards for actions. As norms are often implicit they can, therefore, resist change. Norms are substantiated by values and create the mindset that dictates the correct form of appreciation and response to a situation (Davies and Ledington 1991).

For example, in this study, the person in the position of Professor of Nursing (Prof (N)) fulfilled the role of the position of professor. The expected behaviour, or norms, of this person was one of researcher and leader. Performance in this role was judged according to certain values considered to be good or bad by role holders. These values included being professional, being political, diplomatic and promoting the role of the midwife in the care of childbearing women. Other players may have viewed the values of the Prof (N) as being powerful, all controlling and ambitious.

It is important to note that the social system analysis in this thesis consists of the researchers' perceptions and interpretations of peoples' actions based on the available evidence from minutes of meetings, field notes, supported from the interview data of key stakeholders and the literature. Davies and Ledington (1991) believed that this is not problematic as there is no absolute true picture of any problem situation. What is important is making a start in developing a bigger picture of any problem situation in order to identify issues.

- **Political system analysis**

The other examination of the cultural inquiry process is the political system analysis and involves accommodating the different interests of the members involved. Checkland and Scholes (1991:50) define politics as " ... a process by which differing interests reach accommodation." All behaviour at any level within an organisation and in any situation may be regarded as political (Mangham 1979). This is a power-related activity involving

relations between different interests that need to be managed, and determine who gets what.

Every situation has its unavoidable political dimension. This is analysed by asking how power is expressed in the situation under study. Power is simply the ability to make things happen (Davies and Ledington 1991). In other words, power is attributed to individuals and used to influence the behaviour of others. According to Mangham (1979), power is part of all negotiations and the foundation of organisational behaviour and may have a positive or negative impact.

Delicate judgements are required concerning the public visibility of this political analysis. This sensitivity stems from the fact that politics is ultimately concerned with power and its disposition, issues not faced overtly in human dialogue. However, Checkland and Scholes (1991 & 2001) believe that if the results of this political analysis are made public, then the results can themselves become a potent commodity of power in the real politics of the situation.

Summary

In summary, soft systems methodology forms an ordered conceptual framework for problem solving by facilitating the process of examining different perspectives (see for example, Checkland 1972 & 1981a; O'Meara and Strasser 2002). It is a holistic approach, providing rigour and discipline through measurement and evaluation (Kelleher and Cole 1989). Leddington (1992) claims that soft systems methodology has made a substantial contribution in aiding and facilitating real-world problem solving. One of the strengths of soft systems methodology is the practical usability of the methodology; being able to be applied to many situations and be used by people with no technical background (Mingers and Taylor 1992). Soft systems methodology is claimed by Prevost (1976) to be well structured and adaptable. In the area of organisational problems it has been demonstrated to produce appreciable results. Watson and Smith (1988) claim the methodology itself is also a means of communicating. Braithwaite and colleagues (2002) believe soft systems methodology is ideally suited to address the deep seated problems identified in health care as they tend to be embedded in complex, social systems.

Overall, however, soft systems methodology is seen to be very demanding approach (Kreher 1994). The most common problem identified in the work by Mingers and Taylor (1992) was the time consuming nature of soft systems methodology, and that considerable expertise was needed to effectively use it. This often related to the interaction with the participants, however, rather than the methodology itself, specifically getting people involved and overcoming the jargon. It would appear that good communication skills are a key element to success when using soft systems methodology. Braithwaite and colleagues (2002) believed that the failure to use soft systems methodology related to people having difficulty with changing complex systems and a lack of experience at reflecting. Through the participants' self-reflective inquiry, soft systems methodology aims to improve understanding of situations and thereby improve practice (Brocklesby 1995; Patel 1995).

The project described in this thesis sought to both bring about change through a process of participation and action. This project used action research as a process to achieve change with a balance of action and research. The action was involving the people most affected by the change in the process to plan and implement the change. Added to this action was then a desire to analyse and explain the process, which is the purpose of the thesis. As action research proved inadequate to explain the contextual issues that were occurring or to analyse and explore these within the context of a health system, the research employed soft systems methodology. It is in fact acknowledged that health systems are typically messy and, therefore, particularly suited to the use of soft systems methodology (Lehaney and Paul 1994). If the researchers had continued to use action research on its own, the data collection and analysis would not have been so rich and, consequently, the analysis not as comprehensive. In the main, therefore, soft systems methodology was used to make sense of the change process through retrospective analysis. In addition, soft systems methodology forced the researchers to ask and explore questions in the right areas, being embedded in the methodology and, therefore, became automatic. Further, it is critical that change agents gain an understanding of how internal and external environments can influence organisational change, an important consideration with this research. Soft systems methodology provides the means to do this (Hill and Collins 2000). With action research, the researchers had to be more aware of questions and areas that would probably only become an identified issue after the event.

Application to the research

As identified above, action research is an effective strategy for facilitating, learning about and achieving organisational change (East and Robinson 1994; Morton-Cooper 2000). The actual process of action research, given the situation and problem, was the ideal method for planning the midwifery model of care in this thesis. In order to undertake an action research project, a group of participants needed to be established. This then allowed those affected by the planned change to have primary responsibility for deciding on how the change will take shape and be, in essence, the planners of that change (Kemmis and McTaggart 1990a). Being involved in the action research process enabled the participants to better understand and solve the problem (Carnall 1995; McKibbon and Castle 1996). Further, participation enabled the participant's experiences to be drawn on in solving the problem (O'Brien, Bradfors and Gibb 1995). The action research group in this project consisted of midwives and managers from the hospital, Area Health Service (Area) and the university, as well as representatives from the general practitioners (GPs) and the obstetricians. These people were participants who were to develop an appreciation of the value of potential change and become committed to achieve that change through the action research process. The participants, therefore, would potentially own the change that they had worked on and feel part of the solution (Carnall 1995; Eccles 1994; Robinson 1995).

Participants in the action research group were selected on two bases. Firstly, representatives from the midwives and GPs, were the actual people who would be members of the new model of care, that is, midwives collaboratively working with GPs (as identified in Chapter Three). The midwives were chosen specifically as they were the managers for the areas in the maternity unit, that is the labour ward, postnatal ward, antenatal clinic, early discharge and the midwifery educator. It was envisaged that these midwives would then disseminate the information about the project to all midwives in the maternity unit. Further, these midwives predominantly worked Monday to Friday, day shifts meaning it was more feasible for them to attend meetings, both from a time perspective and the fact they did not necessarily carry a clinical load. It was envisaged that once the planning was well under way, the midwives who would be the new midwifery model would be part of this action research group. Further, it was anticipated that some

managers would be part of the new midwifery model. The GPs that were on the action research group were suggested as people who would be interested in the proposed model of care, put forward an expression of interest and, therefore, would be receptive to the planning process.

Various other people were involved in the action research process. These people were considered to be key stakeholders and part of the guiding coalition, including managers for the maternity unit, the hospital, the Area, the GPs and the obstetricians. The support of these people in the planning process was crucial to the success of the project, as these people were the power brokers in the organisation. The Prof (N) and the researcher were also part of this group.

Once members were identified, the Prof (N) and the researcher approached each participant in the action research process, to gain their interest and consent to be part of the project. Further details regarding the establishment of the action research group and the social system analysis of these participants are in Chapter Five. Ethics approval was gained from the Area and university for conducting the project.

Before the action research process was able to start in earnest, however, it was first important to assess the feasibility of the project with the GPs and management of the hospital. Following positive assessment of the feasibility, the action research process started and involved meetings to then plan the midwifery model of care and to inform people of the planning and gain their support. This was at the commencement of the informal and then formal Management Committee (MC) meetings. The action research process involved a large number of meetings in an attempt to engage the participants in the planning of the change and the model. Further, formation of the action research process was the start of data collection to record the process of change and was when the project became research based. It is important to note, however, that the change and action research process started the minute the researchers first collaborated on their desire to implement a midwifery model of care. The roles that various people played in the planning process formed the basis of this data. It was this data collection and subsequent analysis that formed the basis of this thesis and research of the process of change.

Data collection

Action research is predominantly qualitative in nature, though it can be combined with a quantitative research approach (Hart and Bond 1995a; Nichols 1995). Dick (1993) believes that using a qualitative research approach means that the project is more responsive to the situation and the people. The fact that action research is participatory tends to favour the use of qualitative research methods. This is because the participants are more likely to be able to join in the process as equal partners if they can understand what the researcher is talking about and are contributing to it. Use of every day English, frequently associated with qualitative research methods, is more conducive to collaboration of participants than the use of numbers or technical language associated with quantitative research methods (Dick 1993).

There is, however, no specific method identified in action research through which to collect data to make identification of the problem possible (Holter and Schwartz-Barcott 1993). The range of possibilities for data collection suggested in the action research literature and that were used in this project include observation and recording of field notes (Bellman et al 2003; Kerr 1996); meetings (Bellman et al 2003); interviewing (Bellman et al 2003; Wilson-Barnett et al 1990) and review of literature (Bellman et al 2003; Kerr 1996). Data collection was a multi method approach designed to provide an opportunity to use different sources of evidence in order to develop converging lines of inquiry (Bellman et al 2003). This triangulation aimed to enhance the validity and credibility of the findings in this research (Patton 1990).

As part of planning for change, and so as to study this process using soft systems methodology, a vast amount of data was collected. The aim was to explicate as many perceptions and build the richest possible picture as possible (Checkland 1972 & 1981a). With this in mind, data consisted of minutes of formal meetings and field notes (FN) of issues not appropriately placed in the minutes, as well as observations and reflections on these meetings. Added to this, field notes were made of informal meetings that occurred, as well as telephone conversations, any meeting for which minutes were not taken and notes of any significant events that related to the project planning, such as newspaper articles about a pay rise for obstetricians and closure of the hospital. Further, field notes were made of other discussions that the researcher was privy to involving the Prof (N)

relating to the research, such as postgraduate meetings, meeting with action research experts, or field notes to summarise events that occurred outside of regular meetings, such as writing up funding proposals. Data were collected chronologically, with field notes attached to specific minutes of meetings. Minutes were tabled at the subsequent meeting for ratification as a true record, with changes being made as appropriate.

There were a total of 162 meetings that the researchers had and an additional 18 meetings or phone conversations that the Prof (N) participated in and relayed back to the researcher. On the whole, these meetings lasted approximately one hour. In total, there were 127 pages of minutes and 227 pages of field notes. The minutes and field notes form part of the discussion of the events that occurred during the planning of change and add insight into the exploration of what happened. These notes have been analysed for concepts and themes, with quotes from these minutes and field notes added to the discussion. Throughout the analysis there are various quotes, identified in *italics*, which are either from minutes, field notes, interviews, letters or the project newsletters. The source of the quote is identified by being bracketed, followed by the date of that quote. For example, Director of Nursing (DON) '1' had written a discussion paper, ... *suggesting a community based midwifery services of some kind* (Field Notes (FN): 25.3.93 (this is the date on which this piece of data was recorded)).

The data included transcripts from semi-structured interviews undertaken by the researcher, with a number of the key people involved in the planning. Interviews were undertaken in order that those in the situation are able to discuss their perception. This is particularly important, according to Smyth and Checkland (1976), when researchers are outsiders applying soft systems methodology to a situation. The people interviewed were chosen as representative of the key groups and stakeholders. Prior to the interview an information sheet was given to the interviewee who then signed a consent form (Appendix Three). These interviews occurred twice, once around May 1994 and then again one year later. The people that were interviewed were the Prof (N), the chairperson of the Division of General Practice, GP 'C', midwifery managers from the labour and postnatal ward, Midwife 'W', the Area Health Service Director of Nursing (Area DON), the midwifery educator, Director of Nursing (DON) '3' and Research Assistant (RA) '2'. These people were chosen because they would be able to provide various aspects of interpretation to the

project planning for the following reasons:

- The Prof (N) was one of the researchers;
- The chairperson, Area DON, and DON '3' formed part of the guiding coalition with Prof (N);
- GP 'C' and the midwifery managers from the labour and postnatal wards were to take ownership of the project planning. As well, both of these midwives were resisting the planning process at various stages;
- The midwifery educator was resisting the project planning;
- Midwife 'W' was an outside consultant to the project who had been involved in the planning of a similar midwifery model of care herself;
- RA '2' was employed by the researchers fairly late in the project planning and was able to be an objective outsider to the project planning.

There were a total of 15 interviews, each lasting between 30 to 45 minutes. Demographic data were not collected, as it was not relevant to the research. The first round of interviews asked the following questions:

- Describe what you think has happened up to now in the general practitioners midwifery shared care project in your own words
- What has been your understanding of the political process in leadership roles in relation to the project
- What are the crucial political issues
- Describe what you think is happening now
- What major issues are yet to be addressed?

The second round of interviews, conducted one year later around May 1995, asked the following questions:

- Describe what you think has happened up to now in the general practitioner midwifery shared care project in your own words
- What has been your understanding of the political process in leadership roles in relation to the project
- What are the crucial political issues

- Describe what you think is happening now
- What major issues are yet to be addressed
- What role do you think that Professor of Nursing and myself have played over these three years
- How has your role changed over this time?

During the interview, the researcher, if necessary may have sought clarification of issues. These interviews were taped, transcribed verbatim and analysed for theoretical ideas and concepts. Various comments taken from these interviews were then incorporated into the discussion as quotes to add meaning or support the observations being made.

Other forms of data include letters written to the researchers or written by members of the committees to various people (13 pages); newspaper articles referring to some aspect of the project (7 pages); the project newsletter (15 pages); GP interviews report (17 pages); Obstetric Review and information gathered to formulate aspects of data collection, such as costing of confinement (14 pages) (Appendix Four). Further data included literature written about various aspects of maternity services, as highlighted in Chapters Two and Three, and to add meaning to the explanations outlined in Chapter Eight.

Analysis of the data

According to Morton-Cooper (2000), once a significant amount of data had been collected, they need to be analysed for concepts and themes that explain the process. From the data themes were then extrapolated and grouped together. Even though this project did not actually succeed in implementing the model, it was still important to explain the process in order to provide an invaluable source of information from which others could learn. It was also important to identify the areas that the researchers did well in to achieve some organisational change. Other researchers can avoid the pitfalls and undertake the positives from this experience. It should be emphasised that some level of change did occur in that the participants became determined to pursue the project, and hence had moved forward from when the planning started.

Analysis of data was undertaken by extrapolating themes and grouping them together to form a rich picture of the difficulties encountered in achieving organisational change. This analysis process occurred at various levels along the way. Firstly, at the level of transcription through the researcher preparing the minutes and observational notes of meetings, which became the field notes, at the time that they were occurring. The next level of analysis occurred through the researcher critically analysing the content of the data for theoretical ideas and concepts. This data were then categorised into segments that firstly, outlined the history of the situation in soft systems methodology terms, to build the richest possible picture of the situation of maternity services (see Chapter Two). From this history of the maternity services, specific data were extrapolated to identify possible solutions to the problem situation to then begin the planning. Once the action research group had been set up and the planning had started, the data were initially organised chronologically in order to 'tell the story' of the process and the key events in this story (see Chapter Five).

In the more formal evaluation of the action research process, the data were categorised into what worked and what did not work in trying to introduce the change (see Chapter Six and Seven) and the strategies that were used to assist the process. This analysis was undertaken using the framework derived from Kotter (1996). Part of this analysis also involved an examination of the role that various people played in the planning of the midwifery model of care. Action research and soft systems methodology formed the groundwork for this process, with soft systems methodology guiding the analysis of the data.

In conclusion, this chapter has provided the theoretical framework for implementing the midwifery model of care and analysing the change process, through a discussion of the organisational change literature. What then follows is what needs to be in place in order to achieve organisational change. The next section describes the use of action research as a process to achieve organisational change and a justification of the research process. Chapter Five then describes in detail the processes and strategies that were used to plan the midwifery model of care. Described in this chapter are the groundwork events before the planning of the project started in earnest.

Chapter Five

The process and strategies

The previous chapter provided a theoretical framework for implementing and analysing the change process. This framework provides the backdrop for this chapter, which describes the events and activities that occurred before planning for the midwifery model started in earnest, together with the process and strategies used to plan the midwifery model. The description of events includes the determination of the structural processes needed to assess the feasibility of undertaking this project. This feasibility assessment occurred before the action research process began, though the principles of participation were adhered to in these initial discussions. The reader is reminded that the study purpose was to record and analyse the process of change associated with planning and implementing a midwifery model of care.

The instigation and impetus for implementing a model of continuity of midwifery care came from the then recently appointed Professor of Nursing (Prof (N)). The Prof (N) appointment and her interest in improving maternity care provided an opportunity for the researcher to become involved in instigating a model of continuity of care in the Area Health Service (Area). Together, the Prof (N) and the researcher were the researchers referred to in this thesis. These researchers held a vision of maternity care that would not have progressed to a model of care without the initiative of the Prof (N) in pushing this research forward. The Prof (N) was able to gather around her a number of supportive people, most importantly, people who were in positions of authority. This chapter, therefore, begins by describing how the vision was disseminated to others, and how their commitment to innovation in the Area was gained. Added to this, how the researchers worked towards the formation of an action research group and started the process is described. The key strategies employed by the researchers at this initial stage in gaining support from appropriate people and instigating the right process to succeed in bringing about change is further described. Data collection commenced in this period as the researchers first collaborated in planning the development of an innovation in midwifery care. This chapter, therefore, describes the initiation of the planning process as it unfolded in the planning of the midwifery model of care.

Background

Identifying a site for change

The project aimed to plan a continuity of midwifery care model at one of the three hospitals in the Area and to document this planning process. Ideally, the researchers wanted to implement a model where hospital salaried midwives functioned autonomously, providing continuity of care for low risk, non-insured women in the community (illustrated in Figure 5.1). Autonomous in this instance, refers to midwives who practise in the full sense of the word 'midwife' and does not refer to 'independent' midwives. This model of care would only involve obstetric care if a deviation from normal childbearing occurred, in which case, the women would be referred to an obstetrician. The role of the obstetrician is to care for women when complications occur during the childbearing experience.

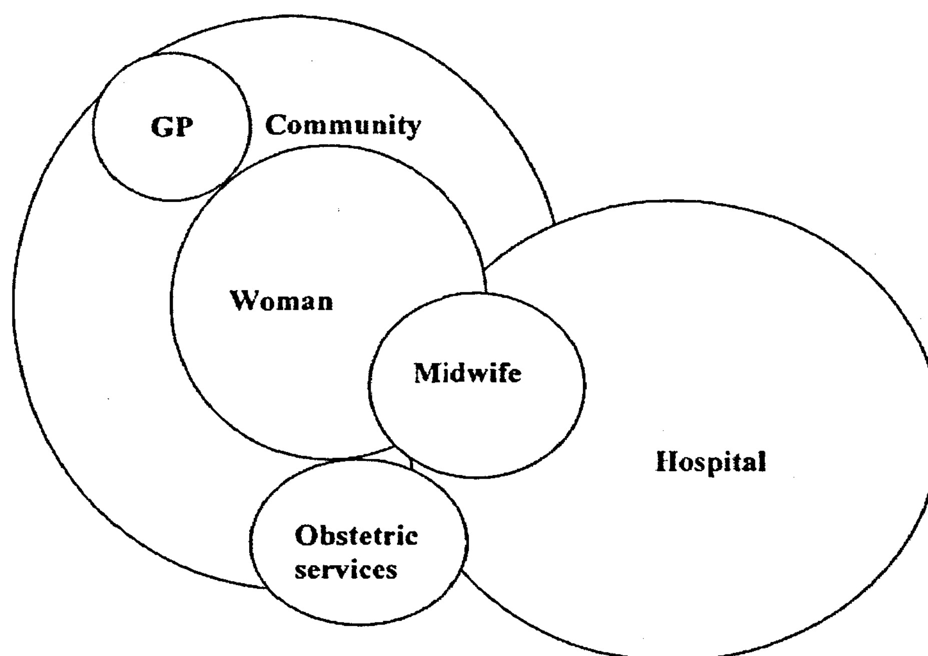

Figure 5.1 Ideal model of midwifery care

The researchers had gathered enough information about the Area in the context to make certain assumptions about potential models for maternity service. The model depicted in Figure 5.1, or one of 'independent' midwifery, was rejected for a number of reasons. Firstly, setting up such midwifery models could potentially exclude obstetricians and possibly alienate them, never the intention for the project. In addition, midwives did not

appear to be strong enough in their own right professionally to be able to assume an autonomous role. This was partly because, educationally, midwives were not prepared for such an autonomous role. Added to this was the fact that midwives' are subordinate to obstetricians. It was evident from an examination of this Area that the struggle between obstetrics and midwifery, which has long dominated the history of maternity services, continues today. This struggle for dominance between women and men in midwifery in Australia and Britain has continued to be perpetuated by hospital structures, where obstetricians are in more senior positions than midwives, even though most obstetricians are not directly employed by the hospital (Cochrane 1995; Duffield and Lumby 1994). This situation has resulted in midwives being structurally subordinate to doctors (Hobbs 1996b; Lane 2002). In Britain, Cochrane (1995) does not believe that obstetricians' subordination of midwives will change because obstetricians would have no political, financial or social advantage in allowing this to happen. Added to this is the fact that men have been shown to be unwilling to relinquish power and instead use it to gain more power (Senior 1997).

The subordination of the midwifery profession stems from being an oppressed group controlled by outside forces that have greater power, prestige and status then itself (Friere 1971; Roberts 1983). Midwifery, as a predominantly female group, is controlled by obstetrics for a number of reasons: obstetricians are predominantly male (Game and Pringle 1983), of a higher class (Willis 1989), receive longer and harder education (Hoekelman 1978) and consequently, have a higher status than midwives (Wagner 1994). Obstetricians, therefore, have greater power and prestige compared to midwives, who then become the oppressed group. This results in obstetricians, as the dominant group, identifying their norms and values as the right ones and exercising their right to control decision-making. In turn, this restricts the autonomy of midwives (see for example, Ehenreich and English 1973; Willis 1989; Kitzinger et al 1990).

It could be hypothesised that midwifery perpetuates this subordinated position because midwives are not prepared to work as autonomous professionals and carry the full responsibility of practice. Instead, most midwives tend to work in a bureaucratic, hierarchical, non autonomous model associated with nursing, thus giving precedence to obstetricians and remaining in a subordinate position (Brodie 2002; Hobbs 1993b; Lane 2002). This acceptance of the status quo is partially explained by the fact that midwives are

initially educated as nurses (see for example, Brodie 2002; Brodie and Barclay 2001; Leap et al 2002) and behave, therefore, more as nurses, being more comfortable to work within a medical model of childbearing. Another possibility is that midwives' attitudes and perceptions of childbirth may be so distorted from witnessing obstetric catastrophes that they believe in the hospital safety net and their role as handmaidens to obstetricians (Fenwick 1995). The result is that midwives resist change and revert to the status quo in times of uncertainty. Further, Brodie (2002) found in more recent work, that midwives supported a medical approach to birth, as midwives believed the benefits of midwifery models were not generally recognised. Herbert (1995) claims that the expanded role of the midwife participating in such innovations as team midwifery and caseload in some circumstances has resulted in salary cuts. This outcome is an example of government forcing midwifery to adopt a nursing framework where extended roles do not exist and to accept a change in remuneration (Herbert 1995).

It was clear from the literature (see Chapter Three) that midwives need to work collaboratively rather than competitively with medical officers in order to gain their support and succeed in caring for childbearing women. As argued earlier, underlying this thinking was the view that obstetricians have a place in caring for childbearing women when, and if, a complication occurred. Childbearing is considered to be a normal, healthy occurrence appropriately managed by a midwife until complications occur. Further, the literature reveals a medical domination of maternity services, with obstetricians not supportive of midwifery models of care. The literature strongly recommends the instigation of models of midwifery care in collaboration with general practitioners (GPs) as a favoured model (see for example, Macklin Report 1992; Shearman Report 1989; Stewart and Beresford 1988).

Having considered the most appropriate midwifery model, an analysis of the environment of the Area and the hospitals within it was needed in order to ascertain the most suitable site for the implementation of the model. This analysis included the ideas of the people in the Area in regard to the type of continuity of midwifery care model that would work for them. With this in mind, Prof (N) began to discuss with the Area Director of Nursing (Area DON) the feasibility of instigating a model of care involving midwives working with GPs (November 1991). Consistent with the process of providing a rich description before assuming solutions, this thinking was at a preconceptual stage, with decisions not yet

taken. As many perceptions as possible, drawn from a wide range of sources, were gathered in accordance with soft systems methodology (Checkland and Scholes 1991 & 2001; Davies and Ledington 1991).

In order to take the environmental analysis of the Area further, a meeting was convened, aiming to seek interest and support from a group of experts managing the delivery of clinical maternity services. The group consisted of the midwifery managers from the three hospitals within the Area, two significant midwifery leaders from outside the Area, the Prof (N), the Area DON and the researcher, forming the first Steering Committee (SC). This group discussed where and how a continuity of midwifery care model could be instigated within the Area (Field Notes (FN): 21.2.92 (this is the date on which this piece of data was recorded)). A key factor taken into consideration was the involvement of the obstetricians, because of their dominant role in maternity services in the past (see for example, Cochrane 1995; Hobbs 1996b; Willis 1989) and their power and control over midwives when midwifery innovations were instigated (Hambly 1997; O'Donnell 1998). If this innovation was instigated at a site where obstetricians were heavily involved, particularly with privately insured women, it was thought they might block an innovation that would threaten their power, status and financial gain, and lead to failure of the project. The level of obstetrician involvement in the three hospitals in this Area is indicated in Figure 5.2, as well as demonstrating where the Prof (N) was placed. The level of obstetric involvement is based on the percentage of insured women, and taking into account the rate of caesarean births, normal vaginal births and spontaneous births at each of the three hospitals.

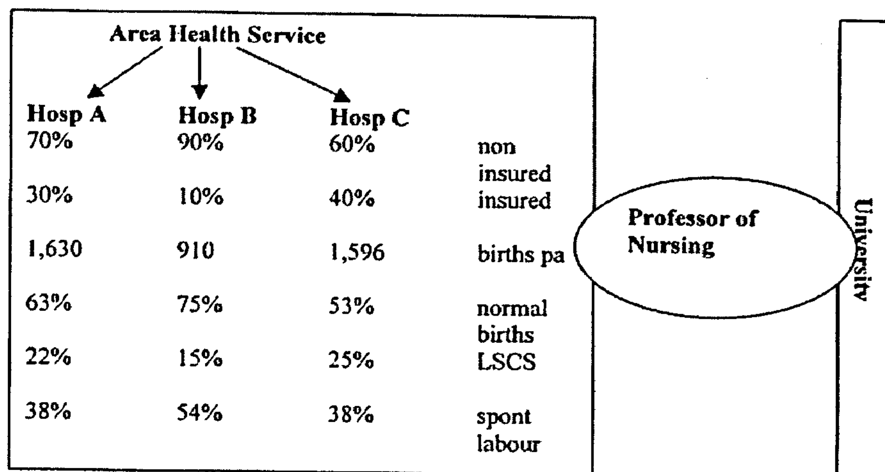

Figure 5.2 Breakdown of the Area in relation to obstetric involvement (NSW Health Department 1993a).

A further factor taken into consideration, which became clear from initial discussions with the midwifery managers, was the need to identify those managers who were more supportive of change in their units that would benefit consumers. For instance, during the discussions it was suggested that Hospital A could be the site for the project, with the project caring for women from non-English speaking backgrounds. At this suggestion, the midwifery manager from Hospital A was noted to say, ... *women with an English speaking background would be disadvantaged if Hospital A were chosen* (FN: 21.2.92). In other words, women from non-English speaking background would be targeted and English women would be disadvantaged by not being able to participate in this midwifery model of care. This comment led to the conclusion that this was not a supportive environment in which to introduce change.

On the whole, there was overwhelming support from this first SC for the continuity of a midwifery care model to be instigated in the Area. The committee members strongly believed that the only way such a model was achievable would be, as the Area DON was noted to say, ... *go via the back door* (FN: 21.2.92). This strategy would involve midwives collaborating with GPs at a hospital that cared predominantly for uninsured women of non-English speaking backgrounds. There would be, therefore, limited obstetric involvement and virtually no privately insured women. Hospital B was considered to be the optimal environment for such an innovation.

The meeting, at which the decision was made to use Hospital B with midwives collaborating with GPs, was particularly dynamic (FN: 21.2.92). This was because the decision for the type of midwifery model was exactly what the researchers had been discussing as a possibility, but had not expressed at the meeting. The collaborative interaction at this meeting was the first positive moment in the history of the project planning, and gave the researchers confidence to pursue the project planning.

Hospital B (from this point referred to as the hospital) was selected, therefore, as the site for a midwifery model of care involving GPs collaborating with midwives. At a much later stage, this choice was reaffirmed by General Manager (GM) '3' who was noted to say, ... *this was the most appropriate hospital in the Area to set this project up* (FN: 5.7.94). The hospital will now be described in more detail.

Description of the hospital

The midwifery model of care was to be instigated at a district hospital in Sydney. During 1992, there were approximately 918 births in this maternity unit (NSW Health Department 1993a), with 90% being non-insured and 10% insured women (Management Committee (MC) FN: 26.10.93). In order to understand the environmental context within which the hospital was situated at the time planning started, it is first important to outline its history. From the time of the Shearman Report (1989) this hospital had faced continual threats of closure. Closure of the hospital was recommended provided that resources were transferred to upgrade services for non-English speaking background women and that staff would be transferred. The recommendation for closure was based on the dilapidated state of the hospital at that time even though it had recently been refurbished (Reference removed). Despite this threat of closure, the project was to be pursued as the site for the study as women could still receive continuity of midwifery care in the community, the hospital building being necessary only for birth. At the time project planning commenced, there was no immediate threat of closure. The maternity unit, however, required an injection of funds in order to rebuild it to an acceptable standard. Further, the unit had recently closed beds due to a lack of demand. At that point only 60% of maternity admissions came from the local area with the remaining being 'inflows' (FN: 25.2.93). 'Inflows' refers to women who decide to have their baby outside their own local area hospital and choose another

local area hospital. These 'inflows' were expected to decrease because a number of new maternity units were being built in the local areas, resulting in the occupancy rate in this hospital declining even further.

One of the strengths of this hospital was the provision of culturally sensitive services to the large ethnic community that it served (Shearman Report 1989; Reference removed). The provision of culturally sensitive services is critical for non-English speaking women in Australia as they have special needs in relation to birthing services (Chan, Roder and Macharper 1988; Halloran et al 1992; Shearman Report 1989). These women characteristically present late for antenatal care and have fewer antenatal visits and higher intervention rates because they are deterred from services that are perceived to be culturally inappropriate and inaccessible (Convey and Goga 1997; Pincombe 1992). One solution for the late presentation of non-English speaking background women was the introduction of Antenatal Shared Care (Shearman Report 1989). Such women probably already attended non-English speaking background GPs who have a close liaison with hospitals. Webster and colleagues (1995) found in their analysis of Antenatal Shared Care that more non-English speaking background women would avail themselves of the service if it were culturally appropriate. This factor was a driving force for change.

Consequently, Antenatal Shared Care was introduced in the hospital in 1991 as a strategy to boost bed occupancy rates, stall closure of the unit and meet the needs of non-English speaking background women (Reference removed). Antenatal Shared Care is collaborative care provided by GPs in private practice and midwives in the hospital antenatal clinic, with women having care provided by both GPs and midwives. This strategy was already in place, though problematic in its implementation, when this project was in its initial planning stage (FN: 17.3.93). The potential for expansion of Antenatal Shared Care was evident in the interviews undertaken with GPs in February-March 1994. Over 80% of GPs interviewed had women who chose to visit them for antenatal care rather than attend the hospital antenatal clinics (Hospital Division of GP Obstetric Shared Care Project Survey Report May 1994). In addition, the hospital midwives were noted to say, ... *currently there are 27 GPs who participate in shared care and 42 who are listed* (FN: 7.4.93). The potential for more women attending the GPs for antenatal care, and hence the hospital, was, therefore, evident from this.

Staffing

To gain further insight into the circumstances operating in the selected hospital that affected the planning process, it is necessary to outline the dynamics and relationships between different professionals at the time. This hospital had a number of administrators, including a Director of Nursing (DON), Medical Superintendent (MS) and General Manager (GM), positions usually occupied by three different people. The obstetric department had a head obstetrician, who reported to the MS. Reporting to the MS also, before the Chairperson of the Division of General Practice was appointed, were GPs participating in Antenatal Shared Care. These aforementioned professionals were considered to be key players in the planning of change and formed part of the guiding coalition.

Then at the maternity unit level, there was a midwifery unit manager who reported directly to the DON. The role of this midwifery manager was to supervise the operation of the unit on a daily basis, with responsibilities for staffing and resources. Reporting to this position were the midwifery managers for labour ward, antenatal clinic, postnatal ward, and early discharge, and a midwifery educator. As these midwives would be the change agents, they were essential participants in the action research group. The relationships between these people are illustrated in Figure 5.3.

