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Protecting the Public:
The Current Regulation of Midwifery

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Abstract

Throughout the 20th century, the regulatory frameworks that govern midwifery in the UK have grown, such that the current practice of midwifery and the provision of maternity care are now influenced by a myriad of regulation. Despite these controls there is little empirical data, especially in relation to the practice of midwives, which demonstrates the effectiveness of these systems and strategies. Whilst maternal mortality rates are at an all-time low, patient safety incidents still occur and claims of clinical negligence have continued to climb over the past thirty years. This raises the question of whether the regulatory mechanisms which are designed to ensure the health and wellbeing of the pregnant woman undermine or promote quality care and, whether the current statutory aim of 'protecting the public' is being realised. Whilst this is too ambitious a question to resolve fully in a doctoral thesis, I aim to make a contribution to answering it by giving voice to one specific group who are particularly well placed to comment but to whose voices are rarely heard, namely midwives.

The study offers a socio-legal exploration of midwifery governance through an examination of the understanding and experience of a group of midwifery practitioners. The study gathered both quantitative and qualitative data from a cohort of midwives practising in the South East of England between the period of May 2012 and March 2013. This data was analysed in order to establish the views and opinions of the midwives in relation to the regulatory frameworks. As a result, a complex picture of regulation emerged, with a particular focus on the importance of clinical governance, the Nursing and Midwifery Council and statutory supervision of midwives. The themes that emerged included: the impact of regulation on the provision of care, the role of regulation in facilitating woman centred care, and the unease about mechanisms used to address issues of poor practice. Whilst good practice was evident, concerns and challenges also arose in terms of the regulatory framework, which, to the study participants, at times did not appear to support the provision of safe quality care.

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Wier J., Current Perceptions of Statutory Supervision of Midwifery: Time for Change?
British Journal of Midwifery 23(4) (April 2015): 288-295

Glossary of Terms and Abbreviations

Glossary of Terms

Haemostasis	the arrest of bleeding.
Hypno-birthing	a method of supporting a woman in labour through the reduction of anxiety and pain using deep relaxation.
Normal Physiological Labour and Birth	giving birth without medical intervention.
Medicalisation of childbirth	the practice of introducing medical regimes and treatment into the childbirth process.
Risk management in healthcare	the attempt to reduce the threat to patient safety associated with certain conditions and procedures in healthcare provision.
Shoulder Dystocia	the failure of the shoulders to negotiate the pelvis spontaneously after the birth of the fetal head.
Post Partum Haemorrhage	haemorrhage which occurs within 12-24 hours of delivery, from the genital tract, which either measures 500 ml or more, or which adversely affects the woman's condition.

Abbreviations

AIMS	Association for Improvement in Maternity Services
ARMS	Association of Radical Midwives
CHI	Commission for Health Improvement
CMB	Central Midwives Board
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
ENDPB	Executive Non-Departmental Public Body
LSA	Local Supervising Authority
LSAMO	Local Supervising Authority Midwifery Officer
NCC	National Collaborating Centre
NCT	National Childbirth Trust
NICE	National Institute for Clinical Excellence/ National Institute for Health and Care Excellence
NHSLA	National Health Service Litigation Authority
MDF	Maternity Defence Fund
NMC	Nursing and Midwifery Council
NPM	New Public Management
NPSA	National Patient Safety Agency
PSA-	Professional Standards Authority
UKCC	United Kingdom Central Council for Nursing Midwifery and Health Visiting
VBAC	Vaginal Birth after Caesarean (section)
VE	Vaginal Examination

Table of Legislation and Statutory Instruments Cited

Data Protection Act 1998

Health Act 1999

Health and Social Care (Community Health and Standards) Act 2003 (c.43)

Health and Social Care Act 2008

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Health and Social Care Act 2012

Human Rights Act 1998

Midwives Act 1902 (c.17) (England and Wales)

Midwives Act 1918

Midwives Act 1926

Midwives Act 1936

Midwives Act 1951

National Health Service Act 1948

National Health Service Act 1999

National Health Service and Community Care Act 1990

National Health Service Reorganisation Act 1973

National Institute for Clinical Excellence (NICE) (Establishment and Constitution) Order No 220 1999

National Insurance Act 1946

Nurses Midwives and Health Visitors Act 1979 (c.36)

Nurses Midwives and Health Visitors Act 1997 (c. 24)

Nursing and Midwifery Order 2001 no.253

Safeguarding Vulnerable Groups Act 2006

Statutory Instrument (SI) 1977 No.1850

Table of Case Law Cited

Bolam v Friern Hospital Management Committee [1957] 2 ALL ER 118

Colton v The Nursing and Midwifery Council [2010] NIQB28

R v Allitt 1992 [2007] EWHC 2845 (QB)

Re M B (An Adult: Medical Treatment) [1992] 2 FLR 426

Tehrani v. UKCC [2001] IRLR 208

The Midwife

International Definition*: 'A person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located and that is based on the International Confederation of Midwives' (ICM) Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery'* (International Confederation of Midwives, 15th June 2011).

Scope of Practice: *'The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the new-born and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures'* (International Confederation of Midwives, 15th June 2011).

1. Midwives, Pregnant Women and the State

1.1. Introduction

It has been suggested that there is a paucity of empirical data on which to measure the efficacy of healthcare regulation generally,[1] and midwifery more specifically.[2] Brennan notes:

> 'We regulate in an empirical void, often addressing anecdotes and hysteria with far-reaching initiatives.'[3]

This observation would seem particularly relevant given that current governance structures have in part been implemented as a result of healthcare scandals which have stunned the wider community.[4] In responding to such scandals, the state has introduced reforms to regulatory systems as a way of controlling health care and the professions who provide care.[5] As such these scandals enabled the state to implement policy that was informed by neoliberal concepts, which has been the predominant political ideology for over thirty years. This was particularly evident in Blair's New Labour Government, whereby questions of safe effective care provision were informed by neoliberal Third Way tenets, and which envisaged that legal frameworks such as clinical governance and risk management strategies could address deteriorating standards of care within the NHS.[6] Here the objective of protecting the public may be seen as a broad political goal which is operationalised through the development of strategies that function at local level. Notably, NHS Trusts will develop their own clinical governance policies

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[1] Brennan T.A., The Role of Regulation in Quality improvement *Milbank Quarterly* 76(1998):709-31.
[2] This point will be demonstrated in the literature review in this chapter.
[3] Brennan n1 above at 725.
[4] Department of Health (DH) *Safeguarding Patients – the Government's response to the Shipman Inquiry's fifth report and the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries* (DH; London, 2007a); Department of Health (DoH) *Learning from tragedy, keeping patients safe: Overview of the Government's action programme in response to the recommendations of the Shipman Inquiry* (DH; London, 2007b); R v Allitt 1992 [2007] EWHC 2845 (QB).
[5] Butcher T., *Delivering Welfare: The Governance of the Social Services in the 1990's* (Open University Press, Buckingham, 1995) at 161.
[6] Symon A., *Risk and Choice in Maternity Care: An International perspective* (Churchill Livingston; London, 2006).

and guidelines, with risk management systems an important tool within these. Within these policies, the general aim of protecting the public both foregrounds a specific set of risks to be managed whilst offering an important point of reference against which the Trust's clinical governance systems can be assessed. Nevertheless, at times these regulatory strategies appear to exist in tension with the broader objectives, and in doing so, have the potential to impact on the pregnant woman, when care is provided by the maternity services.[7]

The pursuit of excellence in healthcare is visible within several statutes enacted in recent years. These include the Health Act 1999,[8] which first articulated the duty of quality in legislation, as well as the Nursing and Midwifery Order 2001, which outlines current midwifery specific governance.[9] The 2001 Order expresses this goal of quality care provision through the aim of 'protecting the public'.[10] Whilst it is true that maternal mortality and stillbirth rates have never been lower,[11] patient safety incidents,[12] and claims of clinical negligence in obstetrics have continued to climb.[13] This raises the question of whether the regulatory mechanisms which are designed to ensure the health and wellbeing of the pregnant woman undermine or promote quality care and, whether the current statutory aim of 'protecting the public' is being realised.

The impetus for this research study is the long experience (which is in excess of twenty five years) that I have had as a midwife. As a result of my direct experience of ongoing waves of

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[7] Freemantle D., Part 1: The cultural web: a model for change in maternity services. *British Journal of Midwifery* 21(9) (2013): 648–53.

[8] Health Act 1999.

[9] Nursing and Midwifery Order (2001).

[10] ibid Part II s.3 (4) states: the main objective of the Council in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registrants.

[11] Knight M., Keynon S., Brocklehurst P., Neilson J., Shakespeare J., Kurinczuk J.J., (eds) on behalf of MBRRACE-UK *Saving Lives, Improving Mothers' Care- Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-12* (National Perinatal Epidemiology Unit; Oxford, 2014); Office of National Statistics (ONS) *Statistical Bulletin: Births in England and Wales 2013* (ONS; London, 16TH July 2014) http://www.ons.gov.uk/ons/dcp171778_371129.pdf (accessed 21/04/15).

[12] National Reporting and Learning System (NRLS) *Six Monthly data on patient safety incidents Report* (NHS England; London, 24th September 2014).

[13] National Reporting and Learning System (NRLS) *Patient Safety Resources* (National Health Service Litigation Authority (NHSLA) *Learning from Maternity Claims* (NHSLA; London, 10th January 2014); National Health Service Litigation Authority (NHSLA) *Fact Sheet 2: Financial Information 2013-14* (NHSLA; London, August 2014).

reforms within the NHS, I have been able to observe these regulatory transformations personally and, have witnessed the impact that they have had on the care offered to pregnant women. This involvement has led to an interest in how these governance frameworks influence the practice of midwifery and the relationship between the midwife and the pregnant woman. It has also led me to question whether the measures introduced by successive governments are successful in achieving the aims that motivated their introduction. Whilst this is too ambitious a question to resolve fully in a doctoral thesis, I aim to make a contribution to answering it by giving voice to one specific constituency who are particularly well placed to comment but whose voices are only infrequently heard: midwives. This research will therefore aim to draw the experiences of midwives in the practice setting.[14] Further, given my focus, I will only consider such regulation that was in force in 2010, which is when this study commenced.

In the following section the research question will be defined (1.2). The chapter will then go on to examine both the empirical evidence and non-empirical literature to ascertain how the legal and regulatory frameworks are working in practice (1.3). Following this, the chapter will describe and give reasons for the methodological approaches that were employed to obtain empirical data for this study (1.4.). The chapter will then close with a synopsis of the remainder of the thesis and will outline the content of the chapters that follow (1.5).

1.2 The Research Question

The aim of this study is to explore whether the regulatory frameworks are assisting the provision of safe care from the perspective of the midwifery participants. The broad research question upon which this study is based is therefore:

[14] Glaser B.G., Strauss A.L., (1967) The Discovery of grounded theory: Strategies for qualitative research cited in Polit D.E., Hungler B.P., *Essentials of Nursing Research: Methods, Appraisal and Utilization* 3rd ed. (Lippincott; Philadelphia, 1993); Wisker G., Using Grounded Theory, Case Studies, Journals and Synetics in authors ed. *The Postgraduate Research Handbook* 2nd ed. (Palgrave Macmillan; Basingstoke, 2008): 213-226.

'*Do midwives believe that the current regulatory frameworks that govern midwifery practice support or undermine the protection of the public?'*

This overarching question may be subdivided into a number of smaller questions which are as follows:

1. What is the midwifery practitioner's experience of current regulation? How does this relate to what was intended by the legislature?
2. The stated legislative purpose of the current Nursing and Midwifery Order 2001 is the 'protection of the public'. What does this mean and why is it considered necessary given midwifery's longstanding commitment to being 'with woman'?
3. Regulation is achieved through a myriad of complex strategies within the National Health Service, including clinical governance and risk management strategies. Do midwives believe these methods to be appropriate and effective?

In the following section the existing literature and empirical evidence related to the research question will be examined**.**

1.3 Midwifery Governance: A Review of the Literature

'Regulation' has been a topic of academic interest in a variety of disciplines over the past four decades, and includes economic activity, law and public policy.[15] However today 'regulation' has become something of a world-wide phenomenon and is now more broadly conceived to include areas as diverse as: health and safety, healthcare, consumer protection, and protocols

[15] Baldwin R., Cave M., Lodge M., *Understanding Regulation: Theory, Strategy and Practice* 2nd ed. (Oxford University Press; Oxford, 2011).

to protect the environment.[16] The term regulation may be defined as the persistent and focused control by a public authority of the actions and pursuits of the community.[17] This control may include detailed commands and rules that are intended to have an effect on behaviour.[18] Therefore, although frequently perceived as restricting the activities of individuals, in the wider sense regulation may also be viewed as a means of enabling individuals to enhance or improve their actions.[19]

In the UK, the state influence in healthcare has generated an expansion of regulatory activity in recent years, where specific improvements in healthcare are encouraged through regulation. [20] As a result, legislation such as the Health Act 1999, as was mentioned above, was enacted to ensure that quality care is provided across the NHS.[21] This important government objective has been supported by the growth in regulatory instruments and the creation of institutions including the National Institute for Health and Care Excellence (NICE), and the Care Quality Commission (CQC). The role of these regulatory bodies is to oversee the provision of healthcare through standard setting, monitoring, evaluation and intervention. [22] In addition to these authorities, in order to further safeguard the public, healthcare professional regulators also exist. These regulators are responsible for establishing and maintaining registers of practising registrants and setting profession specific standards in terms of professional

[16] Quick O., *A Scoping Study on the Effects of Health Professional Regulation on those regulated: Final report submitted to the Council for Healthcare Regulatory Excellence* (University of Bristol; Bristol, May 2011) http://research-information.bristol.ac.uk/en/publications/a-scoping-study-on-the-effects-of-health-professional-regulation-on-those-regulated(1f2f0f09-defc-46ea-8488-ed670a54e2cc).html (accessed 07/05/15).
[17] Selznick P., Focusing Organisational Research on Regulation in Noll R., ed. *Regulatory Policy and the Social Sciences* (Berkeley; California, 1985) at 363.
[18] Baldwin, Cave and Lodge n14 above.
[19] Harlow C., Rawlings R., *Law and Administration* 3rd ed. (Cambridge University Press; Cambridge, 2009).
[20] Trubek L.G., Rees J.V., Bryce- Hoflund A., Farquhar M., Heimer C.A., Health care and new governance: the quest for effective regulation, *Regulation and Governance* 2(2008):1-8.
[21] n 8 above.
[22] Salter B., Change in the governance of medicine: the politics of self-regulation *Policy and Politics* 27(2) (1999): 143-58.

behaviour.[23] These regulators include the Nursing and Midwifery Council (NMC) which is responsible for ensuring quality care is provided by all of its 680,858 registrants.[24]

The current research aims to explore midwives' experiences of this complex regulatory arena. As such it was necessary first to assess the existing literature on the regulation of midwifery practice. A variety of health and health and social science databases were utilised in order to accomplish this task. These encompassed: CINAHL, MEDLINE, Cochrane Library, Social Policy and Practice, PubMed Central, Westlaw UK, and JSTOR. The search terms which were used in a number of different combinations incorporated: 'regulation/regulator', 'regulation/ conduct', 'healthcare professional/ regulation', 'compliance', 'regulation/midwife'. A number of findings emerged from this literature review. First it became clear that the regulatory systems studied are not well supported by detailed empirical research;[25] second, that the existing literature concentrates on the impact of regulation at organisational level;[26] third, that there is a bias towards research on the medical profession at the expense of other healthcare professions; and finally, such empirical evidence as does exist tends to originate mainly from the United States of America (USA).[27]

Nonetheless, the literature review did reveal a range of work of relevance to the current study including work on clinical governance (1.3.1); on healthcare professionals' views of regulators (1.3.2) and third statutory supervision of midwifery (1.3.3).

[23] n 8 above.
[24] Nursing and Midwifery Council (NMC) *Our Register: An NMC Fact Sheet* (NMC; London, February 2014a).
[25] Brennan n1 above.
[26] Quick n16 above.
[27] Mays N., Pope C., Qualitative Research: Observational Methods in health care settings *British Medical Journal* 311(6998) (1995): 182-84; Sutherland K., Leatherman S., *Regulation and quality improvement: a review of the evidence* (Health Foundation; London, October 2006): these authors note that there are additional challenges in terms of transferability and generalisability of the results of research carried out in one country when attempting to apply it to other cultures and healthcare regimes.

1.3.1 Clinical Governance: The Literature and Evidence

Clinical governance and risk management strategies are essential tools, employed to ensure compliance with regulatory objectives.[28] As will be seen in the following two chapters, they have been central to a series of reforms which have introduced a complex mass of regulation over the past four decades. Nevertheless, as Brennan observes above, there is limited empirical evidence to support the impact of these systems on the excellence of healthcare,[29] and that which does exist has frequently been generated from observational studies.[30] The difficulty however, with using observational research generally, is that the researcher has little control over the situation which is being observed.[31] As a result, it is difficult to determine what has produced the actions being witnessed, and therefore this type of research cannot confirm the causal link between regulation and enhancements to care.[32]

When searching the literature for this study it was discovered that the empirical research which has been undertaken to date, has had a tendency to focus on the impact that regulation has on the organisation rather than the individual.[33] Institutional regulation has as its emphasis the defining and conveying of anticipated levels of performance, together with surveillance and policing of behaviour,[34] and research studies which examine this type of regulation often concentrate on the regulatory compliance of the organisation.[35] As such the findings from these studies whilst not entirely unrelated to the current research question, might not provide specific insights about how individual healthcare professionals might react to governance in practice.[36]

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[28] Quick n16 above.
[29] Brennan n1 above.
[30] Sutherland and Leatherman n27 above.
[31] Mulhall A., In the field: notes on observation in qualitative research *Journal of Advanced Nursing* 41(3) (2003):306-13: this type of research permits the researcher to recognise and interpret the activities of the participants.
[32] Sutherland and Leatherman n27 above.
[33] Quick n16 above.
[34] Sutherland and Leatherman n27 above.
[35] Quick n16 above.
[36] Quick n16 above.

Several of the studies which examine the influence of clinical guidelines on patient care established that guidance was most effective when used in conjunction with other strategies.[37] Thomas et al.'s (2009) Cochrane systematic review found evidence that clinical guidelines had the potential to improve care.[38] These studies were nonetheless recognised as being of limited relevance to the current project, as the data related only to the nursing profession and did not address the nurse's decision making in detail.[39] Similarly Phillips et al.'s (2010) systematic review identified that clinical governance strategies which are dependent solely on guidelines have not been shown to be effective.[40] This review focuses on the application of clinical governance in general practice and primary care, and as a result the findings may be limited in terms of the current study. These authors moreover note that clinical governance within the literature is an expression which is not well understood, and which is frequently associated with bureaucratic power and medical authority,[41] and suggest that more research is needed to determine whether interventions improve safety.[42]

Other studies which have examined the individual rather than the institutional influence of clinical governance indicate that regulation that is led by the professions and is designed to ensure public accountability is more effective than regulation which is imposed by the

[37] Bloor K., Freemantle N., Khadjesari Z., Maynard A., Impact of NICE guidance on laparoscopic surgery for inguinal hernias: analysis of interrupted time series *British Medical Journal* 326(2003):578; Hassan Z., Smith M., Littlewood S., Bouamra O., Hughes D., Biggin C., Amos K., Mendelow A.D., Lecky F., Head Injuries: a study evaluating the impact of the NICE head injury guidelines *Emergency Medical Journal* 22(12)(December 2005):845-849; Sheldon T.A., Cullum N., Dawson D., Lankshear A., Lowson K., Watt I., West P., Wright D., Wright J., What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes and interviews *British Medical Journal* 329(30th October 2004):1-8; Wathen B., Dean T., An evaluation of the impact of NICE guidance on GP prescribing *British Journal of General Practice* 54(2004):103-7.

[38] Thomas L.H., Cullum N.A., McColl E., Rousseau N., Soutter J., Steen N., Guidelines in professions allied to medicine (Review) *Cochrane Database of Systematic Reviews* Issue 1 Art. No.: CD000349 (2009).

[39] ibid.

[40] Phillips C.B., Pearce C.M., Hall S., Travaglia J., de Lusignan S., Love T., Kljakovic M., Can clinical governance deliver quality improvement in Australian general practice and primary care? A systematic review of the evidence *Clinical Governance: An International Journal* 193(10) (November 2010): 602-607.

[41] O'Connor N., Paton M., 'Governance of and 'governance by': implementing a clinical governance framework in an area mental health service *Australasian Psychiatry* 16(2) (April 2008): 69-73.

