New midwifery? A qualitative analysis of midwives' decision-making strategies

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Abstract

Title. New midwifery? A qualitative analysis of midwives' decision-making strategies

Aim. This paper is a report of a study to explore the reasons why midwives decided to adopt observed decision-making strategies relating to the use of technology.

Background. Literature on the development of midwifery and nursing has suggested that they are developing more egalitarian relationships with clients in decision-making processes.

Methods. A qualitative approach was adopted, using participant observation with a convenience sample of midwives (n = 16), and a focus group of midwives (n = 8). Data collection took place over 9 months in 2004.

Findings. The dominant mode of decision-making was bureaucratic decision-making, which involved adherence to written policies and procedures. The least frequently used was 'new professional' decision-making, which involved collaboration with clients. The reasons for midwives' approaches could be categorized under three main headings: first, context, including possible litigation, management strategies, workload pressures, and medical dominance; second, midwives' characteristics, including both lack of experience and the reliance on tradition of some experienced midwives; and third, women's perceived characteristics, some of whom were seen by midwives as either unwilling or unable to participate in decision-making. There was also implicit evidence that some midwives were uncomfortable with the new professional rebalancing of power relations between professionals and the laity.

Conclusion. Managers need to question whether the strategies they adopt hinder or support clinicians in their efforts to involve women in decisions. Clinicians need to consider whether they wish to be selective or universal in their use of new professional strategies.

Keywords: clinical decision-making, focus groups, midwifery, new professionalism, observation, qualitative research

Introduction

Much recent midwifery literature has emphasized the need for midwives to work with women in an empowering way that recognizes their mutual interdependence (Hsia 1991, Fleming 1998a). Yet there is evidence that the rhetoric of women-centred care does not always successfully inform practice (Fleming 1998b, McCourt 2006). Given that there are now more than 70 countries with national midwifery organizations (ICM 2007), and where it is generally accepted that midwifery is an autonomous profession with practitioners able to care for women throughout the whole of the normal childbearing period if complications do not arise, questions around the midwife–woman relationship are of considerable international pertinence. Moreover, the issue of professional–client relationships is of equal pertinence to nurses of all specialities.

Background

Given the major impact that the way nurses and midwives perceive their professional roles has on their relationships with clients, consideration of insights from the sociology of professions can provide an important reflexive tool. It can allow us to stand back and look dispassionately on our professional self-image. Thus, for example, from a sociological perspective, rather than being simply a badge of an occupation that displays skills, service and altruism, 'a profession is distinct from other occupations in that it has been given the right to control its own work' (Freidson 1970, p. 71). The issue then becomes one of the manner of occupational control. At least three conceptual models of occupational control are pertinent to nursing and midwifery:

- Classical professional, where control lies with the professionals themselves.
- Bureaucratic, where organizational rules govern practice.
- New professional, where control is shared between professional and client.

During the 1980s, the latter approach to healthcare professionalism took root in nursing and midwifery. In contrast to classical professional approaches, which assumed that the professional knew best and should therefore be able to make unilateral decisions about care, and bureaucratic approaches, where nurses and midwives automatically followed set rules of practice, new professionalism promoted decision-making based on negotiation between professional and client, each with their own pertinent knowledge-base. Thus, for example, in 1987 the United Kingdom Royal College of Nursing's *Position Statement on Nursing* asserted that 'each patient has the right to be a partner in his (sic) own care-planning' (RCN 1987). In addition to patient involvement in care planning, new professionalism was manifest in such innovations as primary nursing and patient advocacy. To distinguish this novel approach to clients from more traditional approaches to professional power, it was dubbed 'new nursing' (Lee 1989, Salvage 1990, 1992). The analogous term 'new midwifery' has been used to denote the reassertion of the importance of women's involvement in their birthing decisions (Burtch 1987, Page 2000, MacDonald 2006).