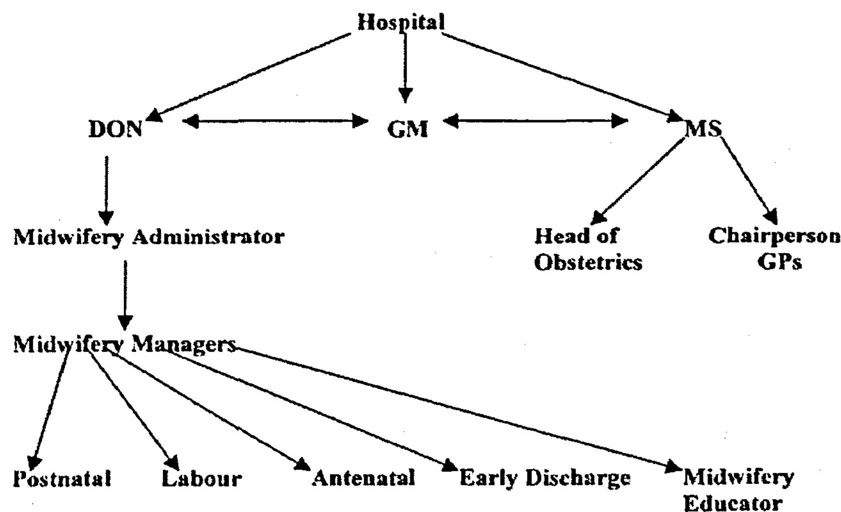

Figure 5.3 Relationships of key players within the hospital.

Midwives are employed by the hospital to work in the maternity unit and care for women during the antenatal, labour/birth and postnatal period. The midwives undertake the assessment and care of women in collaboration with their medical colleagues. Each midwife is answerable to the midwifery unit manager through the manager of the area in which they work. There were 40.94 full time equivalent midwives working in the maternity unit at the start of planning for this project (FN: 7.4.93).

The midwifery manager represented midwives from the hospital maternity unit in the preliminary discussions with the researchers. These discussions were designed to be strategic and gain support from the Area for the project. Initially, the Prof (N) represented the profession of midwives' position, which did not support the domination of maternity services by obstetricians. Instead the midwives were eager to practice as midwives rather than as obstetric nurses (see Chapter Two). The researchers understood that midwives from the maternity unit wanted to reclaim their role as primary carers of low risk women. It was, however, often unclear how much the midwives supported the concept of the project, with different midwives offering varying levels of commitment and support over time (see Chapter Six).

Care of childbearing women attending the maternity unit was also provided by the obstetrician. At the time project planning commenced, there were ten obstetricians with visiting rights to the hospital (FN: 7.4.93). Despite their visiting medical officer status, the obstetricians were very involved with the operation of the maternity unit. For example, when a new policy was developed, it first had to be presented to the obstetricians for approval. This requirement meant the obstetricians had a degree of control over the operation of the maternity unit despite their visiting status and lack of direct employment by the hospital itself.

There was no direct relationship between the GPs and obstetricians (see Figure 5.4). Both groups worked in the community, with the obstetricians providing some direct hospital care, through consultations for non-insured women. The GPs provided care to women in their own rooms, undertaking Antenatal Shared Care with the hospital antenatal clinic.

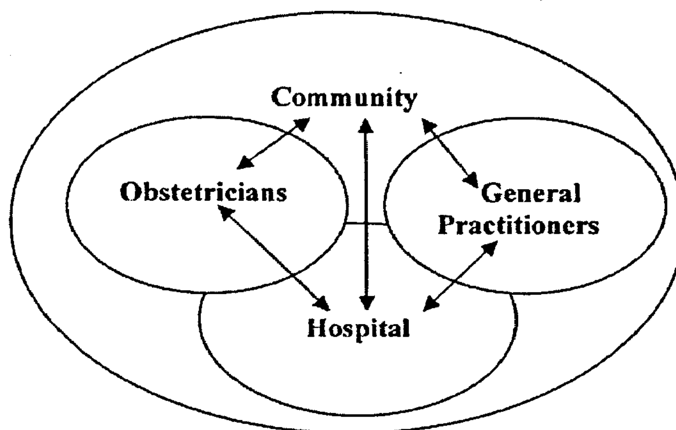

Figure 5.4 Relationship between the obstetricians, GPs and the hospital.

Assessing the feasibility of the project

The literature strongly recommended that midwifery care projects be instigated in collaboration with GPs (see Chapter Three) (see for example, Macklin Report 1992; Shearman Report 1989; Stewart and Beresford 1988). For example, according to the Macklin Report (1992), GPs are essential to health care in Australia, with 82% of the population visiting a GP at least once each year. The report noted a perception that the GPs primary role is that of carer of the sick, which, in fact is only a small component of the GP role. Instead, GPs are involved in managing ongoing health conditions, undertaking health promotion activities and health education as well as making referrals to appropriate health practitioners. Life cycle care is provided by GPs for their patients. For many of these reasons, therefore, GPs were the appropriate collaborators for midwives.

On analysing the literature regarding GP involvement in intrapartum care in Britain and Australia, it became apparent that some GPs want to be involved while others do not (see for example, Flint 1993; Halloran et al 1992; Smith and Jewell 1991). Over the last twenty years there is evidence of a decreasing number of GPs being involved in intrapartum care (see for example, Lewis et al 1978; Prentice and Walton 1989; Young 1987). Reasons given by GPs for not wanting to be involved in intrapartum care included impracticality because of time constraints and inconvenience (Halloran et al 1992; Flint 1993; Waters 1997), safety and fear of litigation (Waters 1997) and that GPs did not believe they were appropriately renumerated for undertaking care during birth

(Bull 1981). For these reasons, Taylor et al (1980) believed GPs should be advised against undertaking intrapartum care. Marsh and Channing (1989), however, believed it was imperative for GPs to visit women during labour and be present at the birth for psychological and clinical support reasons. The GPs involved in the midwifery project planning for this thesis were not interested in providing intrapartum care and saw this as one of the major reasons for collaborating with midwives.

The researchers themselves, being aware of literature findings, having assessed the maternity services in the Area and taken advice from senior colleagues (FN: 21.2.92), concluded that collaborating with GPs was the most appropriate way a midwifery model of care could be implemented within the political and cultural climate of the Area. Before embarking on further planning, there was a need to ascertain whether the GPs within this particular hospital's maternity unit would be interested. Prior to direct discussion with the GPs, discussions occurred with the Director, the Division of General Practice from another Area (director). The Prof (N) used her networks to start discussions with the director who in turn used his networks to negotiate further within the Area. Consequently, the director became an external adviser to the project as he was in a position of power, and involved in his profession and medical politics. The researchers began by discussing their understanding of the project philosophy with the director. From these initial discussions (FN: 4.5.92; 13.10.92; 3.11.92 (these were the dates when these discussions occurred)) it was ascertained in principle that it was politically and professionally feasible for GPs and midwives to collaboratively care for childbearing women.

During meetings with the researchers, the director made suggestions about strategies that would deal with medical politics and further advance the project. These strategies included suggestions for funding sources (FN: 13.10.92; 3.11.92) and assistance with a patient satisfaction survey (FN: 3.11.92). The director mentioned people in the hospital (MS '1') (FN: 3.11.92), and in the hospital Division of General Practice (the chairperson appointee), who would be receptive to the project (FN: 3.11.92). Further, the director suggested appropriate GPs who would be receptive to membership of the SC (FN: 17.2.92), which would oversee the project planning. The researchers were warned by the director of the extreme sensitivity of many GPs to the use of nurse practitioners (FN: 3.11.92). It was obvious from this warning that the relationship between midwife and GP would need to be carefully and sensitively described in early negotiations with medical colleagues.

The director organised for the researchers to be invited to a meeting of GPs enrolled in the hospital Antenatal Shared Care program (FN: 16.12.92). The purpose of this meeting was to discuss the project and further assess its feasibility. Only five GPs attended this meeting with a mixed response. For example, a number of GPs took some time to grasp the notion of the project. Not all understood the researchers' proposal at the end of the two-hour meeting. Some GPs, however, supported the proposal and responded positively (FN: 16.12.92). The researchers called for expressions of interest from GPs to become SC members and GP 'C' ... *expressed keen interest* ... (FN: 16.12.92). Previously, the director had suggested this person for the SC (M: 17.2.93).

Not long after this meeting, the hospital's Division of General Practice was formed and a chairperson appointed. The researchers arranged a meeting with the chairperson during which it was noted that he was, ... *very enthusiastic about the idea of the project ... he saw this as a great idea and said that the researchers could use his name* (FN: 8.3.93). A further example of the chairperson's enthusiasm was his comment, ... *he would be very happy to have a midwife working with him* (FN: 8.3.93).

During the researchers' meeting with the chairperson, he suggested names of GPs he believed would be supportive and willing to be on the SC. It was noted that the chairperson added, ... *he was too busy himself to attend the SC, but would want to be kept informed about what was going on* (FN: 8.3.93). All minutes and relevant documentation from subsequent formal meetings held were sent to the chairperson. In addition, the representative from the Division of General Practice (GP 'L') reported back to the chairperson.

The chairperson organised for the researchers to be invited to a second meeting of GPs enrolled in the hospital Antenatal Shared Care program, three months after the first meeting (17.3.93). This was a general meeting of GPs, with the project listed as an agenda item. The chairperson introduced the researchers and project to the 25 GPs in attendance. The project presented to this gathering was greeted with enthusiasm by most present. It was noted, however, that four GPs had difficulty understanding the concept of the project, appearing concerned more about the impact of the project on their income. A paper was circulated asking for expressions of interest in participating in the project, with 14 GPs

responding. This response was very encouraging and confirmed the next stage in which the feasibility of GP involvement in working with midwives would be investigated.

A further step in assessing the GPs' engagement was the undertaking of interviews with them, thereby definitively determining their level of support for the project. The researchers first discussed this step with the chairperson (FN: 15.4.93), and the SC (SC M: 24.6.93). Later the chairperson informed the researchers, ... *the Board of the Division of General Practice were about to sign a letter to approve the go ahead for the interviews* (FN: 17.11.93). This decision indicated the support of the Board, not only for the interviews, but also the project.

The Division of General Practice Research SC, set up specifically to oversee the interviews, decided that 40 GPs would be interviewed. This number included 20 actively participating in hospital Antenatal Shared Care and 20 who did not actively participate (Division of General Practice SC M: 14.12.93). The interviews were conducted over February and March 1994 by an independent researcher (FN: 24.3.94). A report was completed in May 1994. Thirty-seven GPs were interviewed with the results indicating that 78% of these would be interested in working collaboratively with a midwife (Division of General Practice Shared Care Project Survey Report May 1994). The significance of these findings was summarised by the Prof (N) who was noted to say, ... *I'm very positive about these because we could have had one or two interested if the obstetricians had really succeeded in stopping the project. The GP interviews are very important* ... (Interview (I): 10.5.94). These results indicated that misinformation given to GPs by the obstetricians at that time had not discouraged them from wanting to participate (more details in Chapter Six). Further, the results indicated that some GPs were seeing more pregnant women than previously believed and, therefore, ... *there is a potential to pull women back to the hospital as some of the GPs refer women to other hospitals currently* (MC M: 12.5.94). This trend would strengthen the maternity unit by increasing the number of women seeking care there and also make the project more viable.

At the same time the researchers were discussing the project with the GPs, discussions were held at the hospital. Initial discussions occurred with DON '1', who had written a discussion paper, ... *suggesting a community based midwifery service of some kind* (FN:

25.2.93) should the hospital close. It was believed that if the hospital closed, women would be denied antenatal care as culturally appropriate care was only provided at this hospital in the Area. DON '1' suggested that an informal survey of the women receiving antenatal care be undertaken in order to test this belief and find out which alternative hospital they would attend if the hospital closed. The midwifery manager enthusiastically agreed to undertake this task, deciding on the survey questions and course of action. At the next meeting scheduled with DON '1' (FN: 11.3.93), the researchers met with acting DON '2', who had replaced DON '1'. This sudden change of DON was the first indication of instability in the executive structure in this organisation.

Having gained support from the hospital and midwifery unit manager, it was appropriate to move to the next level. The researchers convened a meeting with the midwives from the maternity unit (MC M: 24.3.93), a year after the first SC. The length of time between meetings indicated the amount of groundwork necessary with the GPs in order to assess feasibility. The researchers were convinced that where the midwives were concerned, the project was feasible. This conviction arose from an understanding that the midwives shared the same perception of the problems with maternity services. The meeting was attended by DON '2', the midwifery unit manager, the midwifery managers from the postnatal ward, labour ward, and antenatal clinic, the midwifery educator and Midwife '1' with the early discharge program. This meeting was about establishing the action research group together to begin the planning process. These people were chosen as they could undertake the survey in their own area, would be able to disseminate information about the project to their own staff and be privy to the information necessary to calculate the cost of confinement. The midwives took responsibility for the survey, thereby acknowledging their support of the project. The inclusion of the calculation of confinement cost was thought necessary in order to justify the cost of the project and provide an argument in support of it. This group of midwives and the researchers spent considerable time working on the cost of confinement (MC M: 7.4.93; 14.4.93; 5.5.93) (see Appendix Four). As part of this work, the researchers consulted with experts in calculating costs (FN: 24.3.93; 31.3.93).

This work with the midwives was designed to elicit their support and paralleled the work designed to elicit the support of the GPs. The researchers had convened meetings

with GPs who provided direct care (FN: 17.3.93). With the midwives, however, the research activities were targeted more at personnel from the management level and less at the practice level, that is, the midwives providing direct care to women. It was assumed by the researchers that the managers of this small unit would then relay the initiative to their own staff. Further, the researchers assumed that all midwives were like-minded about the sense of urgency for change. Both of these assumptions revealed themselves to be incorrect (see Chapter Six).

The midwifery model of care

During the refinement process of the midwifery model, the philosophy remained consistent. This philosophy embraced a caseload approach that promoted continuity of carer that was aimed at low risk, non-insured women, and that provided care throughout the childbearing experience and incorporated education and support. Midwives working collaboratively with GPs would provide the care for childbearing women in the community. An obstetrician would assess the women's suitability for the project and be the point of referral if a problem occurred. The midwives would be employed by the hospital and, in effect, be an outreach service. These midwives would provide antenatal and postnatal care for women in her GPs rooms, home or community centre. The GP would either share these visits with the midwife or just be available if a problem occurred. During labour and birth, the known midwife would undertake care of a woman in hospital. The model was a reorientation of a maternity service that was different to, yet built on the work of other projects at the time, such as those run by Midwife 'N' and Midwife 'W'. Both of these midwives had implemented midwifery models of care elsewhere and were thus consultants to this project planning. There would be four GPs involved in the project, with two midwives and a relief midwife. The process of ascertaining what the relationship between the GPs and midwives would be is conceptually illustrated in soft systems methodology terms in Figure 5.5.

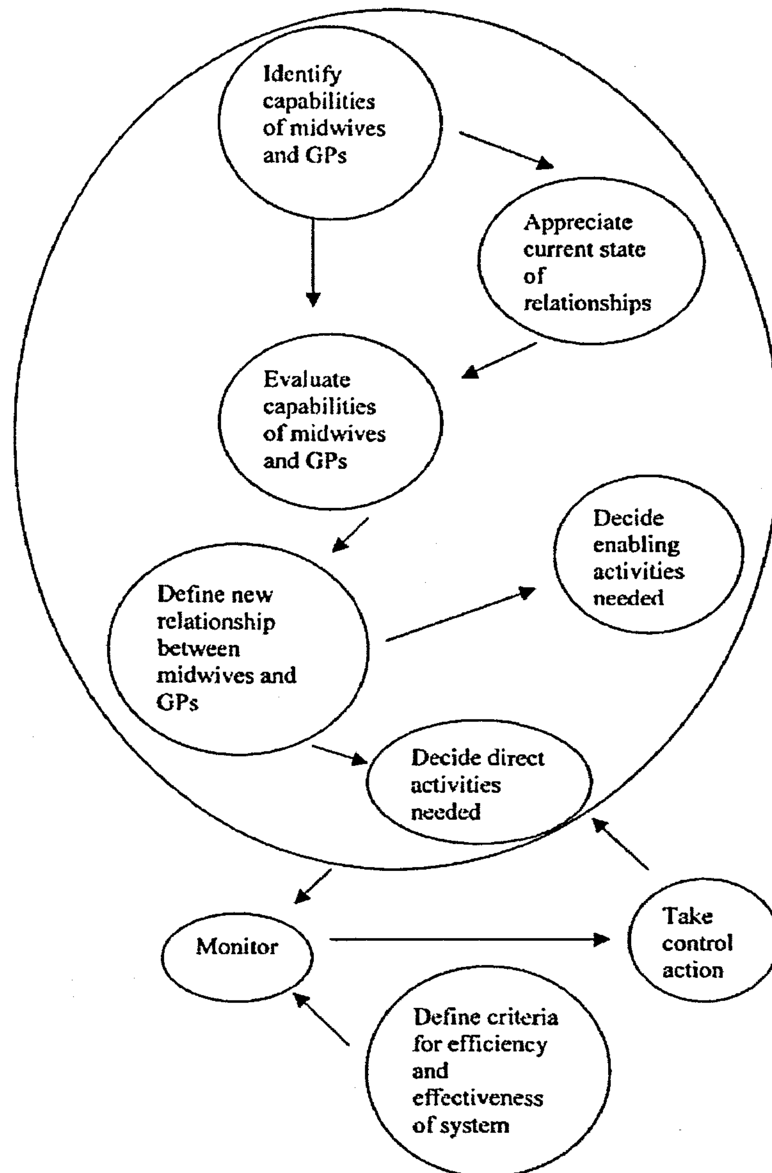

Figure 5.5 Conceptual model of the process of ascertaining the current relationship between the GPs and midwives and determining the new relationship.

Based on the results of a review of antenatal care protocols, it was decided that the number of visits would remain the same, but the nature of these visits would change to prevent overlap (FN: 14.6.94). The GPs received government reimbursement for up to ten antenatal visits. The midwives would, therefore, undertake a portion of these ten visits. It was envisaged that on occasions women would visit only the midwife, being referred to

the GP if the need arose. In this regard, Midwife 'N' suggested that it could be,

> *... put to the GP the status quo of the midwife doing the antenatal assessment and then the GP can decide what they should be doing. It will not be duplicating as it will be qualitatively different. Hands on facilitates the communication process* (FN: 7.11.94).

During the five years of project planning, discussions regarding the development of these antenatal care protocols continued. What appears here regarding the sharing of visits between the midwife and GP was the essence of the protocol. In order to clarify the midwifery model further, a diagram of the existing model is illustrated in Figure 5.6, with the proposed midwifery model illustrated in Figure 5.7.

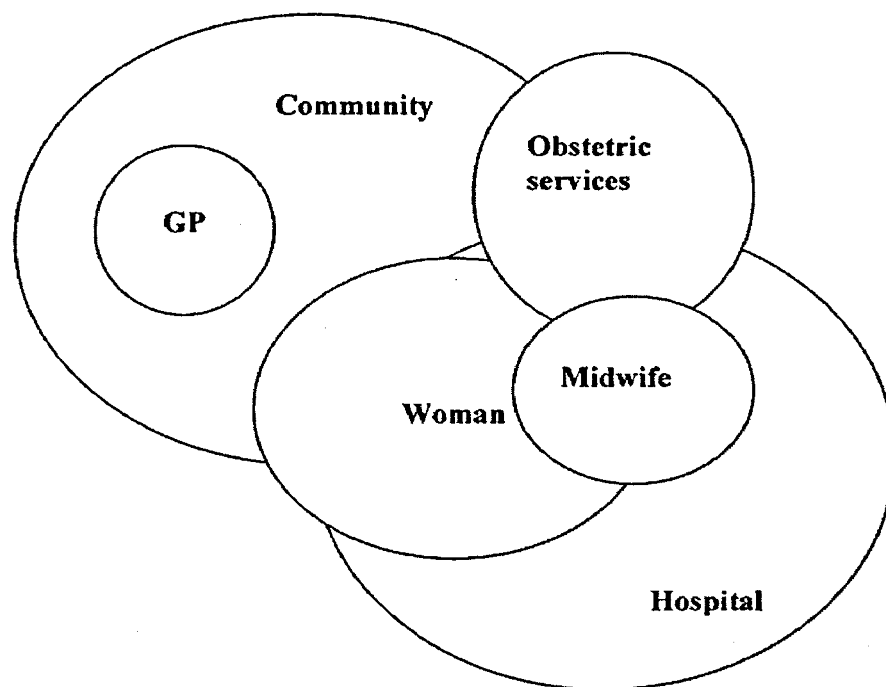

Figure 5.6 Existing model of care in the hospital.

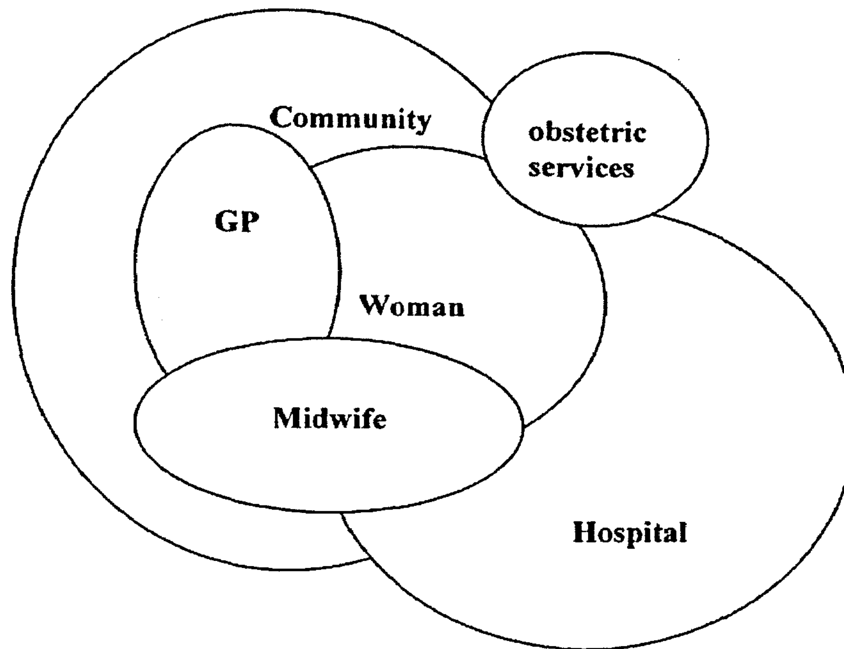

Figure 5.7 Proposed midwifery model of care.

A number of key stakeholders were involved in the project planning in this initial stage. An important aspect of the analysis of the planning process is a social system analysis of these stakeholders. Social system analysis is used to explore the human and social aspects of the situation.

Social system analysis

A social system analysis of key stakeholders involved in the initial planning process for the project was undertaken. This social system analysis examined the continually changing interaction between the three elements of roles, norms and values, described in soft systems methodology (Checkland and Scholes 1991 & 2001) (see Chapter Four). The purpose of this social system analysis was to identify the various roles different people played in the planning of the midwifery model of care. Each key stakeholder will be discussed in turn.

The Professor of Nursing

The Area DON and the academic director responsible for postgraduate programs at the university jointly engineered the Prof (N) position. The Area DON held particular hopes

for the Prof (N) position, envisaged as one of great leadership in Australia. This position was sure to be closely scrutinised for its success or otherwise, across the country. As previously mentioned, because this was the first position of its kind in Australia, there was a certain level of investment in its outcome, for it to be successful and influential (Donoghue and Jones 1993; Schmied et al 1992).

The university employed the Prof (N), by nature of the position. Monies for this position came substantially from the Area. In order to implement this position, cost savings were necessarily made across the Area, with money being taken from the maternity services budget. This budgeting strategy led to a certain level of resentment from maternity services managers across the Area about this position.

The person appointed to the Prof (N) position had proved herself to be a leader in the profession, as well as being a leader by virtue of her position. Leadership plays a significant part in achieving change and requires vision, passion, and ability to motivate others to bring about that vision (Kotter 1996; Kotter and Cohen 2002). Eccles (1994) argues that most of the characteristics necessary to be a successful leader apply to leaders of change. Managing change is also necessary, but leadership is crucial (Kotter 1996; Kotter and Cohen 2002).

The planning for this research project required significant leadership skills. Further, planning required the researchers to demonstrate an understanding of interpersonal processes, specifically by Prof (N). The Prof (N) put a great effort into developing rapport and engendering colleagueship with any person the researchers met. The leadership style exhibited by the Prof (N) was an important factor in the achievement of change, as it was she who lived and embodied the midwifery model of care. The persistence of the Prof (N) to motivate others to bring about the vision was the reason the midwifery model planning was maintained for such a long period.

Together, the Prof (N) and researcher, instigated the need to change, with the Prof (N) recognised as the leader in the project planning. Initially, the Prof (N) was the key political player, interacting with various key stakeholders in order to sell the project. Selling the vision is part of the management of change and, to be effective, must be sensitive to people's needs and the present situation (Carnall 1995). The expected role

behaviours, or norms, of the Prof (N) were for research and political leadership activities. Further, the values of the Prof (N) included being professional, political, diplomatic and promoting the role of the midwife and, to a lesser extent, the GP, in the care of childbearing women. The Prof (N), herself a midwife, had an interest in promoting the role of the midwife as a priority. The persistent motivation, passion and commitment that the Prof (N) carried can clearly be seen in this comment made by her during an interview,

> ... *We've played an immensely important political role in trying to achieve change, to get people thinking about change and to stimulate change. Just the fact that we're prepared to go every Tuesday morning for two to three years says something about how motivated and interested we are in helping them. We didn't run away when things got difficult.* (Interview (I): 31.5.95).

The Prof (N) was, therefore, both a manager and a leader of change in this situation and played an essential part in the guiding coalition (Kotter 1996; Kotter and Cohen 2002).

The Area Director of Nursing

Another one of the key people of the guiding coalition was the Area DON. The Area DON was committed to promoting the role of the midwife in the care of childbearing women and wanted to improve maternity services in the Area. She could not, however, directly control the provision of services in individual settings.

During the planning process it became evident to the researchers that the Area DON was committed to the vision of the midwifery model of care and was impatient for progress. The Area DON was a strong, determined individual, saying and doing what she wanted, not necessarily what other people expected of her, even if this made people feel uncomfortable. For example, a senior person from the Australian Medical Association, wrote an article arguing against the project, and was subsequently invited to attend a SC (M: 18.8.94). The Area DON debated the issue, expressing strong opinions regarding the opposing views of the obstetricians. In response the senior person felt very uncomfortable about these comments, evidenced by her being very quiet, squirming and sinking down in the chair (SC FN: 18.8.94).

To the researchers, the Area DON was a critical element in the project planning, being both visionary and politically astute. These qualities were demonstrated in a number of initiatives, such as a Nursing Council, Nursing Innovations Seminars and production of an Area nursing newsletter (Ross 2001). Further, the Area DON had superior management and leadership skills and was able to motivate and support others to change. She was determined to improve nursing and midwifery care and strongly promoted the place of nursing and midwifery in relation to medical care. The Area DON was highly supportive of the project, to the extent that she was prepared to find a way to fund the project if research funding was not obtained. For the Area DON, research was a relatively new endeavour and she learned much from the expertise and experience of the Prof (N). The Area DON was heartened when the researchers consulted Midwife 'N' and Midwife 'W' who had undertaken similar projects. The researchers were building on existing research and, therefore, involving colleagues who had led innovations themselves in the planning phase of the project (FN: 24.6.93).

The Area DON described her role as a force and an advocate,

> *... being available for Prof (N) to discuss the concept, and then carry that whenever the need arose, and be the link in anticipation of the medical backlash that we have had, to be able to weaken the damage and weaken the blow ... that's what an advocate has to do* (I: 17.7.95).

The Area DON was, therefore, a significant influence in the guiding coalition. She offered dynamic leadership, inspiration, determination and a 'can-do' approach to the project planning.

The Director of the Division of General Practice from another Area

Another contributor to the guiding coalition was the director. The director, a GP, was familiar with the hospital and the Area. For the researchers, the director was the key political player on the GP side and very much an advocate for the project to his colleagues. The director was in a position of power, knew the GP professional politics and was able to influence his medical colleagues.

The role of the director was that of an outside adviser and, subsequently a consultant to the researchers. He offered a realistic understanding of what could be achieved with his medical colleagues, and what strategies were needed to achieve results. The director played the vital role of advocate, a role that continued throughout the project planning, carried out mostly in an informal and unobtrusive way. Further, the director was in a position to know people who would be receptive to the project and put forward the names of those who would be willing to participate in the planning. The director was, therefore, significant in this situation. He was very supportive of the project, as evidenced by his contact with the researchers when issues arose about which the researchers needed to be kept informed (FN: 26.8.93; 13.12.93).

The expected role behaviours, or norms, of the director were those of adviser, consultant, researcher, leader and advocate. The director demonstrated professional, political, and diplomatic values and promoted the role of GPs. He was, therefore, a key person in the guiding coalition of the change process (Kotter 1996; Kotter and Cohen 2002).

The Chairperson of the hospitals' Division of General Practice

The chairperson of the hospitals' Division of General Practice was a GP with his own private practice. The researchers saw the chairperson as a key political player on the GP side. The role of the chairperson was that of an adviser for the project regarding the level of support the researchers could expect from his colleagues, an advocate and an assessor of that which realistically could be achieved. As advisor, the chairperson suggested names of colleagues who would attend various planning committees with the researchers (FN: 8.3.93; 15.4.93). The chairperson was very supportive of the project as shown by his recommended strategies and his generosity. At one stage, he made time to meet with the researchers for six meetings in a seven-month period of at least an hour each meeting, despite having a busy schedule. The fact that there were identified problems in the existing Antenatal Shared Care (FN: 17.3.93) made it easier for the chairperson to accept the need for change (Eccles 1994). This situation created a sense of urgency for change where the chairperson was concerned (Kotter 1996; Kotter and Cohen 2002).

The expected role behaviours, or norms, of the chairperson were those of adviser, watchdog and leader. It was obvious to the researchers that the chairperson was concerned to provide high level care for his patients and, therefore, could see the value of the project in improving care. Other values demonstrated by the chairperson included being professional, political and diplomatic, and his promotion of the role of GPs in the care of childbearing women. The chairperson was a further key person in the guiding coalition of the change process (Kotter 1996; Kotter and Cohen 2002).

The Director of Nursing '1'

The position of DON held an important role in the formation of the guiding coalition and in supporting the project planning. From the first meeting the researchers had with DON '1' it was obvious she supported the project (FN: 25.2.93). Her discussion paper prepared for the hospital and Area executive was further evidence of support. A suggestion made in this discussion paper was for a community based midwifery service, a suggestion that fit well with the researchers' proposed project. DON '1' was a visionary and was influential in guiding and informing the researchers. For example, DON '1' suggested a survey of women currently going through the maternity service to ascertain where they would attend antenatal care if the hospital closed. Further, DON '1' suggested that ascertaining the current costs of confinement and those projected for the project would assist in justifying the project.

The expected role behaviours, or norms, of DON '1' were those of manager and leader. The values held by DON '1' included being professional, political, diplomatic and promoting the role of the midwife in the care of childbearing women. These important qualities assisted in the formation of the guiding coalition. DON '1' worked closely with the midwifery unit manager, another person in the guiding coalition.

The midwifery manager

The midwifery manager was in charge of the maternity unit midwives and, therefore, was a key person in the planning of the project. It was envisaged by the researchers that the midwifery manager would support the project and disseminate this information to the midwives. After the meeting with DON '1', and gaining permission to proceed with planning, the researchers met with the midwifery manager (FN: 25.2.93). Following

discussion about the survey, the midwifery manager took responsibility for the development of this survey and its management, and gave regular feedback on its progress. The midwifery manager was initially very enthusiastic about the project stating, ... *the project sounded great. The increased job satisfaction was most appealing* (FN: 24.3.93). The midwifery manager was also noted to be, ... *very enthusiastic about the work that needed to be done and about taking on a caseload herself when the project started* (FN: 5.5.93). This enthusiasm, however, was not always consistently maintained (see Chapter Six).

The expected role behaviours, or norms, of the midwifery manager were those of a manager rather than a leader. Although the midwifery manager held professional values, these values varied when promoting the role of the midwife. In promoting the role of obstetric nurse and siding with obstetricians rather than the midwives, the midwifery manager from time to time demonstrated a mixed set of values.

Obstetrician '1'

It was envisaged initially that one of the obstetricians, Obstetrician '1' (FN: 15.3.93), would be the referral obstetrician for the project women. This meant that Obstetrician '1' would screen women for suitability to participate in the midwifery model of care. If problems occurred at any stage, women would be referred to this obstetrician for further care. Obstetrician '1' was Head of the Obstetric Department, the reason why the researchers held him to be a key person in the guiding coalition.

Instilling a sense of urgency was crucial in order to achieve change (Kotter 1996; Kotter and Cohen 2002). In having a sense of urgency those affected by the planned change are more likely to take on primary responsibility for deciding on how the change will take shape and to become the planners of that change (Kemmis and McTaggart 1990a). In addition, it was important that an obstetrician be part of the guiding coalition. The researchers' first attempt in gaining the obstetricians' support appeared to be successful. This support, however, did not continue. The researchers received mixed messages, as in the following example. The researchers convened the first meeting with Obstetrician '1' in order to gain his support for the project. Prior to the meeting, a proposal, with an outline of the project, was sent to him (15.3.93). At the meeting, the Prof (N) gave an

overview of the project's background, during which she explained, ... *the theoretical basis for this project is that women are dissatisfied with their maternity care* (FN: 15.3.93). In response Obstetricians '1' countered by saying, ... *women are not dissatisfied with their care at all* (FN: 15.3.93). This was one example of how the obstetricians' views differed regarding maternity services.

It was obvious, however, that Obstetrician '1' had thoroughly read the proposal. Obstetrician '1' added that he believed the, ... *proposal is anti specialist* (FN: 15.3.93). There was an unfortunate oversight by the researchers. The researchers had neglected to specify in the proposal that an obstetrician would review women during their pregnancy. The researchers had made an assumption that this review would continue as currently practised and, therefore, had not made it explicit. At the time, Obstetrician '1' was the proposed person to review the project women. Once this inclusion was clarified in the meeting by the researchers, there was no apparent disagreement from Obstetrician '1'. Reluctantly, Obstetrician '1' agreed to take part in the committee set up to oversee the project. In fact, Obstetrician '1' attended one meeting (SC M: 24.6.93) and received copies of all minutes and documentation in the months that followed.