[42] Phillips et al n40 above at 606.

employer.[43] It has also been argued that regulatory and monitoring measures are only successful when they are merged with the actions of the healthcare professional in practice.[44] However the focus of this regulatory impact literature tends to be on the medical profession.[45] Within this literature some researchers report that ensuring that individual practitioners, specifically doctors, follow the advice contained within clinical guidelines, is generally problematic.[46] It is suggested that this is a result of the perceived loss of professional autonomy that doctors fear, which may be associated with inflexible adherence to clinical guidelines, the so called 'cookbook' medicine.[47]

The issue of professional autonomy amongst different healthcare groups was explored in Parker and Lawton's (2000) UK study which examined the issue of compliance with guidelines in practice.[48] These researchers analysed the views of 310 healthcare professionals (midwives, doctors and nurses) in relation to the behaviour of colleagues that either conformed to or flouted guidelines in hypothetical situations.[49] The findings from this study indicated that midwives were the most disapproving of actions which did not comply with guidelines even when the outcome was good, whilst doctors were the most accepting of infringements regardless of the outcome.[50] Parker and Lawton suggest that these findings may be directly linked to the

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[43] Sutherland K., Leatherman S., Professional regulation: does certification improve medical standards? *British Medical Journal* 333(2006):439-441.
[44] Currie G., Humphreys M., Waring J., Rowley E., Narratives of professional regulation and safety: the case of medical devices in anaesthetics *Health, Risk and Society* 11(2) (2009):117-135.
[45] Quick n16 above.
[46] Michie S., Johnston M., Changing Clinical Behaviour by Making Guidelines Specific *British Medical Journal (BMJ)* 328 (7) (2004):343-345: 41 studies were included in this review; Roland M., Rao S.R., Sibbald B., Hann M., Harrison S., Walter A., Guthrie B., Desroches C., Ferris T.G., Campbell E.G., Professional values and reported behaviours of doctors in the USA and UK: quantitative survey *British Medical Journal Quality and Safety* 20(6) (June 2011): 515-521.
[47] Harpwood V., *Medicine, Malpractice and Misapprehensions* (Routledge-Cavendish; Oxon, 2007); Crawford R., Risk ritual and the management of control and anxiety in medical culture *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 8(4) (2004):505-528.
[48] Parker D., Lawton R., Judging the use of clinical guidelines by fellow professionals *Social Science and Medicine* 51(2000): 669-677.
[49] ibid.
[50] ibid.

professional autonomy and decision making which is prized by the medical profession,[51] and as such mirrors the research discussed above. Although guidelines can cause similar professional anxiety for some midwives,[52] the researchers maintain that for many midwives compliance has become accepted over time.[53] Here it is the collaborative nature of guideline development which the researchers suggest has generated ownership, trust and respect from midwives in terms of guideline usage.[54] Additionally, these authors argue that greater knowledge and understanding amongst women about pregnancy and childbirth has increased the potential for complaints if quality care is not offered, and as a result evidence-based guidelines which provide clear direction for the midwife is seen as preferable to professional autonomy.[55]

This interpretation of midwifery adherence to clinical guidelines may be compared to Hollins-Martin and Bull's (2009) qualitative study of midwives' views of guidelines in the UK.[56] Within this study, the twenty participants reported tension and challenges for midwives when attempting to comply with clinical guidelines particularly in relation to facilitating woman centred care.[57] The findings draw attention to the conflict that can exist when assisting the woman to make safe decisions when in labour which might be contrary to the directions contained within the guidelines. Hollins-Martin and Bulls argued that in order to facilitate woman centred care it may be simpler to circumvent the guidelines instead of challenging them.[58] This study provides useful insights and data about the practice of midwifery and their experience of working with clinical guidelines which appears to be more complex than Parker

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[51] ibid.
[52] Wilson J.H., Symon A., *Clinical Risk Management in Midwifery: The Right to a Perfect Baby?* (Books for Midwives; Oxford, 2002) at 159.
[53] Parker and Lawton n48 above.
[54] Parker and Lawton n48 above.
[55] Parker and Lawton n48 above at 676.
[56] Hollins-Martin C.J., Bull P., Protocols, policy directives and choice provision: UK midwives' views *International Journal of Health Care Quality Assurance* 22(1) (2009): 55-66.
[57] ibid.
[58] ibid at 62.

and Lawton's study would seem to suggest. In presenting a more nuanced picture, this research appears to offer a useful setting for the current study.

Other research from the USA which considers obstetric practices, additionally indicates that when guidelines are complied with there may be an improvement in practice, as measured by a subsequent reduction in the number of claims for clinical negligence particularly in relation to fetal heart rate monitoring in labour.[59] Although this research originates in the USA and as such presents challenges in terms of generalisability of the findings, it does nevertheless provide additional awareness of the impact of guidelines in terms of addressing the increasing numbers of litigation claims particularly within the speciality of obstetrics in the UK.[60]

The picture that emerges from the existing literature on clinical governance strategies is thus complex and varied but not well supported by detailed empirical research. Of the studies that do exist, few considered the effect of regulatory strategies on individual practitioners. This is of particular relevance as the current study will therefore aim to add a new dimension to this empirical research by focusing on the views of midwives. Further those studies which did so concentrated primarily on the medical profession.[61] Two studies were found which examined the impact of guidelines on midwifery practice.[62] While more narrowly focused than the current project, these two studies might nonetheless provide useful points of comparison. However the broad picture which emerges is one of the limited availability of empirical data that relates directly to the topic of the current study: midwives' experience of regulation.

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[59] MMI Companies, Inc. *Transforming insights into clinical practice improvements: A 12 year data summary resource* (MMI Companies, Inc., Illinois, 1998).

[60] National Health Service Litigation Authority (NHSLA) *NHS Litigation Authority: Report and accounts 2013/14- Supporting the NHS* (The Stationary Office; London, 9th July 2014) at 24: this report states that currently maternity claims represent the highest value within the NHS and are the third highest number of clinical negligence claims.

[61] Stacey M., *Regulating British Medicine: The General Medical Council* (Wiley; Chichester, 1992); Rosenthal M., *The Incompetent Doctor: Behind closed doors* (Open University Press; London, 1995).

[62] Hollins- Martin and Bull n55 above; Parker and Lawton n48 above.

1.3.2 Healthcare Professionals Perceptions of Regulation and Regulators: The Evidence

In addition to clinical governance, the midwifery profession is also subject to professional regulation which is administered by the Nursing and Midwifery Council (NMC).[63] The NMC is charged with the 'protection of the public' and attempts to do this through: maintaining a register, setting standards, performing disciplinary investigations and issuing sanctions for those deemed to have contravened the rules and standards.[64] Two recent official reports examined the NMC's performance as a regulator at an organisational level.[65] Each identified that the NMC had weak governance structures in areas such as leadership of the organisation and fitness to practice procedures and as a result was not perceived to be functioning effectively.[66] Within the wider literature little empirical data was found which addressed the specific question in this research which considered midwives' perceptions of regulation and the NMC, particularly in relation to whether or not the regulator was functioning effectively in the view of midwives. A reader poll conducted by the *Nursing Standard* in 2013 found that several nursing respondents, as a result of personal experiences, had little confidence in the NMC and its ability to ensure robust disciplinary procedures.[67] Although the *Nursing Standard* poll does not present rigorous information about the research methods that were used, such as sample size, it does nevertheless offer some general insights into at least some nursing registrants' views of the NMC and its ability to be an effective regulator.

Further research exists regarding other health care professional groups and their perceptions of regulation and regulators. Within this literature the empirical research focused on the medical

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[63] n 9 above .

[64] n 9 above; Nursing and Midwifery Council (NMC) *The Code: Standards of Conduct, performance and ethics for Nurses and Midwives* (NMC; London, 2008a).

[65] House of Commons Health Committee *5th Report of Session 2013-14 :2103 accountability hearing with the Nursing and Midwifery Council* (Stationary Office; London, 3rd December 2013); Council for Healthcare Regulatory Excellence (CHRE) *Strategic review of the Nursing and Midwifery Council: Final Report* (CHRE; London, 3rd July 2012).

[66] CHRE ibid.

[67] Kendall-Raynor P., Nurses have their say on the regulator *Nursing Standard* 27(32) (10th April 2013):16-18.

profession and included a study by McGivern and Fischer (2010).[68] These researchers carried out a small scale UK study which used interviews with doctors, medical regulators and service users to examine their views and experiences of regulatory disciplinary procedures.[69] The results of this study, although limited in terms of numbers of participants (eighteen) used in the research, identified that doctors often had feelings of guilt, particularly in relation to disciplinary processes, and that these emotions were influential in terms of how they perceived regulation and its impact on practice.[70]

As a result of extending the search terms, empirical research was found that examined the impact of professional registration, and which confirmed the apparent connection between registration and the provision of safe care.[71] This research was mainly conducted in the USA and once again focused on the medical profession. In the context of the disciplinary role of the regulator and fitness to practice procedures, the literature provides a consensus opinion that professional regulation is often perceived by registrants as being related to chastisement and punishment.[72] There is however little empirical evidence to support this assertion.

Only one small study was found that explored the opinions of healthcare professionals other than doctors.[73] This study, undertaken by LaDuke (2000), examined the perceptions and experiences of nurses in the USA who had been disciplined for professional misconduct.[74] The findings from this research indicated that the impact of being disciplined went further than the

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[68] McGivern G., Fischer M., Medical regulation, spectacular transparency and the blame business *Journal of Health Organisation and Management* 24(6) (2010): 597-610.
[69] ibid.
[70] ibid.
[71]Brennan n1 above; Sharp L.K., Bashook P.G., Lipsky M.S., Horowitz S.D., Miller S.H., Specialty board certification and clinical outcomes: the missing link *Academic Medicine* 77 (2002):534- 542.
[72] Quick n16 above; Morrison J., Wickersham M.S., Physicians disciplined by a state medical board *Journal of the American Medical Association* 279 (1998): 1889-1893.
[73] LaDuke S., The effects of professional discipline on nurses' *American Journal of Nursing* 100(6) (June 2000): 26-33.
[74] ibid.

punishments that were levied against the nurses when found guilty.[75] LaDuke's (2000) study was limited as it had a poor response rate (19 per cent) and did not explore in depth the additional comments that were provided by the participants.[76] Nevertheless, the observations that were offered indicated that the nurses who had been disciplined experienced loss of confidence both in themselves and in others with whom they worked.[77]

When searching the literature for evidence related to the research question it was established that there was very little available data on the views and experiences of UK midwives in terms of regulation and the NMC. The studies which explored healthcare practitioners' perceptions of regulation focused in the main on the medical profession and did not relate directly to midwives. Further these studies were too small to be generalizable, and were undertaken in the USA. As such, it is difficult to extrapolate their findings to the very different context of the UK. In terms of the current research question, the results of these studies do nevertheless draw attention to the negative perceptions of the regulator and its ability to positively influence the behaviour of registrants.

1.3.3 Statutory Supervision of Midwives: Reviewing the Literature

Statutory supervision of midwives has formed part of the regulatory framework for midwives in the UK since the first Midwives Registration Act in 1902.[78] It has undergone more empirical scrutiny than any other regulatory activity connected to midwifery governance in the UK. This has included a range of studies which have generated diverse findings. Henshaw et al., (2013) in a recent literature review,[79] evaluated nineteen studies, and found that thirteen had been

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[75] ibid.
[76] ibid.
[77] ibid.
[78] Midwives Act 1902 C.17 (England and Wales).
[79] Henshaw A., Clarke D., Long A.F., Midwives and supervisors of midwives' perceptions of the statutory supervision of midwifery within the United Kingdom: A systematic review *Midwifery* 29 (2013):75-85.

conducted before the publication of contemporary NMC *Midwives Rules and Standards*.[80] Some of the studies reported by Henshaw et al. have particular relevance to the focus of the current study and have therefore been reported below. These authors found that the empirical research currently available may be limited and dated, and that further research needs to be undertaken which would help to inform future regulatory frameworks in midwifery.[81] Henshaw et al. additionally note that there was inadequate detailed evidence which endorses the manner in which statutory supervision contributes to safe quality care provision in the maternity services.[82] This was a sentiment which was echoed by the *Kings Fund Review* (2015) who reported that there was limited data which demonstrated that supervision prevented midwives from being referred to the NMC for fitness to practice issues.[83] This report did however recognise that the lack of evidence was in part due to limitations in the NMC's own data collection processes.[84]

In the context of the current study which aims to explore midwives' perceptions of the regulatory framework including statutory supervision, one of the studies reviewed by Henshaw et al. was that of Stapleton et al. (1998). These researchers examined midwifery perceptions of supervision and found that knowledge and understanding of the statutory framework was varied, with fundamental differences being noted between supervisors and midwives.[85] In Stapleton et al.'s (1998) study, 168 in-depth interviews were carried out with supervisors of midwives and midwives across six sites involving a variety of grades and areas of practice.[86] These authors note that the participants thought that supervision was necessary to protect them

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[80] Nursing and Midwifery Council (NMC) *Midwives Rules and Standards* (NMC; London, 2012a).
[81] Henshaw, Clarke and Long n79 above at 84.
[82] Henshaw, Clarke and Long n79 above at 84.
[83] Baird R., Murray R., Seale R., Foot C., Perry C., *Kings Fund Review of Midwifery Regulation* (Kings Fund; London, 2015).
[84] ibid.
[85] Stapleton H., Duerden J., Kirkham M., *Evaluation of the Impact of Supervision of Midwives on Midwifery Practice and the Quality of Midwifery Care* (English National Board (ENB); London, 1998).
[86] ibid.

from complaints and litigation.[87] In this study the issue of monitoring of standards of care by the supervisors of midwives was considered by participants to be oppressive and, as such, prevented the development of an empathetic association between supervisors of midwives and the midwife.[88] Again, another study reviewed by Henshaw et al. was Williams (1996) qualitative study which explored the supervisor/supervisee relationship and recommended that the supervisors of midwives should be considered as a 'professional friend', who possesses substantial experience in the clinical arena with which to support the midwife.[89]

This issue of gaining support through the supervisory relationship was similarly highlighted in Ball et al.'s (2002) study. In this study, which examined the reasons midwives left the midwifery profession, and which included a postal survey of 1975 midwives (with a response rate of 52 per cent) and 28 ethnographic interviews with midwifery participants, the researchers found that junior midwives were more likely to feel unsupported by supervision than more senior colleagues.[90] This concept of lack of support was also reported in McDaid and Stewart-Moore's (2006) research.[91] In McDaid and Stewart- Moore's (2006) study, midwives were asked about their views and opinions of the role of statutory supervision of midwifery in Northern Ireland.[92] In this research, participants spoke about an inequitable relationship that existed between the supervisor and supervisee such that all of the participants were 'grateful or thankful they did not need supervision', as it was perceived primarily as a mechanism for addressing problems.[93] Overall this lack of confirmation in the empirical literature that

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[87] ibid.
[88] Stapleton H., Kirkham M., Supervision of Midwives in England 1996-1997 in Kirkham M., ed. *Developments in the Supervision of Midwives* (Books for Midwives Press; Oxford, 2000): 61-92.
[89] Williams E.M.J, Clinicians views of supervision in Kirkham M., eds. *Supervision of Midwives* (Books for Midwives press; Oxford, 1996):142-162.
[90] Ball L., Curtis P., Kirkham M., *Why do Midwives Leave?* (Royal College of Midwives (RCM) and the Department of Trade and Industry Partnership Fund, 2002).
[91] McDaid C., Stewart-Moore J., Supervision: how can the gap be bridged? *Midwives: The official Journal of the Royal College of Midwives* 9(5) (2006):180-183.
[92] ibid.
[93] ibid.

statutory supervision facilitates the protection of the public is challenging given that concerns about the provision of maternity care persist, [94] and claims of negligence and litigation continue to increase.[95]

There is a rich and evolving literature which examines the regulation of health care. However the research tends to be dominated by studies conducted at institutional level. Those studies that consider the individual healthcare professional instead of the institution tend to focus on the medical profession and the experience of doctors. Much of the existing literature is focused on the US experience, where regulatory frameworks and practice experiences are very different. Further given the pace of reform and change within health service regulation, much of the existing literature, particularly in relation to statutory supervision of midwifery, predates the current NMC *Midwives Rules and Standards*.[96] This review of the literature has demonstrated that there is a lack of high quality empirical research which examines midwives' perceptions of the regulatory framework and addresses the research question posed in this study.

1.4. Methodology

The current study was designed to offer a socio-legal exploration of midwifery governance frameworks, which might seek to fill some of the gaps in the existing literature, as identified above. [97] Ewick and Silbey suggest that socio-legal studies may be defined as the exploration of the function of law in shared societal situations in an attempt to understand the influence

[94] Knight et al n11 above.
[95] National Health Service Litigation Authority (NHSLA) *NHSLA Risk Management Standards 2013-2014* (NHSLA; London, 2013a).
[96] NMC n78 above.
[97]Fitzpatrick P., Being Social in Socio-Legal Studies *Journal of Law and Society* 22(1) (March 1995): 105-112; Cotterrell R., Why Must Legal Ideas be Interpreted Sociologically *Journal of Law and Society* 25(2) (June 1998): 171-192.

that each has on the other,[98] in this instance the impact that regulation has on facilitating safe midwifery care in practice. This study was initiated as a result of my interest in how midwives perceive governance, its impact on their practice and the relationship between the pregnant woman and the midwife. By employing a strategy which examines the 'lived experience' of the subjects, their understanding of regulation and its influence on the midwives' role may be described and analysed.[99] Importantly for the current study, in so doing the midwife's actions may be understood from the individual's own perspective.[100] The resulting data can then be utilised to determine whether, in the view of the participants, the regulatory framework supports or undermines the statutory aim of protecting the public. As acknowledged above, the study cannot hope to provide a definitive answer to the question of whether the regulatory framework has operated to facilitate safe care. It can, however, hope to offer new insights by giving voice to one significant group of actors, namely midwives, whose perspectives are not well represented in the existing literature.

The chapter will now explain the methodological techniques that have been employed to obtain and analyse the empirical data in this thesis with regards to the midwives' perceptions and experiences of governance and regulation in the clinical setting today. The study draws on both quantitative data gathered in a survey and qualitative data from semi-structured interviews. The following section will review the ethical issues which were identified and addressed prior to undertaking the empirical research (1.4.1), it will then examine the research strategies used to collect the data (1.4.2 and 1.4.3), and the methods that have been drawn upon to analyse the data (1.4.4).

[98] Ewick P., Silbey S.S., The Social Construction of Legality in author's ed. *The Common Place of Law: stories from everyday life* (University of Chicago Press; London, 1998):33-53.
[99] van Manen M., *Researching lived experience: Human science for an action sensitive pedagogy* (State University of New York Press; Albany, 1990).
[100] Bogdan R., Taylor S.J., *Introduction to Qualitative Research Methods: A Phenomenological Approach to Social Sciences* (Wiley; New York, 1975):13-14.

1.4.1 Ethical Considerations

As this study involved interviews with human subjects, it was a requirement that ethical approval for the study was obtained from the Higher Education Institution supporting the research study and the local NHS Trusts from where most of the participants would be drawn, prior to the commencement of the study.[101] This is in accordance with the guidance in the Department of Health (2011) *Governance Arrangements for Research Ethics Committees* document, which recommends that research that involves NHS staff who are recruited as a consequence of their professional role does not necessitate NHS REC (Research Ethics Committee) review, but does however require authorisation from the relevant local NHS Trust Research and Development (R and D) offices.[102]

The ethical guidelines produced by these organisations, which were consulted as a result of the ethical review process, emphasise the importance of consent and beneficence as well as confidentiality.[103] Recognition of and commitment to these principles is considered an essential part of the research process when conducting research that involves people.[104] Within this process, strategies were therefore devised to address concerns related to consent, risk and confidentiality.

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[101]Ethical approval for this study was sought from University of Kent Law School the Research Ethics Advisory Group; East Kent Hospitals University NHS Foundation Trust Research and Development Department; Maidstone and Tunbridge Wells NHS Trust Research and Development Department.

[102] Department of Health (DH) *Governance Arrangements for Research Ethics Committees (GAfREC)* (DH; Leeds, May 2011a).

[103]University of Kent (UOK) *Code of Ethical Practice in Research* (UOK; Canterbury, 2009); Socio Legal Studies Association's *Statement of Principles of Ethical Research Practice* (January 2009) http://www.slsa.ac.uk/images/slsadownloads/ethicalstatement/slsa%20ethics%20statement%20_final_%5B1%5D.pdf (accessed 29/01/12).

[104] World Medical Assembly (WMA) *World Medical Association Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects* (WMA; Edinburgh, October 2000).

1.4.1.2 Consent and the Risk of Harm

Before commencing the survey,[105] the participants were provided with an introductory letter which outlined the nature and purpose of the research, and the demands it would place on them if they agreed to take part in the study. Following consideration of the information they could then choose to consent to participate in the research.[106] It was assumed that by completing the survey that participants had given their consent.

An information sheet (see appendix one), was provided to participants before the semi structured interviews were conducted. This gave the participant the opportunity to have any queries clarified so that informed, written consent could be obtained prior to commencing the interviews (see appendix two for a copy of the consent form). Furthermore, they were made aware that they could withdraw from the research at any time should they choose, although no participant chose to do so. Voluntary, informed consent to participate in research in this manner endorses the subject's right to self-determination and reinforces the respect for that person by the researcher. [107] As such it was considered pivotal to the empirical research activity.

The midwives who took part in the research study, either in the survey or the semi-structured interviews, were not expected to be exposed to physical risks or harm as a result of participating in the study as they would not be subjected to procedures or treatments. However, within the research process it is also essential to facilitate the reduction of psychological harm to participants.[108] Therefore prior to the interview being carried out it was determined that in the event that participants became distressed or embarrassed during the interview, for example in relation to incidents in practice where care provision had been poor or where there had been a

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[105] In this chapter the term survey will be applied to both the online survey and the paper questionnaire methods that were used to collect data for the quantitative arm of the research.
[106] Tangwa G.B., Ethical principles in health research and review process *Acta Tropica* 1125(2009):52-57.
[107] Polit D.E., Hungler B.P., *Essentials of Nursing Research: Methods, Appraisal and Utilization* 3rd ed. (Lippincott; Philadelphia, 1993); Knudson P.L., Ethical Principles in Human Subject Research *Archives of Medical Research* 32(2001):473-474.
[108] Polit and Hungler ibid at 74.

poor outcome, that the interview would be suspended whilst the researcher offered assistance and alternative avenues of support for the participant. In this way it was hoped that the welfare and safety of participants would be maintained.[109] This strategy was considered an important element of the study as in doing so the research would not unduly impact on the participant.[110] In the event the participants did not experience any psychological difficulties throughout the interview process and as such the strategy was not implemented or required.