A number of commentators have made strong claims about the beneficial potential of new professionalism. Amongst those was Porter (1994), who concluded in a paper entitled 'New nursing: the road to freedom?' that:

> Nursing care is changing, and changing for the better. The new nursing provides a model for nurse–patient interaction which accredits patients with the full humanity that is their due. It therefore deserves the support of all those who wish to see truth, freedom and justice extended to all realms of life including that of health care (Porter 1994, p. 274).

Porter's argument went beyond the contention that a transformation in nurse–patient relationships was in progress, where the gap in power between them was diminishing. Using Habermas' (1970) notion of ideal speech, he argued that the approach to decision-making embodied in new professionalism meant that it was not just a novel approach to patient care, but was symptomatic of a more general, liberatory approach to social relations.

For Habermas, human freedom is defined by our ability to communicate, persuade and be persuaded on rational grounds: to engage in a style of communication, which he terms 'ideal speech', that is not corrupted by egocentric calculation or the exercise of power. The importance for striving for this ideal form of communication cannot be overestimated, in that 'so far as we master the means for the construction of the ideal speech situation, we can conceive the ideas of truth, freedom and justice' (Habermas 1970, p. 370).

The choice of new professionalism in midwifery

In seeking to examine the progress of new professionalism over the last decade, we have chosen to focus on midwifery on the assumption that midwifery practice offers a more propitious context for exploration of new professionalism than nursing for at least three reasons. First, in contrast to nursing's emergence as a profession subordinate to medicine, midwifery has always insisted on its autonomous space around the management of normal childbirth. Second,

because a core activity of midwifery is being with women during childbirth, the new professional project is reinforced by feminist aspirations. Third, rather than dealing with people who are sick or incapacitated, midwives' clients are capable and well. Thus, the focus of this paper is on 'new midwifery' (Page 2000), with its focus on women-centred care.

The study

Aim

The aim of the study was to explore the reasons why midwives decided to adopt observed decision-making strategies relating to the use of technology.

Design

A qualitative descriptive design was adopted. This used participant observation and a focus group interview to collect data in order to analyse the pertinence of three *a priori* conceptual models of decision-making strategies to the day-to-day decision-making strategies of midwives, and to uncover the reasons why midwives made decisions in the ways that they did.

Setting and participants

The fieldwork took place in the delivery suites, antenatal assessment units and postnatal wards in two public hospital maternity units in England. Both units had a mixture of physician-led and midwifery-led care. The focus group took place in a prebooked room in one hospital.

The number of midwives whose practice was observed was 6 in the larger unit (approximately 5000 births per annum) and 10 in the smaller unit (approximately 2500 births per annum). The total number of clients involved was 36. Observations continued until data saturation was reached, where themes were found to be recurring both within and between cases.

The inclusion criteria involved selecting midwives who had personal responsibility for caring for or managing individual women in labour, had completed their preceptorship (first year as a Registered Midwife), had worked on the unit for more than 6 months and consented to participate. Hence, inexperienced midwives and those in general managerial positions were excluded. The same criteria were used for the selection of focus group participants. All eligible staff were invited to attend the focus group and eight consented and participated. Five of the eight participants in the focus group had also taken part in the participant observations.

Data collection

Data collection took place in two phases over a 9-month period in 2004.

Participant observation

In the first phase, data were collected by means of participant observation. This involved observing the activities of a single midwife per field trip. The researcher followed her through the normal activities of a shift, which involved being present in rooms when care was being delivered to pregnant women or women in labour. A midwife who had previously consented to be observed was approached at shift handover and asked to confirm her consent for the researcher to shadow her during the shift. If she consented, the midwife then sought consent from her client(s) for the researcher to be present. The researcher made written field notes during the observation, covering conversations, technologies used and decisions around care that were informed by the outputs of the machines. While the researcher did not participate in midwifery work, she did participate in the social world of the workplace, thus filling the role of 'participant as observer', rather than 'complete participant' in Gold's (1958) classic typology of fieldwork roles.