After the first meeting, the researchers had a further meeting with Obstetrician '1' that was very different from the first. This second meeting was rather negative with Obstetrician '1' noted to say, ... *he did not want to be on call 24 hours a day for the public 'patients' from this project* (FN: 15.4.93). He was noted to add, ... *obstetrics is a very socially disruptive profession* (FN: 15.4.93). Obstetrician '1' suggested that project women should be admitted under the obstetrician for the day, meaning the registrar would be consulted if the need arose. Obstetrician '1' was noted to say, ... *he was concerned about the care that non-insured women receive, but did not want to be involved in their care himself* (FN: 15.4.93). This statement appeared to the researchers to be contradictory, in that it would be difficult to be concerned about the care of non-insured women without being involved with that care. The proposed project was designed to create an ideal opportunity to improve the care for non-insured women. Previously, however, Obstetrician '1' had commented that women were happy with their care (FN: 15.3.93). This was a further contradiction from the comments made during the first meeting. It is possible that between the first meeting and the subsequent meeting Obstetrician '1' may have reflected on the ideas presented by the researchers,

or he had communicated the nature of the meeting to his colleagues who held a different viewpoint. The latter is the likely explanation for this sudden change in opinion about the midwifery model of care. The hesitancy of Obstetrician '1' at the first meeting to support the project would certainly back up this claim.

The role of the obstetricians was one of a dominant player in maternity services (see Chapter Two). This role was evident in the obstetricians' control of policies and practices, and their support for prominence in the system. In this planning stage, Obstetrician '1' was not part of the guiding coalition, an involvement that took considerable time to achieve (see Chapter Six).

The Medical Superintendent '1'

In relation to medical care provided to women in hospital, the obstetricians and GPs were accountable to the MS. It was important, therefore, to gain the support of the person in this position for the project. Previously, the director had informed the researchers that MS '1' would be receptive to the project. This receptivity was evident from the first meeting (FN: 16.12.92). MS '1' was a manager and leader of the medical staff of the hospital and demonstrated values that included being professional, political and diplomatic. He promoted the role of medical staff in the care of childbearing women, but was receptive to the role of midwives in that care.

This part of the planning phase included key strategies for ascertaining the feasibility of the project, identifying the key players and gaining their support. All the essential pieces were now in place, allowing the project planning to commence in earnest. The next step was the implementation of the action research process that would plan the midwifery model of care. At this point the collection of data could commence in earnest and provide the material for analysis (see Chapter Six and Seven).

The process of introducing change

The researchers' next task was to develop the participants' sense of urgency for change through the action research process (Kotter 1996; Kotter and Cohen 2002) (see Chapter Four). Change occurs by involving those people who are part of the situation targeted

for change, in an action research process that plans that change. With this in mind, an action research group was formed, known as the MC (24.3.93). Initially this group consisted of midwives from the maternity unit. GP 'L' and GP 'C2' were added to the action research group as they were considered vital to the planning (a decision made at SC 20.4.93). The MC was seen as crucial to the success of the project and to the mechanism by which the project would work. The MC had its first formal meeting on 22.6.93, at which the following terms of reference were documented:

> *Contribute to decision making; assist with developing documentation; provide information on the project; provide regular feedback to the Steering Committee; meet regularly with the researchers until project finalised; be prepared to discuss, analyse and contribute to the process of implementing the project; be actively involved in project implementation; represent clinicians who will be implementing the process; develop, monitor and amend protocols for the project* (Terms of Reference of MC: 20.4.93).

The SC was an extension of the MC and, therefore, also part of the action research process. In addition, the SC had a part in the wider ownership of the action research process. This participation of the SC in the process enabled an easier change and solutions to be more appropriate and acceptable. The members of the MC were more familiar with the problem and the planning, but less aware of the big picture. Being aware of the bigger picture was than the function of the SC. Membership of the SC consisted in part of those people forming the guiding coalition (Eccles 1994; Kotter 1996; Kotter and Cohen 2002). The Prof (N) was noted to point out, ... *this is being worked out together rather than one person from outside working it out and makes this model unique* (SC FN: 24.3.93). It was, therefore, important for the collective group to make the decisions about how the planning would progress. The SC met for the first time on 20.4.93, with documented terms of reference that required the SC to, ... *advise and act as consultants to the project; receive reports on progress and offer comments; to ensure that the project receives wide oversight and support guidance from relevant people* (Terms of Reference of SC: 20.4.93).

Membership of the SC consisted of MC members as well as a number of key stakeholders. These stakeholders included GP 'C', the chairperson, the Area DON, DON

'1', MS '1', GM '1', and Obstetrician '1'. At the time planning commenced, there were two team midwifery projects operating in New South Wales. The midwives coordinating these projects, Midwife 'N' and Midwife 'W', were also invited to be on the SC.

This action research group, in consisting of the SC and MC, met the criteria for the involvement of people at several levels in the organisation. This configuration should, therefore, achieve a sharing of distributed expertise and ensure people with management authority would not block the strategies developed by the group (Eccles 1994). Further, this group met the criteria suggested for large projects of involving practitioners at several levels and from different professional groups (Morton-Cooper 2000). This is supported by Brodie (1996) in her work on organisational change, who concluded that support was needed from the wider organisational structure to guarantee successful planning. Added to this, involving a range of people was part of communicating the project to all people potentially involved in the change (Eccles 1994; Kotter 1996; Kotter and Cohen 2002). Gathering together this group of people was an act of good leadership that allowed for the establishment and broadening of the guiding coalition to make it more effective (Kotter 1996; Kotter and Cohen 2002).

The aim of the action research group was to be truly participatory and work collaboratively through the process of planning the midwifery model of care. The researchers did not force the process onto the participants, as it was important for them to feel part of the process (Eccles 1994). Problem identification emerged out of a general concern voiced by the participants. Both the midwives and the GPs would have been aware of the problems with maternity services and the need for change (as identified in Chapter Two). Neither the midwives nor GPs, however, had sought assistance from the researchers to effect change. The researchers, in being aware of the problems, were in a position to work with the midwives and GPs in instigating change. Added to this, in her role the Prof (N) was required to instigate research in order to improve maternity services within the Area. The researcher wished to instigate a caseload model of midwifery care and research the process for her doctoral study.

The initial political process undertaken by the researchers aimed to facilitate the participants in becoming more aware of the existing problems with maternity services and, therefore, disrupt their attachment to the status quo. These outcomes were the researchers'

agenda. Through the process of being more aware of the problem, Dunford (1997) believes, assists the reduction of anxiety and motivates participants to support change. Challenging the participants' values, however, can be very disruptive. Through the action research process, the participants became involved in planning the change and developed a sense of urgency to achieve change (Kotter 1996; Kotter and Cohen 2002). A sense of urgency was vital in order to facilitate cooperation in the planning process. The action research process, therefore, provides participants with the purpose and the initiative to bring about change (Eccles 1994).

Meetings

The action research process involved the participants in regular meetings to plan the midwifery model of care. There were a number of groups meeting. Firstly, the fortnightly MC meetings, commencing at 0800 hours, being agreed to, ... *aim to keep meetings to a maximum of one hour* (MC M: 22.6.93). Starting at 0800 enabled the GPs and researchers to attend the meetings before commencing their workday. Meetings were held at the hospital maternity unit to be convenient for the midwives. The midwives attending these meetings started their day at 0800 hours and the meetings, therefore, were scheduled before they became caught up in the day's work. Meeting in the maternity unit meant considerable travelling for the GPs and researchers, requiring travel from home to the meeting and then onto work. The venue and time was specifically chosen to maximise attendance, a strategy that was not always successful. While the researchers and GPs attended every meeting, the midwives' attendance was erratic and unreliable (see Chapter Six).

The SC meetings were held in the evenings at the hospital once every two months, or as the need arose. A time of 1800 hours was chosen for this meeting for the convenience of those able to attend at the end of the working day. For the midwives, the meeting time meant they had to stay back for an hour to attend and, consequently, often did not. In order to facilitate attendance at the SC, it was decided; ... *the meeting had a time limit of one hour* (SC M: 24.6.93). This was, however, not a successful strategy as attendance at this meeting was erratic on the whole. The researchers provided refreshments, which was appreciated for an evening meeting and encouraged social interaction. Social maintenance is crucial in achieving change (Eccles 1994; Kotter 1996; Kotter and Cohen 2002) and was

demonstrated by the researchers through their interest in the participants (Kerr 1996). The maintaining of relationships with participants was crucial for this action research process. Providing refreshment was an important aspect of this maintenance.

All proceedings of the MC and SC meetings were recorded as formal minutes initially by the researcher and circulated prior to the next meeting for ratification. A research assistant took over this minute taking role much later in the planning phase. There was a total of 54 MC and 16 SC meetings over the five years of planning. Added to this, the researchers met with certain key stakeholders individually. The events of these meetings were recorded in field notes made by the researcher. No formal minutes were written.

In addition there were a number of meetings with various people organised by the researchers in order to inform them about the project. This political exercise aimed to gain the endorsement of strategic key players (Eccles 1994). These meetings included the Chief Nursing Officer and Women's Health Nurse Adviser from the Department of Health. The purpose of these meetings was to inform Department personnel about the project directly from the researchers rather than through other sources (FN: 6.11.92). Likewise, the researchers met with the president of the College of GPs, a political strategy to inform him directly of the project in case he heard negative opinions from other sources (FN: 6.7.94). This meeting was timely in that the president was noted to say; ... *he had heard some bad rumours about what the researchers were proposing* (FN: 6.7.94).

Meetings were also organised with others who could offer advice to the researchers on specific aspects of the project. For example, there were discussions with two financial advisers from the Area on calculating confinement costs. It became clear from this meeting that it was important to demonstrate that this project would be cost effective and not result in over servicing (FN: 11.3.93). Economic advisers from outside the Area were also consulted in relation to calculating confinement costs (FN: 31.3.93). This group of economic advisers made some suggestions, but no conclusive method could be applied. Calculating the confinement costs appeared not to have been done elsewhere. The literature confirmed the difficulty of calculating the cost of maternity care (Bower 1993; Flint 1991; Kenny et al 1994). Contributing factors to this difficulty were ascertaining the specific cost of procedures and use of facilities (Flint 1991) and the scarcity of appropriately collected data to enable such costing. A further contributing factor relates to

the fact that maternity care is often provided by different health professionals, that is, midwife, registrar, resident or obstetrician (Kenny et al 1994). Bower (1993) concluded that an accurate comparison of costs with innovations such as team midwifery was virtually impossible. The researchers' crude costing at the time was considered to have sufficient face and practical validity for the senior managers to move forward (see Appendix Four). More recently, such costing has been achieved by evaluating specific costs carried by the organisation (Homer 2002; Homer, Matha, Jordan, Wills and Davis 2001; Tracy and Tracy 2003). This costing included salaries and wages, goods and services and maintenance costs (Homer et al 2001).

At one stage, the SC was concerned about the legal liability status of the project and recommended the researchers seek clarification of this with the Area Legal Adviser (SC M: 28.10.93). In other words, were the midwives, GPs and obstetricians covered for vicarious liability when working in the midwifery model of care? The researchers convened a meeting with the Area Legal Adviser, who was noted to advise, ... *this project is no different to the current system* (FN: 29.11.93). The project was covered for legal liability in the same way as the existing system and, therefore, legal liability of health professionals with the project was not an issue.

Further, the researchers convened a meeting with the general secretary of the state nurses' union about the progress of proposed changes to the nurses' award. These proposed changes would allow for time in lieu and overtime for midwives working in innovative models of care as opposed to straight shifts (FN: 11.8.93). Midwife 'N', ... *had worked against the award with her midwifery project with midwives being on call and having time in lieu* (FN: 11.8.93). This arrangement had worked very effectively but contravened the state nurses' award. On the other hand, it was noted that Midwife 'W', ... *had worked the midwives in her midwifery project within the award, which was found to be restricting and not satisfying for the midwives* (FN: 11.11.93). The recommendation from these project midwives was that midwives working in such midwifery models of care should receive an annualised salary through a union agreement, instead of a wage that was dependent on the shifts worked.

The researcher recorded field notes for all the project meetings. As a general rule, the researchers sought permission to take notes at the meetings and record the process of

change, after first explaining this to those concerned. For example, ... *information about action research was circulated to the MC and there was a discussion about the process* (MC M: 22.6.93). Although all participants had agreed to be involved as part of the action research process for planning change, in one meeting with Obstetrician '2' it became clear he did not agree to the researcher taking notes. Obstetrician '2' was noted to say to the researcher, ... *are you writing everything I am saying down* (FN: 25.8.93)? Further, it became obvious that he, ... *did not want the researcher to write everything down and was very aggressive about this* (FN: 25.8.93).

The researchers convened a total of 162 meetings from which 127 pages of minutes and 227 pages of field notes were produced. These pages of minutes and field notes formed the basis of the data analysis. The researcher critically analysed the data for theoretical ideas and concepts (as outlined in Chapter Four), to explain the difficulties encountered in achieving organisational change.

The description of the action research process revealed that this was the beginning of an ongoing struggle between creating a sense of urgency to plan the model of care and permitting obstacles to block the vision. It was almost as if this was the first indication of what turned out to be a larger ongoing struggle.

This chapter began by describing how the vision of the project was disseminated to others, and their commitment to innovation in the Area was gained. In addition, how the researchers worked towards the formation of an action research group and process is described. The key strategies employed by the researchers at this initial phase in gaining support from appropriate people and instigating the right process to succeed in bringing about change is further described. Data collection commenced in earnest at this stage as the researchers first collaborated in planning the development of an innovation in midwifery care. Finally, an overview of the planning events and summary of the meetings are given from which the data was obtained and analysis undertaken.

The next chapter reports on the results of data analysis from the action research process through which the implementation of the midwifery model of care was planned. An emerging theme from the data analysis was the interplay between creating a sense of urgency and permitting obstacles to block the vision to plan the model (Kotter 1996;

Kotter and Cohen 2002). These activities reveal the continual struggle that occurred as various strategies were put into place to overcome obstacles and defuse resistance to change. This process was an attempt to empower broad based action and, therefore, increase the sense of urgency.

Chapter Six

Creating a sense of urgency to change

The purpose of this study was to record and analyse the change process associated with planning and implementing a midwifery model of care. This is the first of two chapters reporting on the results of the data analysis from the action research process through which the implementation of the midwifery model of care was planned. The data were analysed using a framework derived from Kotter (1996), outlining certain conditions that need to be in place in order to achieve change (see Chapter Four). An emerging theme from the data analysis was the interplay between creating a sense of urgency and permitting obstacles to block the vision to plan the model (Kotter 1996; Kotter and Cohen 2002). These activities reveal the continual struggle that occurred as various strategies were put into place to overcome obstacles and defuse resistance to change. This process was an attempt to empower broad based action and, therefore, increase the sense of urgency. Chapter Seven follows with a discussion of the strategies used by the researchers.

In addition, the examination of the data involves the social system analysis, specifically the roles, norms and values of different players in this struggle (Checkland and Scholes (1991). These elements determine how a person sees and values various situations (Jackson 1982). The nature of the social system emerges through reviewing events and making inferences about the roles, norms and values of people. A social system analysis was, therefore, included to establish meaning to this interplay between creating a sense of urgency and permitting obstacles to block the vision. This examination began in Chapter Five with a brief analysis of the key players in the initial planning process and is taken further here.

As previously outlined (see Chapter Four), one factor in achieving a sense of urgency is believing that what exists is unacceptable and, therefore, recognising a need for change to improve that situation (Kotter 1996; Kotter and Cohen 2002). In order to realise a current situation is unacceptable, however, participants need to identify that there is a

problem and establish a sense of urgency to change that problem. Consequently, participants are described as engaging in the project planning. In this study, there was evidence of engagement by the main participants in the project planning and evidence of numerous obstacles that blocked the vision. Different groups engaged in the planning process at different times.

Each of the roles of the main professional groups will be examined in turn, starting with the midwives. As this project concerned a midwifery model of care, gaining support of the midwives was a critical step in planning. An examination of the role of the general practitioners (GPs) who were to be collaborators in care with the midwives then follows. Lastly, the role of the obstetricians is examined. The obstetricians presented the biggest obstacle to the planning. These three professional groups are examined as they engaged with the process of change and used obstacles to block the new vision for change.

The midwives

Engaging

Instilling a sense of urgency in the midwives, one of the main players in the midwifery model of care, was critical in order to achieve change (Kotter 1996; Kotter and Cohen 2002). Having a sense of urgency allows those affected by the planned change to have primary responsibility for deciding on how the change will take shape and, be in essence, the planners of that change (Kemmis and McTaggart 1990a). The engagement of the midwives was, therefore, crucial for the action research process to succeed. As Page (1995b) stresses, unless there is considerable support from midwives, such change is virtually impossible.

Over the five years in which this midwifery model of care was planned, the midwives continued to display some resistance. During this planning time, it was often unclear how engaged in the project planning the midwives were, with different midwives displaying varying levels of engagement over time. For example, the midwifery manager initially appeared very enthusiastic about the project (see Chapter Five). Later, when the planning was well under way, her attendance at meetings became erratic (Management Committee Field Notes (MC FN): 26.4.93 (this is the date on which these minutes were

recorded). The variable support of the midwives undertaking the planning of midwifery models of care had been identified elsewhere as an issue (Brodie 1996). The midwives in this study, however, eventually gained a sense of urgency and engaged in the project planning.

The earliest indication that the midwives participating in the planning were starting to develop a sense of urgency occurred some 16 months into the planning. A comment was made by the Professor of Nursing (Prof (N)) that, ... *the midwives are finally committed and supportive of the project* (Steering Committee Field Notes (SC FN): 24.6.93). Evidence to support this was when the midwifery managers from the labour and postnatal wards, ... *made a valuable contribution to the discussion and came across as being very positive about the project* (SC FN: 24.6.93). At this Steering Committee meeting, for example, both midwives answered questions about the project instead of expecting or waiting for the researchers to answer, plus they asked questions about the project development rather than its feasibility (SC Minutes (M) and FN: 24.6.93). The announcement that the hospital would stay open, which occurred just before this meeting, no doubt helped this enthusiasm and engagement (Reference removed). Not long after this, the midwifery manager from the labour ward brought a pertinent article for the researchers (MC M: 20.7.93). Such interest and involvement seemed to affirm her commitment to the project planning.

One contributing factor to the midwives' complacency was the continual tension in working to overcome the obstacles presented by the obstetricians. Over time, the midwives began to slowly assert themselves, responding to the obstetricians instead of being intimidated by them. This shift was evident when it became clear that the midwives had changed their language, describing the project as, ... *our project* ... to the obstetricians (MC FN: 17.8.93), as opposed to, ... *your (researcher's) project* ..., used earlier. A further example of this assertive shift in the midwives was noted when the maternity unit was reported to be under an unusually high level of scrutiny by the obstetricians (MC M: 31.8.93). It was the usual practice in the maternity unit for the obstetricians to regularly undertake an audit of the medical records. This audit had not been undertaken for some time. The obstetricians' usual process was to first discuss the

medical records with the midwifery manager from the antenatal clinic in order to fully understand the documentation. Instead Obstetrician '2' reportedly,

> ... *went to the antenatal clinic and took some patient records himself to do an audit and did not understand how the records worked, believing that something was wrong. He then stormed into the maternity unit with what he thought was a complaint about the records* (MC FN: 31.8.93).

The midwifery manager from the antenatal clinic and the midwifery manager responded by suggesting that, ... *the obstetricians could conduct regular three monthly audits if they liked* (MC FN: 31.8.93). Obstetrician '2' immediately, ... *backed down* (FN: 31.8.93). This incident revealed that the midwives were able to assert themselves, and respond to an obstetrician's intimidation. In addition, the midwives were beginning to gain confidence in themselves and engage with the project (Bowman 1986). In response to this, the Prof (N) commented that, ... *we have taken our midwifery colleagues into learning that it is okay to work together* (Interview (I): 10.5.94). According to Bowman (1996), such developments indicate that the midwives were beginning to trust and respect the role of the researchers as change agents and consequently were able to accept the project. Researchers obtaining the trust of the participants is an important aspect of action research (Meyer 2000). Further, the midwives exhibited teamwork and felt more comfortable in responding to the obstetricians.

After this audit incident, the midwives' developing sense of urgency became more obvious as the planning progressed. For example, the midwifery manager from the postnatal ward brought some pertinent articles to a meeting (MC FN: 14.9.93). The midwifery manager from the labour ward arrived at the next meeting with an article and cartoon, presenting them to the researchers. The cartoon depicted two midwives conversing, one midwife said, ... *of course giving birth to a team scheme is bound to be difficult* (MC FN: 28.9.93).

Further evidence of the engagement of the midwives appeared some six months later after the release of the Obstetric Review, which had triggered the tenuous engagement

of the obstetricians. The evidence included:

- The midwifery manager from the postnatal ward reporting that two midwives from the unit were interested in participating in the project (MC M: 12.4.94);
- The midwifery manager from the labour ward working on the development of protocols as part of her Master degree (MC FN: 12.4.94);
- The midwifery managers from the labour and postnatal wards offering comments and suggestions about the project during meetings (MC M: 26.4.94; 5.7.94; 21.7.94);
- The midwifery managers from the labour and postnatal wards taking it in turns to attend the SC (MC M: 16.8.94). Their attendance pattern ensured senior representation from the maternity unit but meant both of them did not attend every meeting;
- The midwifery manager responding to a suggestion to employ extra midwives as a way to ease the project into the maternity unit. She exclaimed that, ... *this project is a reorientation of services which then does not equate if a midwife is an 'add on'* (MC FN: 29.11.94). Employing extra midwives would mean that the project was not a reorientation of services, instead being an addition;
- Nearly three years into the planning, the midwifery manager became the chairperson of the MC, albeit unofficially. She questioned the involvement of the obstetricians, demonstrated concern about the effect of fewer antenatal visits and pushed to move on with staffing issues (MC FN: 31.1.95);
- The Prof (N) asked the midwifery manager if she would formally chair the MC, to which she agreed (MC M: 31.1.95). After the midwifery manager resigned from her position and left, the midwifery manager from the postnatal ward formally became the chairperson of the MC (MC FN: 20.6.95);
- The midwifery manager suggested a working party that would examine the client-held records, pursued the issue of obstetric support for the project and asked what would happen if there was no support (MC M and FN: 7.2.95);
- The midwifery manager from the postnatal ward was noted to comment, ... *I really believe that it can work and that we can take it ... in a bigger, bigger way* (I:

22.6.95). This was referring to the fact that the midwifery model of care would be successful.

It took considerable time, and involved a lot of work on the part of the researchers, to overcome the midwives' obstacles and defuse resistance to change. Others noted these factors. For example, Director of Nursing (DON) '3' described the overall process of the midwives' attempts for broad based action and an increased sense of urgency to change, *... the project belonged to the researchers initially and it has taken the midwives a year to realise that it is not any more* (FN: 15.6.95). The Prof (N) then more explicitly described this process of empowering the midwives,

> *...it has been a huge exercise in professional education that has been directed at our midwife colleagues. We have done a lot of changing of attitudes, sensitising people and increasing their awareness, preparing them ...* (I: 10.5.94).

Finally, the fact that the researchers' strategies to empower the midwives had been successful in increasing their sense of urgency to change, was noted by Midwife 'W',

> *... there's increasing commitment from all members of the team to work more closely together; there's a lot more trust and respect. People aren't feeling so threatened* (I: 15.8.94).

Further evidence that the midwives developed a sense of urgency to change was noted by DON '3' saying, *... we're just entered the next phase where the midwives are gradually taking over responsibility ...* (I: 7.6.94). In addition, DON '3' articulated, *... being a milestone when the midwives themselves are fronting the project at a meeting with the obstetricians* (I: 7.6.94), with Prof (N) adding, *... people are ready for it at the level of midwives ...* (I: 10.5.94).

The main indicator of final engagement was when the midwives took on ownership of various aspects of the project planning and ultimately, ownership of the planning. It is crucial for researchers to promote and support the participants in action research to become the owners of the project planning (see for example, Abraham 1994; Eccles

1994; Grundy and Kemmis 1981). An important by-product of the action research process is the ability to bring about an improvement in the capacity of the participants to continue the process of change after the researchers have gone (Forbes 1992). The participants, in taking ownership of various aspects of the project planning were, therefore, moving towards this ability for participants to continue the process. What follows is a discussion of the obstacles that were created by the midwives in order to block the vision. Such obstacles are indications that the midwives continued to be complacent in planning the midwifery model of care.

Obstacles used to block the vision

Despite their displays of commitment, the midwives created many obstacles in order to block the vision of the midwifery model. These obstacles took various forms, for example, erratic meeting attendance, not undertaking agreed tasks, displaying disinterest and articulating a lack of trust in the researchers. The following incidents demonstrate how obstacles were created and applied:

- The researchers and the GPs arrived at a MC to find no midwives in attendance (FN: 22.6.93 and 22.6.93). The MC and SC meetings were held in the maternity unit to make it easier for the midwives to attend, and required considerable travelling for the GPs and researchers. The midwives were on site and yet had to be sought out to attend the meeting. It was acknowledged that sometimes the maternity unit may have been too busy for the midwives to leave, except that the meeting was specifically scheduled at the start of their day before they became caught up in the day's work. It is likely, however, that the midwives did not want to attend the meetings, as evidenced by the prickly behaviour of the midwifery managers from the postnatal and labour wards at an early meeting (MC FN: 22.6.93). Such prickly behaviour was verbal in nature. The midwives were snappy and short during discussions with the researchers. Insight into the possible reason for this behaviour occurred later when the midwifery manager from the labour ward spoke about her experience in contemplating change and articulated that, ... *being a bit of an outsider nobody likes change. Then when something might be changed they tend to look at the negative aspects* ... (I: 14.6.93);
- Initially, when the obstetricians confronted the midwives regarding their negativity towards the project, the midwives were very angry at having to defend, ... *your*

(researcher's) project (MC FN: 3.8.93). What had become shared ownership of the project with the researchers was later rejected. It was almost as if the midwives were joining the obstetricians in their negative stance and becoming sceptical about what the researchers were trying to achieve. The midwifery manager from the labour ward commented that she felt pressured and asked, ... *why should she have to talk with Obstetrician '2' about a project that was not hers* (MC FN: 3.8.93). It would appear the midwives were placed in a very difficult position. They were dominated by the obstetricians, but had to work with them. On the other hand, the researchers were unknown;

- Midwives not undertaking designated tasks created an obstacle. For instance, the midwifery educator and the midwifery manager from the antenatal clinic were to work on the development of protocols. When this agenda item came up in a meeting, both midwives claimed they had been too busy to undertake the task. (MC M: 31.8.93). It was unclear as to whether they were indeed too busy, or they had forgotten about the task which would indicate their complacency;
- Research assistant (RA) '1' telephoned the midwifery manager from the postnatal ward to determine the ethnic mix of women in the ward at that time, in order to undertake a client satisfaction survey. The midwifery manager from the postnatal ward did not return the call despite a number of attempts to make contact (FN: 19.4.94). Whether this was because the midwifery manager from the postnatal ward was too busy or whether this was a sign of her disinterest was not clear;
- It was arranged that the midwifery manager from the postnatal ward would collect client satisfaction surveys from the women for the researcher to pick up later. When the researcher arrived, only three surveys were completed and collected. The midwifery manager from the postnatal ward said she had forgotten to collect the others (FN: 27.4.94). The researcher left after asking her to collect the remaining survey forms, and returned later to collect them. It would have been easier and less time consuming if the midwifery manager from the postnatal ward had collected the survey forms, than for the researcher to drive for an hour to the hospital to do so. The midwifery manager from the postnatal ward appeared to do very little to assist with the project indicating her complacency;
- The midwifery manager from the postnatal ward made a comment at one meeting that raised questions about whether she had taken in the information at the meetings.

She was noted to say, ... *the GPs, I feel a lot of them are interested in the project but I don't know that a lot of them would be interested in having a midwife in the rooms with them* (I: 18.8.94). This observation was made despite the results from the GP interviews and the discussions with the four participating GPs that indicated they were indeed interested. A possible explanation for this lack of enthusiasm came later when the midwifery manager from the postnatal ward herself was noted to say,

> ... *from the midwives' point of view they feel threatened by change, and this is the way that it has always been. It works, why change it. Why would we want to go out into the community and be with GPs. We don't know enough about it ...* (I: 18.8.94).

Whether 'it' referred to the protocols, the project or something else was not clear. The protocols were still being developed. The overall framework for the project at that stage, however, was clear. This degree of uncertainty may well have been a consequence of the process that allowed those involved in the change to shape the project (see for example, Carnall 1995; East and Robinson 1994; McKibbon and Castle 1996). The action research process resulted in the project formation being slow and possibly frustrating for people who want immediate results.

The continued uncertainty about the midwives' engagement with the project was identified by the Area Health Service Director of Nursing (Area DON) who was noted to say,

> ... *whether the midwives we've got are going to be happy to be involved, that's a major stumbling block. It's difficult to change some of the old thinkers. We have to employ midwives that have the right kind of thinking* (I: 23.8.94).

The insinuation here is that the 'old thinkers' are not about achieving change for whatever reason, whether it be security in the status quo, lack of enthusiasm to work harder to plan the change, confidence in their own ability to perform, lack of education regarding the need to change or not able to identify that there is a problem requiring change. Part of the explanation could be that many of these midwives had worked in this

maternity unit for a long time setting up a certain culture and sense of security that resists change.

The final piece of evidence for the midwives' complacency about the project planning was seen during a MC meeting. At this meeting the midwives articulated a number of issues of concern that had little or no substance. For example, the midwifery manager from the postnatal ward was noted to declare,

> ... *the whole project does not seem to have had any firm direction. Nothing finite was organised regarding the clinical. There are no parameters set. We have been wafting along. This is a worthwhile project if it is handled properly. We need an obstetrician on side. This is a big project and not suitable for the midwifery manager level to be handling it. We very much supported the project. We wanted to be given parameters as to what needs to be done. The project was being dumped and left. We were kept informed but not involved. It is time to bring in the people that are interested* (MC FN: 6.6.95).

The midwifery manager from the postnatal ward added that she believed the project, ... *was very abstract at the moment and that once the midwives were appointed then the project will be more concrete ... do not feel that we are supported from the management side* (FN: 6.6.95). At this point, the researcher listed all those in management who supported the project at both hospital and Area level. It was almost as if the midwives were looking for someone to blame for the project's planning not moving ahead. Instead, it was the midwives who were resisting the change and not being empowered to take broad based action to change.

Further evidence of the midwives' complacency came when the midwifery manager from the labour ward herself was noted to say, ... *she felt that she has just been drifting along* (FN: 6.6.95). This was an apt statement to make as the researchers had concluded that the midwives had not been pulling their weight with the project planning. Instead, the midwives appeared to be frustrated, trying to blame someone else for their own inactivity. The researchers had taken on the leadership role in the action research group for some three and a half years at this stage. Even though some midwives had taken on

tasks, true ownership from the midwives had not occurred. This situation presented a difficulty for the researcher because the midwives were holding up the project planning. The researchers had handed the project planning to the midwives, supporting it by taking responsibility for the research. At that stage in the planning process, the researchers had two research assistants assisting with the research side of the project. This MC meeting indicated the midwives' complacency was probably the last step in the process through which the midwives finally took control of the project, evidenced by the meeting referring to the midwives' agenda, not that of the researchers (MC FN: 6.6.95). The midwifery manager from the labour ward later was noted to apologise to the researcher, *... for her outburst, saying she was feeling frustrated and wanted to voice this frustration* (FN: 13.8.95). This event provided evidence to support the researchers' interpretation of the midwives behaviour during this MC meeting.

The Prof (N) had not attended this particular MC meeting (6.6.95), otherwise the events of the meeting may not have occurred. The Prof (N) was perceived to be in a position of power over the midwives and, therefore, they would not have felt comfortable being as open in front of her. At that time it was obvious that the Prof (N) had not succeeded in establishing equality with the midwives through the action research process.

There was evidence suggesting that, in fact, the midwives were unhappy that the Prof (N) had not attended many of the MC meetings prior to this one. This could further explain these events. For example, RA '2' was noted to say,

> *... the midwives feel dumped on. The Prof (N) left it kind of hanging there. She doesn't come to the meetings. There is something unresolved between herself and the midwives. Its like she started it and needs to sort of follow it through for them (midwives) to be able to feel that she's still interested ...* (I: 31.7.95).

Further evidence that the midwives were displeased with the Prof (N) was provided by RA '1', articulating that she, ... *sensed the staff were cross with Prof (N). Maybe because the staff did not know what the project was all about and were possibly not interested* (FN: 15.8.95). This was despite the fact that planning had been occurring for some three and a half years, but would continue to take time because that was the nature

of the action research process. In addition, the midwifery manager from the labour ward had discussed with RA '1' on a number of occasions about, ... *the midwives displeasure regarding the Prof (N) dumping the midwives and the project* (FN: 16.10.95).

The considerable confusion and ambivalence exhibited by the midwives was summed up in the following comment noted to be made by RA '2'.

> *The midwives have to feel that they are very involved in making decisions. That has only happened recently. They have now decided to take it as their own. This type of research is involving the people who will actually be implementing the project* (I: 31.7.95).

The midwives made these comments to RA '1' and RA '2' because they had managed to gain their confidence and ascertain their viewpoint. Added to this, both research assistants were probably viewed as equals by the midwives and not in a position of power as the researchers were. From the researchers' perspective, however, this viewpoint was frustrating as the midwives had been involved in making decisions through the action research process of the MC. This was something that the Prof (N), as leader of the action research process, had worked hard to achieve. It was conceivable that the midwives did not have the same perception of the action research process as that held by the researchers.