Equally, in the discussions that took place prior to commencing the interviews, the participants were made aware that if information about perceived poor practice or poor outcomes was disclosed during the interview, that the interviewee would be informed of the need to divulge this information to the participant's supervisor of midwives or midwifery manager so that the identified issues could be investigated in more detail. Although this might present a conflict of interest for me as the researcher,[111] as a registrant midwife and healthcare professional I have a duty of care to pregnant women and as such must reveal such material to ensure safe practice is maintained.[112] Within this empirical research the information that was provided by the participants did not identify unsafe practice, and so again there was no need to invoke this procedure.

1.4.1.3 Confidentiality, Anonymity and Data Protection

Participants within research studies have the right to privacy and it is therefore the responsibility of the researcher to ensure that the research is as discreet as is possible.[113] As such within the consent process, study participants were informed that confidentiality, anonymity and data protection would be assured. This was believed to be particularly important

[109] Roberts C., *Ethical Guidelines* (Social Research Association; London, 2003).
[110] Bryman A., *Social Research Methods* 4th ed. (Oxford University Press; Oxford, 2012):129-155.
[111] Roberts n109 above.
[112] Nursing and Midwifery Council (NMC) *Raising concerns: Guidance for nurses and midwives* (NMC; London, 2013a).
[113] Polit and Hungler n107 above.

as the participants were drawn from a specific setting in the South East of England, a relatively narrow geographical area, which might make re-identification more likely.[114] The online survey, which was constructed using a secure server and which encrypted responses, did not contain any names of participants or any other identifying information.[115] The invitation email which was sent to participants inviting them to complete the online survey was accessed by a separate link contained in the email. The researcher did not have access to online survey participants' responses through this email which facilitated anonymity and confidentiality of the respondents, as anonymity is secured when the researcher is unable to connect a subject with the data that the subject has provided.[116] The participants who wished to access a paper questionnaire or summary of the results or participate in the interviews were invited to provide email contact details. These details were not linked to the survey responses which enabled anonymity to be maintained. The data produced was kept in a secure place during the study, which only the researcher could access. All data will be destroyed two years after the completion of the doctoral study.[117]

For the face to face semi-structured interviews, participant contact information has been kept separately from the transcripts from the interviews so that participants could not be identified.[118] All information derived from this process, including information about individual service users, was anonymised to help to maintain confidentiality.[119] This was continued throughout the analysis of data and in the presentation of results in this thesis through the use of pseudonyms when direct quotes from participants are employed.

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[114]Flick U., *Introducing Research Methodology: A Beginners Guide to Doing a Research Project* (Sage; London, 2011).

[115] Data Protection Act 1998.

[116] Polit and Hungler n107 above.

[117] n 115 above.

[118] Wiles R., Crow G., Heath S., Charles V., The Management of Confidentiality and Anonymity in Social Research *International Journal of Social Research Methodology* 11(5) (2008):417-428.

[119] Hennink M., Hutter I., Bailey A., Ethical Issues in Qualitative research in author's ed. *Qualitative Research Methods* (Sage; London, 2011):61-79.

1.4.2 Sampling

The process of selecting participants for an empirical research study is referred to as sampling.[120] The choice of the sample should be related to the research question in the context of the nature and objective of the investigation. In this study the participants were purposively selected for their knowledge and experience of the regulation and governance of midwifery. [121] An important element of the sampling process in this study, was that it should be representative of a wide range of categories of qualified midwives working within the locale.[122]

As a practising midwife myself, working within the South East of England, this position helped me to gain access to the community of midwives who also practice in this area. I am currently a Senior Midwifery Lecturer with a local Higher Education Institute and as part of that role I support students and midwives in an educational capacity, in the clinical setting in a local NHS Trust. Additionally, I have in the past been employed as a clinical midwife in another NHS Trust in Kent and remain in contact with a number of the midwives who work in the Trust. Whilst I am a member of the local midwifery population, I am not currently (and was not at the time of interview) in a position of authority over the participants. As such, there was no potential problem of undue influence or that their responses would be biased as a result of our relationship.

Drawing on the professional contacts established through this position within the local midwifery community, I was able to approach the Heads of Midwifery (one of whom agreed

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[120] Pitney W.A., Parker J., Conducting a Qualitative Research Study in author's ed. *Qualitative Research in Physical Activity and the Health Professions* (Human Kinetics; Northern Illinois University, 2009): 29-40.

[121] Cleary M., Horsfall J., Hayter M., Data Collection and Sampling in qualitative research: does size matter? *Journal of Advanced Nursing* 70(3)(2014):473-475; Denzin N., Lincoln Y., *Handbook of Qualitative Research* 2nd ed. (Sage; London, 2000); Collingridge D.S., Grant E.E., The quality of qualitative research *American Journal of Medical Quality* 23(5)(2008):389-395; Paton M.Q., *Qualitative Evaluation and Research Methods* 2nd ed. (Sage; London, 1990).

[122] Bryman n110 above: 415-429: Bryman refers to this type of sampling as criterion sampling where sampling takes place across all units (or individuals) that meet the criteria.

to participate in the study) to gain their approval for conducting this research study. The impact of this commonality within this group of midwives, was that I was accepted and trusted by the managers,[123] who gave their permission for me to approach the midwives working within their NHS Trust. Once ethical approval was granted from the Research and Development (R and D) departments at the NHS Trusts where the midwives were employed, these midwifery managers gave me access to the database of email addresses for midwives working in these two Trusts. Following which I was able to send emails to a large number of midwives.

Interestingly, although the midwifery managers initially advised me that the midwives might be unresponsive to the request to participate in the survey and the semi-structured interviews, when I sent the email invitations to participants inviting them to complete the questionnaire, the response from the midwives appeared to demonstrate that the midwifery managers' fears were unfounded. Upon hearing of the study, midwives willingly completed the survey and volunteered to participate in the interviews. As a result of my position within the local midwifery population, there may have been an assumption amongst participants that I would have been likely to share their midwifery interests, commitment and values, which might have generated a desire to become involved in the research.[124]

Consequently, I achieved a 70% (n≠132) response rate to the survey and conducted 20 semi-structured interviews. Throughout the entire process of the study, midwives were genuinely interested and supportive of my research, and would often take the time to discuss the concept of midwifery governance and the impact that it has on their ability to provide safe care to

[123] Dwyer S.D, Buckle J.L., The Space Between: On Being and Insider-Outsider in Qualitative Research *International Journal of Qualitative Methods* 8(1)(2009):54-63
[124] ibid at 58

pregnant women. As such my position within this community assisted with the collection of data for my study.[125]

In this study, I was able to gather a range of diverse types of experience of regulation,[126] where differences in the sample included: length of time the participant had been qualified, whether or not they were a supervisors of midwives, whether they worked either as an independent midwife or within the NHS, and whether or not they had any experience of developmental or supervised practice within the statutory supervision of midwives framework. For those midwives working within the NHS, the criteria also incorporated the different pay scales (from band five to band eight) which represented midwives with a range of experience from the most junior (band five) to the more senior in positions of management (band eight). In ensuring such a broad sample, it was anticipated that the findings might then be more relevant and applicable to the wider population of qualified midwifery registrants working in the UK.[127]

The survey was distributed to a small sample of 192 of the 40,000 midwifery registrants working in the UK,[128] in the NHS or as independent midwives in the South East of England between May 2012 and March 2013. In order to achieve a high response rate the topic needed to be interesting or relevant to the participants.[129] In this study a response rate of 70 per cent (n≠132), appears to indicate that the topic was important and one that participants had opinions and views on that they wished to share with the researcher who was also a midwife. Further the high response rate for the small sample size was considered to be more useful to the integrity of the study than a larger sample that might generate a lower response rate, within the time frame given for the research.[130] Additionally, the respondents who completed the survey

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[125] ibid

[126] Sandelowski M., Focus on Qualitative methods: sample size in qualitative research *Research in Nursing and Health* 18(1995): 179-183.

[127] Silverman D., *Doing Qualitative Research* 2nd ed. (Sage; London, 2008).

[128] NMC n 24 above.

[129] Bryman n110 above: 653-682.

[130] Evans S.J.W., Good Surveys guide *British Medical Journal* 302(1991):302-3.

had a range of experience across the midwifery spectrum which may be seen to support this claim.

The on-line survey was administered via a web address which was sent to the participant's email address. The email contact addresses were accessed via the local Kent Primary Care Trusts. The independent midwives' email contact details were obtained via online information from the Independent Midwives' Association. An invitation email was sent to the potential participants that contained information about the research and a link to the online survey. The invitation email provided the participants with the opportunity to contact me via email if they wished to take part in a follow up semi-structured interview.

When conducting an online survey bias may occur as a result of non-response from individuals and there is some evidence to suggest that online surveys often generate low response rate.[131] In the current study in order to achieve as high a response rate as possible,[132] the participants were offered within the introductory email, the opportunity to complete a paper version of the online survey questions. This was undertaken, as paper questionnaires are generally considered to have higher response rates than online surveys.[133] This was confirmed in the study as 88 paper questionnaires were requested and returned whilst 46 participants completed the online survey. Within the literature when research of this nature is undertaken a response rate of 60 per cent or more is considered the minimum necessary to ensure that the sample is representative of the population and large enough to produce robust results.[134] As such the

[131] Sheehan K., Email Survey Response Rates: A Review *Journal of Computer Mediated Communication* 6(2) (January 2001) http://onlinelibrary.wiley.com/doi/10.1111/j.1083-6101.2001.tb00117.x/full (accessed 27/12/14).
[132] Evans n130 above.
[133] Nulty D.D., The adequacy of response rates to online and paper surveys: what can be done? *Assessment and Evaluation in Higher Education* 33(3) (June 2008):301-314.
[134] Rubin A., Babbie E., *Essential Research Methods for Social Work* 2nd ed. (CENGAGE Learning; Belmont C.A., 2010); Herold J.M., Virgil Peavy J., Surveys and Sampling in Gregg M.B., *Field Epistemology* (Oxford University Press; Oxford, 2002): 196-216; Fincham J.E., Response Rates and Responsiveness for Surveys, Standards and the Journal *American Journal of Pharmacological Education* 72(2) (15 April 2008):43.

response rate for this study exceeded the minimum standard and there is therefore some grounds for believing that the sample is broadly representative of midwives practising in the South East of England.

The study attempted to recruit participants who were representative of the broader population of midwives in the UK. The demographic of participants who completed the survey was as follows; 95 per cent of respondents (n=127) were employed within the public sector whilst the remaining five per cent of midwives (n=7) were either working currently in independent practice or had recently been engaged as independent midwives. Whilst these figures are disproportionate to actual numbers of midwives working in the public sector compared with those working as independent practitioners where it is estimated that only 0.4 per cent of midwives are employed independently in the UK,[135] within this study the over representation of IMs was a deliberate and important strategy as these practitioners were likely to offer a different perspective of governance and regulation. 99 per cent of the participants (n=133) were females who had gained their midwifery qualification within the United Kingdom, compared to 99.6 per cent of women in the national figures for midwifery.[136]

The sample also contained a broad level of experience: 37 per cent of participants (n=50) had been in practice for five or less years; 12 per cent of participants (n=16) had been in practice between six to ten years; 28 per cent of midwives (n=37) had been in practice between eleven and twenty years; whilst 23 per cent (n=31) had had more than twenty years' experience as a registered midwife. Within the sample, those participants who were employed in the NHS also held a variety of positions: 12 per cent (n=15) of the participants were band five midwives, 67 per cent (n=81) were band six midwives, 13 per cent (n=16) held a band seven role, and 8 per

[135] Department of Health (DH) *Independent Midwives: Insurance options outlined* (DH; London, 6th March 2014).
[136] Nursing and Midwifery Council (NMC) *Statistical Analysis of the Register 1 April 2007 to March 2008* (NMC; London, 2008b): in the most current data the number of men working as a midwife in the UK is 0.4%.

cent (n=10) were working as a band eight or above.[137] These figures particularly those which relate to the pay banding framework correlate with workforce figures produced nationally.[138]

The midwives who took part in the survey were all based in the South East of England, where the provision of maternity services includes midwives who provide care in both the acute and community settings.[139] Within the sample 51 per cent (n=68) worked in the acute hospital environment, whilst 42 per cent (n=56) were practising in the community setting. These figures reflect the large geographical area over which care is provided in the South East Coast region, which includes both urban and rural locations. It is therefore recognised that the sample might not reflect the experiences of midwives in areas where provision of care is more predominately urban or rural in nature and whilst there is no apparent reason why these factors should have a significant impact on midwives' views of regulation, this must remain a matter for future research.

The face to face interviews began towards the end of the time allotted for the survey. Four pilot interviews were conducted drawing on contacts and associates known to the researcher.[140] This permitted the testing of the interview schedule (appendix three for a copy of the interview schedule) to determine whether it was fit for purpose. As a result some of the questions were refined. For example in the pilot interviews, midwives were asked to consider perceptions of

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[137]National Health Service (NHS) *Agenda for Change (AfC): Pay Rates* (NHS; London, 1st April 2014): the national pay system for the NHS known as *Agenda for Change (AfC)* applies to all directly employed staff except doctors and the most senior managers. In the NHS pay scales or bands are employed to denote seniority of positions, band 5 positions are usually allocated to midwives who are newly qualified; band 6 to those who hold some responsibility within their role; band 7 roles are normally given to midwives with some managerial responsibility including for example managing the labour ward or as a community team leader, whilst band 8 midwives are usually those in management positions such as risk manager or matrons.

[138] National Audit Office (NAO) *Maternity Service in England* (Department of Health (DH); London, 8th November 2013); Midwifery 2020 Programme *Midwifery 2020 Workforce and Workload Final Report* (Workforce and Workload Workstream Group; Scotland, 31st March 2010).

[139] East Kent Hospital University NHS Foundation Trust (EKHT) *Pregnancy and Childbirth: Maternity Services in East Kent* http://www.ekhuft.nhs.uk/patients-and-visitors/services/a-z-of-services/pregnancy-and-childbirth/ (accessed 29/12/2014).

[140] Kvale S., Brinkmann S., Conducting an Interview in author's ed. *Interviews: Learning the Craft of Qualitative Research Interviewing* 2nd ed. (Sage; London, 2009): 123-141.

statutory supervision of midwifery in general terms. However this was later amended to include specific comparative questions about whether the nursing profession (which is not regulated in the same way), should also have this form of statutory regulation. This enabled an exploration of what the advantages and disadvantages to the nursing profession might be if this were to be implemented, and permitted a more nuanced understanding of the influence of statutory supervision for midwives. The revised interview schedule was then adopted in subsequent interviews.

Following the interview, the participants were asked to recommend other participants who met the study criteria. This method of recruitment is referred to as snowball or chain sampling as the number of participants in the study is increased as each new person is recruited to the study.[141] The advantage of this type of sampling is that recruitment to the study takes place through a familiar and reliable individual who can outline the process to potential participants and increase participation as a result.[142]

Nevertheless it is acknowledged that snowball sampling may not enable a representative sample of the midwifery population.[143] As such, in an attempt to ensure that the sample reflected the wider population of midwives working in the UK with a range of experience, after ten interviews had been conducted, the sample was reviewed. As a result of this process it was identified that there was a need to recruit more midwives who had been qualified less than ten years and who worked in the NHS. Recruitment was enhanced by participation in the survey, with one volunteer being gained from the online survey, and three from the paper questionnaire. These midwives had differing levels of experience but included registrants who had less than ten years' experience post qualification. In this way the specific criteria for the study amongst

[141] Hennink, Hutter, Bailey, n119 above: 169-200.
[142] ibid.
[143] Bryman n110 above: 183-207.

midwifery registrants who had a diverse experience of regulation and governance in practice could be maximised.

This sample size should be sufficient to offer important insights into at least some of the perceptions and experiences of regulation for this group of healthcare professionals who are currently under-studied in the literature. Further, midwifery regulation has undergone and continues to experience significant change,[144] and as such this study is limited in so far as it represents the views and opinions of a particular cohort of midwives at a particular point in time. It is hoped that further studies may emerge to confirm or refute these findings.[145]

The sample of midwives (n=20) who participated in the semi-structured interviews were as follows: all participants (n=20) were female who had gained their midwifery qualification within the United Kingdom. 85 per cent (n=17) of the sample were employed within the public sector whilst 15 per cent (n=3) were currently or had recently been engaged as an independent practitioner. Again, whilst higher than the national average, this was felt to be useful, as this cohort was likely to contribute different experiences. The sample of participants in the semi-structured interviews therefore consisted of: 40 per cent (n=8) who had practised as a midwife between nought to ten years, 30 per cent (n=6) who had been in practice between eleven to twenty years, whilst a further 30 per cent (n=6) who had been a registered midwife for more than twenty years. Figure one below is a diagrammatic representation of participants who took part in the survey and the semi-structured interviews in terms of their years of experience.

[144] Department of Health (DH) *Government Response to the NHS Future Forum Report* (The Stationary Office; London, June 2011b); Parliamentary and Health Service Ombudsman (PHSO) *Midwifery supervision and regulation: recommendations for change* (The Stationary Office; London, December 2013).
[145] Silverman n127 above at 213.

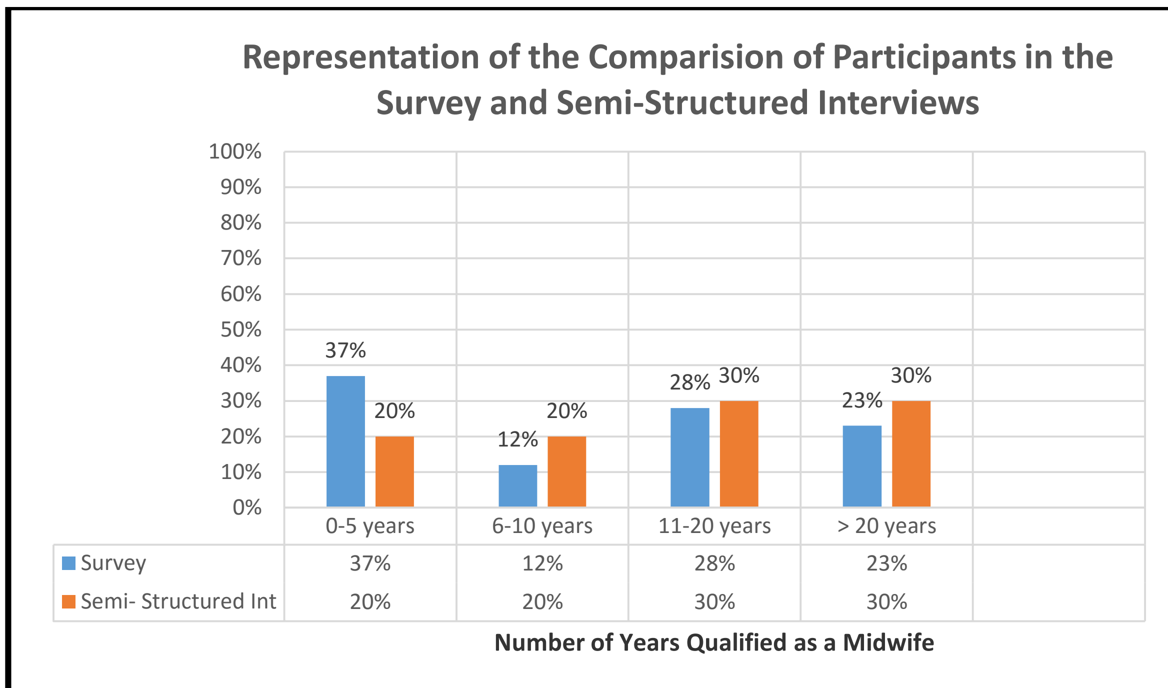

Fig 1.

For those midwives working in the NHS the sample (n=14) was broadly representative across the NHS pay banding structure.[146] The exception to this was band five midwives, who were not included in the semi-structured interviews. Within the NHS, band five is the entry level pay band which is normally awarded to newly qualified midwives.[147] Therefore whilst it is acknowledged that band five midwives would have some experience of governance, it was decided that they would not have the necessary depth of experience to be able to participate in the interviews with confidence. The sample consisted of the following: 57 per cent (n=8) were employed as band six midwives, 29 per cent (n=4) held a band seven post and a further 14 per cent (n=2) were employed as band eight midwives. As with the survey, there was an equal representation of midwives in the NHS who were practising in either the acute hospital setting (51 per cent, n=11), or the community environment (49 per cent, n=9). Within the sample, 20 per cent (n=4) were supervisors of midwives, this is somewhat higher than the Nursing and

[146] n137 above: band 6 positions are usually given to midwives who have ben qualified at least one year and who have completed additional competencies which are identified by the local NHS Trusts employer.
[147] n137 above.

Midwifery Council (NMC) estimates.[148] However it was felt that participants with direct experience of the statutory supervision of midwifery framework might offer some valuable insights when compared to midwives who were not supervisors of midwives. Moreover, it was believed that the inclusion of four supervisors of midwives, although recognised as a small sample, would help to produce a more balanced view of the opinions of this specific group.

The collection of data can be discontinued when saturation or redundancy is reached. Redundancy may be described as the point at which after carrying out numerous interviews concepts reoccur several times, and the interview process appears to produce no new additional ideas or themes.[149] Saturation is defined as being reached when all the research questions have been comprehensively examined and no additional concepts or themes appear in later interviews.[150] Saturation was reached in this study after a total of twenty midwives, who met the criteria, took part in the semi-structured interviews. This was in accordance with the initial estimate which was identified at the start of the research study. At the saturation point, the data was extensively examined and it was determined that themes were being repeated without generating any new additional concepts.