Focus group interview

The second phase involved a focus group consisting of eight midwives. There was equal representation from each of the study units. The primary purpose of the focus group was to explore the reasons given by midwives to explain why they acted in the ways that they did. This was carried out by presenting the focus group with ideal-typical vignettes describing decision-making strategies to see if they accorded with their experience, and allowing them to discuss why they thought midwives adopted these strategies (see Table 1).

Ethical considerations

Ethics approval was obtained from the research governance committee which covered both units where participant observation took place and the research ethics committees for both hospitals. An information sheet and consent form was provided and the midwives and the women who took part in the study gave their consent. Women were assured that their decision to participate or not would have no effect on their care. They were also assured that only the researcher collecting the data would be aware of their identity. Written

Table 1 Vignette to illustrate bureaucratic control

The midwife admits a woman who has previously telephoned to say that she thinks labour has begun. The woman is expecting her second baby. Her first pregnancy was normal with no complications and she gave birth vaginally to a healthy infant. The only complication was a retained placenta, which was removed manually under a general anaesthetic.

When the woman arrives she is obviously labouring and the midwife shows her to a room and takes a brief history before beginning a routine examination. She uses the datascope to record the blood pressure. She palpates the abdomen and connects the CTG [cardiotocograph] machine.

On performing a vaginal examination the midwife finds a breech presentation. She explains this to the woman, who is a healthcare professional and immediately understands the implication of this finding. The woman asks if this means that she needs a caesarean section and the midwife confirms that this is the policy.

The midwife then summons an obstetric registrar and on his arrival she states that she is '99% sure' that the presentation is breech. He fetches a portable ultrasound machine to confirm the diagnosis. Whilst the registrar gains the woman's consent for the procedure the midwife summons other professionals required to attend. She calls the anaesthetist, the operating department assistant and a paediatrician. She delegates a health care assistant to act as a theatre runner and another midwife to receive the baby when it is delivered.

She returns to the room, where she finds the woman making grunting noises that indicate that the second stage may have begun. The midwife performs another vaginal examination which confirms that the cervix is fully dilated. The midwife notifies the registrar who indicates that there should be no delay in transfer to theatre. The woman is encouraged not to push and is transferred to theatre, where a caesarean section is performed. A live healthy infant is delivered. After the delivery the midwife writes up the events and attaches the record strips from the CTG monitor.

informed consent was obtained both from midwives and the women for whom they were caring.

Data analysis

Participant observation data were analysed by means of constant comparison of the data with the *a priori* conceptual models of occupational control that had been developed within the sociology of professions. Data coding was based on the strategies midwives were observed to use to decide about the appropriate technology to use in childbirth.

The content of the focus group transcript was analysed according to recognition of modes of decision-making, and expressed explanations for those modes. These explanations were then coded into three core categories: context, midwives' characteristics and women's perceived characteristics.

Rigour

Rigour was ensured by a number of mechanisms:

1. Points of the observation were clarified with the observed midwives to maximize accuracy (Silverman 2001).
2. To ensure that the conceptual models of decision-making strategies remained grounded in the raw data, thus maintaining theoretical validity (Strauss & Corbin 1998), those models were tested by constant reference to the data.
3. Separate and independent analysis of the data was carried out by the authors, which generated a general consensus of interpretation.

Findings

While the findings of both phases of the research are reported and discussed here, emphasis is on the second phase which explored the reasons why midwives acted in the ways they did.

Participant observation data

Coding of fieldwork data concerning decision-making strategies confirmed the salience of three conceptual models of occupational control. The first category was new professional decision-making, which involved a partnership between midwife and mother (Porter 1994). The second category entailed midwives rigidly making decisions in accordance with policies and procedures without recourse either to their own discretion or to the wishes of mothers. This was termed bureaucratic decision-making (Weber 1978). The third category involved midwives making unilateral decisions on the basis of their own discretion. This was termed classical professional decision-making because it assumed that professional knowledge and expertise gave the professional power to make decisions in the manner of the classical professions such as medicine (Parsons 1951).