The ambivalent behaviour exhibited by the midwives was noticed by Midwife 'W', who was noted to say,

> ... *I'd like to see a bit more midwifery strength. They seem to be sort of hovering, playing a waiting game. This may be a reflection of their uncertainty. I don't know how much they'll be able to really fully embrace it and develop a passion for it* (I: 12.5.95).

According to Kotter (1996; Kotter and Cohen 2002), it is important to remember it is impossible to remove all obstacles, and that this is acceptable. In this project not all the midwives achieved a sense of urgency for change and continued to present obstacles to

block the change. This pattern is clearly illustrated in the behaviour of the midwifery educator and the midwifery manger with the early discharge program. The researchers worked around these two midwives by inviting and welcoming their participation in order to include them but continuing on without them. Evidence of the continued lack of engagement of these two midwives with the project planning included:

- The midwifery educator attended most of the MC meetings, but rarely contributed to the discussions, almost being outside the group. This behaviour was aptly summarised by Midwife 'W' when she was noted to say, *...I'm not sure that we've got everybody with us. I think we make assumptions that everybody's with us, that they're physically present at the meeting, but ...* (I: 15.8.94);
- At one stage, the Prof (N) suggested that the midwifery educator could be incorporated into the midwifery model of care (MC M: 26.4.94). This inclusion would have enabled the midwifery educator to have her own caseload of women at the same time providing a role model for the midwifery students. It was noted that the midwifery educator responded, ... *she did not want to be divorced from the maternity unit* (MC FN: 26.4.94). This statement confirmed the researchers' impression of the midwifery educator and her apparent failure to embrace the project. The point here being that the midwives working in the midwifery model of care would be part of the maternity unit even though they functioned as an outreach team;
- During a MC meeting, a discussion regarding the need to translate a client satisfaction survey into Arabic was on the agenda (MC M: 29.11.94). The midwifery educator made a somewhat contradictory statement when it was noted she said that at this hospital, ... *Arabic are the second biggest group, Anglo Australians being the largest* (MC FN: 29.11.94). While undertaking the client satisfaction survey pilot, the researcher had approached approximately 20 women and not encountered one Anglo Australian woman. After the midwifery educator's comment, the midwifery manager from the postnatal ward was noted to look at her sternly, almost disapprovingly (MC FN: 29.11.94). The perceived impression from this behaviour was that the midwifery educator's colleagues did not value her contribution highly;
- In contrast to the midwifery educator, the midwifery manager with the early discharge program attended very few meetings overall. Flint (1993) claims that people rarely attending meetings are making as strong a statement as those who

enthusiastically attend every meeting. The fact that the midwifery manager with the early discharge program attended few meetings and appeared to rarely read the minutes became fairly obvious. For example, the midwifery manager with the early discharge program at one MC meeting was noted to raise her concern about, ... *the increase in workload in the unit once the midwives started working on the project* (MC FN: 21.2.95). This had been discussed during two MC meetings previously (MC M: 5.7.93 and 29.11.94) and demonstrated a complacency in the midwifery manager with the early discharge program for the project planning. Women participating in the midwifery model of care would have attended the maternity unit if they were not part of the model. Even though the same numbers of women were being cared for overall, the model midwives, and not the unit, would undertake the care. Consequently, midwives working in the maternity unit would be caring for fewer women than previously.

These were the obstacles put up by the midwives to block the vision of the project. The midwives participating in the action research group required constant reinforcement from the researchers in order to achieve final engagement. The strategies used to empower broad based action that would eventually overcome these obstacles from the midwives, and thus achieve a sense of urgency to plan the project, are outlined in Chapter Seven. The sense of urgency in the GPs for the project planning, however, was more assured from the start.

The General Practitioners

Engaging

Instilling a sense of urgency and engaging with the GPs, was another critical step in achieving the midwifery model of care (Kotter 1996) if the GPs were to collaborate with the midwives. Such participation meant the GPs, who would be affected by the planned change, would have primary responsibility for deciding on how that change would take shape and be, in essence, the planners of change (Kemmis and McTaggart 1990a). The engagement of the GPs in the project planning was, therefore, crucial for the action research process to succeed.

The engagement of the GPs was present from the start of the planning, as evidenced by the response of the Director of the Division of General Practice from another Area (director) and the Chairperson of the hospitals' Division of General Practice (chairperson), and the results of the feasibility interviews (see Chapter Five). There was a continued and consistent sense of urgency on the part of the GPs to the project planning process. The evidence included:

- One year into the project planning, the chairperson invited the researchers to a second gathering of 25 GPs enrolled in the hospital Antenatal Shared Care (FN: 17.3.93). This meeting clearly identified problems with Antenatal Shared Care (FN: 17.3.93; Letter: 26.11.93). The existing system was unacceptable as far as the GPs were concerned and, therefore, needed to be changed (Eccles 1994). Enthusiasm for the project was then a logical step. This position was confirmed later when the chairperson reported to the researcher that, ... *Antenatal Shared Care is not working properly and there needs to be a total overhaul of the current system of shared care* (I: 17.5.94);
- The main GP participants in the action research process, GP 'L' and GP 'C', consistently attended meetings. For example, GP 'C' attended 16 out of a total of 16 SC meetings and GP 'L' attended 12 SC meetings, plus 50% of the MC meetings. This pattern of attendance was despite the fact that these GPs had their own full time practice and family commitments. A contributing factor may have been the benefit that GP 'L' and GP 'C' gained from attending the SC meetings. It became evident at these meetings that GPs work in isolation. Both GPs often stayed after meetings to talk (SC FN: 24.6.93; 18.8.94). The isolation of GPs has been identified in the literature (Mira, Ryman, Leslie and Fett 1993);
- During a SC meeting, it was noted that, ... *the GPs appeared to grasp the notion of the project and what it meant to them* (SC FN: 24.6.93). This was evident by various comments the GPs made at this meeting. For example, GP 'L' was noted to comment about, ... *the great thought of having midwives working with her* (SC FN: 24.6.93), and that, ... *these midwives would be more skilled than the hospital midwives* (SC FN: 24.6.93);
- GP 'L' wrote an article in the project's first Newsletter stating that, ... *the GPs and midwives will work together to establish ways of <u>complementing</u> each other's skills,*

thus providing high quality maternity service and job satisfaction for all (Newsletter (N) 01: September 1993);

- When the Prof (N) reported that the GP interviews revealed their preference for bi-lingual midwives, it was noted that GP 'L' responded, ... *a caring midwife was better then a bi-lingual midwife* (MC FN: 31.5.94). This comment indicated that GP 'L' had grasped the philosophy of the midwifery model of care;
- GP 'L' took on the task of assessing the accreditation programs of other hospitals in order to formulate a program that would then be presented to the chairperson for approval (SC FN: 12.5.94);
- GP 'L' reported that she was informing the women she sees professionally about the midwifery model of care in readiness for its commencement (MC FN: 19.7.94).
- GP 'C' attended both preliminary meetings the researchers had with the GPs (FN: 16.12.92; 17.3.93), indicating her enthusiasm for the midwifery model of care from the start;
- GP 'C' became the self appointed representative from the Division of General Practice on the SC (SC M: 18.11.93);
- GP 'C' reported to the researchers that the Australian Medical Association (AMA) had sent out a brochure with their membership renewal stating that the project had been stopped (AMA Brochure: November 1993). GP 'C' then wrote a supportive letter requesting corrections be made to this statement in their next mail out and that,

> *The scheme seeks to remove public patients who are not ill from the hospital illness oriented outpatient setting and to transfer them into their own community. I see this move can only have positive outcomes for the patients and the general practitioner who has of late lost some 'control' of the patient's care to specialists and hospitals* (Letter (L): 26.11.93);

- The director reported to the researchers that the AMA had put out a further publication again stating that the project had been stopped (FN: 15.3.94). GP 'C' wrote a follow up letter to the person responsible for this statement, referring to the

project planning and saying that,

> ... *there had been times when I have been frustrated with the slowness of the progress. Because I can see the potential benefits to all those involved I think that it is preferable that the researchers continue with their meticulous attention to detail so that the model is given every opportunity to succeed* (L: 19.9.94).

These letters written by GP 'C' reaffirmed her engagement with the project and understanding of the project philosophy;

- GP 'C' was very articulate and forthright about issues raised at the SC meetings. For example, GP 'C' supported the notion of midwifery students and doctors being part of the project to learn (SC FN: 18.8.94);
- GP 'C' investigated the issue of the legal liability of GPs with the project. A concern had been raised that their indemnity insurance may not cover them if they worked in the midwifery model of care (SC M: 18.8.94).

Likewise, the sense of urgency of the two male GPs, selected from the interviews to participate in the midwifery model of care, was obvious from the start. For example:

- When the researchers went to see GP 'C3', the questions he asked, the comments he made, saying, ... *the midwife will be in charge which is very good. He felt honoured to be chosen to participate* (FN: 7.9.94), indicated he understood the model and supported the philosophy;
- GP 'P' was noted to make similar comments, such as, ... *he was privileged to be selected. He was thinking of having one afternoon off per week, which could be when the midwife could have her session* (FN: 7.9.94).

The engagement of the GPs was further noted by others in their various comments, with the Prof (N) reflecting on, ... *the loyalty of people like GP 'L', she's been just incredible* (I: 10.5.94). Likewise, the comments made by Midwife 'W' acknowledge the GPs sense

of urgency for the model planning,

> *... there has certainly been a change of attitude from the medics. They were perhaps a bit sceptical in the beginning, a bit cautious. Now I see a change in their attitude with a level of commitment and interest ...* (I: 15.8.94).

Later, Midwife 'W' was noted to say that she could see, ... *the GPs are very much central to the process now ...* (I: 12.5.95). Their involvement probably reflects the increased confidence that the GPs had in the midwifery model of care and the researchers.

The involvement of the two female GPs in the project planning was identified by Director of Nursing (DON) '3' as a very positive move, noted to say, ... *I think that courting the two female GPs in the SC so there's ownership of the actual mechanics of the project has been very effective* (I: 7.6.94). So effective was the tactic of enlisting the GPs from the Division of General Practice that DON '3' was noted to argue, ...*the grass roots feedback from the other GPs is acceptance of the project* (I: 7.6.94). Here was an acknowledgement of the effective lines of communication that the two female GPs had with their colleagues regarding the midwifery model of care. In addition, the Area DON commented on the engagement of the GPs, stating that, ... *two female GPs have active involvement in it. I think we will do all right with these women* (I: 17.7.95).

Further, the Professor of Obstetrics (Prof (O)) wrote to the Prof (N) about a meeting that had occurred with the obstetricians (FN: 7.3.95), commenting on the engagement of GP 'C'. In this letter the Prof (O) commented that, ... *GP 'C' was a major contributor to the discussion and did extremely well* (L: 20.3.95).

An indication of the GPs' ultimate sense of urgency for the planning of the midwifery model of care occurred when the researchers were invited to the First Annual General Meeting and dinner of the Division of General Practice. During this dinner the chairperson talked with the researchers and thanked them for attending (FN: 21.10.94). This invitation was an honour. The researchers were probably the first midwives to have been invited to such a gathering as this, a further indication of support.

As can be seen from the documentation of meetings and interviews, there appeared to be no obstacles from this group of GPs to the midwifery model of care planning process, despite the fact that the obstetricians and the Australian Medical Association (AMA) were displaying strong opposition to the model. The GPs always had a sense of urgency for the midwifery model of care, which they maintained throughout the project planning

Obstetricians

Engaging

There is a long history of obstetricians, as a powerful group, dominating maternity services and midwives (see Chapter Two). In more recent times, there is evidence of increasing domination by obstetricians over midwifery practice and over midwives when instigating midwifery innovations (Hambly 1997; O'Donnell 1998). For these reasons, there was a need to instigate this midwifery model of care at a site where obstetric involvement was minimal. It was further perceived that the obstetricians might block the innovation, as the model could be seen to threaten their power, status, and financial gain. It was, therefore, important that the obstetricians engage with the project planning.

There was some initial engagement of the obstetricians evident in the first meeting between the researchers and Obstetrician '1' (see Chapter Five). Initially, Obstetrician '1' agreed to be the referral obstetrician for women in the project and also to attend the SC meetings (FN: 15.3.93). Obstetrician '1' not only attended the SC, he appeared positive about the project by asking questions and even offering faintly humorous comments (SC FN and M: 24.6.93).

The engagement of Obstetrician '2', the next Head of Obstetric Department, was also evident in his first meeting with the researchers (FN: 21.7.93). At the initial meeting, Obstetrician '2' appeared to be keen about the project, indicated by his many questions and wanting to know who had been involved in the various meetings. He did not want to be a member of the SC, but was noted to specifically mention, ... *he wanted to be kept informed of what was occurring* (FN: 21.7.93).

What followed next, however, was a period of approximately 18 months of intense resistance by the obstetricians, as obstacles were used to block the project (see next section). The turning point occurred with the publication of the results of an Obstetric Review. The Area had determined that an Obstetric Review would be undertaken, starting on 11 October 1993 to address the concerns raised about obstetric services in the Area (MC M: 17.8.93). There were senior obstetricians on the Obstetric Review team who could be expected to put an 'obstetric' position on the review, and an expert midwife. The expert obstetricians were not private obstetricians but health service and university employees who understood the nature and requirements of obstetricians. The Obstetric Review report was handed down at the beginning of 1994 (FN: 14.1.94). Overall this report was supportive of the midwifery model of care, and recommended the appointment of a Prof (O) who would oversee the obstetricians. The recommendation for the appointment of a Prof (O) was the most influential strategy in achieving a sense of urgency in the obstetricians for the midwifery model of care planning.

Over time evidence of the obstetricians' sense of urgency for the midwifery model of care emerged, starting with the Prof (O) informing the Prof (N) that the obstetricians would support the midwifery model of care in principle (MC M: 7.3.95). A second indication occurred during an Obstetric Department meeting to which the midwifery managers from the labour and postnatal wards had been invited. At this meeting, the obstetricians informed the midwives that they supported the midwifery model, which was previously not the case. In defence of their change of heart, Obstetrician '1' apparently was noted to say, ... *the project had changed because there was never any medical support* (MC FN: 15.6.95). Obstetrician '2' commented to the midwives at this meeting that, ... *the obstetricians wanted to be kept informed about how the project was progressing and he did not want any divisions between the midwives and the obstetricians* (MC FN: 15.6.95).

The evidence for the engagement of the obstetricians took some time to come to light. This delay was an indication of their resistance to the project as obstacle after obstacle was used to block the project. These obstacles greatly impeded progress in planning the

model as much energy was put into addressing them. Engagement of the obstetricians finally occurred but the process was very difficult, as described in the next section.

Obstacles used to block the vision

Obstetricians, as a group, displayed the greatest resistance to the midwifery model of care. The researchers and members of the SC (FN: 21.2.92) had assumed that because the project was aimed at non-insured women, the obstetricians would not interfere, as the project would not affect them directly. In retrospect, this assumption was naïve in light of the obstetricians' response in strongly resisting the project. It appeared the proposed midwifery model of care challenged their status, power and authority.

The obstetricians created obstacles to the project planning through claiming ignorance of trends in maternity services. For example:

- It became evident that the obstetricians believed that current maternity services were acceptable. They did not recognise the need for change in order to improve the situation, and, therefore, lacked a sense of urgency. This misapprehension was clearly identified when the Prof (N) was noted to say, ... *women were dissatisfied with their maternity care*. Obstetrician '1' responded, ... *women are not dissatisfied* (FN: 15.3.93). Later, Obstetrician '1' contradicted his statement, almost as if he was demonstrating his concern, saying, ... *he was very concerned about the care that public women received, but did not want to be involved in their care himself* (FN: 15.4.93);
- There was evidence that other obstetricians lacked awareness of the problems with maternity services. For example, Obstetrician '2' was noted to say, ... *what problems are there with Antenatal Shared Care. He thought that it was running satisfactorily* (FN: 25.8.93). Obstetricians '3' supported this later, saying that, ... *the GP shared care scheme is functioning well* ... (FN: 22.9.93).

In addition, what motivated the obstetricians became an obstacle and blocked the vision. Their motivation almost became a smoke screen for their politicking (Eccles 1994;

Kotter and Schesinger 1991). For example:

- Obstetrician '2' commented on the women being cared for in the midwifery model of care, ... *these 'patients' would get better care than their private 'patients'* (FN: 17.8.93). This statement was surprisingly honest, appearing to reflect the obstetricians' self interest, something obstetricians in Britain had also been accused of under similar circumstances (Thomson 1994). The usual rationale given by obstetricians against midwifery led care is their concern for women's safety or that their care is more costly (Flint 1993). In this instance, Obstetrician '2' was more concerned his patients may not continue to seek his care, preferring midwifery led care instead. This project was perceived by the obstetricians as a direct threat to the financial viability of their practices, despite the fact that only non-insured women were to be considered. The belief that women participating in midwifery led models of care receive special care is a common complaint obstetricians make against such innovations in care (Adams 1997). Obstetrician '2''s statement reflects the perception that the obstetricians were not providing good care. Further evidence for this conclusion came from the Obstetric Review Panel who commented that, ... *the obstetricians had portrayed themselves as having bad practice* ...(and they) ... *were appalled at how poor the obstetric practice was in the Area* (FN: 26.10.93);
- The obstetricians had a meeting with Medical Superintendent (MS) '2' (FN: 18.8.93) and raised concerns about the project's effect on the teaching of medical students and the potential loss of a registrar position. These concerns were based on the assumption that fewer women would be attending antenatal clinics if some were participating in the midwifery model of care. If the registrar position were lost, the implication would be that the obstetricians would have to attend the antenatal clinics themselves. At the time, the registrar predominantly attended women in the antenatal clinic even though it was the obstetricians' responsibility, for which they received reimbursement. Later MS '2' articulated that, ... *at the back of the obstetricians' mind was the fact that the loss of the registrar position would inconvenience them* (FN: 26.8.93).

These examples show how obstacles were created in order to block the vision from the obstetricians. There were a number of other obstacles used by the obstetricians that

inferred political motivations on their part. Such actions included:

- The obstetricians made themselves unavailable to meet and discuss with the researchers on an intellectual level the fact that they did not support the project, choosing instead to passively resist. For example, following the appointment of Obstetrician '2' as the new Head of Obstetric Department (FN: 8.6.93), the researchers were unable to gain an appointment until 21.7.93, despite endeavouring to do so on numerous occasions;
- The obstetricians made comments to the less powerful midwives rather than communicating directly with the Prof (N). It was almost as if the Prof (N) posed a threat to the obstetricians, as she was noted to say, ... *they (obstetricians) would rather vent their complaints in other areas* (FN: 14.9.93). An example of this behaviour occurred when the researchers finally managed to meet with Obstetrician '2'. At this meeting he appeared to be supportive of the project, evidenced by him asking lots of questions, asking who had been involved, asking the Prof (N) to address a Rotary meeting sometime and the meeting lasting for one and a half hours (FN: 21.7.93). Not long after this meeting, the midwives reported that Obstetrician '2' did not support the project. Evidence included Obstetrician '2' vocalising his concerns and making negative comments about the project to the midwives, saying, ... *the project was going to cost millions* (MC FN: 3.8.93) and other comments indicating his lack of support for the project;
- The researchers then specifically convened a meeting with Obstetrician '2' to discuss the negative comments he had made to the midwives about the project. Prof (N) started off the meeting by saying she, ... *was led to believe that Obstetrician '2' had a problem with the project* (FN: 25.8.93). Obstetrician '2' immediately defensively stated, ... *he did not have any problems with the project* (FN: 25.8.93). Despite his claim, his support was not forthcoming. He added, for example, that the obstetricians, ... *had not been aware of the project and not been consulted* (FN: 25.8.93);
- At one stage the Area Chief Executive Officer (CEO) forced the obstetricians to meet with the researchers in order to discuss the project. During the meeting, Obstetrician '2' was noted to say, ... *we have always been happy to talk with the researchers but have not been approached* (FN: 22.9.93). This inaccurate claim was another example of the obstetricians' contradictory behaviour;

- Obstetrician '2' continued to frequently tell the midwives he did not support the project and was very negative about it (FN: 31.8.93). Further, Obstetrician '2' informed the midwives he, ... *did not want to be a consultant to the project* (FN: 31.8.93). This, ... *not wanting to be a consultant* ... was used as a weapon by the obstetricians in order to assert their power through not participating. It was, after all, much easier to find excuses not to support the midwifery model of care than to support it (Carnall 1995). The midwifery model of care was threatening the taken-for-granted world of Obstetrician '2' and he refused to engage in this different paradigm. This behaviour was designed to block the project planning and very nearly succeeded. It became obvious that the researchers' efforts to communicate with the obstetricians were not working. Eccles (1994) alluded to a possible explanation for the obstetricians' behaviour in his work. The obstetricians were given information that they either did not appreciate or comprehend;
- Obstetrician '2' informed the researchers he, ... *wanted his name removed from the SC so that he could remain impartial* ... (FN: 25.8.93). This manoeuvre was another example of Obstetrician '2' not participating in the action research process and thereby asserting his power over the project planning by blocking progress;
- During one meeting, the obstetricians threatened MS '2', saying, ... *they were going to see the Area CEO to get the project planning stopped, and tell him they will go on strike if the midwifery model of care starts* (FN: 18.8.93). The obstetricians were also, ... *going to write to the Australian Research Council and tell them not to fund the project* (FN: 18.8.93). These threats were examples of the obstetricians' efforts to persuade other powerful individuals and organisations to add pressure to stop the project planning. Their desired outcome was that the researchers would be told to stop the project planning and leave the obstetricians alone.

These actions were further examples of intimidation by the obstetricians to cause the researchers to back down and give up the project planning. In trying to achieve their aim, the obstetricians were both unprofessional in their behaviour and driven by political motivation. For example, the obstetricians went to the Area CEO, the ultimate authority in the Area, to tell him to stop the project planning. This act was their first line of resistance with the midwifery model of care and the researchers. Further, this was their alternative to gathering information about the midwifery

model of care, discussing this directly with the researchers and negotiating their concerns. By bullying the researchers and trying to persuade other powerful individuals and organizations to add their pressure, the obstetricians hoped the researchers would be told to stop the project planning and leave them alone. As the Prof (N) was later noted to comment,

> ... *the political leadership is an interesting one because of the role the obstetricians tried to play in providing leadership and saying what would happen, but, in fact, having that turned down by the Area CEO they have lost credibility and are being seen as non effective leaders* ... (I: 10.5.94);

- At one stage, the director informed the researchers about a phone conversation he had with a senior person from the AMA who had, ... *received a complaint from a medical specialist about the project planning* (FN: 26.8.93). The essence of the complaint was that the GPs and obstetricians had not been involved in discussions about the project. This certainly was not the case with the GPs, as shown in Chapter Five, and was a further example of the games the obstetricians were playing in an attempt to undermine the chairperson. The Prof (N) was later noted to comment,

> ... *Obstetrician '2' is currently behaving worse to his medical colleagues than to us. Instead of discussing the project directly with the chairperson, he has gone behind his back to the AMA to make a complaint regarding the GPs involvement* (FN: 31.8.93).

- During the meeting convened by the Area CEO between the obstetricians and the researchers, the obstetricians made threats in relation to the midwifery model of care. For example, Obstetrician '3' was noted to say, ... *if this scheme ever gets off the ground it would have no clients* (FN: 22.9.93). This statement was later confirmed by Obstetrician '3' stating how this would happen, ... *if we (obstetricians) have to screen people to do this scheme then we will not because we do not approve of it and hope this never gets off the ground* (FN: 22.9.93). Such obstruction by the obstetricians had succeeded in stopping midwifery led innovation elsewhere (Hambly 1997), or restricted women's accessibility to midwifery led care (Brodie

1996). Obstetrician '2' repeated this lack of support stating, ... *we are not convinced this is a desirable project* (FN: 22.9.93). Obstetrician '3' reinforced this view saying, ...*the obstetricians did not support this model because it is flawed* (FN: 22.9.93);

- Around the same time, it was noted that the chairperson reported to the researchers, ... *the obstetricians were talking to GPs who were not involved in the hospital Antenatal Shared Care and asking them if they knew about the midwifery model of care* (FN: 23.9.93). These GPs were then confronting the chairperson to explain why they were not informed about the project. The chairperson believed that the aim of this strategy was to, ... *create a division within the Division of General Practice* (FN: 23.9.93). This discussion would then undermine the chairperson and do much damage within the Division of General Practice. Creating political and professional difficulties for the chairperson would, in turn, divert the chairperson from the project planning. Further evidence of this strategy occurred one month later when GP 'L' was reported to say, ... *there had recently been a meeting of the Division where there was nearly a 'no confidence' expressed in the chairperson* (MC FN: 26.10.93). All GPs in the Division had received information about the midwifery model of care in correspondence from the Division, correspondence that obviously had not been read;
- A further complaint had been made to the AMA stating that $1.5 million was to be spent on the project, money which should be spent on other aspects of health care (MC FN: 28.9.93);
- Mysteriously, copies of a confidential research funding application for the project evaluation had been sent to various people. In one example, a reporter from Australian Doctor Weekly contacted the Prof (N) on 29.9.93 about the project planning, having received a copy of the funding application. Subsequently, an article was written and published about the project (Australian Doctor Weekly: 22.10.93);
- The chairperson reported to the researchers that a psychiatrist had been sent a copy of the application and been asked to comment (FN: 1.10.93). Later, the chairperson was noted to comment, ...*everyone seems to know about the project as there are copies of the funding application everywhere* ... (FN: 17.11.93).

The results of the Obstetric Review were made public in 1994, with evidence of the obstetrician's resistance having become minimal. There was, however, still evidence of the obstetricians' use of power in much more subtle ways, that is, by their silence and reluctance of appointments with the researchers (Managham 1979). For example, the researchers made many attempts to convene a third appointment with Obstetrician '2' (FN: 30.5.94). A meeting would be convened, with the receptionist contacting the researchers prior to the appointment to cancel (SC M: 18.8.94). At one stage, the Prof (N) asked her secretary to confirm an appointment with Obstetrician '2' who replied that he had to undertake a caesarean section and was unable to make the meeting, and, ... *he did not need to see the researchers and he had been talking with someone and saw no need to discuss the issue with the researchers* (FN: 7.9.93). As Midwife 'W' put it, ... *the silence from the obstetricians is an obstacle. It would be good to have some feedback from them as their silence is deafening* (I: 15.8.94).

In addition, the obstetricians tried to play down the Obstetric Review in an attempt to discredit the recommendations. For example, it was noted that Obstetrician '2' told the midwives the Review,

> ... *had said nothing and was a load of 'hogwash'. It basically only spoke about bickering that occurred between the midwives and obstetricians that did not happen. The midwives and obstetricians got on very well together* (FN: 15.3.94).

This perceived getting on well together, however, was instead about the obstetricians' determination to control the midwives. In reply to this somewhat astounding statement, the midwifery manager from the postnatal ward interpreted this by saying that, ... *yes, the midwives submit something they want changed and the obstetricians stamp on it and the midwives, and say no* (FN: 15.3.94). As long as this situation of control was retained, the obstetricians interpreted this as, ... *getting on well...* . Further to this, the midwifery manager from the labour ward reported that Obstetrician '2' informed her that, ... *the relationship between the midwives and the obstetricians was like they were in bed together* (FN: 15.3.94). To which the midwifery manager from the labour ward commented that, ... *it would have to be a twin bed* (FN: 15.3.94).

The obstetricians had certainly made paradoxical comments about a professional relationship they believed they had with the midwives, given their behaviour over the proceeding months. This mixed message does, however, make sense if analysed in accordance with the research in this area (Kitzinger et al 1990; Stein (1967). Kitzinger and colleagues (1990) demonstrated that obstetricians were not conscious of that which midwives do or want. It was obvious from the obstetricians' statements that they had no real understanding of the existing situation, therefore, supporting the research findings. Conversely, as speculated as early as 1967 by Stein, obstetricians and midwives have a special relationship, with intense respect and cooperation exhibited by both parties. This relationship seems to continue to hold in the 1990s as shown throughout this thesis. The special relationship is almost symbiotic where one cannot do without the other. It would appear that this is indeed the case and is clearly the belief of the obstetricians in this particular instance. In reality, mutual respect, however, does not always exist. Cooperation is only obtained by playing the doctor-nurse game (Stein 1967).

Even after the appointment of the Professor of Obstetrics (Prof (O)), some nine months after the release of the Obstetric Review, there was still some evidence of the obstetricians' resistance. For example:

- The Area DON reported to the researchers that the obstetricians had again been to see him, believing this would be enough to stop the project planning (FN: 8.11.94);
- The midwifery manager with the early discharge program reported that Obstetrician '2' was continuing to be obstructive regarding the project planning, claiming, ... *he does not know anything about the project* (MC FN: 31.1.95);
- The Prof (O) informed the Prof (N) that Obstetrician '3' had, ... *waved the latest project Newsletter in the Prof (O)'s face saying he thought the obstetricians had stopped the project planning* (FN: 12.2.95);
- The midwifery manager from the labour ward reported that Obstetrician '3' had spoken to her about the midwifery model of care, saying, ... *the Prof (O) was not supporting the project* (MC FN: 21.2.95). This was certainly not what the Prof (O) indicated to the researchers. Either Obstetrician '3' had misinterpreted the Prof (O) or the midwifery manager from the labour ward had misinterpreted Obstetrician '3'. After all, the Prof (O) might not want to appear to be too enthusiastic about the midwifery model of care to the obstetricians. Alternatively, Obstetrician '3' could

have been trying to further undermine the project planning by misinforming the midwives about the lack of support from the Prof (O).

The political upheaval, as a consequence of the obstructive actions of the obstetricians, had created a stalemate in which nothing further could progress with the project planning. Eccles (1994) commented that people like the obstetricians should not be taken too seriously because their objections to the project were ill founded. Despite this reassurance, the resistance of the united obstetricians had a big impact on the project planning. The project planning, however, managed to continue. The obstetricians began to be empowered for broad based action, due to a number of strategies as outlined in Chapter Seven. In addition, there were other obstacles, in the form of hospital and executive instability that blocked the vision.

Hospital and executive instability

Obstacles used to block the vision

A number of other obstacles were encountered that contributed to blocking the project planning. These obstacles included the instability of the organisation and the continual threat of closure and executive changes. The obstacles effectively caused a distraction, mainly with the midwives, as they were employed by the hospital. This distraction, in turn, affected the midwives' sense of urgency to plan the change. Each of these obstacles will be discussed in turn.

On three occasions during the course of project planning, uncertainty arose regarding the possible closure of the hospital, with a decision being made twice to keep it open. The first threat of closure occurred during the initial planning stages of the midwifery model of care (FN: 25.2.93). It was proposed that a new hospital be built on another site, with this hospital subsequently closing (Reference removed). There was substantial community protest against this proposal. Some four months later, following the state elections, plans for the construction of the new hospital were ceased (Reference removed). The announcement was made in the newspaper (FN: 2.7.93). Discussions regarding where the new hospital would be built continued for a further two years (Reference removed).

Over a year later, the Prof (N) commented on further rumours about the hospital closing in order to rebuild or relocate (FN: 20.4.94). This meant the researchers needed to move quickly on the project planning in order to implement the model before the hospital closed. When the researchers spoke to the chairperson about these concerns, he was noted to respond that, ... *he thought there was three years before it would close* (FN: 30.5.94). This was supported by the DON '3' who was noted to say, ... *the hospital would be here until the beginning of 1997* (FN: 23.3.94). There continued to be uncertainty, however, regarding the fate of this hospital, as there were also rumours that the new hospital would be built on the current site. The hospital, therefore, would have to close in order to be demolished to build the new hospital.

Finally, there was an announcement in the newspaper regarding the decision to build the new hospital on this hospital's site, relocating the services while construction proceeded (FN: 12.4.95). At the time, the DON '3' was unsure how the building would affect the current services. The plan at that stage was to build behind the current hospital, meaning services could continue during the building (SC M: 4.5.95).

This was not the only area of instability in the hospital. A further comment noted to have been made by the chairperson one year earlier stimulated further concern for other potential problems, that being, ... *the problem of the new hospital being in a different Area and what the implications would be to the Division of General Practice* (FN: 30.5.94). This situation related to the possible physical relocation of the hospital to another Area, which would impose a different management system. At the time, the Prof (N) decided to ignore the significance of this statement. If the researchers had not done so, the alternative would have been to stop all efforts to introduce a new model of care. In hindsight, this one factor was probably the biggest contributing obstacle to block the vision of the midwifery model of care and, therefore, should not have been ignored. This may well have been the point at which the planning should have stopped.

Over a year later, an announcement was made that this hospital was to be relocated within another Area (FN: 18.7.95). This was apparently the third change of Area for the hospital in the past decade (Reference removed) and is indicative of how unstable the

position of this hospital had been. At that stage, the researchers were unsure of the implications of this decision (MC M: 1.8.95). Apparently, the DON '3' wanted to continue with the project planning, as did the midwifery manager from the postnatal ward, commenting that, ... *I really believe that it can work and that we can take it into the new hospital in a bigger, better way* (I: 22.6.95). The researchers, however, no longer had any standing in the relocated Area to be legitimately involved, which made continued planning virtually impossible.

Following the announcement of a change in the Area boundaries, there was continued uncertainty regarding what would happen with the maternity unit with the rebuilding of the hospital. Information regarding the fate of the maternity unit was finally released six months later. An announcement was made that the maternity unit would move to another hospital from January 1996 for two years until the hospital was rebuilt (FN: 14.12.95).