1.4.3 The Research Strategies

A mixed methods approach was employed for data analysis, combining both qualitative and quantitative research techniques.[151] This approach is useful when, as in the current study, the research question requires a realistic and contextual understanding of the participant's opinions

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[148] Nursing and Midwifery Council (NMC) *Supervision, Support and Safety: report of the quality assurance of local supervising authorities 2012-2013* (NMC; London, 2013b): this report identifies that in the South East Coast region there are approximately 180 supervisors of midwives to 2600 practising midwives which equates to 1:14.The NMC recommended ratio of supervisors of midwives to midwives is 1:15.
[149] Cleary and Horsfall n121 above.
[150] Trotter R.T., Qualitative research sample design and sample size: resolving and unresolved issues and inferential imperatives *Preventive Medicine* 55(5) (2012): 398-400 at 399.
[151] Bryman n110 above: 627-652.

and views.[152] The uniting of multiple research strategies in this manner is defined as triangulation, whereby the researcher seeks to merge the data at a point where an authentic depiction of reality may be obtained.[153] Equally qualitative and quantitative research methods when combined may provide rigour to the assessment and meaning of the constructs under consideration which enables the researcher to draw upon the strengths of each research methodology.[154] The following section will now examine the quantitative (1.4.3.1) and qualitative (1.4.3.2) research methods that were used to gather data for this study.

1.4.3.1 Quantitative Research Methods

Quantitative research may be defined as the collection of numeric data.[155] It may also be described as a goal orientated technique where the intention is to achieve unbiased results through the broad standardisation of the process wherever possible.[156] As noted above, quantitative methods were employed in the form of a survey which I designed (see appendix four).[157] The survey contained three sections: the first set of questions related to individual participant data, the second group dealt with midwifery legislation and the third with clinical guidelines. Some questions had a number of predefined answers where participants were required to choose one response. Other questions permitted the participant the opportunity to choose more than one response. Additionally some questions had a free form section which enabled the participant the opportunity to provide qualitative responses. The questions were tested initially by distributing the questionnaire to a small sample of midwives prior to it being

[152] Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, 1(2), 112-133.
[153] Polit and Hungler n106 above at 448.
[154] Bryman A., Integrating quantitative and qualitative research: How is it done? *Qualitative Research*, 6(1) (February 2006): 97-113.
[155] Polit and Hungler n107 above at 444.
[156] Flick n114 above.
[157] McCabe S.E., Comparison of Mail and Web Surveys in Collecting Illicit Drug Use Data: A Randomised Experiment *Journal of Drug Education* 34(2004):61-73: McCabe suggests that there is limited evidence to suggest that the mode of administering web based or paper questionnaires has any significant impact on the findings.

made available to the participants in the study, in order to ensure that the questions were focused appropriately in relation to the research question.[158] As a result, some minor adjustments were made.

The survey permitted me access to a larger number of participants than would have been attainable through the employment of the qualitative semi-structured interview process alone. This enabled the identification of themes that could be explored in more detail in the qualitative section of the empirical research. It also permitted some confidence that the views solicited in the semi-structured interviews were broadly representative (or not) of a larger sample. Therefore although it is recognised that the total number of participants involved in this study is relatively small (n=132 in the quantitative research arm and n=20 in the qualitative research arm) it is envisaged that the findings of the study may offer a more complete picture of the participants views of regulation and governance as a result of combining together both quantitative and qualitative research methods.[159]

1.4.3.2 Qualitative Research Methods

Qualitative research has as its focus the collection of statements and comments which are analysed to make sense of the participant's experience of that phenomenon.[160] It includes techniques for carrying out investigations into how humans encounter, perceive, comprehend and construct the world around them.[161] It may be understood to be an interaction between existing knowledge and empirical data in a manner similar to solving a cross-word puzzle, whereby the letters provided by answers to solved clues (existing knowledge) are employed to

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[158] Polit and Hungler n107 above at 40.
[159] Bryman n110 above: 627-652.
[160] Bryman A., The end of the paradigm wars in Alasuutari P., Bickman L., Brannen J., eds. *The Sage Handbook of Social Research Methods* (Sage; London, 2008): 366.
[161] Hammersley M., Defining Qualitative Research in author's ed. *What is Qualitative Research?* (Bloomsbury; London, 2013): 1-20; Sandelowski M., Qualitative Research in Lewis-Beck M., Bryman A., Liao T., eds. *The Sage Encyclopaedia of Social Science Research Methods* (Sage; Thousand Oaks CA, 2004) at 893.

help provide part of the answer to the current clue or problem (empirical data).[162] Earlier in this chapter it was identified that there was limited empirical data in the literature in relation to midwives' experiences and perceptions of regulation and governance, which provided the foundation for the current study. Qualitative research methods were therefore employed with the purpose of producing in-depth images of governance and regulation in action, through the collection of deep, probing data which concentrates on the phenomenon being studied.[163]

Within this study, data was collected through the use of semi-structured interviews. Another method of assembling qualitative data that of focus group interviews,[164] was considered but discounted. Whilst I recognise that the focus group interviews might have produced data on the topic from a groups of midwives in an unstructured format, I felt that there were disadvantages to this type of methodology. These included: not being able to exert the same level of control over the group as I would in an individual interview; that the focus group might be difficult to organise with diverse individuals working at different times; there might be a tendency for one or two participants to speak at the same time which might create problems when transcribing the interviews; and likewise there may be participants who might be more vocal than others which would limit the opportunity for some midwives to voice their views and opinions within the group.[165] Following a consideration of the different methods of data collection, I decided that conducting semi-structured interviews with individual participants would be the most appropriate method for this study as it would permit the individual midwives the space and opportunity to explore in detail their views on regulation and governance. This might potentially produce rich data that could then be analysed in the context of the research question.

[162] Haack S., *Evidence and Inquiry: towards a reconstruction of epistemology* 2nd ed. (Prometheus Press; New York, 2009).
[163] Polit and Hungler n107 above.
[164] Polit and Hungler n107 above.
[165] Polit and Hungler n107 above.

Before commencing the interviews, I devised a schedule which consisted of broad questions which allowed the participant to fully explore an issue from a variety of different positions, whilst also allowing me the opportunity to ask further questions in response to significant answers given by the participant.[166] The interviews were conducted in a quiet, secluded environment which was familiar to the participants, either in their place of work or in the participant's own home, as this facilitated relaxed, focused discussions which were free from interruptions. The interviews were typically between forty to ninety minutes in duration and were recorded and transcribed with the permission of the participant. In doing so detailed data could be gathered which would enable a nuanced understanding of how the participants perceive regulation and whether in their opinion it facilitates safe care to pregnant women.

1.4.4 Data Analysis

The analysis of the data was commenced soon after the survey and semi-structured interviews were completed.[167] In the survey, as a result of the way that the questions were structured, the data generated provided a broad picture of the participants' experience and perceptions of governance and regulation. In comparison, the data from the semi-structured interviews enabled the development of this general depiction into a more in-depth appreciation of the midwives' understanding and views of midwifery governance. This detailed picture was constructed from the examination of transcripts from the semi-structured interviews, which were coded prior to the analysis of the data. Coding of data is an essential element of the research process as it enables the researcher to reduce the volume of data to manageable levels which can then be examined in detail.[168]

[166]Kvale and Brinkman n140 above: 123-141; Bryman n110 above: 208-230.
[167] Silverman D., Credible Qualitative Research in author's ed. *Interpreting Qualitative Research Data: Methods for Analysing Talk, Text and Interaction* 2nd ed. (Sage; London, 2006): 219-257; Bryman n110 above: 564-589.
[168] Denzin and Lincoln n121 above.

In the study, the data was analysed and grouped into themes which arose from the transcripts which appeared to be directly related to the focus of the research.[169] As a result of this process, several key themes emerged which provide a substantive focus for the empirical chapters within this study. Thematic analysis may therefore be seen as progressing the analysis of data as it requires the researcher to reflect on the early codes which arose from the analysis of the transcripts with the aim of understanding the connections which linked them together.[170]

It was important that the analysis should be founded on a critical scrutiny of the data and should attempt to avoid anecdotalism.[171] The challenge when conducting qualitative research in terms of the data that is produced is that explanations and analysis may be based on a number of limited examples which might not be representative of the findings in general terms.[172] With the aim of addressing this issue within the analysis chapters, where quotations are used that may be understood to be broadly representative of a significant number of participants, this is acknowledged in the text. When extracts have been employed which are characteristic of the minority of participants this is similarly recognised. Moreover in order to counter the problem of inconsistency still further, triangulation of the results was employed which allowed the findings to be mutually verified.[173]

As a result of thematic analysis, the concepts that arose from the data included concerns with decision making, the impact of risk management and clinical governance, as well as the relationship between the midwife and woman, particularly in relation to woman centred care. These themes determined the way in which the empirical data is presented in the chapters that follow. The centrality of these themes reflects significant changes to the provision of midwifery

[169] Bryman n110 above: 564-589.
[170] Braun V., Clarke V., Using Thematic Analysis in Psychology *Qualitative Research in Psychology* 3(2006): 77-101.
[171] Silverman n167 above: 209-226.
[172] Silverman n127 above: 209-226 at 211.
[173] Bryman n110 above: 627-652.

care over the last three decades which are themselves reflective of important broader shifts in healthcare policy.

1.5 Synopsis of the Thesis

This final section of the chapter sets out the structure of the thesis to follow.

In chapters two and three, the regulatory framework for the governance of midwifery in the UK will be set out in its wider context. As noted above, the changes to the regulation of midwifery can only be fully understood within the broader shifts in government policy. As such, these chapters have two essential tasks. First they will trace the evolution of midwifery regulation from its origins in the first Midwives' Registration Act in 1902 through to the current multifaceted system of control and management of maternity care. Second they will locate this evolving regulatory framework within the wider political reforms. Chapter two will explore the expansion of government policy and legislation in relation to healthcare regulation during the twentieth century, setting out the modifications that were imposed on the provision of health care during the Thatcher administration in the 1980s. The chapter will introduce and critically examine the tenets of neoliberalism and new public management (NPM) which were essential political ideology during the 1980s, and which continue to influence the current provision of maternity care. This discussion will demonstrate that within the maternity services towards the end of the 1980s and early 1990s there was a transformation in the patient – professional relationship as a result of government policy and reform.[174]

Chapter three will continue by examining the reforms of the NHS and maternity services introduced by the (New) Labour Government in the late 1990s and over the following decade. New Labour's so called 'third way' neoliberalism was the impetus for addressing the

[174] Cumberledge J., *Report of the Expert Maternity Group: Changing Childbirth* (HMSO; London, 1993); Ham C., Alberti A., The medical profession, the public, and the government *British Medical Journal* (BMJ) 324 (7341) (April 6th 2002):838-842.

deficiencies of the neoconservative focus of the Thatcher style of neoliberalism.[175] This chapter will examine the regulatory arrangements which were implemented by the Blair administration including clinical governance and risk management strategies which attempted to reduce the risk of poor outcomes and claims of clinical negligence for pregnant women and patients accessing the NHS. This was to be achieved through the provision of standardised 'one size fits all' guidelines and care packages.[176] The discussion will thus both set out the regulations that provide the focus of the empirical data and locate them within a broader political context. As mentioned above the discussion of the regulatory framework will only consider reforms that predate the collection of data and as such will end in 2010.

The next three chapters will present and analyse the empirical research data, and will focus on three key aspects of the current regulation of midwives.

In chapter four, the concept of clinical governance will be considered. The discussion in this chapter will focus on: facilitating safe care in practice through the employment of clinical governance strategies; clinical guidelines, decision making and accountability, and clinical governance and its relationship with woman centred care.

In chapter five, the midwives' perceptions of the Nursing and Midwifery Council (NMC), the concepts of ensuring safe practice through regulation and the question of midwifery accountability will be explored. This discussion will include the midwives' opinions of regulation, and their views of the NMC as a regulator.

In chapter six, the data which related to statutory supervision of midwives will be analysed. The discussion in this chapter will explore statutory supervision in terms of safety in practice,

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[175] Arestis P., Sawyer M., Neoliberalism and the Third Way in Saad-Filho A., Johnston D., eds *Neoliberalism: A Critical Reader* (Pluto Press; London, 2005).

[176] Symon A., *Risk and Choice in Maternity Care: An International perspective* (Churchill Livingston; London, 2006).

midwifery accountability and whether statutory supervision can facilitate the woman centred care policy.

The final chapter (seven) of this study will draw together the themes from the empirical data and will discuss how the regulatory frameworks influence the practice of midwives and the relationships they have with pregnant women who seek their assistance. This chapter will also include a brief consideration of some of the regulatory changes that have occurred since 2010. It will in addition consider how, in light of the concerns that were raised by participants, changes to current regulatory frameworks might better facilitate the protection of the public.

1.6. Conclusion

Since the first Midwives Registration Act in 1902, state control of childbirth and the midwifery profession has burgeoned. Current regulatory frameworks include: clinical governance and risk management strategies, professional regulation and statutory supervision of midwifery. However this regulation has often been implemented without the support of empirical evidence.[177] This paucity of information is particularly marked in relation to the practice of midwives and, as such, it is unclear how effective these regulatory measures are in terms of ‘protecting the public’. Drawing on the views of midwife participants, this thesis will aim to make an original contribution to the question of whether the current regulatory frameworks support or undermine the provision of safe quality care to pregnant women in the UK.

[177] Brennan n1 above.

2. Midwifery Governance in Context 1: (Dis) Locating the Place of the Midwife (1902-1997)

2. 1 Introduction

In the House of Commons debate on the Nurses, Midwives and Health Visitors Bill in November 1978, David Ennals (then Secretary of State for Health and Social Services) observed:

> '[there are] many unique features of midwifery which differentiate that profession from nursing…[specific] clauses in the Bill [are] a recognition of the separate characteristics of midwifery and the need, in order to protect the public, to have adequate control over the way in which midwives operate.'[1]

This comment typifies the nature of the relationship that the midwifery profession has had with the state for more than one hundred years, wherein the distinctive role of the midwife in the provision of care in the maternity services is both acknowledged but constrained. Over the course of the twentieth century, successive governments have sought to regulate and control the practice of midwifery.

This chapter will follow the evolution of midwifery from a time when the midwife's work was informal and unstructured, performed in the main by women outside of the lens of government,[2] through a period of increased regulation,[3] as state regulated welfare replaced traditional liberalism as the dominant political form.[4] It describes regulations which were passed at the beginning of the twentieth century, which have continued to be a fundamental aspect of the governance of midwives in the United Kingdom,[5] and discusses how successive

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[1] HC Deb vol. 958 col. 35. 13 November 1978.

[2] Nutall A., Midwifery, 1800-1920: The Journey to Registration in Borsay A., Hunter B., ed. *Nursing and Midwifery in Britain since 1700* (Palgrave Macmillan; Basingstoke, 2012): 128-150.

[3] Winship J., The UKCC Perspective: The Statutory Basis for the Supervision of Midwives today in Kirkham M., eds. *Supervision of Midwives* (Books for Midwives Press; Cheshire, 1996): 38-57 at 40: Winship defines professional regulation as a method of formal authority which is required with the intention of establishing lawfulness and stability to professional matters.

[4] Midwives Act 1902 C.17 (England and Wales): this will be discussed in more detail below.

[5] ibid.

governments since that time have evaluated the processes associated with childbirth. These reviews have led to the implementation of a series of legislative frameworks which have attempted to direct and organize maternity care provision and the profession of midwifery. This chapter will trace the move away from self-regulation as the preferred model of regulation for health care professionals including midwives.[6] Thus it will show how self-regulation was largely replaced by national welfare regulation following World War II, which in turn was displaced more recently by neoliberal regulation. This later model emphasises state governance of healthcare through the implementation of managerialism and the tenet of New Public Management (NPM).[7]

In exploring the development, role and function of government policy and legislation associated with the governance of midwifery, the aim of the chapter is both to set out the regulation that was introduced over the course of the twentieth century (some of which is still currently in force) and also to locate it in its ideological context, permitting a more detailed and nuanced understanding of what was expected to be achieved by each wave of legislation and its continuing influence today. This will provide the context for understanding the key themes which emerge from the empirical data which are discussed in chapters four, five and six.

The chapter commences by outlining the regulatory strategies that were devised and executed in relation to midwives following the enactment of the first statutory regulation of the medical profession in 1858 (2.2). The chapter proceeds with an examination of statutory supervision of midwifery, its purpose and function (2.3). The focus of the chapter then moves to reflect on how the creation of the welfare state through state interventionists, informed by Keynesian economic theory, together with an emerging belief in science and expertise and national

[6] Allsop J., Jones K., Protecting patients: international trends in medical governance in Kuhlmann E., Saks M., ed. *Rethinking professional governance: international directions in health care* (Policy Press; Bristol, 2008): 15-27.

[7] Peck J., Tickell A., Neoliberalizing Space *Antipode* 34(3) (16/12/2002):380-404; Rose N., *Powers of Freedom* (Cambridge University Press; Cambridge, 1999).

programmes led to the foundation of the NHS. These developments will be explored in the context of the increasing role of the medical profession in the provision of maternity care and the impact that this has had on the nature and character of the work of midwives (2.4). Following this, the chapter will go on to consider the changes introduced as part of Margaret Thatcher's neoliberal agenda which promoted a reduction in the authority of the health care professional in favour of the notion of new public management (NPM) and consumerism and choice in health care (2.5). It will end with the advent of the concept of risk in health care (2.6).

2.2 Health Care Professional Regulation: The Emergence of the Medical Model

Julia Black defines regulation generally as:

> 'the sustained and focused attempt to alter the behaviour of others according to defined standards or purposes with the intention of producing a broadly identified outcome or outcomes, which may involve mechanisms of standard-setting, information-gathering and behaviour-modification.'[8]

Black also highlights that the term 'regulation' has a variety of meanings which are dictated by what the behaviour is that needs to be regulated; who is performing the regulation, be they governments or state institutions; who is to be regulated, for example health care professionals, teachers, the family; and what form of regulation will be devised in order to regulate the behaviour for example rules, monitoring, sanctions or information provision.[9]

In the UK the regulation of health care and the health care professions has been important since at least the 1850s as different strategies have been employed as part of government policy, in order to improve the health of society in broad terms.[10] The first form of regulation for health

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[8] Black J., Critical Reflection on Regulation *Australian Journal of Legal Philosophy* 27 (2002a):1-36 at 26.

[9] ibid: Black also draws attention to the fact that there are many definitions of regulation and cites authors such as Gunningham N., Grabovsky P., Sinclair D., *Smart Regulation: Designing Environmental Policy* (Clarendon Press, Oxford, 1998) 38-50 at 4: who describe it as 'forms of social control available to harness a wide range of actors in addressing a particular problem or set of problems as patterns of social ordering' to emphasise the diversity of regulatory definitions.

[10] Ogus A., *Regulation: Legal form and economic theory* 2nd ed. (Hart Publishing; Oxford, 2004) at 1.

care professionals in the UK was self-regulation which was initiated following the enactment of the Medical Act in 1858,[11] and which was in accord with political *laissez faire* ideology of the time.[12] The 1858 Act established a basic regulatory structure for doctors that ensured that they had control over their training and education. The aim was to engender societal trust in the profession.[13] The implementation of statutory directives and discipline was also part of the drive to generate professional identity and professionalism on behalf of the medical profession. The entrenchment of self-regulation was extended to other health care professionals including midwives over time, as autonomy, particularly in the context of determining standards of competence and skills, was seen as being essential to the provision of effective care.[14]

At the beginning of the twentieth century, it was accepted that the medical practitioner had superior understanding of treatment regimens than the wider public.[15] The medical knowledge and expertise of the medical practitioner was also assumed to be more advanced than that of other health care professionals'.[16] As a consequence, the 'medical model' as it became known, emerged as the dominant method of health care provision in the UK.[17] Foucault argues that the convergence of the state and pathological medicine in a centralised awareness of disease

[11] Allsop and Jones n6 above: 15-27: Allsop and Jones describe self- regulation as the ability to set the rules which control entry to the register for that profession, set standards for practice for that profession and take disciplinary action when practice falls short of the required standard.

[12] Clarke J., Cochrane A., Smart C., *Ideologies of Welfare: From Dreams to Disillusion* (Hutchinson; London, 1987).

[13] Moran M., The Health Professions an international Perspective in Allsop J., Saks M., eds. *Regulating the Health Professionals* (Sage; London, 2002): 19-30.

[14] Kirkham M., Morgan R.K., *Why Midwives Return and their subsequent experience* (Department of Health and Bedfordshire and Hertfordshire Workforce Development Confederation, University of Sheffield Women's Informed Childbearing and Health Research Group; London, 2006); Montgomery J Professional Regulation: A Gendered Phenomenon? in Sheldon S., Thomson M., eds. *Feminist Perspectives on Health Care Law* (Cavendish: London, 1998): 33-51 at 33.

[15] Clarke, Cochrane and Smart n12 above: 48-61.

[16] Harrison S., Pollitt C., *Controlling Health Professionals: The Future of Work and Organisation in the NHS* (Open University Press; Buckingham, 1994).