Bureaucratic decision-making was by far the most prevalent type observed, where the midwife made decisions about care solely on the basis of the policies and procedures of her unit. The second most popular mode was that of classical professionalism, with midwives basing their decisions on individual professional experience and qualifications. This meant that, of the three categories, consultation and collaboration with mothers was least used to make

decisions about care. In short, the evidence that emerged from the fieldwork did not support the thesis that new professionalism is becoming the dominant mode of midwifery work.

Focus group data

The focus group led to confirmation of the categories developed in the fieldwork phase, namely classical professional, new professional and bureaucratic decision-making. It also added two new categories: traditionalist decision-making, where midwives justified their decisions on the basis of 'this is how it's always done', and medically-dominated decision-making, where midwives acted in accordance with decisions made by doctors.

Reasons given for modes of decision-making

The first thing to note was the strong ideological support that midwives gave to new professionalism and the imperative to develop more egalitarian forms of decision-making with women:

M6: Anything that involves giving women choice is where we should always be.

M3: I would actually argue that we probably would all like to think we're veering towards new professional competence.

While the focus group interviewer did not attach a hierarchy to the different modes of professional decision-making, the interviewees regarded new professionalism as superior to the other modes:

M5: It's quite hierarchical, depending on what perspective you look from. From newly qualified to more advanced to new professional.

However, interviewees were prepared to admit that clinical practice did not always match up to ideological aspirations. Thus, M4 qualified the statement above that midwives should be aiming to give women choice with the following:

M4: But I think in the real world it isn't always so.

Nor did they see it as a matter of some midwives acting in a new professional manner and others not. Even individual midwives who were well-disposed towards new professionalism were reported as only acting in that mode for part of their working time:

M5: I don't think it's possible to categorize one midwife in one of those types. She's going to be changing; she's not going to be the same every day.

Much of the discussion was taken up with considering reasons for the gap between new professional theory and midwifery practice. These can be aggregated into three interconnected themes:

- The context within which childbirth took place.
- The characteristics of midwives.
- The perceived characteristics of the women under their care.

Context

Given that the most prevalent mode of decision-making involved adherence to bureaucratic rules in the form of policies and procedures, the reasons why this should be so are of considerable import. The first thing to note is that the midwives were well aware of this factor, regarding guidelines as constituting an increasingly pervasive mechanism of control over their work:

M8: I can remember ... 5 years ago guidelines were guidelines and that was how you would interpret them, whereas now they are put there more as policies instead of guidelines. This is a policy – you have to do it – and I think that guidelines are being interpreted as 'This is what you have to do now'.

That midwives acquiesce to the injunction that 'this is what you have to do' was largely explained by their fear of litigation and its consequences if they had to defend their actions if they did not accord with clinical guidelines:

M4: [Fear of litigation] certainly does affect people in that bracket that think policy is something to follow and you'll be safe, and I think if it wasn't for litigation then they would probably not practise in that way.

The increasing influence of guidelines can be seen as a reflection of changes in healthcare management that have been termed 'new managerialism' (Kirkpatrick *et al.* 2005), which involve the introduction of professional management to the public sector and the development of explicit standards and measures of performance (Hood 1991). Clinical guidelines and protocols are part of the armoury of new managerialism (Eddy 1990, Harrison *et al.* 2002). Their effect is to standardize care to a greater or lesser degree. The proponents of guidelines and protocols argue that they promote the spread of good practice, as identified by scientific research (Eddy 1990, Wennberg 1991). Their detractors argue that they subvert professional autonomy (Charlton & Myles 1998, Beardwood *et al.* 1999).

New managerialism does not just impact upon traditional professional autonomy: it has also been argued that it is in tension with the aims of new professionalism (Wigens 1996,

Hewison 1998). Indeed, there are reasons to believe that nurses and midwives have been particularly affected by new managerialism. These relate to the legacy of a gendered subordination of female 'semi-professions' in relation to male 'classical professions' (Witz 1992, Hunt & Symonds 1995). It might be argued that this legacy leaves nurses and midwives more vulnerable to new managerial control than historically autonomous professions. Thus, Parker and Lawton (2000) noted that, while doctors tend to see protocols as helpful guidelines which they may or may not adopt, nurses view them far more rigidly, seeing them as explicit instructions. Kirkham (2004) mirrored these findings in a study of midwives.