The other area of instability occurring during the project planning that created further obstacles was the high executive turnover at the hospital. This instability involved a total of eight DONs (two were acting in the position), five General Managers (GMs), three MSs and three Obstetric Head of Departments. The position of the midwifery unit manager was also taken away, which was the only change that occurred at the maternity unit level. The vast number of changes that occurred in the executive structure of the hospital may well have been calculated manoeuvres on behalf of the Area, and senior director of health officials, to decrease the power structure at the executive level. The structure of the organisation after all, is an influential element in gauging the effectiveness of the organisation (Carnall 1995). People are more likely to seek employment elsewhere if the environment they are in is continually threatened. The substantial changes to the executive of the hospital may well have been calculated manoeuvres made by the Area to destabilise the power structure. When executive positions continually change, the organisational structure becomes weaker and ineffective. These moves had negative consequences for the morale of all hospital staff, further undermining the collective power base within the hospital. The net result of these changes resulted in less resistance to the threatened closure of the hospital (Aiken, Clarke and Sloane 2000).

When the researchers discussed the issue of changing executive staff with the chairperson, he believed, ... *it looks as if they are progressively closing down the hospital* (FN: 30.5.94). If the executive positions were continually changing, the structure of the organisation becomes weak and ineffective. People were being moved in and out of positions and the hospital very quickly. This was bad for the morale of all hospital staff, further undermining the collective power base within the hospital. The power of the community, however, was underestimated as they lobbied strongly and successfully for the hospital to stay open time and time again.

Both the instability of the hospital and executive provided obstacles, which effectively distracted the participants in the action research group and diminished their sense of urgency to plan the project. The strategies that were then used to empower broad based action in these participants to address these obstacles are outlined in Chapter Seven.

This chapter began the data analysis by examining the interplay between creating a sense of urgency and permitting obstacles to block the vision to plan the model (Kotter 1996; Kotter and Cohen 2002). These activities reveal the continual struggle that occurred as various strategies were put into place to overcome obstacles and defuse resistance to change. These strategies were an attempt to empower broad based action and, therefore, increase the sense of urgency. The next chapter discusses the various strategies that were employed by the researchers in planning the midwifery model in order to empower broad based action among the action research participants and achieve a sense of urgency to change.

Chapter Seven

Strategies for change

This is the second chapter to report on the results of the data analysis from the action research process through which the implementation of the midwifery model of care was planned. The previous chapter identified the emerging theme of the continual struggle that occurred between creating a sense of urgency and permitting obstacles to block the vision to plan the model. This chapter describes the various strategies utilised by the researchers to empower broad based action, thereby creating a sense of urgency in the action research participants to bring about organisational change. The strategies used included leadership activities, the guiding coalition, communicating the vision, achieving gains, and keeping the momentum going. These strategies empowered the participants to broad based action and thereby helped embed the change within the culture of the organisation.

Developing a vision and strategy

Leadership plays a significant part in achieving organisational change and requires vision, passion and the ability to motivate others to bring about that vision (Kotter 1996; Kotter and Cohen 2002). Senge and his colleagues (1999) strongly believed that a change agent must be a leader in order to succeed. An effective change agent, in being a good leader, is able to achieve a vision for change. In the planning of the midwifery model of care, therefore, leadership skills were required by the researchers, in particular by the Professor of Nursing (Prof (N)). The leadership style exhibited by the Prof (N) was, in fact, an important factor in the achievement of change, as it was she who lived and embodied the midwifery model of care. The persistence and perseverance of the Prof (N) to motivate others to bring about the vision was the impetus for the midwifery model planning. In addition, leadership has been identified as significant in the successful planning of other midwifery models of care, together with persistence and tenacity (Brodie 1996; Page 1995b).

As well as leadership, the researcher must exhibit a number of characteristics in order to successfully use the action research process (see for example, Greenwood 1994; Hart

and Bond 1995a; Nicholls 1995; Kerr 1996). These include knowledge, tact, commitment to change, patience, perseverance, deep respect for participants, a high tolerance of uncertainty and an ability to let go when appropriate. These characteristics were overwhelmingly applicable to the Prof (N) as researcher and facilitator of the action research process. She demonstrated leadership consistent with the tenets of action research. Through this process the Prof (N) endeavoured to create self-reliance in the participants rather than dependency by, utilising the participants' capabilities and allowing them to flourish (Eccles 1994). Creating self-reliance in the participants became evident when the midwives took ownership of the project planning. In addition, it is important to develop sufficient leadership within the organisation to sustain the change (Crom and Bertels 1999). The ownership exhibited by the midwives was, therefore, evidence of the development of leadership within the organisation.

The nature of the leadership of the Prof (N), however, changed over the course of planning, as different leadership styles were required at different times. This ability to adapt was a necessary strategy for responding to changing situations. For example, the initial planning was a major political exercise required to instigate the groundwork for the project. At this time, the Prof (N) took on the political activities necessary. The Prof (N) was noted to reflect,

> *... this has been a huge exercise in political education that has been directed at our midwife and medical colleagues and administrators and a huge amount of political work with the General Practitioners (GPs) particularly ...* (Interview (I): 10.5.94 (this is the date on which this quote was recorded)).

This quote refers to the necessity for substantial political skills in order to achieve change (Dunford 1997). In addition, the Prof (N) undertook the role of political negotiator by working to keep the right people informed about the midwifery model of care. Such continued endorsements were a crucial part of the action research process (Eccles 1994). Added to this, was the necessity for the researchers to work with the participants of the action research process. Unless a degree of involvement is achieved with the participants, a successful outcome is not possible (Wilson-Barnett et al 1990).

Nearly 18 months into the project planning, the researchers received their first overt indication that the obstetricians were resisting the change (Management Committee Minutes (MC M): 3.8.93). During this period, the leadership role of the Prof (N) changed as strategies were put into place to counter the obstetric political difficulties (see Chapter Six). Despite these difficulties, the Prof (N) pursued the planning, retaining patience and persistence with the MC and the obstetricians. The bullying behaviour exhibited by the obstetricians did not intimidate the Prof (N) or make her give up the midwifery model of care. The determination of the obstetricians to stop the project planning, in fact, probably made the Prof (N) more determined to pursue the planning.

From February 1994, after two years of planning, the previously predominant role of the Prof (N) as action research group leader, started to diminish. The political difficulties resulting from the obstetricians' efforts to create obstacles to block the vision had dissipated somewhat. This dissipation was a consequence of the Obstetric Review recommendations and the appointment of the Professor of Obstetrics (Prof (O)). Whether the diminished role of the Prof (N) was a response to becoming increasingly more committed in her position, or a lowered interest in response to the midwives ambivalence, was not clear. In addition, at this stage the Prof (N) worked hard to encourage others to take on the ownership role, with little success. For example, encouraging the midwifery manager from the labour ward to take on the task of protocol development.

Some three years into the planning the midwives began to take ownership of the project planning, again changing the leadership role of the Prof (N). It was, however, an uneasy and frustrating time for the researchers as the midwives continued to be complacent. This frustration was evident when the Prof (N) was noted to say,

> *... no one is picking up on the hard work necessary to make it happen. The clinical leadership hasn't come. I'm tired of putting the amount of effort into it. We put so much hard work into it. We probably have succeeded in what we're trying to do but not as fast as I would like* (I: 31.5.95).

Importantly, this change of ownership indicated that the researchers had achieved a level of acceptance from the midwives. Being trusted and respected within the

organisation is an important step in achieving acceptance of the change (Bowman 1986). This acceptance is clearly reflected in the following comment made by the Prof (N), ... *we're well known at the hospital and well respected, seen as colleagues and friends, not as isolated academics* (I: 31.5.95). This comment made by the Prof (N) indicated her perception that the researchers were viewed more as insiders than outsiders and had the advantage, therefore, of both. The researchers could be considered as insiders because they were midwives, and outsiders because they were not employed by the hospital (Williams 1995). This situation could be equated to a double act, as identified by Titchen and Binnie (1993), combining the advantages of being an inside and outside researcher.

Various participants commented on the leadership role that the Prof (N) undertook during this planning phase. This included the Prof (N) herself saying that, ... *my role has gone from leader to support, pusher, continued motivator and evaluator and that's a big change* (I: 31.5.95).

In addition, Midwife 'W' was noted to describe the leadership role of the researchers as,

> ... *maintaining the process through commitment, mediator, coordinator and instigator. When nobody else was interested you had to keep it going and advocate for the whole project, facilitate development of individuals, market and promote the idea, monitor the environment externally and look for potential sources of conflict* ... (I: 12.5.95).

Further, Research Assistant (RA) '2' showed considerable insight, identifying that it was only the researchers', ... *input and push and determination that sort of just made it work* ... (I: 31.7.95).

Added to this, the Director of Nursing (DON) '3' summarised the Prof (N) role by saying, ... *leadership has been very hands on and very active. then gradually lessening off at this stage so I guess it's been very effective* ... (I: 7.6.94). Specifically, the DON '3' believed the Prof (N) had been, ... *doing a lot of work with the players to prepare than to feel comfortable with the project and that's time consuming and can't be underrated* (I: 7.6.94), adding that the Prof (N) had, ... *a dogged persistence* (I: 7.6.94).

Connor and Lake (1994) identified persistence as a necessary quality in the change agent in order to accomplish change. As a consequence, introducing change is very demanding (Bowman 1986). This persistence was evident in this project with the Prof (N) continuing the planning and wanting to succeed. In summary, the DON '3' was noted to believe that, ... *the researchers leadership had been very effective in having the midwives gain confidence* ... (I: 7.6.94) to the extent they had eventually taken ownership of the project.

This discussion clearly identifies the Prof (N) as leader of the change process and consequently, critical to the planning. In addition, leaders of change needs to align themselves with powerful others, that is, the guiding coalition, in order to succeed with change (Kotter 1996; Kotter and Cohen 2002). The people forming the guiding coalition are themselves leaders.

Creating the guiding coalition

An important consideration when implementing change is that change agents align themselves with powerful others to form, what Kotter (1996) describes as, the guiding coalition. This group then works together to plan and achieve the change. With this strategy in mind, the Prof (N) purposefully aligned herself with powerful others, developing support from key stakeholders to provide effective leadership to achieve change (Kotter 1996; Kotter and Cohen 2002). Each guiding coalition member was a leader in their own right as a representative of their professional group and a participant in the action research process. These key stakeholders, or leaders, were the Area Health Service Director of Nursing (Area DON), the Director of the Division of General Practice from another Area (director), the Chairperson of the hospitals' Division of General Practice (chairperson), Director of Nursing (DON) '3' and eventually, the midwifery managers from the labour and postnatal wards, and the Professor of Obstetrics (Prof (O)). All had the vision to change and were able to combine to motivate others to achieve that vision. This group was the guiding coalition, and by working together and presenting a united front, were able to lead and sustain the change process (Kotter 1996; Kotter and Cohen 2002). In addition, this group had the qualities identified to be leaders in order to achieve change, that is, position power, expertise, credibility and leadership (Kotter 1996; Kotter and Cohen 2002). It is vital the guiding

coalition is not only united, but also seen to be united and committed to implement the change. The process of forming a powerful guiding coalition can take some time to develop, as was very evident in the planning of this midwifery model of care.

For much of the planning phase of the midwifery model of care, the missing link in the guiding coalition was leadership from the obstetricians and midwives in order to support the change. Before the DON '3' and the Prof (O) were appointed, the project planning was struggling to survive. The appointment of the DON '3' made a substantial impact. Eventually, the Prof (O) was appointed, providing the significant missing link in the guiding coalition. Prior to the appointment of the Prof (O), the midwifery managers from the labour ward and postnatal ward would alternate their allegiances and commitment (see Chapter Six). The appointment of the Prof (O) firmed the commitment of these midwives to the guiding coalition and the project. This outcome indicated just how strong an impact the guiding coalition had over the process of change.

Evidence of the guiding coalition working politically and strategically together occurred mostly when the obstetricians resisted the project and included:

- When the researchers met with the chairperson the agenda was more about ascertaining if both parties were comfortable to continue with the project planning, reassuring each other, acting cautiously and instilling confidence in each other and then discussing strategies to deal with the political difficulties occurring at the time;
- The researchers met with the newly appointed General Manager (GM) '2' during which it became obvious she did not support the midwifery model of care (Field Notes (FN): 17.11.93). An example of the guiding coalition working together occurred when, on reporting this meeting to the Area DON, she was noted to comment, ... *she would have a quiet word to GM '2' when next she saw her* (FN: 29.11.93). In other words, the Area DON expected to turn the opinion of GM '2' around to support the midwifery model of care;
- At one stage the Area DON specifically asked to see the Prof (N) to inform her of her continued support, despite the difficulties (FN: 23.8.93). Here was an example of one member of the guiding coalition supporting another to continue the planning;
- The Area DON communicated with the Prof (N) by phone to reaffirm her support and discuss strategies;

- Medical Superintendent (MS) '2' crossed his own professional allegiance as a medical practitioner to inform the researchers and midwives about comments made to him by the obstetricians about the midwifery model of care. The researchers gained inside knowledge from this strategy that they could then respond to. This knowledge was important as the obstetricians refused to communicate directly to the researchers;
- MS '2' commented negatively about the behaviour of his colleagues, the obstetricians. This action suggested that MS '2' did not support his colleagues. In addition, MS '2' recommended several strategies to overcome the obstacles created by the obstetricians;
- The director informed the researchers that a senior person from the Australian Medical Association (AMA) told him that they had, ... *received a complaint from a medical specialist about the project planning* (FN: 26.8.93). After speaking to the senior person, the director then contacted the Prof (N), recommending that further discussions with the senior person were needed;
- The guiding coalition provided a united front to the obstetricians by collectively not overreacting to them and by discussing the midwifery model of care with them when ever the opportunity arose (see Chapter Six);
- The Area DON reported to the Prof (N) that the Area Chief Executive Officer (Area CEO), during a meeting at which the obstetricians demanded that the project planning be stopped, told them, ... *to join the real world or get out* (FN: 2.9.93). In addition, the Area CEO told the obstetricians that, ... *if they had any queries or concerns about the project, they should see the Prof (N) directly* (FN: 2.9.93). This contact never eventuated. Ultimately, after further evidence of resistance from the obstetricians, the Area CEO told MS '2' to convene a meeting at which the researchers could discuss the project planning with the obstetricians directly (FN: 14.9.93). The Prof (N) noted to say, ... *the obstetricians would not call a meeting themselves and that they would rather vent their complaints in other areas* (FN: 14.9.93);
- DON '3', the Area DON and the researchers worked together on the issue of resources for the midwifery model of care midwife positions (FN: 18.4.94). This was followed up by the researchers, DON '3' and the midwifery manager from the postnatal ward working together on the same issue (FN: 7.6.94);

- Members of the guiding coalition, the Area DON, DON '3', the midwifery unit manager and the researches, met again later to discuss financial assistance to support the research component of the midwifery model of care (FN: 8.11.94);
- The Prof (O) convened a meeting with the obstetricians and included DON '3', the chairperson and GP 'C' in the discussions about the project planning (MC M: 7.2.95).

These were the strategies employed by the guiding coalition to pursue the planning of the midwifery model of care and that indicated the people who were visibly supported the project. Part of the strategy involved communication that informed people about the midwifery model of care.

Communicating the change

Once the midwifery model of care had been determined, there was a strong need to communicate this solution to people and not just by top-down means (Kotter 1996; Kotter and Cohen 2002). Using varied and frequent forms of communication is instrumental in encouraging others to share the vision, support it and be motivated to change (see for example, Connor and Lake 1994; Kotter 1996; Kotter and Cohen 2002). It is crucial that people are informed of what it is they are changing and why (Buxton 1996). In addition, change creates stress and requires communication to be sustained and extensive to allow information to filter down. Communication cannot be overdone (Eccles 1994). Informing people about a change once is not enough (Connor and Lake 1994). The communication needs to involve a significant amount of face-to-face meetings in order for people to have the opportunity to discuss the issues (Potter 2001). More importantly, communication needs to facilitate a two-way discussion, allowing people to voice their concerns, ask questions and be responded to accordingly in order to help allay their concerns and break down barriers (Dwyer and Eaton 1998; Kotter 1996; Schott 1996).

Further, good communication can be achieved by understanding the range of acceptable points of discussion, and presenting this information in a non-threatening manner (Dunford 1997). It is important, therefore, to understand what motivates different people and not assume it is the same as that which motivates oneself. For example, when the

researchers initially discussed the midwifery model of care with the obstetricians, improving care was the main objective for the proposed project (FN: 15.3.93). The researchers learnt quickly that this objective was not the obstetricians' motivation, as the Prof (O) was noted to point out,

> *Saying that care will be improved is not saying the right thing as far as obstetricians are concerned because they believe they provide the best care. Instead, you need to say that perinatal mortality would improve, that it provides a service for women who would not attend obstetricians and, therefore, are not taking away their business, and medically legally the obstetricians are covered. Saying all of this is what the obstetricians want to hear* (FN: 7.2.95).

Project leaders who had instigated other midwifery models of care had been careful to include various communication strategies, a strategy this project emulated (Dwyer and Eaton 1998; Forster 1998; Rowley et al 1995). As the project planning continued, the researchers utilised more and more avenues to keep people informed about the midwifery model of care. The communication effort was facilitated by a number of means, including:

- The action research process itself through the MC and SC keeping people informed of the planning progress. This information giving included the minutes which were distributed to its members and to key stakeholders, such as DON '3' and the chairperson;
- The action research process of involving people at several levels in the organisation is part of communicating the midwifery model of care to people involved in the change (Eccles 1994; Kotter 1996). By involving people from all areas in the maternity unit and hospital executive in the action research process, information about the project planning was disseminated accordingly. Providing information about the project planning to others was of such importance that it was one of the terms of reference for the MC (Terms of Reference MC: 20.4.93);
- Part of the action research process involved information giving sessions to individual people about the midwifery model of care and providing opportunities to discuss issues. This information giving was considered by Eccles (1994) to be a very important component of planning change, and was about gaining endorsement from

key players for the innovation. Informing new staff members in key stakeholder positions, as well as key people outside the organization was included;

- A Newsletter was suggested as an ideal medium to distribute information about the midwifery model of care and keep people informed of progress (MC M: 6.7.93). Four Newsletters in total were distributed during the project planning. The Newsletters were distributed to the midwives, GPs and obstetricians;
- The Newsletter contained a reference list for people to facilitate further reading about the rationale for the midwifery model of care. This information, however, may not have been utilised by the obstetricians, as was indicated during a meeting between the researchers and obstetricians when Obstetrician '3' was noted to say, ... *we talk with 'patients' we are not interested in theory and research. We do not have time to read journals* (FN: 22.9.93). This was rather an alarming statement to make, as it appeared these obstetricians were not keeping abreast of the research in order to keep their own practice current;
- A suggestion was made to directly involve all midwives from the maternity unit in the preparation for change by conducting inservice sessions (MC M: 17.8.93). This idea was raised by the midwifery manager from the labour ward who believed that, ... *staff would like to know more about the project. An inservice would be helpful* (MC M: 26.4.94). In similar innovations, inservice sessions had been conducted with the specific aim of informing midwives in the maternity unit (Dwyer and Eaton 1998; Fenwick 1994; Kenny et al 1994). Such sessions were crucial in extending the action research process to the entire maternity unit. The inservice sessions were designed to give midwives an opportunity to hear directly from the researchers about the midwifery model of care and to ask questions. A number of inservice sessions were arranged to enable the maximum number of midwives to hear about the project planning;
- One of the initiatives that contributed to the clarity of the project came from a suggestion made by MS '2' to, ... *develop a summary sheet of the project* (FN: 18.8.93) (see Appendix Five). The summary sheet was used to clarify the differences between the current hospital Antenatal Shared Care and this midwifery model of care. The summary sheet was a valuable tool in presenting to various new stakeholders a description of the midwifery model of care and was published in the third Newsletter (May 1994);

- The midwifery manager with the early discharge program was noted to suggest, ... *an open forum be held for the staff to gain information about the project and to ask questions. The staff need to know more about the project and express their concerns* (MC M: 6.6.95). The midwifery manager from the labour ward chaired the open forums, with RA '2' and the researcher in attendance (FN: 15.6.95; 1.7.95; 4.7.95; 5.7.95). The aim of these sessions was to facilitate open discussion about the project;
- A letter was written by the chairperson and sent to the GPs to explain the interviews that were to be conducted to further ascertain the feasibility of the project. This strategy aimed to increase the likelihood of the GPs reading the letter, ... *as GPs tend to get a large amount of mail that does not always get read* (M of Division of General Practice Research Steering Committee (SC): 14.12.93). In addition, the letter was a means of communicating the midwifery model of care to the GPs;
- The Division of General Practice published a Newsletter. In one of these Newsletters the Chairperson wrote an article discussing the midwifery model of care. A copy of the project Newsletter (N 02: December 1993) was then sent out with the Division of General Practice Newsletter;
- Contact was made with people prior to meetings to remind them of the meeting. The researcher undertook this action fairly early in the planning as a consequence of people not attending some meetings (FN: 22.6.93 and 22.6.93). This task then continued, with RA '1' and RA '2' taking over.

These were the strategies employed in order to communicate the midwifery model of care to as many people as possible and to help create a sense of urgency for change. These strategies enabled all people within the hospital, the Area and outside to be aware of the planned project. Further, the communication strategies provided an avenue for people to discuss their concerns about the project and dispel any myths, thus assisting in the process of removing obstacles and working towards progressing the project planning.

Generating gains

The achievement of short-term gains that are visible and unambiguous serve as a reward and motivation to continue (Eccles 1994). In addition, short-term gains reassure the

change agents to push ahead with the change and reward them for pursuing the right goal and motivating the leader (Kotter 1996; Kotter and Cohen 2002). As the project planning continued for some five years, it was vital the researchers achieved some gains in order to continue with the planning. In this project, the short-term gains made the researchers feel the project was actually progressing and kept the momentum going. Added to this, achieving short-term gains helped undermine the resisters, making it more difficult for those opposed to change to block it. These short term gains included:

- The appointment of the Prof (O), which helped motivate the midwives to take on the ownership of the project (see Chapter Six);
- The release of the GPs interview report confirming the feasibility of the midwifery model of care with the GPs (see Chapter Five);
- The acquisition of research funds to support the project. This was viewed as a significant reward, both practically and symbolically (SC M: 15.12.94). This achievement meant the research for the midwifery model of care could be developed further and push the project planning, thus maintaining the momentum;
- The researchers decided the SC meeting on 15.12.94, convened in a local restaurant, should be a social event as well as for the conducting of business. This social gathering reinforced the strong relationship that had developed over time between the committee members and was viewed as a reward for hard work and perseverance.

There were other gains generated that served to keep the momentum of the project planning going. These will be discussed below.

Consolidating gains and producing more change

Even though gains had been achieved, it was important not to lose the momentum and to keep up the pressure by continuing to lead the change (Kotter 1996; Kotter and Cohen 2002). It was important to continue to make adjustments to strategies as necessary and to achieve more gains. Progress for change is then necessarily slow, steady but continuous. This slow rate of change allowed the action research participants to become accustomed to the change, thereby assisting in embedding the change within the organisational culture (Dunford 1997). Learning from unintended consequences of planning and adjusting accordingly, such as occurred with the obstetricians' resistance,

assisted in maintaining the momentum. The researchers, together with the planning group, continually made adjustments and worked on new strategies. Sometimes it was the researchers alone who managed the planning group's survival and maintenance. Leadership is an important component of this stage (Kotter 1996; Kotter and Cohen 2002) and was evident in the energy and perseverance maintained by the researchers, despite the hurdles and distractions operating in the hospital leaders and health system.

As a consequence of the midwives and obstetricians creating obstacles to block the vision and bringing about complacency, the project planning momentum stalled at various stages. Such hold ups were clearly identified in the data and will be outlined first, followed by the strategies used to keep the project planning moving. Evidence of the project stalling included:

- During the time the obstetricians were creating political upheaval for the project planning, the researchers reflected, ... *the meetings did not really achieve much* (FN: 14.9.93), and again, ... *this was really a non-event of a meeting* (FN: 23.11.93). The limited progress was a consequence of the disruption and uncertainty resulting from the obstetrician's actions. These actions were not only unsupportive of the project but also actively and covertly disruptive. Consequently, pressure was placed on the supporters of the midwifery model of care making it impossible to proceed;
- While waiting for the Obstetric Review report to be made public, project planning could not progress as the recommendations could have impacted on the project planning. The mood at the time was aptly described by the researcher as, ... *an air of anticlimax as we still waited for the Review to be presented* (MC FN: 23.11.93). This anticlimax was partly due to the length of time it took for the report to be released. The Review took place in October 1993 and the report was not published until January 1994;
- During the time the midwifery unit manager chaired the MC (MC M: 31.1.95) and the Prof (N) rarely attended meetings, the planning slowed. For example, the frequency of the meeting decreased from fortnightly to monthly. There was concern expressed by others regarding the midwives' ability to progress with the project planning. For example, DON '3' reflected, ... *she felt that now the project would fall into a hole unless the researchers continued to motivate the midwives* (FN: 3.2.95). The researcher added, ... *even though the midwives are now running the project, I still have a sense that we will need to keep directing them on items that need to be*

addressed (FN: 21.2.95). Further evidence of this slow progress occurred when the midwifery manager suggested instigating a working party to develop client held records (MC M: 7.2.95). It was evident at the next meeting that this development had not occurred when the midwifery manager was noted to say, ... *the client held records had not developed any further at this stage and were being worked on slowly* (FN: 7.3.95);

- Project planning stalled every time a new person was appointed to a key stakeholder position. The researchers took time from the planning *worked* to convene a meeting with the new executive person. It was important to ascertain their support before planning continued.

The researchers' frustration when project planning stalled was evident from the data. They had worked hard to encourage the midwives to take ownership of the project planning, but this eventuation was taking time. As the Prof (N) was noted to say, ... *what we're finding we have to do is still push and I'll be really glad the day I stop putting the amount of effort into it, but I clearly still have to ...* (I: 31.5.95).

The researchers were not alone in feeling frustrated when the project planning stalled. Midwife 'W' was noted to say, ... *things have been going quite slowly. I sense that there's a stagnation and the momentum seems to have died quite a bit* (I: 12.5.95). This perception was supported by RA '2' who reflected that, ... *it has been frustrating* (I: 31.7.95).

The researchers, in order to keep the momentum of the planning going, used a number of strategies. The Prof (N) was noted to say at this time, ... *the important thing now is to maintain the momentum* (FN: 27.1.95). This momentum was not always easily achieved, as the Prof (N) was noted to comment, ... *it is really difficult to keep the momentum up when we can't actually move forward and not to get disheartened and fed up. We're putting all this effort into it to keep everyone else motivated and energetic ...* (I: 10.5.94). Midwife 'W' had noticed the same, adding that ... *it would have been easy to have lost your way, given the energy that it takes to keep it going ...* (I: 15.8.94).

In addition to the strategies used by the researchers, a number of fortuitous incidents occurred that had the same impact of pushing the project planning. These included:

- Continuing to make adjustments to the midwifery model of care in response to changing circumstances. For example, with the first threat of hospital closure (FN: 24.3.93), the researchers planned that all women from the hospital would be cared for through the midwifery model of care. These women would then give birth in other hospitals;
- The researchers pursued the research side of the midwifery model of care in an attempt to push the planning forward. For example, the Prof (N) contributed to the research by designating RA '1' to work on the client satisfaction survey. A recommendation was made that the comparison group would need to be evaluated using the client satisfaction survey prior to the commencement of the midwifery model. It was envisaged that once the midwifery model was implemented there would be a cultural change within the organisation that could influence this evaluation (FN: 25.8.93). Achieving a change in culture within an organisation is a necessary component of achieving change. Unfortunately, work did not start on the client satisfaction surveys until eight months later (FN: 11.4.94). Once this data collection commenced, implementation of the model would follow soon after and, therefore, kept the momentum going;
- With the appointment of RA '2', Midwife 'N' as consultant and acquisition of research funds, the research side of the midwifery model of care began in earnest. This development was a further push for the project planning;
- Development of a database to collect the birth outcomes data from the comparison group was undertaken by RA '2'. The data were collected retrospectively from the women's records, with RA '2' trialing the system on a selection of medical records from the hospital to ascertain how readily the data could be abstracted and how long the process took (MC M: 31.1.95). Undertaking this trial meant that everything was ready for the model to be implemented;
- The researchers discussed their concern with the SC that having obtained project funds, a report needed to be submitted to justify the funding, yet little having been achieved (SC FN: 4.5.95). In addition, resources were being used to push the planning along, and as the Prof (N) was noted to comment, ... *DON '3' had a clear message from me. They have an obligation now because we're spending money on it*

to get it up and running ...(I: 31.5.95). The Prof (N) suggested one solution could be to collect the comparison group data on 200 women, as well as the client satisfaction survey and birth outcomes data. The aim was to go into an accelerated mode with the research and hence to push the project ahead;

- The researchers identified starting dates for the project, creating a sense of imminent implementation for the midwifery model of care. For example, after the GP interviews, the Prof (N) suggested an implementation date of August 1994 (MC M: 15.3.94). As the midwifery manager from the labour ward said later, ... *it's changed from a fantasy to a reality* ... (I: 14.6.94). This implementation date was revised somewhat when the Prof (N) pointed out that protocol development would need to be approved by the Prof (O), who was not due to start in his position until September 1994 (MC M: 19.7.94). The implementation date was revised again following the appointment of the midwives to the model, with the realisation that there was a need for continued project planning and orientation time of around three months. The implementation date then became February/March 1995 (MC M: 30.8.94). Following the announcement of the success in gaining research funding the implementation date was confirmed (SC M: 15.12.94);
- Involvement of the Prof (O) and DON '3' was reported to have had, ... *a positive effect on the project* (N 04: January 1995). For example, DON '3', made a deliberate decision to support the midwifery model of care and pushed the planning into an accelerated mode. She wanted to increase the number of women requesting to birth at this hospital. This increase would place the hospital in a more powerful position and, therefore, more able to resist closure. It became clear that DON '3' was,

  certainly going to make a difference in relation to this model going ahead. She is very keen about it and wants to assist with working out the staffing and costing for the project. She will accelerate the process as she wants to achieve change in the maternity unit and this can be used to further the project (FN: 18.3.94);

- The work of the MC accelerated at a much faster rate after the Prof (O) started as he eventually convinced the obstetricians to support the midwifery model of care;
- Not long after her appointment, DON '3' was to undertake the MS role as well (FN: 18.4.94). This was an interesting manoeuvre and one that could well be positive for

the researchers and project planning. As the Prof (N) later was noted to say, ... *DON '3' was in an insidious position regarding tackling the obstetricians head on and I think that she's quite clever with the way she's operating* ... (I: 31.5.95);

- Selection of the GPs to the project was first discussed with the chairperson on 30.5.94 and then the SC on 16.6.94. The suggestion was made that, ... *there be two GPs who were involved in the initial discussions of the project and two GPs who had not* (SC M: 16.6.94) and, ... *there were a number of GPs that saw a large number of pregnant women and we would work with these GPs* (FN: 30.5.94). On this basis, two male GPs were selected in addition to the two female GPs who were already involved in the project planning (FN: 12.7.94);
- After the midwives did not progress with the client held records, the Prof (N) announced that RA '2' would take over (MC M: 4.4.95). This was a deliberate strategy by the Prof (N) to move the project planning along after having reached a stalemate;
- After the hospital was transferred to a different Area there were further attempts to keep the momentum going. One strategy was for the hospital to commit $40,000 to the midwifery model of care, providing the Other Area supported it going ahead (FN: 15.9.95);
- By 13.10.95, three midwives had been appointed to work on the midwifery model of care. These three midwives, together with the midwifery manager from the labour ward and sometimes the researcher, met weekly for the rest of 1995 to work towards implementation. The group became the Operational Team, taking over the work of the Management Committee.

These examples clearly outline incidents when the project planning stalled and the strategies that were put into place by the researchers to keep the momentum of the planning going, despite the obstacles. There was however, a need to instigate strategies to specifically remove these obstacles and empower broad based action among the participants.

Empowering broad based action

With the introduction of any change there is an expectation that certain obstacles to change will occur in an attempt to undermine and stop the change (Kotter 1996; Kotter

and Cohen 2002). It is therefore important to remove as many of these obstacles as possible in order to empower broad based action and, thereby, create a sense of urgency. Many of the strategies discussed contributed to the process of empowering broad based action. This section outlines those specific strategies used by the researchers to overcome the obstacles created by the midwives and obstetricians to block the vision, and to restore organisational instability.

Midwives

The researchers were able to pursue the planning despite individual midwives' exhibiting signs of resistance, at the same time continuing to engage with them through the action research process. Involvement in the action research process was, therefore, the main strategy to empower broad based action in the midwives. Being involved in the action research process gives people an opportunity to express their criticisms of the project planning and, therefore, defuse them (Dunford 1997). One factor that contributed to this strategy, in the view of the Prof (N) was that, ... *one of the things that has been really important is the stability of the midwives with the midwife team staying pretty much the same* (I: 10.5.94). It was important for the researchers to gain the midwives' support and to plan the midwifery model of care in collaboration with them. In order to achieve the engagement of the midwives in the planning process, however, the researchers were required to undertake sheer hard work and perseverance. This effort was acknowledged by the Prof (N), who was noted to say,

> *... on the logistical side, I don't think anybody, other than you and I will appreciate the magnitude and the hard work that's gone into this logistically, organisationally, writing, thinking, and reading. We've done a huge amount of work* (I: 10.5.94).

Others noticed the researchers' effort and hard work, specifically Midwife 'W' who added that,

> *... I think you and the Prof (N) have sort of maintained the whole process really professionally and there's been great attention to detail in terms of looking after*

the committee, meeting process and minutes. You should both be commended on that (I: 15.8.94).