[17] Wilkins R., Poor Relations: The Paucity of the Professional Paradigm in Kirkham M. *The Midwife-Mother Relationship* 2nd ed. (Palgrave Macmillan; Basingstoke, 2010):66-90; Donnison J., *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth* 2nd ed. (Heinemann; London, 1988); Oakley A., Wise Women and medicine men: changes in the management of childbirth in Mitchell J., Oakley A., *The Rights and Wrongs of Women* (Harmondsworth; London, 1976):17-58; Oakley A., The Trap of Medicalised Motherhood *New Society* 34(689) (1975):639-641: these sources form part of a bigger academic literature on the medical control of the midwifery profession which will be referred to throughout this chapter.

excludes social models of healthcare provision.[18] This may be illustrated in maternity care at the end of the nineteenth century, where male doctors successfully prevented the rise of a predominantly female midwifery workforce from becoming an independent profession.[19] Not only did this demote social knowledge, it also eliminated a significant threat in terms of financial competition. As a result of a coalition between legislators and the medical profession, enforced medical control over the occupation of midwifery was successfully instigated.[20]

2.3 Statutory Supervision of Midwifery: 1902-1940

The Midwives Act 1902 was the first statute governing midwives. It introduced the statutory supervision of midwifery, a unique element of the regulation that governs midwifery practice in the UK. Supervision served to entrench medical authority, stipulating that midwives should be controlled by doctors through medical supervision of midwifery practice, and the newly created Central Midwives Board, the regulatory authority for midwives where four of the nine members were doctors.[21] The Central Midwives Board was responsible for devising the rules which governed certified midwives, in addition to the examination and the issuing of certificates for those who wished to be admitted to the Roll of Midwives.[22]

Medical supervision of the midwife was not a new concept in Europe: its deployment has been noted as early as 1513.[23] However in the UK, the Act was an innovative and draconian

[18] Foucault M., *The Birth of the Clinic* (Routledge; London, 1989).
[19] Towler J., Bramall J., Nineteenth-century Midwives in author's ed. *Midwives in History and Society* (Croom Helm; London, 1986): 135-176.
[20] Turner B.S., Women's Complaints: Patriarchy and Illness in author's ed. *Medical Power and Social Knowledge* 2nd ed. (Sage Publications; London, 1996):84-109.
[21] Midwives Act 1902 C.17 (England and Wales): the purpose of this statute was stated as being to secure the better training of midwives and regulate their practice. There was no requirement that members of the governing body had to be midwives, although the first three female members were all qualified midwives.
[22] ibid: the CMB was also to be responsible for publishing an annual Roll of midwives who had been certified under the provisions of the 1902 Act. The CMB could remove a midwife from the Roll for disobeying the rules or for misconduct; and likewise they could reinstate to the Roll any midwife who had been previously removed.
[23] Towler and Bramall n19 above at 47: these authors note that Dr Roesslin might have been the predecessor of the Medical Supervisor of Midwives in the twentieth century.

measure.[24] In order to protect and promote the practice of the physician, (midwives were required to summon a doctor in the event of any complications enabling him access to the working class obstetric market),[25] the midwives' ability to exercise her skills were constrained.[26] This control was endorsed by severe sanctions for those who did not follow the rules, including the loss of the right to practice midwifery in England and Wales.[27] These rules put midwives at great risk, as women in labour would themselves often refuse the attendance of a physician due to their inability to pay for his services.[28] In some instances, this refusal led to the midwife being removed from the Roll as a consequence of being in breach of the rule that required the midwife 'to advise and send for medical aid'.[29]

As an outcome of the 1902 Act, the responsibility for the supervisory framework for midwives was passed to existing County and Borough Councils and it was within this system that the Local Supervising Authority (LSA) played a particularly crucial role.[30] The midwife who was accountable to the County and Borough Councils through the LSAs, might find herself facing

[24] Fox E., An Honourable Calling or a Despised Occupation: licensed midwifery and its relationship to district nursing in England and Wales before 1948 *Social History of Medicine* 6(2) (1993):237-259.

[25] Towler and Bramall n19 above: additionally suggest that at that time midwives were often assumed to be responsible for poor outcomes regardless of social, economic or recurrent medical conditions which contributed to morbidity and mortality in the poor.

[26] Heagerty B.V., Reassessing the Guilty: The Midwives Act and the Control of English Midwives in the early 20th Century in Kirkham M., *Supervision of Midwives* (Books for Midwives Press; Cheshire, 1996): 13-27.

[27] Midwives Act 1902 C.17 (England and Wales).

[28] Heagerty n26 above.

[29] Heagerty n26 above at 21: Heagerty maintains that the purpose of the CMB Rules was to eliminate the autonomy of the midwife and compel her to act according to the standards both personal and professional specified by the Board.

[30] n 27 above: in the 1902 Act the Local Supervising Authorities (LSA) were set up under the auspices of the local government authority and midwives wishing to practice had to notify the council of their intention to practice on an annual basis. As a result of this notification midwives were granted a licence to practice in much the same way as other tradesmen were granted licences to sell goods and offer services. The LSAs were governed by the Central Midwives Board which devised rules for the LSAs which included; the general supervision of midwives practising in the local area; the right to investigate claims of malpractice, negligence or misconduct by any midwife in the locality and if a prima facie case was established this should be reported to the CMB; the right to suspend from practice any midwife in accordance with the 1902 Act particularly in order to prevent the spread of infection; report to the CMB the name of any midwife practising in the locality who was convicted of an offence; keep a list of those midwives who had notified their intention to practice in that area and to supply those names to the Secretary of the CMB on an annual basis; enable the CMB's roll to be updated through the notification of change of address or death of a midwife; and to ensure that all those midwives who were practising were aware of the 1902 Act, the CMB and its rules and regulations.

charges of malpractice and disciplinary hearings for violating the Central Midwives Board Rules.[31] The LSA appointed a midwifery inspector to oversee midwifery practice in the locality where she carried out her duties and it was not uncommon in the first years after the 1902 Act for these supervisors to be either a medical officer of health, a clergyman's daughter, a relative of the local medical officer of health,[32] or even in some circumstances a female sanitary inspector.[33] The utilisation of various individuals to examine the work of the midwife on a routine basis was challenging as many were overburdened with additional public health duties, whilst others had little midwifery knowledge on which to base their inspections, which periodically led to mismanaged supervision or supervision which was limited or lacking.[34] These inspectors were often unwilling or unable to distinguish between unsafe and incompetent practice and conversely, the competent midwife who was attempting to offer care to women who were suffering from chronic ill health and poverty.[35] Statutory supervision was perceived by many midwives as punitive, as there was a presumption of guilt and poor practice especially when investigations of alleged misconduct were carried out.[36]

During the early part of the twentieth century, the 1902 Act appears to have had a highly variable impact, particularly in terms of the quality of service provision.[37] The changes that

[31] n 27 above.
[32] The Midwives Act 1902: Summary of Work 1904 *Nursing Notes* (May 1905): 2-3 at 2.
[33] Brimblecombe P., Historical Perspective on Health: the emergence of the sanitary inspector in Victorian Britain *Journal of the Royal Society for the Promotion of Health* 123(2) (2003):124-131.
[34] Donnison n17 above.
[35] Heagerty n26 above.
[36] Donnison n17 above at 182; Fox n24 above; Kirkham M., The History of Midwifery Supervision in The Association of Radical Midwives ed. *Super- Vision: Consensus Conference Proceedings* (Books for Midwives Press; Cheshire, 1995): 1-9: Kirkham notes that both the inspection of midwives and the disciplinary procedures that were instigated by the CMB were weighted against the midwife such that they charged, prosecuted and judged the midwife in an entirely unfair manner. Kirkham suggests that this situation arose as a result of the power struggle with doctors as midwives presented a threat to the doctor that needed to be controlled. Equally the midwife created a risk to midwifery leaders at that time who sought to raise the status of midwifery but could only do so by being obedient and deferential to the medical profession. Kirkham argues that as such the early inspectors of midwives controlled midwifery in the best interests of the medical profession.
[37] Dale P., Fisher K., Implementing the 1902 Midwives Act: assessing problems, developing services and creating a new role for a variety of female practitioners *Women's History Review* 18(3) (July 2009): 427-452; Donnison n17 above at 182.

were brought about may be viewed through the lens of government policy, which suggested that society (and particularly the poorest elements) needed to be guided and controlled by trained inspectors for the benefit of their own health and wellbeing.[38] However, despite these strategies, the 1902 Act itself did little to change the circumstance for many pregnant women and midwives outside urban areas such as London and Manchester.[39] Indeed, it was not uncommon for doctors in rural areas to arrange for local unqualified handywomen to resist the 1902 Act and attend the births of poor women.[40] Subsequent pieces of legislation including the second Midwives Act in 1918,[41] and the third Midwives Act in 1926,[42] nevertheless attempted to improve the education and training of midwives and the standard of care given to women. In addition the 1926 Act increased the number of midwives to four on the CMB so that they almost equalled the number of medical representatives.[43]

Throughout the 1930s, a burgeoning societal confidence in technology and science occurred, in part, as a result of the discovery of first sulphonamides and then penicillin in 1928.[44] This, together with better understanding of the importance of anti-sepsis and haemostasis in maternity care, meant that death through either puerperal fever or catastrophic haemorrhage

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[38] Cole G.D.H., Review of English Poor Law History Part 11: The Last Hundred Years by Sidney Webb and Beatrice Webb *The Economic Journal* 39(156) (December 1929):572-575.

[39] Marks L., *Metropolitan Maternity: maternal and infant welfare services in early twentieth century London* (Rodopi; Amsterdam; 1996).

[40] Campbell J., *Reports on the Physical Welfare of Mothers and Children. England and Wales vol.2 Midwives and Midwifery* (Carnegie Trust; London, 1917).

[41] Midwives Act 1918: this Act removed the responsibility of the payment of medical fees and mileage expenses from the midwife to the Local Authority in the first instance thus alleviating the midwife of costly expenses. This Act also gave the CMB the power to suspend a midwife whereas previously the only sanction open to them was on of removal from the Roll. Suspension could be instigated whilst an investigation and hearing took place. This Act also guaranteed that all requisite midwifery documentation the midwife needed was provided free with postage being paid for all statutory notification forms including notification of birth after the 28th week of pregnancy which had become compulsory in 1915.

[42] ibid: the 1918 Act attempted to prohibit unqualified women who sometimes under the direction of a doctor and sometimes in an 'emergency' acting as a midwife. If found guilty of this offense these women could face a fine of £10 which was a significant amount in those days. Additionally the 1918 Act divided the CMB Roll into two parts for practising and non-practising midwives.

[43] Towler and Bramall n19 above: 177-243.

[44] Ligon B.L., Penicillin: Its discovery and early development *Semin Paediatr Infect Disjour* 15(1) (2004):52-57.

could be avoided.[45] These developments coincided with a broader government strategy that was motivated by the belief that society was best served by technical specialists across a wide section of disciplines including health, welfare and education, and that the individual citizen should seek the opinion of these professionals wherever possible.[46] In line with this strategy, the Midwives Act 1936 introduced fundamental change to the provision of services which included a midwifery service for the poor and those living in remote communities through the provision of antenatal as well as intrapartum and postnatal care.[47] The 1936 Act additionally increased the scrutiny of midwifery practice by the medical profession and midwifery supervisors, intensifying the control of the midwife as a result.[48] As such the stipulations within the 1936 Act further limited individual midwives' autonomy and helped to shape the character and extent of midwifery practice over the next few years.[49] With the foundation of the NHS and the welfare state in the coming years, supervision practices became more clearly embedded in the management of the maternity services particularly with the implementation of managers

[45] Towler and Bramall n19 above: 177-243; Donnison n17 above at 91.

[46] Lowis G.W., McCaffery P.G., Sociological factors affecting the medicalization of midwifery in van Teijlingen E., Lowis G., McCaffery P., Porter M., eds. *Midwifery and the Medicalization of Childbirth: Comparative Perspectives* (Nova Science; New York, 2004):5-41.

[47] Kirkham n36 above; Donnison n17 above: Donnison remarks that whilst the 1936 Act itself was a 'pre-war measure' as a consequence of concern about the falling birth rate, old animosity towards 'state midwifery' enabled the Conservative government of the time to enact the legislation. This statute ensured that there was to be a salaried midwifery service paid for by the Local Authority which would address local demand. The 1936 Act established the Municipal Midwifery Service of England and Wales. As a result of the 1936 Act it was hoped that the status of the midwifery would be increased and would therefore attract more educated women into the profession.

[48] Towler and Bramall n19 above: these authors note that The 1936 Act permitted the appointment of a Non-medical Supervisor who was normally a senior midwife who worked with the Medical Supervisor. This was furthered in 1937 by a Ministry of Health Circular 1620 *Supervision of Midwifery* (Ministry of Health; London, 1937): paragraph 7 of the circular states that it is not desirable for a supervisor of midwives to be engaged in the actual practice of midwifery. The circular also recommended that the supervisor needed 'essential qualities of sympathy and tact'. The letter recognised the many problems of supervision including being supervised by someone who lacked knowledge and expertise of midwifery. The letter suggested that the supervisor should be a seen as a 'friend to the midwife, rather than as a relentless critic' as was the perception of supervisors in the past.

[49] Hunter B., Midwifery 1920-2000: The reshaping of a profession in Borsay A., Hunter B., ed. *Nursing and Midwifery in Britain Since 1700* (Palgrave Macmillan; Basingstoke, 2012): 151-174.

and managerialism.[50] In such circumstances the role of the manager and supervisor were often blurred, which led to conflict and tension.[51]

2.4. Maternity Services in the New National Health Service (1942-1979): Continued Restraints on the Midwife's Role

2.4.1 The Founding of the Welfare State

During the difficult years of the Second World War the powerful rhetoric and sweeping recommendations of the *Beveridge Committee Report* in 1942 inaugurated a social revolution.[52] Drawing on Fabian origins,[53] the welfare state it was proposed, would facilitate the provision of welfare services within a framework based on expert professional support supervised by government officials. As a consequence, after the Second World War, the state would have a greater role in providing health and social care to the British population.[54] It was envisaged that this would ensure greater economic prosperity and better social outcomes by addressing poverty, disease, ignorance, squalor and inactivity.[55] Following the *Beveridge Report* in 1942, the National Health Service Act 1946 implemented a comprehensive free

[50] Kirkham M., Supervision of Midwives in Nottingham 1948-1972 in author's ed. *Supervision of Midwives* (Books for Midwives press; Cheshire, 1996): 28-36.
[51] Kirkham n36 above.
[52] Beveridge W., *Social Insurance and Allied Services 1942* (British Library; London, 2014).
[53] Murphy M.M., The Role of the Fabian Society in British Affairs *Southern Economic Journal* 14(1) (1947):14-23; Modderidge D.E., *Keynes* (Macmillan; London, 1993):42-43; Clarke, Cochrane and Smart n12 above: these authors acknowledge that whilst Beveridge and Keynes were the recognised architects of the welfare state that many of the ideas on which it was founded were grounded in Fabianism which promised collectivist solutions which were supported by social science experts and administered by the state.
[54] The National Insurance Act 1946; The National Health Service Act 1948: The National Insurance Act 1946 created the framework for the Welfare State and the National Health Service Act 1948 allowed the British people to access health care which was free at the point of contact. This access included medical treatment, diagnosis, in hospital or at home care, as well as dental and ophthalmic treatment. Aneurin Bevan the Minister for Health and Housing was responsible for steering both these Acts through Parliament and is credited with being the founder of the NHS.
[55] Clarke, Cochrane and Smart n12 above: 85-115.

medical service which was to be available to all UK citizens who required assistance.[56] This provision was to include a midwifery service.[57]

The changes introduced by the 1946 Act meant that once again the midwife and the general practitioner were rivals in terms of the provision of care to pregnant women.[58] The inclination towards medical involvement in midwifery practice was further increased following the influential *Cranbrook Committee Review* in 1956, which recommended an extended role for doctors.[59] The 1956 *Cranbrook Review* assumed that doctors, including general practitioners, had expertise which was of a higher standard than that of the midwife.[60] It proposed that, even in normal childbirth where there were no complications, the role of the midwife should be lessened in favour of an increased role for the medical practitioner.[61] This recommendation may be usefully juxtaposed with events in practice at that time. Despite a persistent shortage of midwives, 80 per cent of all births were conducted by midwives who, according to the CMB's evidence to the Cranbrook Committee, were essential to an efficient maternity service.[62] Interestingly, the Committee additionally identified that, whilst the advantage of a homebirth for most women outweighed the risk of unexpected problems in labour and childbirth, there should be a 70 per cent increase in hospital confinements.[63] This contradictory and unsubstantiated recommendation can only be explained by the establishment's uncritical acceptance of the role of medical expertise in the post welfare state.

[56] Beveridge n52 above.
[57] Beveridge n52 above: the report recommended that this medical care should include the provision of dental, ophthalmic and nursing services.
[58] Donnison n17 above.
[59] Ministry of Health Chairman Lord Cranbrook *Report of the Maternity Services Committee* (HMSO; London, 1959).
[60] ibid.
[61] ibid.
[62] Towler and Bramall n19 above: 247-287.
[63] n 59 above at para.57.

Over the next twenty years the nature and purpose of midwifery continued to evolve within the NHS maternity services. Changes were characterised by conflict and unease, arising from the different emerging approaches to pregnancy and childbirth, which increasingly emphasised the medical model, with its reliance on technology and expert obstetricians.[64] Consequently, women were processed through pregnancy and childbirth using machines and medical technology, with science rather than 'low tech' midwifery knowledge becoming the accepted authoritative knowledge.[65] This was supported by policy initiatives such as those proposed in *Peel Report* in 1970, which sought to further encourage the pregnant woman to use hospital services, and which effectively brought to an end the domiciliary midwifery service.[66]

The medical model of care provision championed the 'active management' of childbirth whereby procedures and treatment regimens were implemented to help control the process of labour and birth. This would be facilitated through the routine employment of expensive machinery such as the electronic fetal heart monitor in labour which was carried out either using a fetal scalp electrode or electrodes strapped onto the woman's abdomen, but which were arguably no more effective than the traditional fetal stethoscope.[67] Other methods of 'active management' included: restricting the labouring woman's mobility; recumbent birthing positions; and artificial induction of labour. The latter was advocated as a means of reducing perinatal mortality rates as deliveries would then occur during daytime hours in the week when there was an increased number of skilled obstetric staff available to assist the birth.[68] This was

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[64] Hunter n49: 151-174 at 162.

[65] O'Driscoll K., Meagher D., Boylan P., *Active Management of Labour* (Mosby; London, 1993); Davis- Floyd R.E., Sargent C.F., *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives* (University of California Press; Berkeley, 1997).

[66] Standing Maternity and Midwifery Advisory Committee (Chairman Peel J.,), *Domiciliary Midwifery and Maternity Bed Needs* (HMSO; London, 1970) at 6: this report recommended that the resources of modern medicine should be available for all mothers and babies and that sufficient facilities should be provided to allow for 100% hospital delivery.

[67] Paine L.L, Payton R.G., Johnson T.R.B., Auscultated fetal heart rate accelerations *Journal of Nurse-Midwifery* 31(2) (1986): 68-77.

[68] O' Driscoll K., Meagher D., *Active Management of Labour* (Bailliere Tindall; London, 1986):12-13.

deemed to be particularly important for the first time mother, who it was considered had an inefficient uterus and as such needed medical assistance which could be implemented with 'military efficiency'.[69] Nevertheless, these recommendations were made without substantive evidence in support of them and appeared to be of more benefit to the maternity service than to labouring women.[70] Indeed, it was noted that active management of labour 'shortened the duration of the hospital stay and transformed the labour commitment of the woman's care givers'.[71]

These changes in the provision of care during the post war era meant that many women became increasingly dissatisfied with the quality of care they received.[72] As a result, the Association for Improvement in the Maternity Services (AIMS), one of the foremost consumer organisations in the UK, which attempts to raise awareness about standards of care within maternity service provision was founded.[73] During the 1960s and 1970s, AIMS was concerned about lack of support, poor conditions, midwifery staff shortages and lack of information for pregnant women and urged Parliament to make improvements in care, but with little success.[74]

The alterations to maternity care, which were implemented and affected the pregnant woman, also impacted on the midwife, such that the demise of the profession of midwifery was anticipated within a decade.[75] Where once the importance of the normal physiological process

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[69] ibid.
[70] World Health Organisation (WHO) Having a Baby in Europe *Public Health in Europe* (WHO; Copenhagen, 1985); Tew M., *Safer Childbirth? A Critical History of Maternity Care* (Free Association Books; London, 1994).
[71] Goer H., Active Management of Labour: Not the answer to dystocia *Birth* 20(1993): 99-101; O' Driscoll and Meagher n68 above at 20.
[72] Donnison n17 above at 195.
[73] Association for Improvement in Maternity Services (AIMS) *AIMS Quarterly* 22(4) (2010): this organisation was founded in 1960 by Sally Willington following a ten week stay on an antenatal ward and which coincided with the Ministry of Health Publication in 1961 of the *Human Relations in Obstetric Practice Report* which also identified failings in the provision of maternity services http://www.aims.org.uk/Journal/Vol22No4/campaiging.htm#2 (accessed 13/02/2015).
[74] ibid.
[75] Towler and Bramall n19 above: 247-287.

of childbirth had been recognised and understood,[76] the medical model was now seen as preferable to the traditional knowledge and skill of the midwife, which were symbolized by the title midwife which is derived from the Middle English word meaning 'with woman',[77] which indicates the importance of supporting the individual labouring woman through 'masterful inactivity'.[78] This change in perception of both the public and the professions to pregnancy and childbirth meant that what little power and control midwives had in terms of the provision of care was eroded and relocated to medical practitioners. Accordingly, many midwives were effectively relegated to the role of maternity nurse with token autonomy.[79] In such an environment midwifery practice was limited within the confines of contemporary obstetric procedures and routines, where midwives learnt to care for the technology to which the pregnant woman was connected.[80]

Consistent with this approach to maternity service provision, the National Health Service Reorganisation Act in 1973 introduced the unification of maternity services, with Nursing Officers to manage midwives in both the acute and community sectors.[81] In these circumstances, some women and midwives struggled to maintain the concept of 'normality'

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[76] Lowis et al. 46 above: 5-41; Oakley A., Who Cares for Women? Science versus love in Midwifery today in Van Teijlingen E., Lowis G., McCaffery P., Porter M., eds. *Midwifery and the Medicalization of Childbirth: Comparative Perspectives* (Nova Science; New York, 2004):319-328; DeVries R.G., The contest for control, regulating new and expanding health occupations *American Journal of Public Health* 76(9)(September 1986): 1147-1150.

[77] Webster's On Line Dictionary defines the term midwife as follows: Middle English midwife, from Anglo-Saxon *mid* with (akin to Greek ...) + ... woman, wife http://www.encyclo.co.uk/webster/M/64 (accessed 21/07/2013).