Another major contextual factor identified by midwives was the heavy workloads they were often faced with. The greater the workload of an individual midwife, the less likely it was that she would act towards her clients in a new professional manner because the interactions implicit in new professionalism took up more time than midwives felt they could afford if they were to fulfil basic standards of care:

M4: I think it would depend on workload pressures, how many women you were looking after, how much time you've got to spend, how much rapport you've built up with one woman … You know that an open-ended question is going to take longer. It's a time constraint that probably you will flip between classical and new professional, knowing that new professional is where you should be, always.

The abandonment of new professional modes of interaction could also result from changes in the condition of the mother or baby, and hence the context of care. The interviewees explained that, in response to adverse developments, they often felt obliged to take control of the situation and to institute unilaterally what they saw as the appropriate care response:

M3: The care of one woman can change over the time you look after her so you adapt and move from new professional to bureaucratic.

M7: I can think of when the woman has asked for something and I've been trying to do that, then something's happened, then I've had to go back. Like you trying to let them have a normal delivery without any intervention then you listen in, you hear there is a deceleration, so you end up putting her on the CTG then the doctors come in, then there's all that sort of thing.

The other major contextual factor concerned the attitudes and actions of the midwives' medical co-workers. For some midwives, the professional superordination of doctors remained a reality, investing them with an authority that enabled them either to encourage or stifle the new professional practices of midwives:

M7: That will depend on them [doctors] how we can be. Because if they're being bureaucratic, then we probably haven't got any option but to be bureaucratic as well. If they're being new professional, then we can carry on.

However, not all midwives perceived the medical position as being as unassailable as this, as is evidenced by the following retort to M7's assertion:

M3: But your rules state you've got to be an advocate for your women. So in fact, if you don't think what they're doing is in the best interest of the woman, you would actually argue, wouldn't you.

M5: It depends on the competence and confidence of the midwife to stand up to the doctors.

This exchange reminds us that midwives are not simply ciphers, reacting automatically to the contexts with which they are faced. Different midwives will interpret contexts differently and act accordingly. Thus, the distinction between contextual factors and the characteristics of midwives is to a degree artificial.

Midwife characteristics

One of the most notable aspects of explanations that cited the characteristics of midwives was their contradictory nature. Specifically, the factor of length of experience was interpreted by interviewees in different ways.

On the one hand, lack of experience was used to explain why some midwives adopted bureaucratic modes of behaviour in their rigid adherence to guidelines:

M6: I think this new professional competence is very much oriented towards a midwife that's very experienced … rather than a newly-qualified midwife, because she would be the bureaucratic one and as you become more experienced you are heading to the new professional.

It was also used to explain the authoritarianism of some doctors in their interactions with midwives, and the degree to which midwives had the confidence to resist that authoritarianism:

M2: Yea, I think some doctors will react differently to different midwives. If they know it's a senior midwife who has got lots of experience … the doctor would perhaps be more inclined to take a bit more of a back seat and let the midwife direct them. And if they know it's a newly-qualified midwife they will do what they want to do because they know you're not going to be in a position to say anything.

However, length of midwifery experience was also viewed in a less favourable light, in that some interviewees identified longstanding midwives as being inflexible:

M4: In my experience people that fit that bureaucratic competence are not necessarily newly-qualified that are under-confident; more people who have been doing it for years and that hide behind. 'You know we do it this way because this is how we do it'.

M3: 'This is how it's always done'.

M4: 'Because this is how we always (did) it; it works, so why should we change it?' (nods all round).