Factors that further assisted the process of empowering broad based action included the midwives getting to know the researchers better and that they worked together as a team on the planning. A further contributing factor empowering the midwives was the fact that the obstetricians had finally agreed to support the midwifery model of care (see Chapter Six). Continual strategies were required before this was achieved, however, as outlined in the following section. The action research process resulted in the eventual empowerment of the midwifery managers from the labour and postnatal wards to take over ownership of the planning.

Obstetricians

The obstetricians collectively presented the biggest obstacle to block the vision of the midwifery model of care. Strategies were required constantly to empower broad based action and achieve some level of a sense of urgency for change amongst the obstetricians. The researchers' use of soft systems methodology greatly assisted in the development of these strategies. Undertaking the history and political system analysis of the situation using soft systems methodology helped explain the obstetricians' behaviour, their role and resistance to the project that, in turn, identified possible strategies that the researchers could use. For example, a political system analysis better informed the researchers, thereby enabling them to communicate more effectively with the obstetricians. By referring to improved perinatal mortality rather than improved maternity care more acceptable justification for this model of care was provided.

There were a number of other strategies that the researchers and guiding coalition used to help empower broad based action in the obstetricians. These included:

- The researchers continuing to meet with the obstetricians to directly discuss the project planning with them, providing an avenue to express their criticisms and help resolve conflicts (Dunford 1997) (FN: 15.3.93; 15.4.93 with Obstetrician '1'; FN: 21.7.93; 25.8.93 with Obstetrician '2'; FN: 22.9.93 with Obstetricians '1', '2', '3' and '4');
- The researchers learning the best means of communicating with obstetricians;

- Undertaking the GP interviews in order to defuse the obstetrician's resistance directed towards the GPs (FN: 15.4.93). For example, the obstetricians indicated to the researchers that they did not believe any GP would be interested in collaborating with midwives. Obstetrician '2' was noted to say, ... *why would GPs want this* (FN: 25.8.93). In addition, the chairperson believed that, ... *this issue with the obstetricians would not be fully resolved until the interviews were undertaken* (FN: 1.10.93). The implication being that only by interviewing the GPs and gaining authorative results presented in a report, would opponents of the project be convinced of the feasibility and, thereby, decrease the resistance of the obstetricians;
- Conducting the interviews with a broad sample of GPs to further ensure that the results were authorative (FN: 1.10.93);
- The chairperson was noted to comment that, ... *it was crucial these interviews are seen to be independent and we are seen to not be pushing our own barrel* (FN: 17.11.93). 'We', in this case, was the perceived alliance the obstetricians believed existed between the chairperson and the researchers. With this in mind, a SC was convened to oversee the interview process and an independent researcher conducted the interviews;
- Members of the guiding coalition tried not to over react to the obstetricians' tactics. For example, the Area CEO, ... *had purposefully made himself unavailable to the obstetricians and showing the obstetricians he will not jump just because they asked him to and not over react* (FN: 23.8.93). Likewise, the chairperson commented to the researchers that, ... *he would organise a meeting with the obstetricians down the track sometime* ... (FN: 25.8.93). From this comment, it would appear that the chairperson also did not want to over react;
- The fact that the researchers had a guiding coalition that collaborated in using strategies to empower broad based action in the obstetricians;
- DON '3' felt the best strategy to use with the obstetricians was to, ... *just weather the storm because they run out of steam fairly quickly and they accept what happens* (I: 7.6.94).

These strategies were insufficient on their own, however, to entirely remove the obstetricians' obstacles to block the vision. The one strategy that brought influence to bear was the Obstetric Review, an external review of obstetric services in the Area.

Later the Prof (N) was noted to say, ... *the Obstetric Review will support the project and the obstetricians will then have to participate. If they do not want to then the Area will have to contract someone who will act as a consultant to the project* (FN: 31.8.93). In addition, the fact that, ...*Midwife 'W' was one of the reviewers and is also on the project SC* (SC M: 31.8.93), would certainly have assisted with this process.

The Obstetric Review occurred in October 1993 (MC M: 17.8.93), with the report published at the beginning of 1994 (FN: 14.1.94). Comments in the Review referred to the obstetricians' obstruction of the project,

> ... *the panel found a predominantly negative set of attitudes amongst most, but not all, of the obstetricians interviewed. The panel was left with the impression of a group of professionals resisting cooperative endeavours, sometimes without any rational explanation, and as a result losing opportunities to provide health care leadership* (Obstetric Review: January 1994)

Further, the report recommended,

> ... *the encouraging the development of general practitioner shared care and midwives' clinic models of antenatal care: that the Area proceed as rapidly as possible with its plans to establish a Chair with Area wide responsibility* ... (Obstetric Review: January 1994).

The Obstetric Review itself provided strategies to empower broad based action in the obstetricians. For one thing, it presented the obstetricians with a distraction from the midwifery model of care as they sought to dispute the recommendations. This was aptly described by the Prof (N) reflecting that, ... *the obstetricians will be too busy defending themselves to be worrying about the project* (MC FN: 26.10.93).

In addition, strategies within the Obstetric Review, such as recommendations being gradually introduced, enabled acceptance of small changes. Such small changes could go unnoticed. If all recommendations were introduced at once, changes would be more likely to be noticed (MC M: 9.5.94). A further strategy described by the Area CEO was that the two professors, the Prof (N) and the Prof (O), together, ... *will be able to sort*

the obstetricians out between them and have the obstetricians under control in no time (FN: 9.5.94). Certainly the appointment of the Prof (O) was a significant strategy in empowering broad based action in the obstetricians. The Area DON reflected,

> *The onus was going to be on the new Professor to sort out the situation with the obstetricians. Nobody apart from the obstetricians had any difficulty accepting the results of the Review. Everyone was happy that someone openly said the truth about what was happening in the Area in relation to the obstetricians. The problem is how can things be changed as they should be when the obstetricians are so powerful and able to block change* (SC FN: 12.5.94).

These strategies gradually worked in empowering broad based action in the obstetricians, with the midwives reporting to the researchers that, ... *they had not received much feedback from the obstetricians lately* (MC FN: 17.11.93). This situation contrasted with the ongoing negative conversations the obstetricians had had with the midwives in the past. The obstetricians, however, were still showing signs of resisting through their comments about the Obstetric Review. It was noted that the obstetricians said to GM '2' that they,

> *Discounted the Review on two grounds. This was on the basis that one of the Review Panel was an academic and another was a left-winger because he had set up birth centres. The obstetricians liked the new Prof (O) because he was apparently anti midwife* (FN: 1.3.94).

This information was of tactical and strategic importance. Clearly the obstetricians' tactic in dealing with the Obstetric Review was to discount the Review membership. The recommendations of the Obstetric Review, therefore, were worthless from the obstetricians' viewpoint. In addition, the new Prof (O) was anti midwife and, therefore, on their side, or so they believed. Consequently, as far as the obstetricians were concerned, they had won.

A key factor in removing the obstetricians' obstacles to the midwifery model of care was the appointment of the Prof (O), a direct supervisor of the obstetricians. Eccles (1994) describes this action as injection change, that is, when an outside person is

placed structurally above people who are perceived to be inadequate. This appointment had the biggest impact on the defusing of the obstetricians' resistance as it had the potential to remove them from their positions of power. In other words, the Prof (O) was able to use positional power to influence the obstetricians (Murphy-Lawless 1998; Senior 1997).

One strategy employed by the Prof (O) to reduce the obstetricians' resistance to change was to appoint an obstetrician who he had worked with in Britain as a staff specialist (FN: 30.5.94). The staff specialist position would be responsible for the registrars. The Prof (O), through the staff specialist, would require registrars to support the midwifery model of care. Otherwise the registrars, under the direction of the obstetricians to comply with them, might refuse to care for women referred to them from the midwifery model of care. From this, the Prof (N) concluded that once the staff specialist was appointed, ... *the Area will not need the (private) obstetricians because ultimately there will not be enough work for them* (FN: 19.4.94). The on call allowances and clinic attendance fees for the obstetricians were effectively threatened.

Before the Prof (O) took up his position, he met with the Prof (N) (MC M: 26.4.94). Apparently, the Prof (O) was instigating a team midwifery project in Britain and this project was the reason for his delayed start. Needless to say, the Prof (O) did not want the obstetricians to know about this, wanting to develop a relationship with them first. It became obvious from this meeting that the Prof (O) supported the philosophy of the midwifery model of care, commenting that, ... *he had no patience with obstetricians caring for women with normal pregnancies* (FN: 26.4.94). The Prof (O) suggested a strategy in relation to the obstetricians; was to slowly introduce the midwifery model of care. The impression from this meeting was that the Prof (O) was anxious not to get the obstetricians off side. At the same time he supported the project but would not initially declare this support.

The Prof (O) was noted to have suggested other strategies,

> *Clearly the obstetricians are out of touch and not up to date at all. The obstetricians are frightened by midwifery care. Midwives are a vital part of care. He wants to facilitate the political link between the obstetricians and the*

project planning and tell the obstetricians the rumours they are spreading are wrong. This midwifery model of care is a great idea. He will say to the obstetricians there are safe guards in the project that should be given a chance to run. It is obvious some obstetricians are not reading the newsletters and their information is incorrect (MC FN: 1.11.94).

These views indicated that, in relation to the obstetricians, the Prof (O) would not back down or allow them to get their way. He treated the obstetricians as equals even though it appeared he had a low opinion of them. This determination maximised the Prof (O)'s influence over the obstetricians in order to force their acceptance of the midwifery model of care. Such a strategy needed to be carefully undertaken as people will resist being subjected to force (Eccles 1994). In other words, the Prof (O) was rearranging staff in order to remove them from their powerful position (Eccles 1994). Placing the Prof (O) in a position above the obstetricians effectively undermined their position and legitimate base and, hence, their power base. The obstetricians, therefore, lost their power and were unable to undertake further politicking because of the power held by Prof (O). This strategy successfully defused the obstetricians' resistance to the midwifery model of care.

Another strategy suggested by the Prof (O) was for the researchers to be viewed as observers and supporters only to the project planning (MC FN: 1.11.94) because the obstetricians believed the project was run by the Prof (N). He explained that,

This was not acceptable to the obstetricians. If the project was seen to be driven by the staff from the maternity unit rather that this terrible woman (Prof (N)) this would be more acceptable to the obstetricians. To convince the obstetricians, the project needs to be driven by the staff, academics then are seen as only supporting the project (MC FN: 1.11.94).

A further strategy suggested by Prof (O) regarding the development of project protocols was that,

> *... setting up the protocols from research and setting up a new project was possibly too much to do at once. Both are a good idea, but not sure it is good idea to combine them at the same time* (MC FN: 1.11.94).

The obstetricians did not support the midwifery model of care. If this project included practice deemed to be unsafe through operating outside established protocols, the obstetricians would have more to complain about. It would make more sense politically, to transfer current protocols to the project. Such a strategy would be less confronting to the obstetricians (Eccles 1994). The non-insured women participating in this midwifery model of care would be referred to the registrar in the hospital antenatal clinic for screening and assessment. The obstetricians would rarely attend. The project would, therefore, become an integrated part of the current system and, thereby, be permitted to move ahead.

Communicating directly with the obstetricians was another strategy instigated by the Prof (O). For example, a meeting was convened with the obstetricians to discuss the midwifery model of care, with the chairperson and GP 'C' invited. The Prof (O) planned to tell the obstetricians that, ... *this project now has funding and there is no reason why the obstetricians should not support it* (FN of MC: 7.2.95). If the obstetricians did not support the project, the Prof (O) warned them by saying, ... *we will carry on the project without them* (MC FN: 7.2.95). Prof (O) believed the obstetricians would support the project and listen to the chairperson and himself at this meeting.

The Prof (O) continually undertook to directly communicate with the obstetricians. Following a negative comment about the project, for example, it was noted that he stated to Obstetrician '3',

> *This is a university department, which needed to do research on new models of care. If the model has not worked after trying it for three to four months, then we will know. We should give the project a go. The project was the Prof (O)'s*

responsibility and the obstetricians do not have to have anything to do with it (FN: 12.2.95).

These further strategies used by the Prof (O) to trial the midwifery model of care, reinforced the fact that the midwifery model of care was not going to be the obstetrician's responsibility. Later, Obstetrician '3' commented to the midwifery manager from the antenatal clinic, ... *the Prof (O) was supporting the project and everything was alright* (FN: 2.5.95), indicating that the strategies were working.

Other people commented on the effectiveness of the Prof (O) in defusing the resistance of the obstetricians to the project planning. For example, Midwife 'W' said she sensed the, ... *level of support from the new professor and thought people were probably reassured and more confident that he's supporting it* ... (I: 12.5.95). This certainly was the case according to the midwifery manager from the postnatal ward, who reflected, ... *the fact that we had the professor wanting this to be trialled and hopefully working out, that's a big plus* (I: 22.6.95). Research Assistant '2' supported this, saying, ... *with the Prof (O) on the scene has been a fairly substantial step in the right direction* (I: 31.7.95). As a consequence, the resistance of the obstetricians was dissipated and project planning was able to progress. The Prof (N) reflected at this time, ... *the medical issue is now a non-issue because of the way the Prof (O) is working* (I: 31.5.95).

This section has outlined the multiple strategies used by the researchers and the guiding coalition to empower the obstetricians for broad based action and achieve a sense of urgency for change. At the same time various strategies were being used to overcome the obstacles created by the hospital and instability of its executive.

Hospital and executive instability

The MC utilised a number of strategies whenever a new obstacle in the form of hospital instability occurred. For example, with the first threat of hospital closure, the MC had to rethink the possibilities for the midwifery model of care. A proposed solution was to work with 50 GPs caring for 20 women each, thereby caring for all women booked into maternity care at this hospital. One midwife would work with three GPs and be in a team of four or five midwives (MC M: 24.3.93). With the hospital closing, the women

would give birth outside the hospital district at alternate sites. When the hospital was rebuilt, birthing facilities would be all that was required. Midwives from the midwifery model of care would provide all antenatal and postnatal care in the community. The researchers' rationale for continuing with the project planning was that these women would still require care. It was believed by the researchers that it was possible to finish the planning and implement the midwifery model of care before the hospital closed, thereby, ensuring that the service would be retained.

In addition, the researchers employed strategies in response to hospital executive changes. Each time a new appointment was made, the researchers convened a meeting with the newly appointed person. The meeting allowed the researchers to describe the midwifery model of care and the planning process. Each time a new appointment was made, the progress of the project planning was halted until the new person was adequately briefed and their support gained. This situation resulted in the researchers spending a considerable amount of time in meetings with these people, time that took them away from project planning. The difficulty in achieving change when participants in the action research process were frequently changed, with the process lacking continuity and reduced effectiveness, is obvious (Crickshank 1996; Meyer 1993). Full collaboration was difficult to achieve when working with different people who had differing levels of support and commitment to the process. A supportive environment is an important element necessary for achieving change and unless there is considerable support from the top, this kind of change is almost impossible to achieve (Allcock 1996; Page 1995b). Behaviour in organisations may change as a consequence of the advent of new members and the possibility of different dynamics (Managham 1979). For example, when DON '3' was appointed, she wanted to make numerous changes in the maternity unit, resulting in the midwives becoming preoccupied.

The level of support from the executive was variable, adding further difficulties. The researchers arranged to meet further to try and gain their support, or sought to work around them. If support was not achieved, there was such executive instability that all the researchers could do was wait for them to leave. For example, the Prof (N) believed, *... the project would not start until GM '2' left as she is entrenched with the obstetricians and, therefore, will not support the project going ahead* (FN: 26.4.94).

These strategies aimed to empower participants to broad based action by removing the obstacles and breaking down resistance to achieving a sense of urgency to change (Kotter 1996; Kotter and Cohen 2002). Empowering people is one of the aims of the action research process (Kemmis and McTaggart 1990b). Through this process, GP 'C', GP 'L' and the midwifery managers from the labour and postnatal wards were empowered to take on various tasks and ultimately to own the project planning. Action research belongs in the critical social paradigm of empowering participants to achieve change (Kemmis and McTaggart 1990b). In other words, coming to believe that which exists is unacceptable and achieving a sense of urgency to achieve change (Kotter 1996; Kotter and Cohen 2002).

The successful change became the change in ownership of the project as well as a shift in the professional boundaries to make it possible. Midwifery managers from the labour and postnatal wards eventually took on an ownership of the project and were prepared to pursue it. There was, therefore, an improvement in the capacity of these two people to continue the process of achieving change. Despite this positive step, the researchers made the decision to cease the active planning of the project, mainly because of the overwhelming organisational instability. The researchers had come to the realisation that enough energy and resources had been expended. This realisation was heightened when the change in Area boundary occurred, followed soon after by the maternity unit being moved to another site for two years. This resulted in further administrative changes that created a situation where it became more difficult for the researchers to continue the planning of the project. As a consequence, the researchers ceased the project planning and the midwifery model of care was not implemented.

This chapter has described the various strategies utilised by the researchers to empower broad based action, thereby creating a sense of urgency in the action research participants to achieve organisational change. The final chapter to follow shows why the midwifery model of care was not implemented and why there were such obstacles to the project planning.

Chapter Eight

Organisational change?

This chapter examines why, despite the planning process, the midwifery model of care did not reach the implementation phase and discusses the lessons learnt as a consequence. Some of what is discussed in this chapter has been outlined elsewhere in the thesis and is noted here in explaining and conceptualising the process further. Following the identification of the most appropriate midwifery model of care for implementation in the hospital, the researchers commenced the project planning through an action research process. The critical first step in planning for change was to instil a sense of urgency for planning in the midwives, general practitioners (GPs) and obstetricians. This sense of urgency for change was present in the GPs from the start of the project planning, diminishing only slightly towards the end. The diminished interest in the GPs was predominantly a consequence of the project planning continuing for five years. Throughout the planning phase, the midwives maintained some resistance but eventually achieved a sense of urgency. The obstetricians exhibited strong resistance to the midwifery model of care throughout the planning phase, eventually achieving a somewhat tenuous sense of urgency that was essentially forced upon them. The researchers used various strategies in order to instil a sense of urgency in all participants (see Chapter Seven). Despite this, however, some issues were never resolved and the midwifery model of care was not implemented. An overview of this planning process in soft systems methodology terms, is illustrated in Figure 8.1, followed by the conceptual model used during the planning of the midwifery model of care (Figure 8.2).

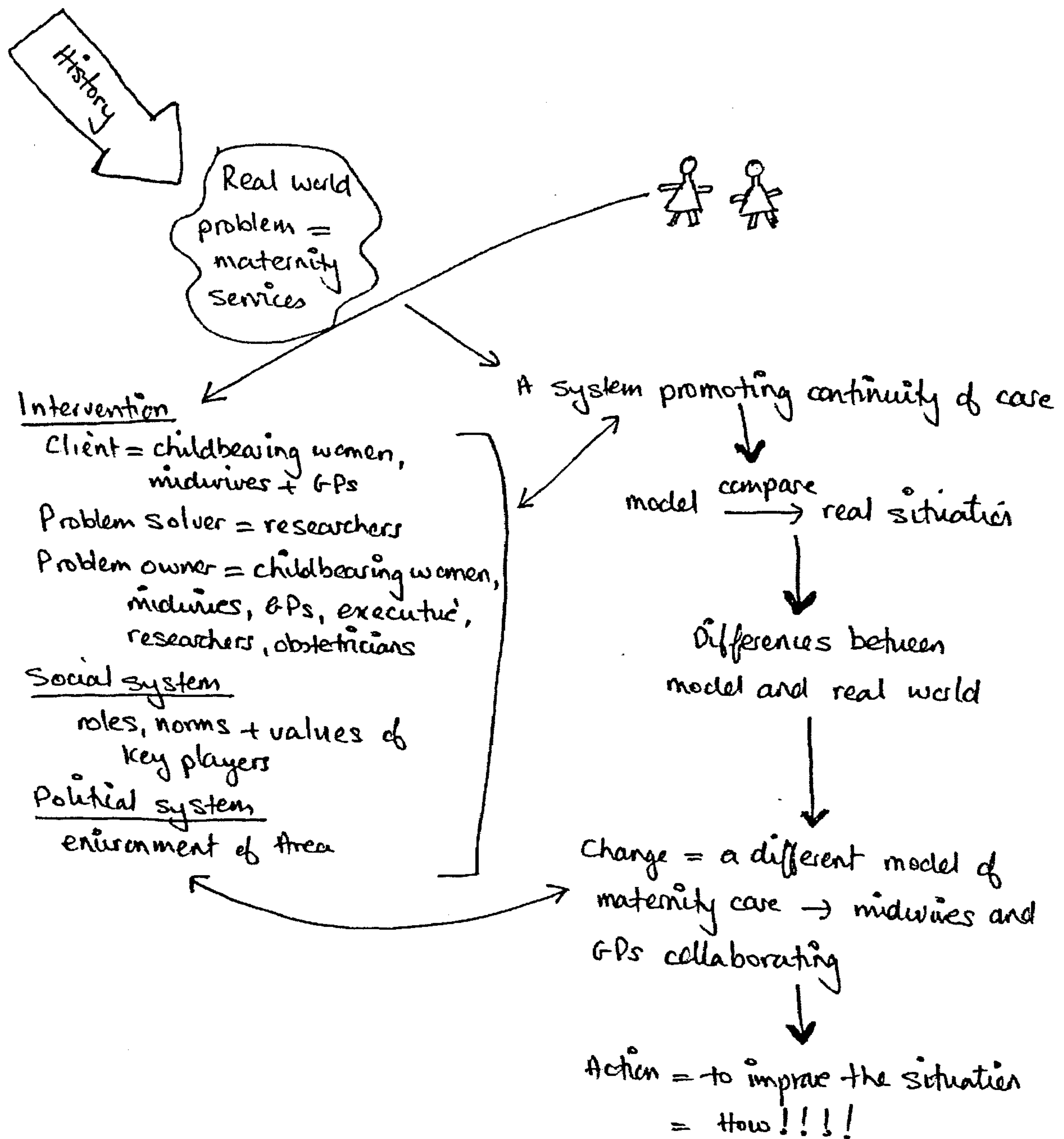

Figure 8.1 Soft systems methodology overview of the project planning.

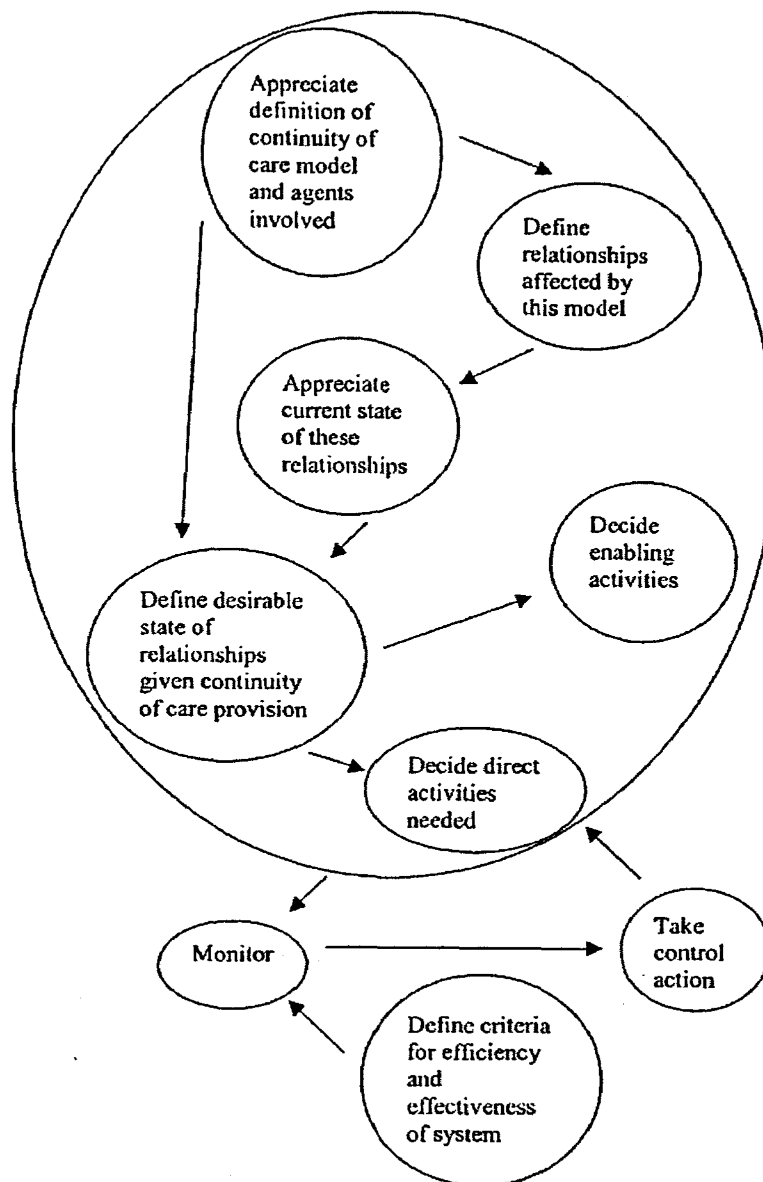

Figure 8.2 Conceptual model used during the planning of the midwifery model of care.

This midwifery model of care was conceived in an environment of instability that made the planning process difficult, when in reality, this instability should have provided an ideal environment for change. After outlining the events related to the midwifery model of care, explanations for the outcome will be discussed.

Environment of instability

The data clearly indicate that one of the key factors contributing to the difficulties that occurred during the planning of the midwifery model of care was the extreme organisational instability at that time. It is generally anticipated that any organisation

will constantly undergo some degree of change. In this instance, however, the instability was prolonged and protracted, and possibly overwhelming for its personnel. McKibbin and Castle (1996) believe it is difficult for participants to fully participate in the planning process if there is pressure from such external events as occurred with this project planning. The process of cyclical engagement and disengagement of the planning group reinforces the principle that the social context of the health care system is a vital factor in achieving change (East and Robinson 1994). This instability had a significant impact on the planning and, ultimately, the implementation of the proposed midwifery model of care.

The health system instability resulted from the uncertainty about whether the hospital would close, the high turnover of executive staff, and a change in the Area Health Service (Area) boundary. This boundary change resulted in a larger number of hospitals under the Area's management, making it the largest Area in Australia. In more recent times a further boundary change has occurred creating an even larger Area. This organisation instability, especially the threatened hospital closure, impacted more on the midwives who were employed by the hospital. The midwives had much to lose, specifically their jobs, should it close. At the time of initiating planning for this project, the midwifery workforce was fairly stable with few vacancies in other maternity units (NSW Health Department 1993b; Tracy et al 2000b). For the midwives, therefore, job security was important in an environment where few jobs were available if they became unemployed. This situation has changed considerably since then with widespread midwifery workforce short falls (Australian Health Workforce Advisory Committee Report 2002; NSW Health Department 1996; Reid 2000).

For the midwives, this organisational instability resulted in a sense of insecurity. The midwives became distracted and preoccupied by what was happening at the organisational level. Inevitably the midwives could not see the point of initiating change under these circumstances, particularly as they had no control over the organisational instability. In contrast, when it was confirmed that the hospital would remain open, the midwives felt secure enough to participate in the planning process.

The organisational instability did not have the same impact on the GPs and obstetricians. It should be remembered that the GPs and obstetricians, even though part

of the organisation, are actually situated outside it (see Chapter Five). Both groups receive fee for service, are individually contracted, have more freedom in what they do and, therefore, would be minimally affected by the organization instability. For the obstetricians and GPs, therefore, if the organisation closed they would refer their women to another hospitals for care.

Another manifestation of the organisational instability was the high turnover of executive staff. The data clearly supports the difficulty in achieving change when the key participants in the planning process keep changing, with the process subsequently lacking continuity. When working with different people who may hold varying levels of support and commitment to the planning process, true collaboration becomes difficult to achieve. A supportive, stable environment is an important element necessary for achieving change and unless there is considerable support from top administration, this kind of change is almost impossible to achieve (Allcock 1996; Page 1995b). Added to this, behaviour in organisations changes as a consequence of the advent of a new executive member, with different dynamics likely to come into play (Managham 1979).

In addition, the organisational instability meant the executive team had no continuity of vision. This lack of continuity then affected the organisational culture. The executive team became unable to provide support for the planning, as survival became their driving force. There was no leadership as a consequence, with both the situation and the staff being ineffectively managed. Ironically, the role of the executive was to provide the resources for the best quality care for women, which was the aim of the proposed model of midwifery care. In the midst of this instability, the researchers were attempting to instigate change in order to resolve the problem situation in maternity services.

When the researchers were confronted with this organisational instability they used various strategies in an attempt to overcome the barriers this instability created (see Chapter Seven). Undertaking this research project, however, tended to increase this instability. One of the ways this occurred was through the position of the Professor of Nursing (Prof (N)) itself. Prior to commencing the planning process, the position of Prof (N) had been created, the first of its kind in Australia (References removed). This appointment caused issues within the Area as money was redirected to pay for the position. Other issues were created by this position setting up a different organisational

structure with, for instance, the midwifery educators. Prior to the appointment of the Prof (N), the educators had run their own programs reporting within the hospital structure. Following the appointment, these midwives had a level of accountability to the university and reported directly to the Prof (N). The professorial appointment, therefore, contributed to the instability of the organization and the research team. Added to this instability was the fact that undertaking action research is an intensely political exercise, which may be threatening to organisational norms and causing more instability (Bellman, et al 2003).

According to Bryne (1998), organisational instability may in fact provide an 'ideal' environment for change to occur within the chaotic state. One of the consequences of organisational instability should be the emergence of a leader, with change more likely to occur (Kearin, Duffield and Johnston 2004). In addition, organisational instability creates an environment where the status quo becomes unacceptable. This effect together with the recognition that the status quo around maternity care was unacceptable, should have achieved a sense of urgency as a natural progression. Eventually the extreme instability did result in a sense of urgency in the midwives to take on the change, but this took considerable time and effort. It was in this 'ideal' environment that the researchers began planning the midwifery model of care, having first gained the support of a guiding coalition and instigating an action research process. The high level of organisational instability should not necessarily have meant failure for the project planning and again could have provided an 'ideal' environment through which change resulted. For all these reasons, the planning of the midwifery model of care should have been more successful, but for many reasons it was not.

Confronted with this instability, the researchers used various strategies in an attempt to overcome the barriers created by the instability resulting in cyclical process between the researcher, organisation and executive, illustrated in Figure 8.3. This depicts the continual engagement and disengagement as the researchers went backwards and forwards in the action research process of planning the midwifery model of care. At this stage, the researchers and GPs were the only stabilising influence in the planning process.

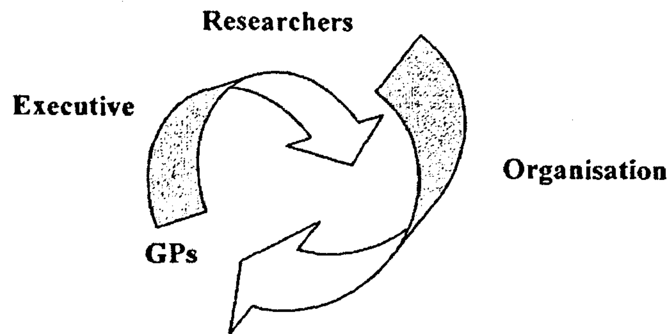

Figure 8.3 Cyclical process used between the researchers, organisation, executive and general practitioners.

So what happened

The researchers were planning a service model change within a maternity care environment, as described in Figure 5.6 (page 132). In summary, this involved non-insured low risk women attending the hospital antenatal clinic, with midwives providing the majority of care during the childbearing experience under obstetric supervision. This arrangement is described as midwifery care, which the majority of women at the hospital received. As well, GPs provided shared antenatal care to a minority of women in conjunction with the hospital antenatal clinic. Again, it was the midwives who provided the majority of care for these women. Findings from the literature (see Chapter Two) revealed this status quo was not acceptable to midwives, GPs and women. There was a sense of urgency for change, a factor, identified by the researchers.

Initially, the researchers' aim was to achieve a model in which hospital salaried midwives functioned as autonomous practitioners, providing continuity of care for low risk, non-insured women in the community (see Figure 5.1, page 116). Autonomous in this sense refers to midwives who practice in the full sense of the word 'midwife' but not at the level of independently practising midwives. This midwifery model of care meant that obstetricians would not be involved unless a complication occurred, in which case the women would than be referred to them. In other words, a caseload midwifery model of care as supported by the literature examined in Chapter Three.

Having undertaken an assessment of the maternity services in the Area, the researchers elected for a planning model, as illustrated in Figure 5.7 (page 133). In summary, this

model involved hospital salaried midwives, in collaboration with the GPs, caring for low risk, non-insured women in the community. An obstetrician would assess the suitability of women to participate in the model and be referred to if a problem occurred. This arrangement effectively resulted in the midwives linking with the GPs to provide care and moving away from their relationship with the obstetricians. Initially, the researchers wanted the obstetricians to be part of the midwifery model of care.

The midwifery model of care that the researchers ended up with is illustrated in Figure 8.4.