[78] Hunter n49 above at 163.

[79] Oakley n17 above; Kirkham M., Labouring in the Dark: Limitations on the Giving of Information to enable patients to orientate themselves to the likely events and timescale of labour in Wilson-Barnett J., ed. *Nursing Research: Ten studies in Patient Care* (Wiley; Chichester, 1983):81-99.

[80] Dingwall R., Rafferty A.M., Webster C., *An Introduction to the Social History of Nursing* (Routledge; London, 1998) at 171; Oakley A., *The Captured Womb: A history of the medical care of pregnant women* (Blackwell; Oxford, 1984); Towler and Bramall n19 above.

[81] National Health Service Reorganisation Act 1973: within this Act hospital, community and other services were brought together into unified Health Authorities. Regional Health Authorities were appointed as Local Supervising Authorities (LSAs) and supervisors of midwives were nominated by the District Health Authorities and were sanctioned by the LSAs. In 1977 the requirement for a medical supervisor of midwives was ended. Midwives now supervised midwives within the hospital setting and the structural context of the health authorities. After the reorganisation of the NHS in 1973 no organised data was collected or published which reflected midwifery care in terms of maternity outcomes.

within the birthing process, leading sociologists such as Kitzinger to assert the need to 'humanise childbirth' in order to raise standards.[82] However, other policy and legislative amendments continued to challenge the profession and the regulation of midwifery. In 1972 the *Briggs Committee Report*,[83] caused much division and debate by proposing that there should be one statutory authority which would replace all existing statutory and non-statutory authorities, effectively eliminating the CMB.[84] The Report recommended these fundamental changes as it considered that there was little difference between the role of the nurse and that of the midwife. Indeed it acknowledged that the midwife held 'an unusual degree of clinical responsibility' and tacitly suggested that this should be reduced.[85]

2.4.2 Midwifery Provisions within the Nurses, Midwives and Health Visitors Act 1979

Following the *Briggs Report* in 1972, the Nurses, Midwives and Health Visitors Act 1979 was enacted. In line with the report's recommendations the 1979 Act abolished the Central Midwives Board and replaced it with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).[86] Within this organisation there were to be no more than 45 members of the Council, its membership being derived from an equal number of nominations drawn from the membership of the National boards, together with political appointees made by the Secretary of State.[87] Whilst the nominations from the national boards were to be nurses and midwives, the ministerial appointments were to be drawn from amongst

[82] Kitzinger S., *The Midwife Challenge* (Pandora; London, 1988) at 18.
[83] Briggs A., *Report of the committee on Nursing* (HMSO; London, 1972) at 187: this Committee was responsible for reviewing the role of the nurse and midwife in the hospital and the community and examining the education and training required for that role.
[84] ibid.
[85] ibid.
[86] The Nurses Midwives and Health Visitors Act 1979 c. 36 states that: it is an Act to establish a Central Council for Nursing, Midwifery and Health Visiting, and National Boards for the four parts of the United Kingdom. The UKCC was able to determine who should be admitted to a new single register and were able to control standards of professional conduct and determine which registrants should be admitted to or remain on the register.
[87] ibid s.1 (2) & (3).

any of the health professions and this included medical practitioners.[88] This stipulation meant that involvement of the medical profession in the governance of the midwifery profession continued unabated. Additionally, as a result of the 1979 Act, for the first time since the enactment of the original Midwives Act in 1902, there was no separate regulatory body for midwives.

However, as was indicated by the quote at the beginning of this chapter, the legislative provisions within the 1979 Act recognised that midwives needed their own specific regulation in certain key aspects which included rules and standards as well as education and training.[89] Thus, as part of the stipulations of the 1979 Act, a Midwifery Committee was established within the UKCC, with membership comprised of practising midwives and which had as its function the directing of all issues relating to the practice of midwifery.[90] This provision, together with the rules that regulated midwifery practice,[91] ensured that midwifery, which was a minority profession within the UKCC, was acknowledged as being distinct from nursing. However, this recognition appears on occasion to have been somewhat limited, as was demonstrated by subsequent UKCC proposals which endorsed the concept that midwifery was a subdivision of nursing and which recommended that all future midwives should be qualified nurses in the first instance.[92] Indeed the Royal College of Midwives (RCM) argued that the regulation of the midwifery profession in the UK, which was once renowned as being an inspirational global standard, had since 1983 when the CMB ceased to exist, had a "constant battle to ensure that

[88]ibid s.1 (4).
[89]ibid.
[90] ibid s.4: this committee was deemed to be essential to the regulation of Midwifery and required close liaison between the Midwifery Committee and the UKCC.
[91] ibid s.15.
[92]United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) *Project 2000: A new preparation for practice* (UKCC; London, 1986): interestingly due to financial considerations this proposal was never implemented as it was not deemed a cost effective approach for safeguarding retention within the midwifery workforce.

the regulatory processes recognised the distinct way in which midwives work with women in order to maintain high standards of education and practice."[93]

As with previous midwifery legislation, the 1979 Act outlined provisions that related to the local statutory supervision of midwifery,[94] and in doing so, this historic management of midwifery was endorsed by the Labour Government of the time.[95] In these circumstances, statutory supervision of midwifery continued to be the policing activity envisaged in earlier statute, whereby the supervisor of midwives, who was also likely to be a Nursing Officer, would investigate clinical incidents in practice and determine strategies to address alleged wrong doing.[96] The 1979 Act was drafted by the Labour administration and was eventually enacted in the April just before Margaret Thatcher took office on 4 May 1979. Hence, the stipulations for midwifery regulation may been seen in the context of the outgoing collectivist ideology which promoted the concept of health and welfare in terms of medical expertise, science and technology. As was seen above, this had created significant difficulties with regard to the midwife's traditional role. In the ensuing years, the reforms to the welfare state that the Thatcher administration implemented, which were based on neoliberal ideology and new public management theory, created a further set of challenges for midwives.[97]

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[93] House of Commons Health Committee *Annual accountability hearing with the Nursing and Midwifery Council: Seventh Report of Session 2010-12* (The Stationary Office; London, July 2011) at 48.
[94] n 85 above s.16.
[95] n 1 above.
[96] Statutory Instrument (SI) 1977 No.1850: medical supervisors of midwives were abolished as a result of this SI. All supervisors of midwives were to be practising midwives who had to undergo training for the role with the Local Supervising Authority (LSA).
[97] Harvey D., *A Brief History of Neoliberalism* (Oxford University Press; Oxford, 2007).

2.5. Thatcherism and New Public Management (1980-1990)

2.5.1 The Neoliberal Focus

Since the election of Margaret Thatcher in 1979, neoliberalism, in its various forms, has become the dominant political philosophy in the United Kingdom.[98] Much of Thatcher's agenda for reform of government and public institutions, including the National Health Service (NHS), was motivated by a neoconservative and neoliberal agenda.[99] This was designed to address the problems that Thatcher identified in Britain at that time including, amongst others, the stagnant national economy or 'stagflation' and the power of the trade unions and the professions.[100]

Neoliberalism may be understood as a philosophy that advocates limited intervention by the state in the market and which has its geneses in liberal theory and the work of Adam Smith in the 18th century. Smith suggested that trade would flourish if governments refrained from interfering in economic affairs.[101] As the prefix 'neo' suggests, neo-liberal paradigms may be seen as the redefining of traditional liberal ideology, which focuses on a consumerist free-market economy that encourages private rather than public sector growth; the notion of personal responsibility, and the rule of law.[102]

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[98]Roy R.K., Denzau A.T., Willett T.D., *Neoliberalism: National and Regional Experiments with Global Ideas* (Routledge; London, 2006); Watkins S., New Labour: A weightless hegemony *New Left Review* 27(May/June, 2004):1-28.

[99] Harvey n97 above.

[100] Clarke J., *New Times and Old Enemies: Essays on Cultural Studies and America* (Harper Collins; London, 1991); Clarke J., Newman J., *The Managerial State: Power Politics and Ideology in the Remaking of the Social Welfare* (Sage Publications; London, 2001).

[101] McGregor S., Neoliberalism and Health Care *International Journal of Consumer Studies* 25(2) (June 2001):82-89; Crouch C., The Previous Career of Neoliberalism in author's ed. *The Strange Non-Death of Neoliberalism* (Polity Press; Cambridge, 2012):1-23; Turner R.S., *Neo-Liberal Ideology: History, Concepts and Policies* (Edinburgh University Press; Edinburgh, 2008) at 4.

[102] Rose n7 above; Hayek F., *Law, Legislation and Liberty* (Routledge &Kegan; London, 1976); Turner n101 above: 1-18.

Within this philosophy, the premise of government and the concept that Foucault referred to as Governmentality or the strategies by which authority is exerted over populations,[103] are based on the capitalist principles of competitiveness and individual self-interest, together with regional rather than central government by the state.[104] As such, the neoliberal state has, as its primary focus, a strong and effective individual who through the rule of law, robust financial institutions, private property rights and unrestricted trade agreements is enabled to make broad and diverse choices.[105] Opposition to such ideology is then dismissed as outdated and collectivist.[106] Mitchell Dean suggests that this type of modern liberal thinking is alluring as it appeals to the individual through the allocation of autonomous rights and liberties.[107] Moreover, neoliberalism in this context may be perceived as 'rolling back' the state,[108] with state involvement seen as unduly hampering the development of the market by inhibiting competiveness, stifling enterprise and distorting individual choice.[109] The neoliberal claim here would be that the society constructed on such market principles would foster individual freedom as a consequence.[110]

Nevertheless, neoliberalism should not be envisaged as a broad ranging panacea for the individual since, in this instance personal freedom may be perceived as being at once subjective and limited.[111] It exists as a corollary of the government's need to influence and shape the individual citizen so that they can make controlled choices, which are coherent with the aims

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[103]Foucault M., Governmentality in Burchell G., Gordon C., Miller P., eds. *The Foucault Effect: Studies in Governmentality* (Harvester Wheatsheaf; London, 1991): 87-104.
[104] Steger M.B., Roy R.K., *Neoliberalism: A very short introduction* (Oxford University Press; Oxford, 2010).
[105] Harvey n97 above; Munck R., Neoliberalism and Politics in Saad-Filho A., Johnston D., eds. *Neoliberalism: A Critical Reader* (Pluto Press; London, 2005): 60-69.
[106] Peck and Tickell n7 above.
[107] Dean M., Neoliberalism and Advanced Liberal Government in *Governmentality: Power and Rule in Modern Society* 2nd ed. (Sage; London, 2010): 175-204.
[108]n 7 above.
[109] Clarke and Newman n100 above: 1-17.
[110] Munck n105 above: Milton Friedman in the 1970s is credited with a pragmatic neoliberal approach which championed macroeconomic stability, liberal trade agreements and transfer of commerce from the public to the private sector.
[111] Munck n105 above.

and objectives of the state.[112] This includes the emphasis on the implementation of the principles of the free market, and the reduction of welfare budgets and curtailed public sector spending.[113] The economic crisis of the 1970s saw the end of the consensus politics that had supported the welfare state for the previous twenty five years.[114] This political transformation arose in part as a result of the profound change in popular opinion, which moved from the belief in shared solutions for social welfare problems towards favouring market provision as a means of fulfilling the needs of the individual.[115] Additionally, during the same period, Marxist and feminist critiques of the welfare state emphasised the dysfunction that was generated as a result of this state funded institution.[116] Mitchell Dean argues that the Marxist and feminist accounts of welfare were intimately associated with the professions, who devised systems of knowledge exclusion.[117] Feminism in particular asserted that the medical profession, which was predominantly male, managed women's health issues by authoritarian treatment regimes, whilst disregarding women as healers and controlling the female professions such as midwifery and nursing.[118] In these circumstances, Dean suggests that the 'politics of voice and representation' was employed to replace the welfare state which was seen to be paternalistic.[119]

At this time, despite being recognised as 'the most cost effective health service in the world' the crisis within the NHS meant that it was now categorized as being 'unaffordable'.[120] In such a climate Thatcher was able to mobilise this dissatisfaction with large and unresponsive

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[112] Munck n105 above.

[113] White M., Neoliberalism and the rise of the citizen as consumer in Broad D., Antony W., eds. *Citizens or Consumers? Social Policy in a Market Society* (Fernwood Publications; Halifax NS, 2000): 56-64.

[114] Pierson C., After the golden age from Crisis through Containment to Structural Adjustment in author's ed. *Beyond the Welfare State: The New Political Economy of Welfare* 2nd ed. (Polity Press; Cambridge, 1998): 136-166.

[115] ibid at 150.

[116] Wilson E., *Women and the Welfare State* (Tavistock; London, 1977); Gough I., *The Political Economy of the Welfare State* (MacMillan; London, 1979).

[117] Dean n107 above.

[118] Dean n107 above at 181.

[119] ibid at 181.

[120] Pollock A.M., *NHS plc: The privatisation of Our Health Care* (Verso; London, 2004) at 16.

institutions through the medium of neoliberal ideology. Thus in order to address the problem of the NHS, the onus for health and wellbeing was to be transferred from the state to the individual.[121] The individual was to be encouraged to manage his or her own health through the facilitation of state selected options which were deemed to be suitable and, in so doing, reduce the burden to the state. Within such a system, the perceived excesses in public spending and the large, so-called inefficient state health institutions which were deemed not to meet the needs of the individual were to be addressed.[122] In these circumstances private sector health provision was promoted as an efficient method of service provision that promoted individual choice in health care services.[123]

However the neoliberal agenda was not without its critics, particularly in terms of attempts to privatise the NHS.[124] During 1982, the Central Policy Review Staff (CPRS) working party was tasked by the Treasury to explore fundamental changes that would be necessary for public spending to be reduced. One of the suggestions included the replacement of the NHS with a private insurance scheme as a method of controlling public spending.[125] This initiative caused such a political controversy that work on radical alternatives to funding were essentially blocked for the next six years.[126] Nevertheless, some of the other recommendations, including the part privatisation of ophthalmic and dental services and paying hospitals for the work they performed, were implemented at a later date, albeit not by the working party that had initially proposed them.[127]

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[121] Rose n7 above.
[122] Savas E.S., *Privatising the public sector: how to shrink government* (Chatham House Publishers; Chatham New Jersey, 1982).
[123] ibid.
[124] Clarke and Newman n100 above; Smee C., Alternative Funding Mechanisms in author's ed. *Speaking Truth to Power: Two decades of analysis in the Department of Health* (The Nuffield Trust; Oxford, 2005): 29-41.
[125] Smee n124 above.
[126] Smee n124 above at 32.
[127] Smee n124 above.

Since the onset of neoliberal influence in the welfare state in the 1980s, a key component of Thatcher's reform programme was to implement change to its organization and management.[128] General management in these terms included budget cuts and restraints, accountability for service performance, competition, the separation of services and the involvement of patients in care.[129] This so called New Public Management (NPM) was key to the Thatcher Government and part of the neoliberal tenet. This aspect of Thatcher's reforms had a considerable impact on the welfare state in general and the health sector in particular. The extent to which these evolving reforms still effect the provision of care today was evident in my own empirical research as will be seen in chapters four, five and six. In these chapters, the issue of the management of the maternity services in terms of the drive for cost effective care with the emphasis on financial savings and the impact that this has on the care offered to women will be clearly seen.

2.5.2 Reforming the Management of the NHS: Disenfranchising the Healthcare Expert

New Public Management is thought to have originated in scholarship related to managerialism and public choice theory.[130] Managerialism in this context describes a collection of standards, concepts and expectations which sanction the managers' 'right to manage' and outlines particular methods of 'how to manage', which includes changes in power and organisational structures within the NHS to mirror private business models.[131]

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[128] Gruening G., Origin and theoretical basis of New Public Management *International Public Management Journal* 4(2001):1-25.
[129] ibid.
[130] Aucoin P., Administrative reform in public management: paradigms, principles, paradoxes and pendulums *Governance: an International Journal of Policy and Administration* 3(1990):115-137.
[131] Clarke J., Newman J., The right to manage: a second managerial revolution? *Cultural Studies* 7(3) (1993):427-41 at 434: Clarke and Newman identify that there are strong links between managerialism and neo-liberal economics where there is a homogeneity between the state, the institution and the individual whereby excessive regulation limits activity in all 3 areas, and where 'free enterprise' is a common thread connecting the 3 areas.

Initially, the early Thatcher reforms were principally concerned with adjustments to the structure of administration and management within the NHS. These were symbolized by budget constraints and devolved management initiatives which were coherent with neoliberal policies.[132] The *Griffiths Report* in 1983,[133] argued that the previous consensus management style within the NHS, whereby service provision was determined mainly as a result of teams of clinicians, predominately doctors, at management level making decisions, with the manager acting in a 'diplomat' role, was mostly ineffective and should be curtailed.[134] This style of management had occurred, it was claimed, as a corollary of medical autonomy, where doctors rather than managers were the most dominant actors, with all other non-medical professionals being perceived as being subordinate to the doctor.[135] In these circumstances, the provision of health care services was seen as focusing on the producer of the service (the doctor) rather than on the patient/client and management strategies were recognised as reactive rather than proactive.[136] Consequently, the *Griffiths Report* recommended that there be a change of emphasis in management terms and stressed the importance of delegated responsibility and regionalisation through systems of accountability and performance related processes.[137] This was articulated by Roy Griffiths in the NHS Management Inquiry that preceded the Report who remarked:

> 'If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge'[138]

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[132] Pollitt C., *Managerialism and the Public Services* 2nd ed. *(*Blackwell; Oxford, 1993).
[133] Griffiths G., *NHS Management Inquiry Report* (Department of Health and Social Security; London, 1983).
[134] Harrison and Pollitt n16 above.
[135] Griffiths n133 above.
[136] Harrison and Pollitt n16 above.
[137] Smee n124 above: 101-129.
[138] Department of Health (DoH) Chairman R Griffiths *The NHS Management Inquiry* (HMSO; London, 1983) at 12.

The Report launched a period of sustained growth in managerialism and an increase in the numbers of managers within the NHS.[139] This new system of management or 'New Public Management' (NPM) was said to be in stark contrast to the old bureaucratic systems, as it was to be based on efficiency (performance and outputs rather than inputs), value for money, competitive markets, consumerism, choice and customer care.[140] This change in management style was to have a profound effect on the organisation of the NHS for managers, clinicians and patients (who became known as service users). Consistent with NPM and neoliberal philosophy, these reforms represented a broad transfer of the control of health care away from the professions to managers, of whom there was a rapidly increasing number in the NHS.[141] Within NPM, Le Grand argues that the medical practitioner is portrayed as a 'Knave' who pursues self-interest and the acquisition of autonomy, status and power.[142] This is in contrast to the previous public perception of the doctor as a 'Knight'[143] who provides care to a trusting public as a result of altruistic motivation.[144] Indeed within NPM, it is the manager who is a 'Knight',[145] able to challenge the position of the doctor, his clinical decision making and

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[139] Ferlie E., Ashburner L., Fitzgerald L., Pettigrew A., *The New Public Management in Action* (Oxford University Press; Oxford, 1996) http://www.kingsfund.org.uk/projects/general-election-2010/key-election-questions/how-many-managers (accessed March 14th 2014).

[140] Butcher T., *Delivering Welfare: The Governance of the Social Services in the 1990's* (Open University Press, Buckingham, 1995) at 161; Dawson S., Dargie C., New Public Management: An assessment and evaluation with special reference to UK Health *Public Management* 1(4) (1999):459-481; Dunleavy P., Hood C., From old public administration to new public management *Public Money and Management* 14(3) (1994): 9-16; Olsen J.P., Maybe it is time to rediscover bureaucracy *Journal of Public Administration Research and Theory* 6(1) (Jan 2006): 1-24: Olsen explains that bureaucracy although often considered a derogatory term refers to a specific organisational environment, the 'bureau' or 'office' which is large, standardised, formal, rule based and impersonal. Olsen's definitions are drawn from the work of Max Webber who he suggests developed a critique of 'bureaucracy' in the 1970s.

[141] Kings Fund *The Future of Leadership and Management in the NHS: No more Heroes* Report from the Kings Fund Commission on Leadership and Management in the NHS (Kings Fund; London, 2011); Kings Fund Report *General Election 2010* (Kings Fund; London, 2010): this report states that while the total number of staff working in the NHS between 1999 and 2009 increased by approximately 35% the number of managers increased by 82% in the same period.

[142] Le Grand J., *Motivation Agency and Public Policy: Of Knights and Knaves, Pawns and Queens* (Oxford University Press; Oxford, 2003a) at 26.

[143] ibid.

[144]Ahern M., Hendryx M., Social Capital and Trust in Providers *Social Sciences and Medicine* 57(2003):1195-1203.