Lack of experience as a factor in inflexible reliance on protocols is a familiar theme, in that it accords with the Dreyfus model (Dreyfus & Dreyfus 1986), as popularized in nursing by Benner (1984), which offers a five-stage typology of the development of expertise. The first stage of development is the 'novice' stage, which involves a rigid adherence to rules resulting from limited situational perception, and hence limited discretionary judgement.

While the inertial power of tradition, as seen in the reported behaviour of more senior nurses, has been previously identified as a powerful factor (Porter 1995), it is not clear why the midwives who commented on it here conflated it with adherence to protocol. To the degree that protocols develop over time in response to new evidence, they challenge traditionalist approaches which, by definition, change very little. While the midwives' comments would seem to indicate their perception that protocols and policies tend to be rather inflexible in their development, more research is required in order to ascertain just how responsive they are to new evidence.

Women's perceived characteristics

Probably the most disquieting reasons given for midwives not adopting new professional practices were characteristics of clients that militated against the possibility of them engaging productively with midwives in decision-making. Two classes of women were identified – those who were seen as not wanting to be involved in decisions and those not capable of being involved.

Midwives felt justified in dealing with some women in a unilaterally prescriptive manner on the grounds that these women wanted to be treated in that way, and therefore telling them what to do was in fact adhering to their choices:

M5: I think also it depends on the woman you are looking after … There are going to be some people who do not respond well to that kind of information or wouldn't understand it or wouldn't want to know. Some people want to be told what do.

M7: And if you've got a woman who doesn't really want to make her own decisions and doesn't know anything, you may end up being more bureaucratic than with somebody that's well read where you end up being the new professional, so you might change.

These midwives typify those who do not wish to be involved in decision-making as not being able to understand or not having sufficient knowledge. In other words, while there was an attempt to explain lack of new professional interaction on the basis of choice, that choice was based on women's individual capacities. If the woman was seen as lacking sufficient intelligence, then she was not regarded as an appropriate collaborator:

M6: I also think in the real world a lot of it is down to the lady that you are looking after, her personality and her intelligence level.

Similarly, some women were seen as lacking credible knowledge and experience about pregnancy and childbirth:

M1: People are growing up and they haven't had to experience pain and they don't seem to be able to cope with everyday life things.

M4: Some women come in and they show you this blood loss they've had on a tissue and it's the minutest smear.

M1: It's common sense, isn't it.

This lack of realistic knowledge and experience was put down to two factors. The first was the demise of the extended family, which was seen as a repository of knowledge about childbirth, passed from mother to daughter, which gave each generation a realistic notion of what childbirth was like and the level of discomfiture it involved. Second, was the influence of the (largely North American) media, which midwives thought gave mothers unrealistic perceptions of childbirth, leading them to believe that it would be pain-free and highly medicalized. The level of animosity towards television's intervention in childbirth education (or mis-education as they saw it) was very high:

Researcher: How do you think media effects women's expectations?

M4: Greatly.

M5: Horrendously.

M4: Badly.

Women's perceived lack of understanding of what childbirth entailed, and the unrealistic expectations that were predicated upon this, were seen by some interviewees as devaluing women's contribution to any discussion about the way their delivery should be managed.

What is already known about this topic

- New professional practice, where decisions about care are based on negotiation between professional and client, has been promoted over the last two decades in midwifery and nursing.
- This approach has been identified as promoting the human dignity of clients.
- 'New midwifery' has been used to denote reassertion of the importance of women's involvement in their birthing decisions.

What this paper adds

- New professionalism is widely supported, but not widely practised by midwives.
- Midwives tend most often to make decisions on the basis of bureaucratic rules rather than negotiation with clients.
- The reasons for the lack of success of new professionalism lie in the context within which midwives work, the characteristics of some midwives, and their perceptions of the characteristics of some women.