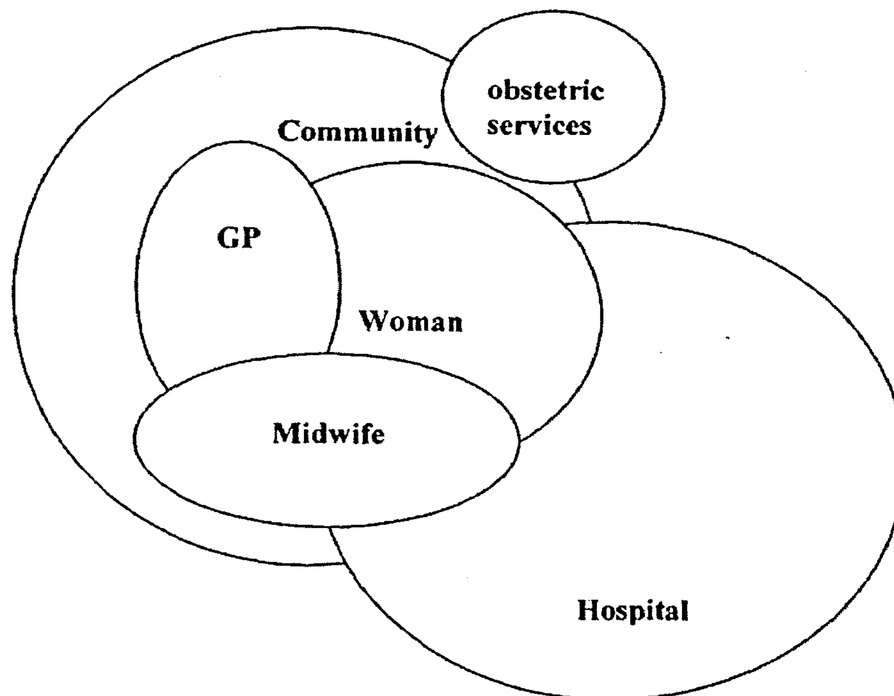

Figure 8.4 The midwifery model of care that resulted.

In this model, the role of the GP and midwife would be the same as described above. The difference being that the obstetricians would not to be directly involved in care of the women if complications arose. Instead, a staff specialist obstetrician, who fulfils the same role as an obstetrician, was to be appointed at the hospital. This arrangement resulted in the midwives moving further away from their relationship with the obstetricians.

The process of how the researchers ended up with the model as illustrated in Figure 8.4, can be summarised in Figure 8.5. This diagram illustrates the backwards and forwards process that needed to occur between the researchers, obstetricians, midwives and executive in the planning process. This depicts the continual engagement and disengagement of these participants in the action research process of planning the midwifery model of care. As the GPs were the only constant in this part of the planning process, they do not feature in this diagram.

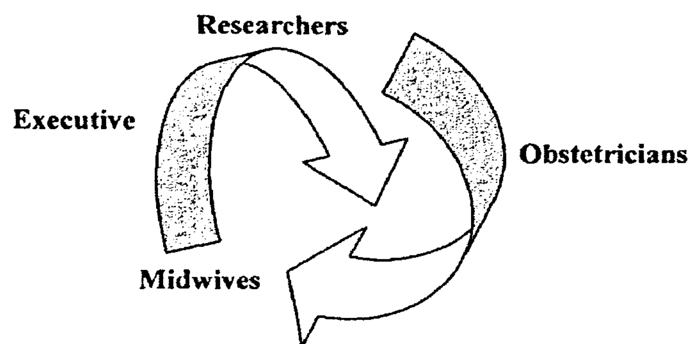

Figure 8.5 Cyclical process used between the researchers, obstetricians, midwives and executive.

An explanation as to why the midwifery model of care, as illustrated in Figure 8.4, resulted involved the GPs, midwives, obstetricians and the planning process itself. Each of these will now be discussed.

The GPs

There were many reasons why this midwifery model (see Figure 8.4) emerged. One of the reasons being that neither the GPs nor the midwives were sufficiently adept in working independently of the other in caring for childbearing women. The GPs had previously been excluded from providing maternity care by the obstetricians and would, therefore, have difficulty regaining entry into this area. These GPs were attracted to participate in this midwifery model of care because aligning themselves with the midwives would make re-entry into maternity care more achievable. In addition, the GPs' role in collaboratively caring for women with midwives is clearly substantiated in the literature (see Chapter Three). A further driving factor to the GPs returning to

providing maternity care is the fact that this would potentially increase the number of women in the GPs' practice as women could be attracted to GPs who provide this form of care. An increase in income and influence in maternity care would follow for the GP. Participating in this midwifery model would also increase life cycle care provided by GPs. Women would be more likely to stay with a GP because of this continuity of care. In addition the data analysis reveals that GPs wanted to participate because they believed in the midwifery model of care and recognised the benefits it would provide women.

The alliance between the midwives and GPs should have been effective as these two professional groups, in combination, made for a powerful force that could overcome the obstetricians. Effectively this coalition instead disenfranchised the obstetricians who, in being a powerful lobby group, instigated political manoeuvres to block the change. The obstetricians tried again to exclude the GPs from maternity care. In response, the obstetricians' politicking was designed to block the project planning.

The midwives

The midwives were interested in collaborating with the GPs because they were less subordinated to the GPs than to the obstetricians. Midwives have been exposed to a climate of subordination by the medical profession and this history partially explains the response of the midwives to the project planning. It is evident from the research project data that the struggle between obstetrics and midwifery, which has long dominated the history of maternity services, continues today (see Chapter Six).

Collaborating with the GPs provided a logical progression from subordination to the obstetricians and a way out of the predicament for the midwives. This collaboration was a more comfortable relationship and effectively increased the collective power base. A further explanation for the midwives' participation would be the desire of the midwives to reclaim their role as midwife in the true sense of the word, and in that role they could provide women with better care. In addition, the midwives' motivation to participate may be explained by the fact that the Professor of Nursing (Prof (N)) had authority over them as a senior academic with professional standing. It is not clear from the data whether the midwives wanted to please the Prof (N) or were forced to participate

because of her position over them. The midwives may also have been motivated to participate because of the relationship they had with the obstetricians. These midwives believed they had a good working relationship with the obstetricians; however, they did not support the domination of themselves and maternity services by the obstetricians. In response to the domination of the obstetricians, the midwives may have pursued the project planning as retaliation to the obstetricians' behaviour towards them.

A further explanation as to why the midwives participated in the project planning has been provided in more recent work by Brodie (2002 & 2003). In this work, Brodie (2002) identified that some midwives are able to recognise the barriers to change and consequently are more able to overcome them to bring about change. In this project, two midwives eventually overcame the barriers and became motivated enough to reclaim their role as midwives.

It could be speculated, however, that even though there was evidence for the midwives' support of the midwifery model of care, this may have not been the case. In other words, while the midwives affirmed their support of the project planning they, in fact, did not support it. The researchers had assumed that the midwives were supportive when they may have been withholding their true opinion from the researchers. This possibility would be hardly surprising when both researchers could be considered to be in superior positions to the midwives.

As previously mentioned, midwives were not strong enough as a group on their own in the environment at that time to provide continuity of care without collaborating with the GPs. There were a number of reasons why this was the case and such reasons help explain why the midwives resisted the planning to the extent they did. One speculated reason for resisting being that midwives are not prepared to work autonomously. Instead midwives tend to specialise in one aspect of midwifery and become deskilled in other areas (Brodie 1996; Lane 2002). In other words, midwives provide either antenatal, postnatal, labour/birth or newborn care. This segmentation of practice appears to be a direct consequence of the obstetricians' demand for experienced midwives to work in labour wards and to be efficient (Murphy-Black 1995). The result of this specialisation is to heighten midwives' insecurity in their role as midwives. Midwives subsequently, can lack confidence in acquiring the necessary skills to work in new midwifery models of

care and may be afraid to do so as potential inadequacies may be revealed (see for example, Allison 1992; Kitzinger 1992; Kotter and Schlesinger 1991).

A further indication of midwives' inability to work autonomously can be seen when caring for women becomes more a job than professional practice. This situation creates an allegiance to the institution and colleagues with the undertaking of tasks rather than caring for women, who are viewed then more as patients than clients. Consequently, in being controlled by the institution, midwives undertake tasks with a focus on helping their colleagues (Brodie 1997). For example, the midwives would undertake all the postnatal checks before the afternoon shift thereby giving priority to their colleagues' routine rather than identifying and meeting each woman's needs. A tidy structure is then created with everyone knowing their place and the midwives controlling their patients (Kitzinger 1992). There is a vested interest, therefore, in retaining the traditional power relations where everybody knows what is expected of them and there is a certain level of security. In working in midwifery models of care midwives are required to shift their allegiance from their colleagues to the women in their care (Brodie 1996). This requirement challenges the midwives' relationship with their colleagues resulting in decreased mutual support and collaboration and hence criticisms of models of midwifery care. Midwifery models of care, therefore, have challenged the status quo and organisation of maternity services, and were not always viewed favourably by midwives (Turnbull et al 1995; Waldenstrom et al 2000). New models of midwifery care threaten the security of midwives in requiring them to move out of their comfort zone (see for example, Brodie 2002; Kitzinger 1992; Connor and Lake 1994).

Midwives have also expressed concern about working as autonomous practitioners and the control of work hours (Allison 1992). Hospital midwives often do not want to work in the way team midwives work because they want to be sure of their time off each week (Flint 1993). In addition, midwives have been concerned that they would be permanently on call and the effect that this would have on their personal lives (see for example, Brodie 1996; Dimond 1995; Walton and Hamilton 1995). There is evidence to show that midwives working in a caseload model in fact have more control over their work pattern and are more satisfied as a consequence (Sandall 1997b; Sandall et al 2001). Working with an annual salary increases flexibility, giving midwives more control, but has been hard to achieve. Homer and her colleagues reported that only two midwifery models in

Australia have an annualised salary in 2001 as opposed to an hourly wage. All these factors have contributed to a lack of appeal for working in midwifery models of care (see for example, Allison 1992; Bower 1993; Kenny et al 1994).

In addition, it has been identified that midwifery education in Australia does not produce graduates able to function autonomously (see for example, Brodie 2003; England and Jones 1998; Reid 2000). This is referring to the education of nurses to become midwives through a Graduate Diploma in Midwifery or equivalent. Consequently, those midwives who have been appropriately educated are unable to practice as midwives in the true sense and thus lose their skills and confidence (Brodie 2002). The effect of this educational preparation is a reluctance to work as an autonomous midwife and to maintain the status quo. Despite the move of midwifery education to the higher education sector, there does not appear to have been an increase in the quality of midwifery preparation (England and Jones 1998; Leap et al 2002a; Leap et al 2002b). This situation has changed with the introduction of Bachelor in Midwifery programs from 2005 in NSW.

The poor educational preparation preventing autonomous midwifery practice is compounded by a lack of education about organisational change, research and management. Midwives were not suitably prepared, therefore, for change (Bowman 1986). At the time of the project planning it was not uncommon for middle managers to have received no further tertiary education that would prepare them for their position (Leap et al 2002a; Leap et al 2002b). Similarly, the midwives in management positions had worked up to be managers, having occupied their positions for some time, but had not had the opportunity to acquire leadership skills. The midwives at the project planning hospital had a history of ineffectual management, partly explained by a lack of management education. This background led to a lack of leadership in the maternity unit and in the project planning.

Added to this, midwives fear taking risks, as they do not believe there are alternatives to the status quo and, therefore, they do not adapt to change easily (Perkins 1997). As a consequence of midwives becoming entrenched in the obstetric model of care, any suggestion of returning to a midwifery model of care results in great apprehension (see for example, Brodie 1996; Lane 2002; Roberts 1983). This was compounded by the fact

that the status quo in the situation of this research project was deemed to be successful in providing culturally appropriate care and having a good reputation attributed, in part, to the midwives. Consequently, it was difficult for these midwives to believe there was a need to change (Eccles 1994). Further, midwives want to maintain consistency and the comfort of the familiar and not engage in change (Connor and Lake 1994). These responses may be partly explained by the fact that change would destroy the networks that the midwives have set up (Perkins 1997).

Another factor contributing to the midwives' resistance to the project planning relates to their perception of being overworked and exploited. At the time this midwifery model of care planning was instigated, maternity units were fully staffed with midwives (NSW Health Department 1993b; Barclay 1995). It was, however, a time when length of stay was shortened as women were opting for early discharge at home with midwifery support. Maternity units had not increased their staffing levels to cover an increased workload that resulted (Leap et al 2002a; Leap et al 2002b). Consequently, midwives perceived themselves to be overworked and became exhausted through significant workforce shortages (Kitzinger 1992). Any change implied further burdens of responsibility and work that midwives resisted (Kitzinger 1992). Midwives were concerned, Dimond (1995) claimed, that they would be given too many tasks and become further over worked. More recently it could be argued that midwifery is in crisis because of considerable workforce shortages (see for example, Australian Health Workforce Advisory Committee 2002; Brodie 2002; Leap et al 2002a). Introducing change under these circumstances would be even more difficult because of these workforce issues.

For all of the above reasons, the profession of midwifery could be described as immature (see for example, Brodie 2003; James and Willis 2001; Lane 2002). A further factor that has contributed to such immaturity is the invisibility of midwifery (Brodie 2002 & 2003). Evidence of the invisibility of midwives can be seen in the fact that society in general does not recognise midwifery as a discipline separate from nursing (Brodie 2002; Lane 2002). This perception is hardly surprising as midwifery is invisible even in the Nurses Act (Bogossian 1998; Brodie and Barclay 2001) and is not described or defined in regulations (see for example, Lane 2002; Leap et al 2002a; Leap et al 2002b). In addition, midwifery is not recognised by the providers of midwifery education who in faculties or schools of nursing make no mention of midwifery in their

titles. This has changed somewhat in more recent times with midwifery featuring prominently in titles. For example, the Council of Nurses and Midwives Deans, the Australian Nurses and Midwives Council and Faculty of Nursing and Midwifery.

Further support for the invisibility of midwives is seen in the recent difficulties experienced in Australia regarding professional indemnity and industrial relations regulations (Reid 2000). The industrial relations situation has resulted in inadequate remuneration and a restriction of work flexibility in some cases, because of the constraints of the standard award (Bower 1993; Kenny et al 1994). Midwives in Australia are not eligible for Medicare rebates for services rendered, further evidence of the invisibility of midwifery.

It is sometimes the case that the disadvantaged and oppressed will advocate for social change (Cochrane 1995). The problem is, Cochrane (1995) claims, that too often midwives regard one another as rivals and adversaries rather than joining together as colleagues and partners in order to challenge external and administrative controls. A situation of oppression is thereby perpetuated. This response is clearly identified in the data where individual midwives exhibited signs of resistance in contrast to the united resistance of the obstetricians. The obstetricians, as 'objectors' to the project planning, had substantial power available to them because they presented a united front, an approach that doctors in general do well (see for example, Donnison 1988; Willis 1989; Wagner 2001). If only one or two obstetricians had objected to the project, their objections may well have been overcome. By combining in their objection, the obstetricians created a formidable force (Eccles 1994). The midwives, on the other hand, individually objected and did not combine their latent power. Consequently, the midwives' objections were ineffectual because they did not have the weight of a combined power (Eccles 1994). In not forming a united front the midwives further worsened their case as they, in turn, contributed to an increase in the power of the obstetricians. The midwives' inability to present a united front is a further indication of the immaturity of the profession.

The obstetricians

The researchers had anticipated obstetric resistance but it was important that they be involved in the planning process and the model of care. There are many likely reasons

why the obstetricians resisted this project, one being the closer relationship that had developed between the midwives and GPs. In addition, there is good support for the claim that the obstetricians felt very threatened by this project. This situation can arise when midwives take on responsibilities that the obstetricians perceive to be within their role (Flint 1993). When midwives function in their role of providing continuity of care to women during childbearing they increase their confidence. Consequently, problems such as those identified in this project planning, can occur with the midwife/obstetrician relationship (Flint 1993). The opposition of the obstetricians arises from a fear of litigation and the possibilities of a loss of control, which together are perceived to result in a loss of power (Lewis 1995d). Unless the obstetricians as a group supported this project its implementation would be risky, if not doomed, which was nearly the case. The incidents of obstetric domination previously identified reveal the obstetricians' fear of competition from midwives. Some authors (Brodie 1998; Rowley and Saxton 1992; Walker 1976) have suggested that midwives are not competing or being supplementary to obstetric services but, instead, offer a complementary service.

It became obvious from the data that the obstetricians perceived that they would lose something of value as a result of this midwifery model of care (Kotter and Schlesinger 1991). This something of value was a financial loss as well as a loss of power (Eccles 1994; Dahlen 2004). Financial loss could result from the midwifery model potentially providing better care and outcomes, thereby attracting women away from obstetric care to midwife care and affecting their income. The obstetricians' influence and control was potentially eroded by the proposed change, a change they had not instigated. Further, the obstetricians perceived that their interests were not taken into consideration with the proposed change (Dunford 1997).

It was evident that the powerlessness and subordination of the midwives involved in planning this project was a direct consequence of the greater power held by the obstetricians. Several sources of power contributed to the obstetricians' power base. Firstly, the obstetricians held coercive power stemming from their belief in their legitimate, expert and referent power. In other words, obstetricians perceive they have the right to block midwifery innovations because of their status, and believe they alone have the necessary knowledge and skills for maternity services. In addition, the obstetricians have power because they perceive they are admired and respected by society. Obstetricians

are mainly men, a further basis for power, with women in powerless positions in comparison (see for example, Dunford 1997; Murphy-Lawless 1998; Senior 1997).

Following the findings in this research project, the power exhibited by the obstetricians could be described as negative power, defined as a primitive, unsocialised desire to dominate and control those who are submissive (Senior 1997). Use of negative power usually results in conflict and win-lose situations, most often accompanied by communication breakdown together with an "... unwillingness to contemplate any view but one's own" (Senior 1997: 176). The obstetricians began politicking as they struggled to hold and use power in order to achieve their goal of stopping the project planning (Eccles 1994; Kotter and Schlesinger 1991). Eccles (1994) has speculated that these responses occur because change creates fog and smoke with opportunities arising for dirty deals that can go unnoticed. Further, the obstetricians' resistance can be seen as an active undermining carried out through a frontal assault or a form of guerrilla warfare, the latter being more treacherous as its effects take time to occur (Eccles 1994). There is evidence in the data that supports these claims. For example, the obstetricians retaliated to pressure by sending confidential documents to others for comment in an attempt to create further disruption to the planning process. In addition, the obstetricians did not want to discuss the project with the researchers and actively undermined the project planning (see Chapter Six).

Such resistance has been noted in other midwifery model of care innovations in Australia where obstetricians have perceived a similar challenge. For example, Hambly (1997) reports that obstetricians resisted the inclusion of birth centres in Canberra's maternity units for some ten years. The Canberra obstetricians further refused to provide any back up to a caseload model of midwifery care if it included a planned homebirth option (Hambly 1997; O'Donnell 1998). One team midwifery project had the obstetricians introduce more stringent selection criteria, thereby restricting the service (Brodie 1996). These strategies were undertaken by obstetricians in an attempt to maintain control of maternity services. Shroud waving of this kind are to be expected when recent changes in maternity services begin to limit the obstetrician's influence in normal childbirth (see for example, Lane 2002; Lewis 1995d; Murphy-Lawless 1998).

The researchers, having made an assessment prior to commencing the project planning and found evidence of many of the above mentioned factors, decided that the obstetricians could potentially offer the most resistance to the project. The researchers' estimation of the extent to which the obstetricians would use their power to resist proved to be inaccurate and the politics misread (Clarke and Meldrum 1998). As Connor and Lake (1994) cautioned, the obstetricians' response caused a halt to the project planning. Their resistance sought to delay the project and prevent people from facing the problem (Perkins 1997). The researchers' ability to assess the motivation of the participants to block change was tested in this situation. It has been proposed that the best strategy is to consider whether the proposed change will alter the held amount of power (Senior 1997). If the amount of power held is lowered as a consequence, then resistance to change should be anticipated. The researchers had not perceived the obstetricians would have less power as a result of the midwifery model of care, as non-insured women were involved and would not affect their client load. There was obviously more involved in this issue than had been anticipated, and not realised by the researchers at the time. It became clear that because of their culture it was impossible for the obstetricians to embrace the midwifery model of care of this research. An increased resistance by the obstetricians to the planning process resulted.

Another issue that contributed to the difficulties experienced with this project planning involved the environment itself. The three professional groups were working in an environment that did not have traditional boundaries, with the GPs and obstetricians working in the wider environment of the community. As well, the hospital was situated in an Area with two other hospitals. This hospital was, therefore, not a contained or finite environment. If the hospital were a contained, finite environment, with minimal obstetric involvement, the researchers may well have succeeded in implementing the midwifery model of care. The midwifery model of care that was eventually planned was most appropriate for the hospital in its finite state. The hospital was situated, however, in an Area that effectively had no structural boundaries. This situation allowed the obstetricians to gain more power because it gave them the opportunity to gather more people to their cause in stopping the project planning. The situation became compounded with the change in Area boundary, resulting in an even bigger environment in which the researchers were attempting to plan the project. The influence of the researchers was reduced even further making progression virtually impossible.

The process

In the situation described, using an action research process to plan the midwifery model of care, became an almost impossible ask. Action research is about achieving small changes and is not capable of dealing with such large issues and complexities as eventuated here. Action research has the potential to facilitate the participation of diverse groups of people to develop a shared vision of planned change. This did not eventuate, however, for a number of reasons. There were other issues associated with the organisational change process during the planning that add further explanation to these events.

The data analysis revealed the importance of involving all participants simultaneously from the onset of the action research process. This involvement included all levels of midwives from the managers to the carers, the GPs and obstetricians. All of these people should have been involved in the action research process from the outset in order to create a sense of urgency for change. Achieving this initial involvement, however, may not have been feasible because of the diverse nature of these professional groups. This fact questions the validity of this aspect of action research. It became evident, however, that involving doctors in service delivery change will only work if it fits their model of service delivery and the way payments are received (Silversin and Kornacki 2000). Certainly the GPs were very happy with the proposed midwifery model as they could see the benefits for them. The obstetricians on the other hand were not so pleased. Nevertheless, this research project attempted to work with these three different professional groups each with issues of professional boundaries, who did not practise in the same setting and who worked under different contractual arrangements. It could be claimed that this research project was attempting to achieve the impossible in trying to bring such diverse groups together (Morton-Cooper 2000). The power base and domination differences in these groups could not have been overcome unless the midwives took leadership of the project planning and if the obstetricians had been amendable to change within their role. With the benefit of hindsight, it was obvious that this midwifery leadership could not occur. It may well have been the case that even if one midwife took leadership of the project planning, the other midwives would not have supported this person. Involving all the participants collaboratively in the identification of the problem and its possible solution with the researchers may have resulted in a

natural change of ownership. This situation highlights the importance of fully understanding and appreciating the differences in power and the unique aspects of a situation before embarking on a research project such as this. Certainly if the midwives had presented a united front, there would not have been such a power imbalance between the midwives and the obstetricians.

If the researchers had worked with the midwives from the outset, and not just the managers, the midwives may have been empowered earlier through the action research process and been able to develop professionally. Further, working with the midwives earlier would have facilitated the communication process and overcome the many barriers to change through increasing the midwives' sense of urgency to change. Added to this, working with maternity service consumers would have further helped empower the midwifery profession. There is a growing body of evidence indicating that midwives working with women and consumer organisations are more successful in advocating for midwifery care (see for example, Brodie 2002; Guililand 1999; Maternity Coalition AIMS 2001). Midwives, therefore, need to demonstrate to women more clearly the benefits of midwifery care in order that women can advocate for the services they demand. It is the women's care and services that are the essential concerns in this debate.

Another possible reason for the difficulties experienced with the planning outlined from the data analysis relates to the issue of problem identification. It could be argued that the researchers should not have imposed their solution to the problem on the participants, getting the participants instead to first identify the problem (Morton-Cooper 2000). When using action research, the group should work on the problem and identify the solution together, instead of having an imposed solution presented to them. At the time, the solution proposed by the researchers was the most appropriate considering all the available evidence. The midwives may not have accepted that the GPs played any role in a midwifery model of care because of a philosophy of non-collaboration with GPs. At the time, the proposed model was the only way a midwifery model of care could have been achieved in the Area. A different solution may have eventuated if the group had worked together on the problem identification, an inevitable consequence of an action research process. The researchers needed to be mindful that they had little control in the direction the solution would take. In the case in point, given the midwifery culture and

the belief that the maternity unit was successful, a change would probably not have been possible unless an imposed solution was used.

In addition, the participants may have perceived that the researchers were motivated to plan the project because of their own agenda. The Prof (N) had a need to achieve improvement in maternity services and the researcher needed a project for doctoral research. This may have resulted, in action research terms, a power imbalance in the relationship between the researchers and the midwives, with a lack of shared goals and action. It is, of course, unreasonable to expect the midwives to change because the researchers had identified the problem and then imposed it on them anticipating that they would collaborate in planning the solution (Heywood and Heywood 1992; Morton-Cooper 2000). With the benefit of hindsight, imposing the problem and solution on the midwives would have been the only way that change would occur in these circumstances.

A further contributing factor to the midwives' resistance could be related to the researchers' role. In this project the researchers, in action research terms, had assumed they were insiders as they were midwives and thus could identify with the midwife participants and share in problem identification. The researchers, however, could also be considered as outsiders as they did not work at the hospital and were, therefore, not part of the organisation. In reality, the midwives probably did not perceive the researchers as insiders. Being viewed as outside researchers could have, therefore, further contributed to the power imbalance and lack of shared goals between the researchers and the midwives (Williams 1995).

Added to this, there is much discussion in the action research and organisational change literature about whether the researcher should be part of the organisation to be researched or a professional researcher from outside the organisation (see for example, Abraham 1994; Eccles 1994; Titchen and Binnie 1993b). The main issue in the debate is that outside researchers are not privy to the total political, social and cultural situation within the organisation and may, therefore, influence or even incorrectly identify the problem in the first place (Connor and Lake 1994; Smyth and Checkland 1976). In the instance of this research, whether this situation could have been alleviated if the researchers and midwives discussed the problem situation fully at the start is not known.

Despite initially undertaking interviews with the key players to gain further insight into the situation, this strategy had little impact on the outcome of the process. In addition, the literature criticises outside researchers for having a minimal stake in the long-term outcomes of their actions and recommendations (Connor and Lake 1994). Given the organisational culture in the field of this research, together with little apparent midwifery leadership, the project planning would have not made progress if outside researchers were not used and taken a leadership role with the action research group.

A further factor that may have contributed to the midwives' resistance was whether they perceived the researchers as two powerful people descending on the organisation with a project. The Prof (N) certainly was in a position of power over the midwives as she was a research academic (or academic researcher) and had been appointed to the first funded chair of nursing in a hospital in Australia. The expectations and roles of the Prof (N) were uncertain and unclear. Added to this, the Prof (N) had a high profile in the midwifery community and a superior standing among the midwives. The researcher, being a coordinator of postgraduate students undertaking their clinical placement at this hospital, could also be considered as having superior status. Consequently, the midwives appeared to retreat from these two powerful people, not wanting to participate. Later, when the midwives started to engage with the project planning, they took on a dependent role, with the researchers having to continue to push the change. Dependency was further evident when the researchers disengaged from the project, with the midwives reverting to their previous position by not continuing the planning process. This dependency of participants is a potential outcome when using outside researchers, according to Johns and Kingston (1990). Inevitably outside researchers eventually withdraw from the project planning and organisation. There is an expectation that a leader would emerge from the action research group and take over planning the change (Senge et al 1999). No matter how much the researchers tried to maintain an equal relationship with the midwives in order to facilitate a successful action research process, a transfer of ownership of the project planning was not achieved because of this apparent dependency. Instead, the midwives were angry with the Prof (N) for not involving them in the planning from the start and for withdrawing. Further, the Prof (N) may have been perceived to be more powerful in this situation, and the midwives, as participants in the process, perceiving themselves to be vulnerable.

This issue of dependency raises another point made clear from the data. Action research is a collaborative process, implying an equal relationship between the participants (Meyer 1993). For action research to be successful in achieving organisational change, however, there needs to be a leader as motivator for the change. In addition, the organisational change literature discusses leadership as being critical to achieve change (see for example, Dunford 1997; Senge et al 1999: Senior 1997). In other words, someone has to manage the change and be the change agent (Senge et al 1999; Williams 1995). In this project the change agents initially were the researchers. There was reluctance, however, for anyone inside the organisation to take over this leadership role. The point here is, however, that it is difficult to understand how the collaborative process of action research actually facilitates the process of leadership necessary in order to achieve change. Action research is about collaboratively working through the problem and not about identifying a leader.

A further point to make here is that it is usual for the doctoral student, in this case the researcher, to be the leader of the action research group. This requirement was impossible with this research project because of the complexities of the situation, the chaos in the organisation and the requirement for political leadership available through the Prof (N).

In addition, the data clearly indicates that for those midwives participating in this project planning, the process of introducing change took too long. This delay may well have contributed to the midwives' resistance. Evidence of this can be seen when the midwives expressed frustration at the project planning not progressing following the researchers' withdrawal. According to Street and Robinson (1995), midwifery culture is about the desire for a quick fix, rather than action that is thorough, rigorous and time consuming. Crom and Bertels (1999) believe that many involved in organisational change share this same orientation. The midwives were, therefore, frustrated by the slowness of the action research process of planning. It is likely, however, that this amount of time is needed to instigate such a midwifery model of care. More recently it has been reported to have taken eight years to plan a midwifery caseload model of care at a hospital in Britain (Kinnear 2004).

Many of the factors identified here may have contributed to a level of misunderstanding and lack of trust on the part of the midwives towards the researchers (Kotter and Schlesinger 1991). The researchers' action in spending time with the GPs in order to assess the project feasibility before approaching the midwives may have compounded this effect. Through this action, the midwives may well have perceived that they were less important. Consequently, the midwives took considerable time to develop a sense of urgency for the project planning, or take on the leadership role.

An important consideration in this discussion is that the only change that should be initiated needs to meet the criteria of being systematically desirable and culturally feasible (Checkland 1981a). It could be argued that, given the overt and covert resistance exhibited by the obstetricians to this midwifery model of care over a period of three years, the identified change was not systematically desirable or culturally feasible. Conversely, the Area and the hospital, with varying degrees of enthusiasm depending on who was leading the hospital at the time, wanted change and were generally supportive. While one culture found the proposed change unacceptable, the wider maternity services culture wanted and needed change. This disparity became an important consideration when deciding whether to stop the project planning or not.

It is obvious from the data that without the researchers' instigation of the planning process it would have not started. This instigation aimed to create a guiding coalition of leaders and this aim was part of their role (Kotter 1996; Kotter and Cohen 2002). Organisational change in such an entrenched culture could only be achieved with an action research process. As with any research process, the researchers were obliged to work with participants that are present at the time. While the researchers' objectives were not achieved, there was a shift in the ability of the participants to acknowledge and accept the idea that the midwifery model of care would be implemented in the future. It should be remembered that the first step to change is the hardest (Kotter 1996; Kotter and Cohen 2002). There was, therefore, some level of organisational change. Action research has the capacity to achieve organisational change as long as researchers remember that it may not be their goal that is necessarily achieved. Organisational change, therefore, involves the adjustment of expectations by researchers in regard to the process and the goal.

The process of attempting to achieve organisational change can be summarised conceptually as illustrated in Figure 8.6.

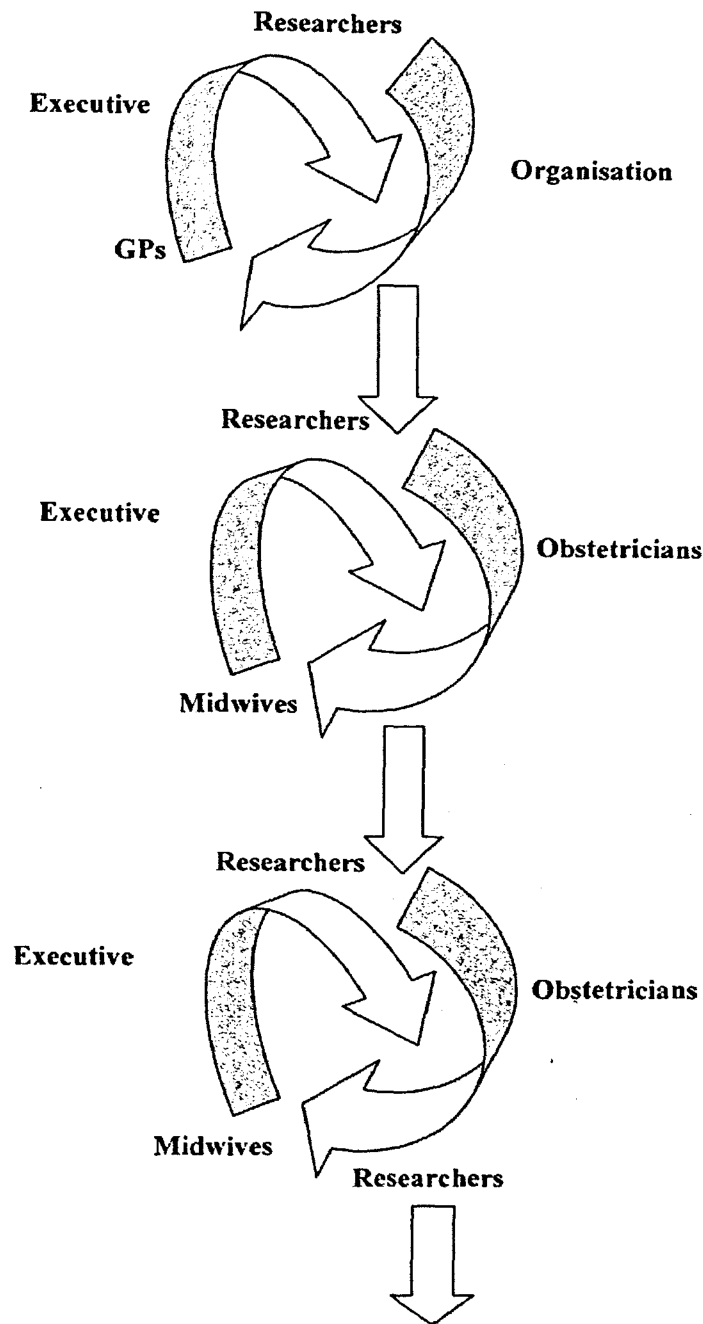

Figure 8.6 The process of achieving organisational change.