[145] Butcher n140 above at 31.

treatment selections, in the name of efficient management, cost effectiveness and patient choice.[146]

The political rhetoric espoused by the Thatcher Government identified the welfare state as integral to the wholesale deterioration of the country, with the professionals who worked within these institutions seen as unreceptive to the public as consumers of healthcare and to the 'rolling back of the state' more generally.[147] Klein argues that such a view may be seen as part of a governmental tactic which seeks to share credit for apparent successes but distances itself from deficiencies and poor outcomes when service provision is perceived to be less than satisfactory.[148] In these circumstances the transfer of power and decision making from direct governance to regional management locates the government in the role of arbitrator and advocate for the service user, able to critically question the provision and quality of service on behalf of the consumer.[149] As was intended, this situation created tensions and challenges for professionals particularly medical practitioners in NHS where, as indicated earlier, there had been a long history of respect and deference on behalf of the patient to the doctor. As a result of bestowing the patient or service user with choice in health care, the dynamic in the patient-professional relationship altered. Whilst patient expectations were elevated, professional authority and autonomy was undermined and diminished.[150]

2.5.3 New Public Management and the Citizen as a Consumer of Healthcare

The New Public Management (NPM) strategy articulates the citizen as consumer (or service user) in an especially potent symbol of neoliberal ideology.[151] Clarke et al (2007) maintain that

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[146] Harrison and Pollitt n16 above.
[147] Clarke and Newman n100: 1-17.
[148] Klein R.E., *The Politics of the National Health Service* (Longman; London, 1983).
[149] Clarke J., Newman J., Smith N., Vidler E., Westmarland L., Public Service Reform in author's ed. *Creating Citizen- Consumers: Changing Publics and Changing Public Services* (Sage; London, 2007):27-46.
[150] ibid: 103-120.
[151] Dunleavy P., *Democracy, Bureaucracy and Public Choice* (Harvester Wheatsheaf; London, 1991); Butler E., *Public Choice-A Primer* (The Institute of Economic Affairs; London, 2012).

large state run institutions, including the welfare state and the NHS, which have a monopoly on service provision, may favour producer interests rather than the concerns of the service user.[152] In such an environment, political and institutional influences were seen as having a negative impact on the public commodities market, which produced incompetent employment of resources and limited consumer choice.[153] Thatcherism made this argument through employing the imagery of the tax payer, the consumer and the scrounger.[154] Whilst the taxpayer was heavily burdened by excessive taxation to pay for the welfare state and the consumer was refused the ability to make real choices when accessing care, the scrounger, was seen as the predictable outcome of the welfare state, exploiting the welfare state for his or her own gain.[155]

As such the ability of the individual citizen to make choices about his or her health care was essential to the neoliberal agenda;[156] and in order to achieve this goal a change within the culture of the NHS was thought to be required. In 1988, Sir Patrick Nairne, the Permanent Secretary in the Department of Health and Social Services (DHSS) had remarked that no public service considered the public to any degree;[157] whilst the white papers such as *Promoting Better Health*,[158] and *Working for Patients,*[159] promoted greater choice of services for patients.[160] In keeping with the market rhetoric, the Conservative Government suggested that funding for services would follow the patient, with the perceived neoliberal advantages being considered

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[152] Clarke and Newman n100.
[153] Clarke and Newman n100; Newman J., Beyond The New Public Management in Clarke J., Gewirtz S., McLaughlin E., ed. *New Managerialism, New Welfare* (Open University Press; London, 2001): 45-61
[154] Klein n148 above.
[155] Dunleavy n151 above.
[156] Savas n124 above.
[157] Smee n124 at 133.
[158] Department of Health (Do) *Promoting better health* (HMSO; London, 1987).
[159] Department of Health (DoH) *Working for patients* (HMSO; London, 1989) cm 555; House of Commons Select Committee (Health) *Commissioning 1948-2010* (House of Commons; London, March 20th 2010): the White Paper 'Working for Patients' was seen as introducing one of the most fundamental changes to the NHS since its inception when it created the 'internal market' and eventually passed into law as the NHS and Community Care Act 1990. http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/26805.htm (accessed 15/04/2014).
[160] HC Deb vol. 146 col.165.31 January 1989.

self-evident. [161] However this proposal was seen by the Labour party, when in opposition, as an attempt to privatise the NHS, thus limiting the choices available to certain types of patients including the elderly, those with chronic illness and the disabled as a result of the high cost of care for these people.[162] It is noteworthy that these reforms when implemented did not offer choice to all patients as was originally thought.[163] Further, once New Labour formed the government in 1997, this criticism of NHS reforms appears to have been forgotten: this will be discussed in more detail in the next chapter.

As a result of the Conservative NPM agenda, the provision of choice and the woman centred care policy became integral aspects of care for pregnant women in the UK.[164] Although this might be seen as a development of the far older notion of being 'with woman', this strategy did nevertheless reformulate this concept in a specific manner, particularly in relation to the relationship between the midwife and woman. This theme is one that emerges in the empirical data and as such requires some exploration below.

2.5.4 Choice and Control in Maternity Care

One interpretation of the justification for choice in health care is that it may be linked to definitions of the democratic capitalist state which ensures that the patient and not the clinician should have decision making power.[165] In the 1980s, in spite of the earlier failures, the consumer organisation AIMS encountered (which were discussed above), it had continued to highlight the challenges that pregnant women experienced. These difficulties were accentuated in 1982 by the prosecution of Brian Radley for attending the birth of his own baby despite there

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[161] Ibid at col. 171.
[162] Ibid at col. 170.
[163] Appleby J., Harrison A., Devlin N., *Shaping the New NHS: What is the Real Cost of More Patient Choice?* (Kings Fund; London, 2003).
[164] Cumberledge J., *Report of the Expert Maternity Group: Changing Childbirth* (HMSO; London, 1993); House of Commons Select Committee *Maternity Services: Second Report of the Health Committee* (HMSO; London, 1992).
[165] Le Grand J., From Pawn to Queen: Economics, ethics and health policy cited in Appleby J., Harrison A., Devlin N., *Shaping the New NHS: What is the Real Cost of More Patient Choice?* (Kings Fund; London, 2003b).

being no law to prevent this occurrence.[166] The public response to Radley's conviction was one of concern that state power and influence was being employed to force women to accept the dominant medical opinion. Notwithstanding, that birth for many women was a normal physiological process not a pathological disease and as such it was unclear why they should be made to obey the doctors' instructions.[167] In response to the Radley case, AIMS established the Maternity Defence Fund (MDF) which was used to make claims of assault against the medical and midwifery professions. The launch of this fund and the pledge to act caused a shift in attitudes virtually straightaway, with discussions of patients' rights and consent coming to the fore for the first time.[168] Consequently, this was recognised as one of the most successful actions by users of the maternity services in recent years.[169]

Following the Radley case and the creation of the MDF demonstrations and rallies were organised which were supported by the Association of Radical Midwives (ARMs), the National Childbirth Trust (NCT), and the renowned obstetrician Professor Wendy Savage, to highlight the problems that pregnant women faced when accessing maternity services.[170] These organisations identified that the individualised care that pregnant women received was very limited and called for greater choice particularly in terms of the place of birth. This was recognised as being problematic because it was acknowledged that any woman wishing to have a home birth would encounter obstructions from service providers who were either unwilling

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[166] Donnison n17 above; Association for Improvement in Maternity Services (AIMS) n73 above: Michelle Williams had refused medical or midwifery attendance as a result of a traumatic hospital birth with her first baby, and believed that staff working in the West Midlands Regional Health Authority, had tried to coerce her into changing her decision to have a home birth for one in hospital. It was this Health Authority who brought the case which resulted in Brian Radley (Michelle's partner) being convicted of delivering his own baby for which he was fined £500. The prosecution was brought using the Midwives Act 1951 s. 4 which was intended to protect women from unqualified individuals acting as midwives, not from men who were supporting their partner's requests. The fine was paid by a consultant psychiatrist who was appalled by the poor treatment Michelle Williams and her partner had received.

[167] Bowes W.A., Selgestrad B., Fetal versus Maternal Rights: Medical and Legal Perspectives *Obstetrics and Gynaecology* (August 1981): 209-214.

[168] Association for Improvement in Maternity Services (AIMS) n73 above.

[169] ibid.

[170] ibid.

or unable to support such requests. [171] The pregnant woman, it was argued, would be required to have patience, courage, political skill and determination in order to overcome such obstacles.[172] Predictably, as a result of the medical opposition to home birth, the home birth rate had fallen from approximately 33 per cent in 1961 to less than 2 per cent by 1982,[173] despite the limited evidence that birth within the hospital setting was safer than birth at home.[174] This denial of consumer choice would therefore appear to be the catalyst for change in the maternity services whereby neoliberal ideology could take centre stage encouraging as it did citizens' rights to choice in health care.[175]

The commitment to choice in the maternity services was articulated in the *Changing Childbirth Report* (1993).[176] The Report took forward the concept of woman centred care, which originated in the earlier proposals of ARM in 1986.[177] Woman centred care may be seen as giving the service user a voice, as it articulates the individual woman, her needs and choices throughout pregnancy, childbirth and the postnatal period.[178] The Report recommended that, pregnant women should have an active role in making decisions about the care and treatment they received during pregnancy and childbirth.[179] However, whilst favouring maximum

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[171] Association for Improvement in Maternity Services (AIMS) *AIMS Quarterly* (Spring 1986):1-2.
[172] Donnison n17 above at 195.
[173] BirthChoiceUK *Home Birth Rates for England and Wales:* 1961-2012 (BirthChoiceUK, 2014): in this data home birth rates have been derived from information collected at birth registration by the Office of National Statistics http://www.birthchoiceuk.com/Professionals/index.html (accessed 13/02/15).
[174] Tew n70 above.
[175] Salter B., *The Politics of Change in the Health Service* (Macmillan; London, 1988).
[176] Cumberlege n164 above.
[177] Association of Radical Midwives (ARM) *The Vision* (ARM; Ormskirk Lancashire; 1986): this group of midwives attempted to challenge the medical model of childbirth and in so doing 'normalise' the birthing process.
[178] Deery R., Kirkham M., Supporting Midwives to Support women in Page L.A., McCandlish R., eds. *The New Midwifery Science and Sensitivity in Practice* 2nd ed. (Churchill Livingstone; Edinburgh, 2006) at 125.
[179] Cumberlege n164 above: in this report the following 'rights' are outlined: access to a named midwife who was responsible for care; access to a consultant obstetrician at least once in pregnancy; access to a consultant paediatrician where problems are identified with the fetus; access to maternity records and confidentiality; information about local maternity services; access to antenatal care which includes being able to be seen within 30 minutes of the designated appointment time; having a birthing partner present during the birth; having the baby identified for security purposes; information on infant feeding; respect for privacy, dignity and cultural and religious beliefs; visitors to have access at all times; access to hospital or community services according to any specific need.

involvement of the pregnant woman in decision making, the rights provided in the Report remained fragile.[180] For pregnant women to act as consumers of health care and make effective choices, they need to have knowledge of all the possible options available to them and this may be beset with problems and challenges. Women may lack sufficient information and as a consequence may make choices which are less than optimal.[181] Equally, competition to provide health care, might be limited whenever the cost of a particular type of health care is considered to outweigh the potential benefits.[182] Consequently consumer choice and empowerment within maternity services may be seen at times to exist in tension with service provision, where the state aim is focused on financial efficiency and the deployment of restricted numbers of qualified staff.[183] This theme also emerged in the empirical data and will be discussed in chapters four, five and six.

Whilst *Changing Childbirth* was heralded as repositioning the woman at the centre of care and decision making, there was no obligation for service providers to carry out the Report's recommendations and, as such, many of the proposals were not implemented.[184] What is more, attempts to maximise individualised woman centred care were not universally recognised as being beneficial to all and as such the initiative appears to have been limited in its success.[185] Again, the theme of woman centred care, and some of the tensions around it, are clearly visible in the empirical data and will be discussed in chapters four and six.

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[180] Dimond B., Woman Centred Care in author's ed. *Legal Aspects of Midwifery* 2nd ed. (Books for Midwives Press; London, 2003): 72-89.
[181] Appleby, Harrison and Devlin n163 above.
[182] ibid.
[183] Kirkham M., The Maternity Services Context in author's ed. *The Midwife-Mother Relationship* 2nd ed. (Palgrave Macmillan; Basingstoke, 2010):1-16.
[184] Sandall J., Changing Childbirth Again? Implications of the NSF: Report of the Meeting of the Forum on Maternity and the Newborn of the Royal Society of Medicine *Midwives* (April 2005). http://www.rcm.org.uk/midwives/features/changing-childbirth-again-implications-of-the-nsf/ (accessed 16/04/2014).
[185] Appleby, Harrison and Devlin n163 above; Kirkham n183 above.

Following the change of Prime Minister in 1990, the neoliberal project was seen to enter a new phase when different neoconservative social policies and agendas were implemented.[186] Within healthcare this included the expansion of patients' rights and the early development of the so-called 'risk management' in health care.

2.6. The Emergence of Risk in Health Care (1990-1996)

At the beginning of the 1990s, John Major's Conservative administration articulated patients' rights in policy documents such as *The Patient's Charter,* which clearly set out the standards of care and choice that patients might expect.[187] However, these rights were often in direct competition with other neoliberal and NPM strategies including the provision of cost effective care and stringent financial controls. This unsurprisingly created tensions in service provision and led to general dissatisfaction with the care that was provided,[188] and which may in part be responsible for the rise in litigation in recent years.[189]

Risk management systems were devised in order to manage the increase in the number of claims and the rising cost of litigation.[190] Beck argues that many risks emerge in society as a consequence of decision making by experts.[191] Given that these experts are inevitably fallible, this can result in a loss of confidence in the professional's expertise and that of their organisation.[192] During the early 1990s, whilst many NHS institutions utilised some elements of risk management such as the reporting of accidents, health and safety committees and

[186] Peck and Tickell n7 above.
[187] Department of Health (DoH) *The Patients Charter: Raising the Standards* (HMSO; London, 1992).
[188] McSherry R., Pearce P., *Clinical Governance: A Guide to Implementation for Healthcare Professionals* (Blackwell; Oxford, 2002).
[189]Pratt R., Morgan S., Hughes J., Mulhall A., Fry C., Perry C., Tew L., Healthcare Governance and the modernisation of the NHS: infection prevention and control *British Journal of Infection Control* 3(5)(2002): 16-25.
[190] Dingwall R., Fenn P. Risk management: financial implications in Vincent C., *Clinical Risk Management* (British Medical Journal (BJM) Books; London, 1995): these authors suggest that between 1975 and 1992 the number of claims per annum in the NHS had risen from 500 to 6000.
[191] Beck U., *Risk Society: Towards a New Modernity* (Sage; London, 1996)
[192] ibid at 4: Beck defines risk as the likelihood of physical harm due to given technological or other processes.

managers who dealt with complaints, there was no formal risk management plan which connected the identification, analysis and control of risk.[193] However, following the Department of Health's endorsement of the risk management programme in 1993,[194] the process was implemented across the NHS.[195] In 1995, the NHS Litigation Authority (NHSLA) was created to manage negligence claims made against NHS organisations and produce risk management standards to improve care provision.[196] Part of this organisations function was to administer the Clinical Negligence Scheme for Trusts (CNST) which offers indemnity to NHS Trust members and their employees for clinical negligence claims that relate to incidents that occurred from 1st April 1995.[197] In the years following the election of the Blair Government in 1997, the attempt to manage risk and control litigation claims solidified into clinical governance strategies. This will be examined in more detail in the following chapter.

2.7 Conclusion

This chapter has begun to set out the historical and political context of the provision of maternity care in the UK during the twentieth century. The story of the regulation of midwifery throughout this time has been one of conflict and control over the process of pregnancy and birth. The main protagonists in this battle have been the doctor, the midwife, the woman and the state. During the early part of the twentieth century this struggle between the medical profession, midwives and the pregnant woman resulted in the partial replacement of midwifery

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[193] Walshe K., The development of risk management in Vincent C *Clinical Risk Management: Enhancing Patient Safety* 2nd ed. (British Medical Journal (BJM) Books; London, 2001):45-60.
[194] Department of Health (DoH) *Executive Letter: Risk Management in the NHS* (HMSO; London, 1993): 111.
[195] Mant J., Gatherer A., Managing clinical risk: makes sense but does it work? *British Medical Journal* 308(1994):1522-1523.
[196] National Health Service Litigation Authority (NHSLA) *NHSLA Risk Management Standards 2013-2014* (NHSLA; London, March 2013a).
[197] National Health Service and Community Care Act 1990 s. 21; Health and Safety Executive (HSE) *Five Steps to Risk Assessment* (HSE; London, 1999) at 2; National Health Service Litigation Authority (NHSLA) *Clinical Negligence Litigation: A very brief guide for clinicians* (Clinical Negligence Scheme for Trusts (CNST)) (NHSLA; London, June 2003): the NHSLA manages Clinical Negligence Scheme for Trusts (CNST) and liabilities to third parties scheme (LTPS). CNST is funded on a pay-as-you-go, non- profit basis. The NHSLA produces standards that have been designed to address organisational, clinical, and non- clinical or health and safety risks.

practice with medical technology and expertise as society became more reliant on science and medicine.[198] These developments were supported by an emerging regulatory framework which underpinned the medical profession's dominance of the midwife and childbirth.

With the creation of the welfare state in the years following the Second World War, the regulation and practice of midwifery may be seen through the lens of the developing NHS. As a result of proposals put forward by the medical profession, which were supported by the state, the 1950s and 1960s saw pregnant women being encouraged to give birth in hospitals despite there being limited evidence to support this change.[199] Consequently older social forms of knowledge were replaced by scientific forms which were deemed by the state and the medical profession to be more beneficial to the pregnant woman and her unborn child.[200] In these circumstances, in addition to caring for the labouring woman as they once had, midwives developed the technical skills needed to ensure that that the machinery being applied to the labouring woman was functioning effectively. Thus, for many midwives, the nature of their work was more akin to that of obstetric nurses, with the pregnant woman being relegated to the periphery of care.[201]

In the last decades of the twentieth century, the conflict within the welfare state shifted once more. During this period dissent and dissatisfaction with the paternalistic model of welfare enabled the Thatcher Government in the 1980s to implement significant reforms. The outcome of this was that the practice and regulation of midwifery was changed again. Consistent with the Thatcherite style of neoliberalism, NPM strategies and public choice policy were endorsed in an attempt to 'roll back' the machinery of the state, whereby professional autonomy was eroded in favour of the individual consumer.[202] For the pregnant woman, this move came at a

[198]Lowis et al n46 above: 5-41.
[199] Towler and Bramall n19 above: 247-287.
[200] Oakley n17 above: 17-58.
[201] Kirkham n79 above: 81-99.
[202] Klein n148 above.

time when many were disillusioned with the care they were being offered.[203] However whilst the public choice model was a part of the Thatcher vision of neoliberalism, it was not until 1993 in the post Thatcherite era that this became a reality for some women.[204] The policy changes which were implemented by the Major Government resulted in another realignment of the actors involved in the provision and regulation of maternity services within a neoliberal framework. As a consequence of attempts to manage increasing claims of clinical negligence, the developing emphasis on risk required the state to devise strategies to address this problem which created new problems for the midwife and pregnant woman.

In chapters four, five and six these challenges continue to resonate in current service provision where the issue of risk and its influence on the care offered appeared to have a direct impact for the pregnant woman regardless of whether she had any underlying health concerns. The question of risk and how to manage it also emerged in my empirical research. Here, the midwife appeared to be involved in balancing the requirements of the service with the needs and expectations of the pregnant woman, which frequently impacted on the outcome of care.

In the next chapter the current governance framework for midwives will be considered in detail. The chapter will examine the regulatory changes that took place during the New Labour Government which came to office in 1997. The discussion will pay particular attention to the reforms that occurred in the NHS, to the maternity services and to the midwives themselves during Blair's administration. It will consider whether these New Labour reforms conflicted with, or further supported those of its Conservative predecessors to determine the influence they have had on the provision of care offered to pregnant women today.

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[203] O' Driscoll and Meagher n65: 12-13.
[204] Cumberlege n164 above.

3. Midwifery Governance in Context 2: Current Maternity Service Provision, Reform and Regulation (1997-2010)

3.1 Introduction

In 1997 Tony Blair's New Labour Government came to power, with the NHS featuring strongly in the Manifesto upon which he was elected. The Manifesto stated:

> 'In health policy, we will safeguard the basic principles of the NHS, which we founded, but will not return to the top-down management of the 1970s. So we will keep the planning and provision of healthcare separate, but put planning on a longer-term, decentralised and more co-operative basis. The key is to root out unnecessary administrative cost, and to spend money on the right things-frontline care.'[1]

This short statement contains the essence of a far-reaching reform programme that was to have an influential impact on the shape of the modern NHS. New Labour recognised serious problems in the NHS, created by Conservative and Socialist policies of the 1970s and 1980s. These problems involved: outmoded managerial ideology, a service which was fragmented and staff who lacked accountability to patients.[2] This situation arose in part as a result of the drive for efficiency and cost-effectiveness so favoured by the previous Conservative Government,[3] and were visible as misconduct and catastrophic failings in care provision in a host of cases including: Allitt,[4] Shipman,[5] and the Bristol Royal Infirmary Children's Heart Service.[6] For the Blair administration, then, reform of the NHS was inevitable. This would consist of significant restructuring, with questions about quality care provision, safety, poor performance

[1] Blair A., new Labour because Britain deserves better *Labour Party Manifesto* (Labour Party; London, 1996a) http://www.politicsresources.net/area/uk/man/lab97.htm (accessed 20/06/2015).
[2] Poole L., Health Care: New Labour's NHS in Clarke J., Gewirtz S., McLaughlin E., eds *New Managerialism New Welfare?* (Open University Press; London, 2001): 102-121.
[3] ibid.
[4] R v Allitt 1992 [2007] EWHC 2845 (QB): In 2006 Allitt launched an appeal against the length of her sentence. Burton J confirmed on 6th December 2007 that Allitt should serve a minimum of 30 years as per her original sentence.
[5] Smith J., *The Shipman Inquiry: First Report* (Shipman Inquiry; Manchester, 2002).
[6] Kennedy I., *Bristol Inquiry: Final Report* (Stationary Office; London, 2001).

and competence being addressed by new regulation. Here, importantly New Labour was also influenced by a perceived need to manage 'risk', a concern that had gained increasing magnitude during the previous decade, providing an enhanced mandate for strong state intervention.