Despite their general rhetorical support for the supremacy of new professionalism, these interviewees believed that in many cases it was more appropriate to deal with their clients according to the paternalistic precepts of classical professionalism, which assumes that the professional knows best and should therefore be in a position to decide what should and should not be done for a client (Parsons 1951). While this espousal of a more authoritarian mode of interaction was often justified on the basis of knowledge differentials, there were indications that it was not simply a matter of disinterested knowledge, but also of power (cf. Foucault 1977). While none of the midwives made a direct claim that they felt they should enjoy a position of power and control during childbirth, some of their interpretations of the effects of having lay third parties present during birth indicated that this was indeed an issue for them:

M7: Sometimes I feel like an outsider in the room. I like it if the woman hasn't got a birth partner, then I can be her birth partner and the midwife. But when you've got a birth partner there who isn't actually doing the right kind of thing and you're somebody they've never met before, it's difficult to come in and …

M8: Some of them are quite intimidating. Some of them, when you go in the room everything goes quiet.

Discussion

Data from the focus group indicate that the nature of decision-making is even more varied and complex than our three initial conceptual frameworks allowed for. The challenge to new professional decision-making (Porter 1994) came not only from bureaucratic decision-making (Weber 1978), driven by new managerialism, fear of litigation and the inexperience of some midwives, and from classical professional decision-making (Parsons 1951), driven by exigencies of work and midwives' perceptions of the capacities of some women. It also came from decision-making based on tradition. This factor should not be underestimated. As Porter (1995, p. 165) has noted, 'We need to be aware of the inertial power of tradition. Once patterns of behaviour become habitualized and institutionalized, it takes more than rationalist rejection to eradicate them'.

New midwifery was also challenged by medical dominance, which can also be at least partially explained in terms of the traditional division of labour. The occupational position of nurses and midwives crystallized during an era which automatically accepted medical superordination in healthcare settings (Dingwall & McIntosh 1978). It would seem that those power relations continue to exert pressure over contemporary midwives.

The identification by focus group members of the significance of entrenched positions and power relations can be applied to Porter's (1994) identification of new professional practice as an instance of Habermas (1970) notion of ideal speech. One of the most telling criticisms of Habermas' model was made by Craib (1984, p. 212), who wryly noted that 'It sometimes seems that if we could just understand each other better, then everything would be all right'. The example of nursing and midwifery would appear to bear out this scepticism, in that the experience of these occupations has demonstrated that ideological commitment is not enough. Ideologies exist in a material context that involves power relations (Marx 1983) and, while that context can be changed by human actions, change requires considerable and sustained effort.

Thus, we have a very complicated matrix of decision-making processes. Usually, midwives act according to decisions made elsewhere (by managers or physicians); sometimes they make decisions independently (according to evidence or tradition); and sometimes in co-operation with clients. The fact that they appear to be convinced that the latter approach is the best one would indicate that there is a need to focus further research efforts not on whether new professional practices are beneficial, but on how they can be fully implemented and sustained in day-to-day practice, given the

numerous countervailing pressures upon them. More broadly, it demonstrates an urgent need for midwifery managers and practitioners to ask themselves questions about the trajectory of their profession.

Conclusion

The dominance of bureaucratic decision-making found in this study can be largely explained by the pervasiveness of new managerialism. Managers need to ask themselves whether they adhere to the tenets of new managerialism or new professionalism, or both. If the answer is both, then they need to ask whether the manner in which they are applied is mutually compatible, or whether new professionalism is merely a rhetorical position which is undermined by rigid managerial requirements upon clinicians. The latter position is untenable as it puts an unfair and insoluble burden on practitioners.

The evidence here suggests that, even if practising midwives were given the managerial freedom to practise new professionalism, some would choose not do so in a universal fashion. Clinicians need to ask whether they favour a universal approach, or whether they believe that new midwifery should be confined to those mothers whom they deem to possess sufficient abilities to engage with midwives. More fundamentally, they need to ask whether new professionalism is indeed the road they wish to travel down or whether they would prefer the comfort and safety of being able to decide unilaterally what to do.

Author contributions

SP, KC, MS and WGK were responsible for the study conception and design and SP was responsible for the drafting of the manuscript. KC performed the data collection and SP, KC, MS and WGK performed the data analysis. KC, MS and WGK made critical revisions to the paper.

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