This diagram (Figure 8.6) illustrates the circular process that occurred as the researchers used various strategies in an attempt to overcome the barriers created by the organisational instability resulting in a cyclical process between the researchers,

organisation and executive. Added to this was the backwards and forwards process that needed to occur between the researchers, obstetricians, midwives and executive in the planning process as these participants waxed between engaging and creating obstacles to block the vision. This then becomes a spiral as the planning process moved on, the spiral indicating the ongoing exploration of the midwifery model of care that occurred (Street and Robinson 1995).

Anchoring new approaches in the organisational culture

Embedding change in organisational culture is crucial for achieving change (Kotter 1996; Kotter and Cohen 2002). This outcome involves anchoring change within an organization's norms and values so that the change becomes so much a part of the organisation that it is the organisation. The culture of an organisation plays a dominant role in achieving substantial or transformational change (Senior 1997). In this research, the action research process, assisted by cultural identification through the use of soft systems methodology, facilitated the embedding of the change within the organisational culture. The embedding of change within the organisational culture was evident when people took ownership of various aspects of the planning. It was crucial for the researchers to promote and support the action research participants in becoming the owners of the project planning (Grundy and Kemmis 1981). The ultimate evidence of this change of ownership of the project to the midwives and GPs included the following:

- GP 'L' taking the lead with the accreditation of the GP shared care educational program;
- GP 'C' taking responsibility for the medical politics that surrounded the project planning;
- The midwifery manager from the postnatal ward becoming the chairperson of the Management Committee (MC);
- The ultimate leadership of the planning by the midwifery manager from the labour ward through the Operational Team.

Other people recognised that this change of ownership had occurred with the project planning. For example, the Prof (N) reflected that,

> *... people were taking ownership of the project to the extent of taking control and deciding themselves what will happen instead of us telling them. They will decide how the project will be implemented and not us* (Field Notes (FN): 12.5.94 (this is the date on which this quote was recorded)).

It was noted that Midwife 'W' commented that,

> *... power and control has shifted from the chairperson (of the Steering Committee (SC)) then it became obvious that the key stakeholders wanted a slice of the power and control and now I see the power and control seems to be equally dispersed* (Interview (I): 15.8.94).

The upheaval created by the instability of the organisation assisted this process of participation and ownership of the project planning. Specifically, the change in Area boundary and the maternity unit moved to another site for two years to rebuild the hospital, resulting in further administrative changes. This situation created a crisis in the maternity unit that, in turn, raised the sense of urgency in the key midwives to plan the change to resolve the crisis (Kotter 1996; Kotter and Cohen 2002). By this time, the project had become firmly embedded in the culture of the maternity unit despite the fact that the researchers had not been directly involved with the midwives for some three years.

Conclusion

The organisational change process used by the researchers attempted to overcome all areas of instability and resistance, and achieve a sense of urgency for planning a midwifery model of care. The report on the findings from this research project reveals the problems of using Kotter's (1996) framework to examine and analyse the data, with the framework being insufficient to guide the change process. A defined process such as action research was required in order to plan the midwifery model of care. Further, action research was found to conflict with the Kotter framework. For example, Kotter

(1996) advocates the need for a leader to drive the change process aligned with the guiding coalition. On the other hand, action research is a collaborative, participatory process. The possibility of a collaborative process that includes a guiding coalition arises. Such a model precludes a participatory process. The action research process is designed to be idea generating with ideas belonging to the group. This principle does not sit well with the notion of a leadership and a guiding coalition.

A further deficiency with both Kotter's framework and the action research process is their inability to analyse the social, cultural and political aspects of a project. The data clearly supports the importance of analysing these aspects in order to assist the change process and add meaning to the events. The identification of instability and resistance was made easier using soft system methodology to explicate the history and the cultural system of the situation (Ragsdell 2000). Using a systems approach enables a problem to be examined in its broader social context by focusing on the larger environment within which the problem occurs (Checkland 1981b). The aim of the analysis process is to take all aspects of the situation and the interactions involved in various parts of the problem into account. Complex problems, such as those in this project, by definition are multi-faceted and contain many relationships, including those real world problems encountered within organisational hierarchies and instability (Checkland and Davies 1986). In addition, the stream of cultural inquiry enabled an exploration of the human and social aspects of the situation through a social and political system analysis (Checkland and Scholes 1991 & 2001). Therefore, Kotter's (1996) work has provided a framework for organisational change, with action research providing the process for change, and soft systems methodology providing the means of data collection and analysis to inform the process.

It is clear, however, that the researchers needed to set clear boundaries as to when the research project should be stopped. The decision about when to cease the implementation of a proposed strategy is difficult to make. This issue is not well documented in the action research literature. More recently Morton-Cooper (2000) has claimed that reaching a level of saturation with the research is an indication of when to stop. A level of saturation is described as a time when the researcher can achieve no more of value or when there is a sense that the participants are fatigued. More often the researcher abandons the process when the research grant money has run out, or when it

is time to write up a report or thesis, rather than stopping the project when it offers no further new findings. This situation, however, presents an ethical issue, as the organisational change may have not yet occurred and the original objectives contained in an ethics submission are not fully achieved.

A very important consideration in this research project concerns the realisation that enough energy and resources had been expended. The researchers kept pushing for the planning to continue. In hindsight, it was naive of the researchers to attempt to implement this midwifery model of care considering the complexities of the different systems it was trying to broach. It became obvious from the data analysis that the implementation of the midwifery model of care was difficult because it attempted to traverse different boundaries within a very complex health care system (outlined in Chapter 5). Inherent in these different systems is that individuals and groups have different agendas and are motivated differently and their participation became an impossible task. It was no wonder so many problems were encountered during the planning phase of this midwifery model of care.

A further factor in these different systems is the issue of funding for innovations such as this project. In Australia, an added difficulty in implementing midwifery models of care arises because of the disparity that exists between health funding and health service provision. This disparity means that if a State had the political will to change maternity service delivery there will be no funds forthcoming from the Federal Government. Instead the state would have to fund these changes for which funding may be inadequate due to Federal Government allocation.

The second factor that impeded the professional interplay was the differences in beliefs that existed between participants. Specifically, there were differences between the researchers and the participants regarding the feasibility of this midwifery model of care. For example, the Prof (N) had access to international resources and was aware that midwifery innovations such as the proposed project were being implemented in Britain. The assumption that the Prof (N) made, therefore, was that such midwifery innovations could be implemented in Australia. Before coming to this conclusion, however, the Prof (N) had taken considerable time to work through the issues involved in maternity services in general and the proposed solutions to these issues. Likewise, the researcher

had read all the available literature on the issues involved in maternity services and was also very much aware of possible solutions. On the other hand, the participants in this project planning had not had this opportunity to work through the literature and reach the same conclusions. This disparity meant there was a difference in the beliefs of the participants and the researchers about the feasibility of the proposed midwifery model of care.

Taking this issue of differences in beliefs further involves a consideration for whether the proposed midwifery model of care was consistent with the values and beliefs of the obstetricians, GPs and midwives. Certainly this kind of midwifery innovation was identified in the literature as feasible and the proposed midwifery model of care, therefore, should have been consistent with the values and beliefs of all participants. It was evident from the data, however, that the midwifery model of care was not consistent with the beliefs and values of the obstetricians, midwives and to a lesser extent, the GPs. This outcome can partly be explained by the shift that would have had to occur in order for people to operate in planning this midwifery model of care. Specifically, this conclusion refers to the necessary boundary crossing that would need to occur and because it would require the participants to move outside their most comfortable operational space.

It was decided, however, that the attempt to shift the professional boundaries was justified. The researchers achieved some shift despite the difficulties. It became obvious that a longer lead-time was required to bring the participants to a sense of urgency for the midwifery model of care. This longer time was needed because of the complexities in the situation and the need to traverse the boundaries previously mentioned. The researchers did not realise at the time that a longer lead time was necessary. The instability of the organisation, however, meant that the researchers at no time had the circumstances in which to effectively plan.

Given the fact that the researchers took responsibility for the instigation of the midwifery model of care, it is reasonable to ask if there was anything further the researchers could have done to maintain the planning process. The answer is that the project probably should not have been started in the first place. It is important to remember, however, that even though the project itself was not implemented, some

progress was made. Those involved in the planning developed professionally and became more amenable to the introduction of the midwifery model of care. This outcome can be seen in the fact that the midwifery managers from the labour and postnatal wards are still very keen to implement the model. These midwives were not keen to implement the model in the first instance. A paradigm shift had occurred, therefore, with the participants (Ragsdell 2000). The educative, enlightening, empowering and emancipatory aspects of action research was certainly important for these midwives who were undervalued in the maternity care environment (Bellman, Bywood and Dale 2003; Rasmussen 1997). Action research belongs to the critical social paradigm of empowering participants to achieve change (Kemmis and McTaggart 1990b). Through the use of critical social theory, individuals can be inspired to identify the environmental problems with which they struggle, collectively examine their experience, plan appropriate action and overcome their oppression. This outcome would appear to have been achieved in this research project.

It was obvious from the outset that the obstetricians would resist the midwifery model of care. Achieving change that appears to fly overtly in the face of the desires of those who exert power in an organisation is bound to be difficult (Clarke and Meldrum 1998). This was the reason for the suggestion that the researchers work at the hospital with the GPs on the midwifery model of care. There may have been a different outcome, however, if the researchers had included the obstetricians from the outset in the action research process. Further, an appointment of a Professor of Obstetrics and an obstetrician at Staff Specialist level, would have assisted this process greatly. It has been shown that success with projects is possible where there is both medical and administrative support for them (Homer et al 2001b).

The data indicate that different professional groups collaborated with the researchers depending on whether they would benefit or not from the midwifery model of care. For instance, the GPs were very engaged in the planning process because they could see the benefits. On the other hand, the obstetricians perceived that they had much to lose from the project and therefore did not support it. In between were the midwives who were ambivalent in all aspects. This situation was further complicated by the fact that the midwives had developed a very workable, though not necessarily ideal, relationship with the obstetricians that would be jeopardised as a consequence of change. Further,

this project involved the midwives developing a closer relationship with the GPs than previously was the case. This closer relationship would have caused a breakdown in the relationship between the midwives and obstetricians.

The question arises whether the women, would have been better off with the model of care that resulted from this planning process. There is evidence in the data to indicate that the obstetricians would screen the women out of the midwifery model of care and influence their choice to participate. The women would, therefore, be worse off unless the staff specialist was appointed to take on this role. This action would further exclude the obstetricians.

In conclusion, what had been achieved was a shift in professional boundaries by changing allegiances, partners, relationships and power. The status quo was changed. Achieving a change in any boundary of practice such as this is hard to achieve because of the dominant position and status of a specialist sector of the medical profession. Midwives became stronger because of their allegiance with the GPs; this allegiance meant they were removed from obstetric influences. The midwives were stronger professionally because of the professional development that had come about from their participation in the action research process. The obstetricians had been excluded, an outcome the researchers had unwittingly facilitated. Obstetricians should not be caring for low risk women. This is the domain of the midwives and the GPs. Instead, obstetricians should be involved if complications arose.

The conclusions that can be drawn from the project planning and the process of attempting to achieve organisational change are threefold. The first relates to the instability of the organisation in which the planned change was to occur. This organisational instability affected the elements identified by Kotter (1996), such as creating a sense of urgency, formation of a guiding coalition, allowing obstacles to occur, communicating the change, and the impossibility of achieving short-term gains and keeping the momentum going. The second conclusion refers to the major impact that followed and contributed to the organisational instability with the constant change in leadership at various levels in the organisation. Finally, it can be concluded that the power imbalance between the different professional groups had an enormous impact on the change process. These different groups appeared to have little in common. It is difficult to bring about change to a culture

that is entrenched across professional boundaries. Such entrenchment explains the power battles that occurred. These power battles were underestimated by the researchers and, on reflection, could not have been overcome in a situation of organisational instability. Added to this situation was the fact that the planning went on for too long. Taking too long to create a sense of urgency means that the urgency eventually diminishes.

Recommendations

The way forward for health service development that can be explicated from this project is a need for a strong and stable executive team in times of instability. This executive provides the leadership and vision for change, as well as the guiding coalition that can push for change. Added to this, there is a need for strong midwifery leadership at the work force level in order to push the planning along at that level. This strong midwifery leadership can be achieved through the educational preparation of midwives who would be more knowledgeable and better equipped for change. The development of midwives to feel more confident and be able to work in an autonomous role occurs through education; continuing education, Graduate Diploma in Midwifery programs that aim to equip midwives to function autonomously and the introduction of Bachelor of Midwifery programs. A greater visibility and recognition of midwives in Australia would assist in strengthening the midwifery profession further. There is no doubt that difficulties in negotiating professional boundaries will remain but their resolution would be made easier with strong midwifery and executive leadership.

The inequalities between the professions involved in this project and the differing boundaries that would need to be surpassed, mean that change is virtually impossible without outside help. This help would come from consumer pressure and legislation change, forces which have meant midwifery models of care have successfully been implemented elsewhere. For instance, in Britain a change in legislation finally achieved the goals of the Winterton and Cumberledge Reports. The legislative changes that have occurred in New Zealand were a direct result of consumer lobbying. Issues also of indemnity, Medicare rebate and remuneration for midwives in Australia would help.

It is important to reiterate that the planning of the project involved activities that suggest something important was happening. For example, a number of midwives and GPs took

ownership of various aspects of the project planning. Their actions provide support for the fact that the GPs and midwives supported the midwifery model of care and were prepared to continue with the project regardless of the chaos that was occurring within the organisation at the time. An important lesson learnt from this project was that imposing change might fail to achieve the goal. There was, however, a shift in the midwives' desire to achieve change and a shift in the professional boundaries to make it possible. Through the organisational change process, the midwives developed professionally leading to an increased capacity to continue the process of achieving this midwifery model of care.

Postscript

An interesting observation can be made in relation to the time in which planning for the midwifery model of care took place. At the time planning commenced the recommendations from the Shearman Report (1989) and Trickett Report (1996) had not been implemented. Later, another government report was published in New South Wales (Reid 2000). This report differed from the Shearman Report and the Trickett Report in that it presented a five-year plan to address specific issues that consumers and health professionals had identified as requiring attention (Reid 2000). The report recommended that the Department of Health adopt a number of standards in the development of maternity services; these standards included continuity of care, collaboration between health professionals and expanding models of care. The standards were reinforced by the National Maternity Action Plan (Maternity Coalition AIMS 2002), which commented on the lack of collaboration between professionals and the lack of recognition for midwives. The recommendations in the Action Plan included the implementation of a nation wide community midwifery program for the care of childbearing women. The role of the midwife in this care was promoted (Maternity Coalition AIMS 2002). New South Wales has recently faced the closure of small maternity units, making the more widespread introduction of midwifery models of care imperative (Goulston 2002; Dahlen 2002). This decision to close small maternity units has been reversed, but the possibility for closures in the future remains (Reibel 2003).

In recent times there have been more discussions about midwifery models of care. An Australian conference in November 1998 was specifically aimed at discussing

midwifery models of care. At this conference, seven papers either discussed the need for doctors to collaborate with midwives or gave examples where this collaboration was occurring. In more recent times there has been a package published specifically to address models of continuity in midwifery care (Homer et al 2001). In addition, there have been many Cochrane Reviews addressing aspects of continuity of midwifery care and more publications have appeared about midwifery models of care. At the time this research project was being planned, there was minimal, if any, public discussion on midwifery models of care or midwives collaborating with their medical colleagues. It is time, therefore, that midwives reconsidered their professional boundaries in order to work in caseload models of midwifery care beyond the restrictions of the organisation to the community and away from obstetric domination. Such a move would help address the issues of power in the organisation and in the obstetric profession.

In conclusion, it is acknowledged that effecting organisational change will always be difficult and that change can occur in ways not anticipated by researchers. If this midwifery model of care planning were implemented now, it would probably be successful. It is important to emphasise that the action research process aims to empower people (Kemmis and McTaggart 1990b), leading to an improvement in their capacity to continue the process of achieving change (Forbes 1992) after the researchers have left (Checkland and Scholes 1991 & 2001). Organisational change occurred, even if this was simply the raising of awareness of differences in professional groups and a shift in the professional boundaries. There was, in addition, an indication that those involved in the project planning re-evaluated their view and now more amendable to the project. For instance, after the planning process was stopped, the Area Director of Nursing (DON) informed the researcher that midwifery managers from the postnatal and labour ward had informed her that they wanted to continue the planning process. More recently, the midwifery manager from the labour ward resigned from her position to become the first midwife to successfully achieve Nurse Practitioner status in New South Wales. This places the midwifery manager from the labour ward in a position of autonomy through which midwifery models of care could be instigated.

As Collins (2001) explained, achieving organisational change is about having the right people on the bus, implying that the wrong people have been removed, and then deciding

on the direction in which the bus should go. There are times, according to Wolfe (1999) when the bus cannot wait for people. They are either on or off the bus. People will move along with change, catch up or be left behind. The journey described in this thesis confirms this prediction. Senior (1997) summarises the change journey,

> Change is about nothing if it is not about persistence. This means persisting in the face of an ultra-unstable environment; persisting in the face of systems that are built for stability rather than change; persisting in the face of plans that are out of date as soon as they are formed. It means applying the same principles to people as are applied to 'things' – that is, the knowledge that nothing is perfect. This means recognising that people will act in infuriating and annoying ways but that, when necessary, will bring the genius of their humanity to solve apparently unsolvable problems. Change is not easy but it can be interesting. It is certainly worth the journey even if the place of arrival is surprising (Senior 1997: 308).

Appendix One -

Summary of evaluations into midwifery care

Study	Research method	Number and type of subjects	Results
Midwives Clinics			
• Convoy 1993	• Cohort, compared to traditional care	• 149, all risk categories	• increased satisfaction, wanted more midwife visits
• Craveley and Littlefield 1992	• Cohort, compared to traditional care	• 156, all risk categories	• no difference in outcomes, decreased costs
• De Costa et al 1991	• Prospective cohort, compared to traditional care	• 396 low risk	• perinatal mortality less, other accepted measures of pregnancy outcomes were low, women satisfied with care
• Giles et al 1992	• Randomised control trial	• 89 low risk	• salary savings, highly valued by women, no difference in perinatal outcomes
• Reid 1989	• Cohort compared to traditional	• 216 low risk	• increased attendance and satifaction, midwife listened, shorter waiting times
Early postnatal discharge			
• Berryman and Rhodes 1991	• Cohort	• 370 vaginal births	• early discharge is safe, and cost effective
• Carty and Bradley 1990	• Randomised control trial	• 131 low risk	• low maternal and infant morbidity, increased rate of fully breastfeeding by one month, more satisfied, hospitalised women were more depressed and had lower confidence
• James et al	• Cohort with	• 710	• no difference in

1987	control group		morbidity, women more adjusted to postpartum
• Lemmer 1987	• Cohort with control group	• 42	• no difference in outcomes between the two groups
• Scott et al 1992	• Cohort with control	• 288 low risk	• no difference in outcomes between the two groups
Midwife versus obstetric intrapartum care			
• Blanchette 1995	• Retrospective cohort	• 1,107 all risk categories	• decreased induction, epidural, instrumental, c sections, no difference in fetal outcomes, increased PPH
• Hundley et al 1994	• Randomised control trial	• 2,844 low risk	• midwife care results in increased mobility and decreased interventions with no increase in neonatal mortality
• Oakley et al 1995	• Cohort	• 1,181 low risk	• decreased antenatal screening and obstetric interventions
• Tew and Damstra-Wijmenga 1991	• National perinatal statistics of all births >32 weeks' gestation	• 184,554 all categories	• 12 times lower perinatal mortality rate compared to obstetric care
Birth Centre			
• Biro and Lumley 1991	• Cohort compared to state statistics	• 2,858 low risk	• as safe as standard care
• Cambell et al 1981	• Cohort compared to labour ward	• 175 low risk	• a safe alternative
• Hodnett 2002a	• Cochrane Review	• 8,677 all risk	• reduced obstetric interventions, increased maternal satisfaction with no difference in outcomes

• Rooks et al 1992b • Rowley and Kostrzewa 1994 • Stern et al 1992	• National Birth Centre study compared to national statistics • Cohort compared to RWH Birth Centre • Cohort compared to traditional care	• 11,814 low risk • 951 all risk • 5,365 low risk	• decreased interventions, Apgar score similar, decreased perinatal mortality and costs • comparably safe to a unit caring for low risk women • decreased instrumental and c section births, safe for women
Team Midwifery			
• Aiken 1997 • Biro et al 2000 • Flint et al 1989 • Homer et al 2001b • Kenney et al 1994 • Morris-Thompson 1992 • Rowley et al	• Descriptive exploratory • Randomised control trail • Randomised control trial • Randomised control trial • Randomised control trial • Questionnaire to two teams • Randomised	• 20 low risk • 1,000 low risk • 1,001 low risk • 1,089 all risk categories • 446 all risk categories • low risk • 814 all risk	• increased midwife and women satisfaction compared to previous pregnancy • less augmentation, electronic monitoring, analgesia, episiotomies, no difference in perinatal mortality • increased satisfaction, less obstetric interventions, inductions, analgesia; neonatal outcomes similar • significantly reduced c section, cost less, slightly less perinatal mortality compared to state, less admissions to SCN, no other differences in outcomes • less antenatal and neonatal admissions, less epidurals, instrumental births, episiotomies, similar neonatal outcomes, costs less • higher degree of satisfaction • less antenatal and

1995	control trial	categories	neonatal admissions, less analgesia, interventions, neonatal resuscitation, cost; perinatal mortality same; increase maternal satisfaction
• Smethurst 1997 • Waldenstrom et al 2000 • Ward and Frohlich 1994	• Cohort • Randomised control trial • Cohort compared to traditional	• 34 • 1,000 low risk • 144	• increased continuity, positive feedback from women • women were more satisfied with team care, especially in the antenatal period. No difference in outcomes between groups • more vaginal births, less c section and instrumental births
Caseload			
• Guilland 1999 • Hambly 1997 • Johnson et al 2003 • McCourt and Page 1996 • Sandall et al 2001 • Thiele and Thorogood 1997	• National figures • Cohort compared to birth centre and state statistics • Descriptive comparative to traditional • Cohort compared to traditional • Cohort compared to traditional • Cohort compared to state statistics	• All births and categories of risk • 73 low risk • 1,177 low risk • 1,403 all categories of risk • 447 • 120	• Midwife care had lower perinatal mortality and interventions • Increased vaginal births and maternal satisfaction; lower induction, c sections, analgesia • Increased continuity, maternal satisfaction, breastfeeding rates • Decreased induction, analgesia, episiotomies with similar neonatal outcomes • High level of continuity, decreased analgesia, c section, increased breastfeeding rates Decreased inductions, c section, analgesia; increased vaginal births, breastfeeding rates

Appendix Two – Summary of evaluations into GP care

Study	Research method	Number and type of subjects	Results
GP units versus obstetric care			
• Banwell and Hamilton 1970	• Cohort	• 1,600 low risk	• low perinatal mortality rate
• Bull 1980	• Cohort over 10 years	• 8,167 low risk	• low perinatal rate compared to national and specialist maternity unit, decreased operative birth compared to specialist unit
• Klein et al 1983	• Cohort	• 252 low risk	• less analgesia, augmentation, forceps, fetal distress, higher Apgar scores, no difference in neonatal outcomes
• Lowe et al 1987	• cohort	• 370 low risk	• lower obstetric interventions, no difference in other outcomes
• Marsh and Channing 1989	• audit	• 1,223	• decreased instrumental births, lower perinatal mortality compared to national figures
• Owen 1981	• Cohort over10 years	• 9,778	• decreased perinatal mortality rate compared to national figures
• Prentice and Walton 1989	• Audit	• 685 low risk	• low interventions and good fetal outcomes
• Reid et al 1989	• Audit	• 2,365 low risk	• lower induction, epidural, instrumental birth, neonatal outcomes similar
• Sangala et al 1990	• Cohort comparing integrated GP	• 14,415 all risk	• lower perinatal mortality

	unit with the consultant unit		
• Taylor et al 1980	• Cohort	• 2,957 all categories	• decreased complications during labour, less analgesia and episiotomy, higher Apgar score, less transfer to nursery, perinatal mortality similar
• Wood 1981	• Cohort	• 818 all risk categories	• low induction, c section and forceps rate, higher breastfeeding rates, less neonatal resuscitations, perinatal mortality rate below national figures
• Young 1987	• Cohort	• 1267 low risk	• lower interventions and mortality rate
Shared care			
• Small et al 1998	• Interview non-English speaking background	• 194	• shared antenatal care is not more satisfying than antenatal clinic care
• Webster et al 1995	• Exploratory survey	• 513 low risk	• equally as satisfied, shared care had more advantages
• Thomas et al 1987	• Cohort	• 196 low risk	• less hypertension, less inconvenience, waiting time
Midwife versus GP/physican care			
• Buhler et al 1988	• Audit	• 132 low risk	• increased spontaneous labours, lower episiotomy rate, provide more adequate and comprehensive care
• Butler et al 1993	• Cohort	• 4,607	• lower risk of abnormal labour, epidural, diagnosis of fetal distress, reduced c section, similar neonatal outcomes
• Chambliss et	• Randomised	• 492 low risk	• lower operative

al 1992	control trial		births, decreased episiotomy rate, no difference in neonatal outcomes
• Levy et al 1971	• All births over 3 years compared to before started program	• 991 low risk	• increase in antenatal care, perinatal mortality decreased
• Montgomery 1969	• Audit	• 360	• decreased perinatal mortality rate, decreased premature births
• Slome et al 1976	• Prospective evaluation	• 438 low risk	• higher antenatal attendance, lower instrumental births, care was as effective, no difference in outcomes
• William et al 1993	• cohort	• 913 all risk	• decreased episiotomy and c section rate, similar management and outcome measures
Midwives versus shared care			
• Guilland 1999	• National figures	• 1,228 all risk categories	• decreased obstetric interventions, increased breastfeeding rates
• Turnbull et al 1996	• Randomised control trial	• 1,299 low risk	• decreased obstetric interventions, increased maternal satisfaction, no difference in outcomes
Midwives working with GPs compared to shared care			
• Street et al 1991	• audit	• 11,189	• women prefer GP and midwife compared to obstetrician, decreased perinatal mortality rate
• Tucker et al 1996	• Multicentre randomised control trial	• 1,765 low risk	• improved continuity of care, fewer antenatal admissions, non attendance and

			day care, fewer inductions, no difference in outcomes
Midwives working with GPs			
• Fenwick 1994 • Issac 1986	• Cohort compared to hospital and state statistics • Cohort	• 16 low risk • 23 low risk	• decreased induction, episiotomy and c section rate • outcome does not seem to have been compromised

Appendix Three – Interview information sheet

GP Midwifery Shared Care Model

Interview Consent and Information Sheet

You are invited to contribute to the collection of data to examine the process of planning an innovative model of maternity care. The planning for this innovation has taken some considerable time and I would like to ask your opinion about how the project has progressed.

You are asked to participate in a semi-structured interview which will involve answering a number of questions. The interview will last for approximately 40 minutes and will be taped and transcribed later.

All information gained from the interview will than be incorporated into the analysis of the implementation of the project. The information that you contribute will remain confidential and at no time will your name be used in the analysis of this data.

Your decision whether or not to participate will not affect your future relationship with the project and the Team. If you decide to participate you are free to withdraw your consent and to discontinue at any time.

If you have any questions at a later time Ms Linda Jones, at the Faculty of Nursing, University .... on 330 4302 or home 365 2977, will be happy to answer them. You will be given a copy of this form to keep.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way. I have read this consent form/information sheet, and understand the purpose and risks of the interview.

Signature of participant	Signature of Investigator
Date:	Date:

Appendix Four – Cost calculations

Revised 20 August 1993

"BOTTOM UP" COSTING MODEL

COSTS PER NORMAL CONFINEMENT

For Early Discharge
Basis of calculation: hours of midwife time per client delivered.

Outpatient services	hours
Clinic women average 10 antenatal visits Average time per visit 18/60 + ^20/60 * 10 visits = 200/60	3.3
Postnatal check takes 30/60	0.5
Education	
1 midwife * 10 couples * 16 hours of classes for each couple	1.6
Preparation time per session (includes preparation, set up, photocopy) * 8 sessions for 10 couples	1.2
Total	6.6
Inpatient services	
Delivery services	
Average midwife time per client	11.85
Postnatal services	
24 hours inpatient midwife time	6.68
Early discharge	
Average midwife time per client 45/60 * 5 days + 225/60	3.75
Travel time 0.124 per client * 5 days + 2 visits for ? 2 days	0.87
Grand total	29.75

Salaries calculated on hourly rate of CNS
inclusive of 20% 'on costs' of $20.48 per hour = $609.29 per confinement

Does not include salary of clerical officer (*1) or hospital/area administrative infrastructure

Excludes Ethnic Liaison Officer team costs and medical costs

Medical costs

Outpatient

Antenatal - first visit 30/60 subsequent visits 10 minutes * 9 visits	2.0
Postnatal - 30 minutes	0.5
Inpatient	
? 30 minute visit	0.5
Total	3.0

Salaries calculated on hourly rate of registrar

"TOP DOWN" COSTING MODEL

COSTS FOR NORMAL CONFINEMENT

Excluding Medical costs

Basis of calculations: budget expenditure in Maternity
Department Canterbury Hospital.

Source - monthly financial statements

Clinic costs (includes education)	15,081
Delivery	26,390
Postnatal (includes Early Discharge)	37,700
Nursery	18,850
? whether this includes on costs	
RMR domestic charges food supplies medical and surgical supplies goods and services	5,000
Clerical officer salary	16,057
Total	119,078

90 deliveries per month

confinement cost = $1,323.09

Excludes Ethnic Liaison Officers

Nursery staff included because they provide relief staffing in other areas

"BOTTOM UP' COSTING MODEL

COSTS PER NORMAL CONFINEMENT

For Hospital postnatal care

Basis of calculation: hours of midwife time per client delivered.

Outpatient services	hours
Clinic women average 10 antenatal visits Average time per visit 18/60 + ^20/60 * 10 visits = 200/60	3.3
Postnatal check takes 30/60	0.5
Education	
1 midwife * 10 couples * 16 hours of classes for each women	1.6
Preparation time 3 hours per session (includes preparation, set up, photocopy) * 8 sessions for 10 couples	1.2
Total	6.6
Inpatient services	
Delivery services	
Average midwife time per client	11.85
Postnatal services	
Average midwife time per client * 6.68 * 5 days inpatient care	33.4
Grand total	52.85

Salaries calculated on hourly rate of CNS
inclusive of 20% 'on costs' of $20.48 per hour

= $1,082.37 per confinement

Does not include salary of clerical officer (*1) or hospital/area administrative infrastructure

Excludes Ethnic Liaison Officer team costs and medical costs

Medical costs

Outpatient

Antenatal - first visit 30 minutes subsequent visits 10 minutes * 9 visits	2.0
Postnatal - 30 minutes	0.5

Inpatient

Postnatal - 5 minutes 5 days	0.42
Total	2.92

Salaries calculated on hourly rate of registrar

"TOP DOWN" COSTING MODEL

COSTS FOR NORMAL CONFINEMENT

Includes Medical costs

Basis of calculations: budget expenditure in Maternity Department Canterbury Hospital.

Source - monthly financial statements

Clinic costs (includes education)	15,081
Delivery	26,390
Postnatal (includes Early Discharge)	37,700
Nursery	18,850
? whether this includes on costs	
RMR domestic charges food supplies medical and surgical supplies goods and services	5,000
Clerical officer salary	16,057
VMO, registrar and residents	35,150
Total	154,228

90 deliveries per month

confinement cost = $1,713.64

Excludes Ethnic Liaison Officers

Nursery staff included because they provide relief staffing in other areas

Appendix Five – Midwifery model summary sheet

Common features of antenatal shared care schemes

1. Uninsured low risk women participate;
2. These women are already clients of the General Practitioner (GP);
3. Frequency and mature of antenatal visits;
4. General Practitioner confirms pregnancy and orders tests;
5. Obstetric screening occurs at hospital antenatal clinic;
6. Women are referred to hospital antenatal clinic;
7. Women give birth in hospital labour ward;
8. If any complications occur during labour or birth, women come under the care of the obstetrician on call.

How the GP/midwife model differs from the current scheme

1. There will be a team of community midwives (hospital salaried midwives working in the community);

2. Instead of women attending the antenatal clinic at the hospital they will see the community midwife and/or GP either in the GPs rooms or somewhere close by in the community;

3. Care will be provided by the GP and the community midwife rather than the GP and the hospital antenatal clinic/obstetrician. One or possibly two obstetrician screening visits will be provided at the hospital antenatal clinic;

4. Education will be provided by the community midwife working with the GP with groups of women at various stages of gestation and in the postnatal period. Fathers' groups may also be run in the neighbourhood;

5. Women will be referred directly by the community midwife to the GP if any health problems are noticed during appointments. If these problems need specialist care, the GP will refer further. If a woman has an obstetric emergency she will ring her midwife and present at the hospital under the care of the obstetrician on call;

6. Labour and birth will be attended at the hospital by the community midwife rather than by the midwives working in labour ward. The labour ward staff will provide backup support if needed. The obstetrician on duty will provide emergency care if problems arise in labour;

7. Postnatally the woman may be discharged early and be followed up at home by the community midwife who will liaise with the GP. The community midwife will undertake home visits and the woman and her baby will see the GP in their rooms for a postnatal check and neonatal clearance. Community midwives will ensure GPs are involved in immunisation, Pap and breast screening and contraceptive advice.

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