However, it is important to view this programme of reforms within the context of the NHS as an organisation, where the workforce is influenced not only by the rules of the organisation but also by its culture.[7] Within this concept of culture, informal rules, processes, traditions and expectations, collective ideals or 'tribalism,'[8] in healthcare as well as limited agreement of roles and work strategies,[9] all play an important function.[10] Nowhere is this more prevalent than in the maternity services, where custom and practice methods of care provision may conflict with more technological advances, and where different groups of clinicians and service users have different expectations of outcomes and ways of achieving them.[11] The provision of care which is seen as safe and effective may be envisaged differently by the different professional groups and the pregnant woman and as a result may be considered at times to be an elusive objective. Thus, as Black argues, in order for regulation to be effective it needs to become institutionalised as part of the culture of the community which is being regulated, in this case the maternity services.[12]

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[7] Baldwin R., Cave M., Lodge M., *Understanding Regulation* (Oxford University Press; Oxford, 1999) at 27; Ayres I., Braithwaite J., *Responsive Regulation: Transcending the deregulation debate* (Oxford University Press; Oxford, 1992); Morgan B., Yeung K., *An introduction to Law and Regulation: text and materials* (Cambridge University Press; Cambridge, 2007).

[8] The Oxford Online Dictionary (2014) defines tribalism as the state of being organised in a tribe. It is usually uncomplimentary and relates to behaviour and outlooks which arise from a strong sense of loyalty to a particular social group or tribe http://www.oxforddictionaries.com/ (accessed 27/04/2014).

[9] Richards A., Carley J., Jenkins-Clarke S., Richards D.A., Skill mix between nurse and doctors working in primary care- delegation or allocation: a literature review *International Journal of Nursing Studies* 37(2000):185-197.

[10] Baldwin, Cave and Lodge n7 above at 31.

[11] Wilson J.H., Symon A., *Clinical Risk Management in Midwifery: The Right to a Perfect Baby?* (Books for Midwives; Oxford, 2002).

[12] Black J., Regulatory Conversations *Journal of Law and Society* 29 (1) (March 2002b): 163-96.

The current chapter will continue the analysis, begun in chapter two, of the shifts that have occurred in the care offered to pregnant women in the United Kingdom. Here, the focus will be on developments from 1997 onwards. These changes have affected the regulation of health care provision and the healthcare professions, which have created new challenges and opportunities within the regulatory community of the NHS, both for those who provide services, as well as those who access them. The chapter aims both to explain the regulation that is currently in place, therefore setting out the foundation for exploring its impact on the midwives who work within it, as well as contextualising the law within the broad ideological shifts that led to its introduction and revision. The chapter will focus on the regulatory reforms that predate the collection of my empirical data and as such will end in 2010.

The chapter begins by analysing the political ideology of the New Labour Government and considers how its policies for the NHS reflected the so called 'Third Way' philosophy (3.1.1). It will then explore the idea of 'risk management' which emerged as a specific and important driver of reform for the Blair administration (3.1.2). Following this, the chapter will go on to examine the regulatory strategies which were devised and developed in order to address the perceived crisis within the NHS (3.2), focusing in particular on questions of quality and safety and the strategies of risk management and clinical governance that were employed to resolve the issues of poor quality and unsafe care (3.3 and 3.4). The chapter ends with a discussion of the important specific regulation of midwifery which was introduced by the Nursing and Midwifery Order 2001 (3.5).

3.1.1 New Labour, the Third Way and the NHS

Throughout the New Labour discourse there is an emphasis on redefining the role of the state, with a movement away from the traditional socialist emphasis on a state which attends to issues of class discrimination and wealth redistribution, towards a state which encourages 'active

citizenship' and 'opportunity'.[13] For the Blair Government, the 'opportunity state' labours together with communities, families and individuals in a rejuvenation of the nation, which Blair articulated as the 'something for something society'.[14] This notion of the 'opportunity' state follows the 'Third Way' ideology of providing increased opportunities for the enhancement of society though a modernized welfare state rather than a return to the post-war welfare agenda.[15]

The 'Third Way' is typically characterised as offering a mixture of free market philosophy and social democracy.[16] It adopts neoliberal notions regarding the distribution of income and recognises the stability of capitalist economies.[17] Importantly, it also accepts the expansion of the market into all parts of society, believing that the quest for increased revenue is the most effective way to achieve economic success.[18] However the neoliberalism anticipated in the Third Way was a much more subtle project than the above description might seem to suggest. Peck and Tickell argue that the Third Way sought to address the limitations of the Thatcher style of neoliberalism which involved a simple 'rolling back' of the regulatory state.[19] Within the Third Way, in contrast, there was an extension of state governance and regulation, which it was envisaged would produce additional benefits across the economy and society in general.[20] Blair's NHS policies must be located within this broad sweep, and can thus usefully be viewed as both building upon and extending the reforms of the previous chapter, but should also be seen as departing from them in certain, crucial areas.

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[13] Poole n2 above at 199.
[14] Blair A., *New Britain: My Vision of a Young Country* (Fourth Estate; London, 1996b): 298.
[15] Poole n2 above.
[16] Arestis P., Sawyer M., Neoliberalism and the Third Way in Saad-Filho A., Johnston D., eds *Neoliberalism: A Critical Reader* (Pluto Press; London, 2005).
[17] ibid.
[18]Arestis and Sawyer n16 above; Giddens A., *The Third Way: The renewal of social democracy* (Polity Press; Cambridge, 1998).
[19] Peck J., Tickell A., Neoliberalizing Space *Antipode* 34(2) (16th December 2002):380-404.
[20]ibid; Greve B., Welfare states and welfare regimes in author's ed. *Welfare and the Welfare State: Present and Future* (Routledge; London, 2015): 29-54.

These subtle shifts between New Labour and the policies of the previous administration are clearly visible in policy documents such as *The New NHS: Modern and Dependable.*[21] This committed New Labour to increases in annual expenditure of 5% in the NHS until 2004, yet with public spending still to be just as tightly controlled as it had been under the Conservatives. Blair put an end to the Conservative 'internal market' in health, believing that it encouraged the bureaucracy, division of the service and inequity of provision that New Labour perceived to be important elements of the crisis in the NHS.[22]

However, this did not signal a return to a higher level of state control of NHS financing. Rather, in keeping with the Third Way philosophy of partnership, a mixed economy of private and public provision in state services and the drive for efficiency were key objectives for the new administration.[23] Interestingly the use of market incentives, such as the increase in the provision of health care services from the private sector, which were unpopular with Labour when in opposition, were implemented through programmes such as the Private Finance Initiative (PFI) when they came to office. Whilst this was seen as a temporary way of managing public finances both in terms of income and outgoings,[24] the schemes have received much criticism from professional organisations such as the British Medical Association (BMA),[25] and in some instances, have caused large scale debt to several NHS Trusts in England.[26]

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[21] Department of Health (DoH) *The New NHS: Modern Dependable* (HMSO, London; December 1997).

[22] Smee C., *Speaking Truth to Power: Two Decades of analysis in the Department of Health* (Radcliffe; Oxford, 2005) at 115.

[23] Flynn R., Williams G., *Contracting for Health* (Oxford University Press; Oxford, 1997).

[24] Poole n2above.

[25] House of Commons Treasury Select Committee *Private Finance Initiative: Written Evidence submitted by the British Medical Association* (HC; London, August 10th 2011): the BMA'S main concerns regarding PFI's were that they were costly, not cost effective, and inflexible and that public funds are transferred to the private sector with no demonstrable benefits http://www.publications.parliament.uk/pa/cm201012/cmselect/cmtreasy/1146/1146vw04.htm (accessed 20/03/2014).

[26]National Audit Office (NAO) *The Report by the Comptroller and Auditor General: Peterborough and Stamford Hospitals NHS Foundation Trust Session 2012-13* (Department of Health (DH); London, 29th November 2012): the Report outlines that the scheme was approved despite the fact that Monitor, the Foundation Trust regulator, raised serious concerns about the cost and affordability of the plan, although these did not foresee the level of the problems that have since arisen. The Report goes on to highlight that the scheme was approved before the

As was noted above, a series of high profile cases,[27] that demonstrated serious failures in care, also proved to be significant policy drivers for the New Labour administration. These cases focused attention on the quality of the outcome which included the patient/ carer experience.[28] Here, Blair's partnership ideology and the administration's preference for active participation in NHS management was significant.[29] The relationship between the state, the healthcare professional and the individual was seen as coherent and fluid. Rather than closely managing specific change, the role of the state was seen as one of motivating other parties to produce health outcomes that will benefit the nation as a whole. The impact of this philosophy is visible throughout the legislative and policy initiatives discussed below.

3.1.2 Eliminating Risk and Uncertainty in Healthcare

The New Labour Government was significantly convinced by ideas of 'risk management', which had gained dominance as part of a broader social anxiety regarding risk.[30] At the time that Blair came to power, the influential theorist Zygmun Bauman was arguing that risk was said to be everywhere in Western culture 'from fatty fast foods…in sex without condoms, in cigarette smoke…in the dirt you see and the germs you do not,' with a corresponding awareness of risk amongst individuals and a set of imperatives for all society which enabled the assessment of what risk is and how it should be dealt with.[31] This apprehension over public

banking crisis in 2008, at a time of fast expansion in health spending. In the time since the hospital has been functioning, spending on health care provision has mostly not increased in real terms. The investment cost of the plan as a percentage of the revenue costs was 142%, the largest in the NHS. The size of the Trust's deficit in 2011-12 was 22 per cent of its costs and income.

[27] Allitt n4 above; Smith n5 above; Kennedy n6 above.

[28] Smee n22 above at 106.

[29] Poole n2 above.

[30] Lupton D., *Risk* (Routledge; London, 1999) at 9: Lupton notes that risk and uncertainty tend to be treated as conceptually the same thing.

[31] Bauman Z., Postmodern Religion? in Heelas P., Martin D., Morris P., ed. *Religion, Modernity and Postmodernity* (Blackwell; Oxford, 1998): 55-78.

safety, and the emergence of what Beck described as the 'risk society,' provides a strong impetus for political policy, debate and legislation.[32] Beck states:

> 'We no longer choose to take risks, we have them thrust upon us….nobody can escape. Our society is riddled with random risks. Calculating and managing risks which nobody really knows, has become one of our main preoccupations.'[33]

The principle of risk is therefore 'not that it is happening but that it might be happening,'[34] and this concern resonates particularly in the context of the provision of healthcare services. Here, the medical profession offer consultations which are loaded with risks, which are understood by the patient as diagnosis, which then require decisions to be made in relation to those risks.[35] Yet whilst this presents a strong mandate to seek to 'manage' such risk, ideas of risk can also sit in considerable tension with other rights and principles such as autonomy, protection, beneficence, and within a midwifery context, woman centred care.[36] Indeed, it is possible that the elevation of risk may result in methods of case management that operate to the detriment of an individual's right to self-determination, or best interests. [37]

It is perhaps unsurprising that these kinds of tensions were clearly visible in the empirical data in chapter's four to six of this thesis, as risk management poses particular challenges within pregnancy and childbirth.[38] A risk analysis will routinely be undertaken within maternity care

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[32]Wilson and Symon n11 above.

[33]Beck U., The Politics of risk society in Franklin S. ed. *The Politics of Risk Society* (Polity Press; Cambridge, 1998) at 12; see further Scott A., Risk or Angst Society in Adam B., Beck U., Van Loon J., ed. *The Risk Society and Beyond: Critical Issues for Social Theory* (Sage; London, 2007) at 39.

[34] Adam B., Beck U., Van Loon J., *The Risk Society and Beyond: Critical Issues for Social Theory* (Sage Publications; London, 2007) at 2.

[35] Samerski S., The decision trap- How genetic counselling transforms pregnant women into managers of foetal risk profiles in Hannah-Moffat K., O'Malley P., eds. *Gendered Risk* (Routledge-Cavendish; Oxon, 2007): 55-74.

[36] O'Malley P., Risk, Uncertainty and Freedom in author's ed. *Risk, Uncertainty and Government* (Glasshouse Press; London, 2004): 173-181.

[37] Preston-Shoot M., Evaluating self-determination: An adult protection case study *Journal of Adult Protection* 3(1) (2001): 4-14.

[38] Royal College of Midwives (RCM) *Assessing and managing risk in midwifery practice* (RCM; London, 2003) at 1.

to indicate a woman's suitability to a specific model of care.[39] Following the Third Way conception of individual responsibility,[40] the pregnant woman is required to be responsible for her pregnancy and to work in partnership with healthcare professionals who will support her in the risk laden endeavour of pregnancy. This approach is justified by evidence based medicine, which creates a significant impetus for the woman to acknowledge the risks that are applied to her pregnancy and to accept the advice given to her, as this will enable her to follow the path of 'greatest benefit with the least risk'.[41]

An additional factor which renders the accurate calculation of safety particularly difficult within the maternity services is that, frequently, the amassed data does not provide an in-depth analysis of reported incidents apart from maternal deaths.[42] However, such evidence as does exist suggests some cause for concern. The Royal College of Obstetricians and Gynaecologists (RCOG) (2013) identified that stillbirth and maternal mortality rates in the UK are amongst the highest in Europe.[43] In the 2014 *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)* Report,[44] there was recognition that there

[39]Wilson and Symon n11 above.

[40] Poole n2 above.

[41] Ruhl L., Liberal Governance and Prenatal Care: Risk and Regulation in Pregnancy *Economy and Society* 28(1) (1999):95-117 at 96.

[42]O'Neill N., *Safe Births Everybody's Business: An independent Inquiry into the Safety of Maternity Services in England Conclusions and Recommendations* (Kings Fund; London, 2008) at 2: O'Neill suggests that in spite of the data that is available it is not possible to say how safe it is to give birth in England, or to compare this with the safety of maternity services elsewhere due to limited or incomparable data about adverse outcomes other than deaths.

[43]Royal College of Obstetricians and Gynaecologists (RCOG) *Patterns of Maternity Care in English NHS Hospitals 2011/12* (RCOG; London, 2013); see further World Health Organisation (WHO) *10th Revision of International Classification of Diseases, Injuries and Causes of Death (ICD10)* (WHO; Geneva, March 2010): The WHO define maternal death as the death of a woman whilst pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes http://www.who.int/classifications/icd/en (accessed 17/05/2014).

[44]Knight M., Keynon S., Brocklehurst P., Neilson J., Shakespeare J., Kurinczuk J.J., eds. on behalf of MBRRACE-UK *Saving Lives, Improving Mothers' Care- Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-12* (National Perinatal Epidemiology Unit; Oxford, 2014): maternal deaths have decreased from 11 (in 2006-2008) to 10 (201-2012) per 100,000 women giving birth.

has been a decline in maternal mortality statistics against the national birth rate.[45] Almost three quarters of the women that died had underlying medical conditions which complicated the pregnancy and it was acknowledged that services for such women need to be provided by appropriately trained professionals in order to reduce the risks to them.[46] This is supported by other recent reports which highlight that the quality of care is impacted by issues related to safety, quality and leadership.[47] When these reports are examined together with the data from NHS England,[48] it would appear that in some circumstances some NHS Trusts are struggling to offer safe quality care.[49] This is notwithstanding the introduction of the risk management strategies, discussed in this chapter, which were intended to provide the pregnant woman and her unborn baby with a good outcome, whilst simultaneously reducing the need to make clinical negligence claims against the service where care was accessed.[50]

Whilst the goal of reducing risk to women's health is laudable, the imposition of a risk analysis can serve to reinforce the superiority of medical expertise, with the label of 'high risk' being applied to women rather than being requested by them.[51] When clinicians categorise a woman

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[45] Office for National Statistics (ONS) *Statistical Bulletin: Births in England and Wales 2013* (ONS; London, 16th July 2014) at 1: this report states that there were 698,512 live births in England and Wales in 2013, a decrease of 4.3% on 2012.
[46] MBRRACE-UK n 44 above.
[47] Care Quality Commission (CQC) *Medway NHS Foundation Trust, Medway Maritime Hospital: Quality* Report (CQC; London, 8th July 2014); Care Quality Commission (CQC) *East Kent Hospitals University NHS Foundation Trust: Quality Report* (CQC; London, 13th August 2014); Care Quality Commission (CQC) *Maidstone and Tunbridge Wells NHS Trust: Quality Report* (CQC; London, 3rd February 2015).
[48] National Reporting and Learning System (NRLS) *Six Monthly data on patient safety incidents Report* (NHS England; London, 24th September 2014).
[49] n 47 above.
[50] National Reporting and Learning System (NRLS) *Patient Safety Resources* (National Health Service Litigation Authority (NHSLA) *Learning from Maternity Claims* (NHSLA; London, 10th January 2014): this report indicates that maternity claims represent the highest value and second highest number of clinical negligence claims reported to the NHSLA and that during the 10 years that were analysed (01/04/2000- 31/03/2010) there were 5,087 maternity claims with a total value of £ 3,117,649,888. They highlight that during the same period there were 5.5 million births in England and as such less than 0.1% of births during this period became the subject of a claim. The most frequent claim categories were those relating to management of labour (14.05%); caesarean section (13.24%) and cerebral palsy (10.65%). The management of labour and cerebral palsy were the most expensive and accounted for 70% of the total value of all maternity claims.
[51] Wilson and Symon n11 above: 1-11.

within a risk framework in order to attempt to guarantee a good outcome,[52] this may ignore the possibility that the individual woman may have a different understanding and perception of risk that is more closely attuned to their own lives. Pregnant women frequently do not consider themselves to be either at a high or low risk of an adverse outcome in terms of care.[53] Thus, whilst the New Labour Government supported the concept of choice and individualised care for pregnant women in maternity services through policy initiatives such as the *National Service Framework for Children, Young People and Maternity Services* (2004),[54] and *Maternity Matters* (2007),[55] these were to be structured within a risk framework. The consequence of this is tension, as efforts to promote choice and individualised care may clash with risk management strategies, as women are required to be responsible decision makers and comply with the package of care offered to them, in the name of safety, for both themselves and their fetus.[56] Again, this is a compelling theme that emerged in the interviews conducted with midwives for this study.

Having briefly outlined the broad ideological drivers which influenced health policy during this period, the chapter now moves on to consider the general NHS reforms that were

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[52] Smith A.F., Discussion of risk pervades doctor patient communication *British Medical Journal* 325(2002): 325-548: Smith maintains that risk is relative and suggests that there is a risk 'ladder' which demonstrates the probability of different risks occurring. For example whilst the risk of dying in a car accident is 1: 10,000, the risk of having a spinal haematoma (a blood clot in the spine) following epidural anaesthesia is less than 1: 100,000. As such the risk of dying in a car accident is 10 times greater than having complications following an epidural and it would therefore follow that there would be increased anxiety about getting into a car, and less anxiety about having an epidural. However this is often not the case which would suggest that people accept certain risks like getting into a car whilst judging that other risks which are less likely to happen are more problematic and unacceptable.

[53] Stahl K., Hundley V., Risk and risk assessment in pregnancy: do we scare because we care *Midwifery* 19(2003):298-309; World Health Organisation (WHO) *World Health Day: Safe Motherhood* (WHO; Geneva, 1998): the WHO define risk in maternity care as 'the probability of dying or experiencing serious injury as a result of pregnancy or childbirth'.

[54] Department of Health (DoH) *National Service Framework for Children, Young People and Maternity Services* (DoH; London, 2004a).

[55] Department of Health (DoH) *Maternity Matters* (DoH; London, 2007c) at 5: this document outlines that there should be 'a wider choice in maternity care' and specifies 'choice guarantees' which should be achieved by the end of 2009.

[56] Royal College of Midwives (RCM) *Reassessing risk: a midwifery perspective* (RCM; London, 2000); Hundley V., Ryan M., Are women's expectations and preferences for intrapartum care affected by the model on offer *British Journal of Obstetrics and Gynaecology* 111(6)(2004):550-560.

introduced by the New Labour Government (3.2, 3.3 and 3.4) and the specific reforms of the regulation of midwifery (3.5), tracing the impact of these drivers.

3.2 The Health Act 1999

In the year following Blair's election the important policy document *A First Class Service: Quality in the New NHS* which foregrounded clinical governance and risk management as central to addressing the varying standards of care was published.[57] This document provided the basis for the enactment of the Health Act 1999,[58] the following year.

The 1999 Act was strongly influenced by concerns to maximise the provision of safe, high quality care in the NHS, with strategies for risk management being seen as an essential aspect of clinical governance.[59] Henceforth, under section 60, all NHS organisations were obliged to meet a statutory duty of quality of care, with a requirement for monitoring to ensure that this was effective.[60] This reinforced the central tenets of monitoring and audit consistent with neoliberal and new public management strategies. However, it also included new management structures which were supplemented by additional governance in order to achieve improvements in the functioning of the NHS as rapidly as possible.[61] In tandem with procedures that scrutinised health care provision, clinical governance strategies were developed to control and unify standards in health care across the UK.[62]

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[57] Department of Health (DoH) *A First Class Service: Quality in the New NHS* (HMSO; London; 16th March 1999a).
[58] Health Act 1999.
[59] Wilson J.H., Principles of clinical governance in Wilson J.H., Symon A., *Clinical Risk Management in Midwifery: The right to a perfect baby* (Books for Midwives; Oxford, 2002):1-14: Wilson suggests that risk management amalgamates accountability frameworks and reporting systems in order to meet Corporate Governance and Controls Assurance obligations.
[60] Health Act 1999 18 (1) Duty of Quality states: It is the duty of each Health Authority, Primary Care Trust and NHS trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals.
[61] ibid: The 1998 proposals meant that poor performance was recognised and the National Institute for Health and Clinical Excellence (NICE) and the National Service Frameworks (NSF) tasked with tackling this area of service provision; this was facilitated through the creation of the Commission for Health Improvements which later became the Healthcare Commission and the Modernisation Agency.
[62] DoH n57 above.

3.2.1 Moving Away from Self-Regulation

The 1999 Act additionally reflected Blair's mission to 'modernise' the NHS, through increased regulation. Within this context professionals would become responsible for shortcomings in the standard of care, with the state controlling and improving standards of healthcare through alterations to the way in which health and healthcare professionals were regulated.[63] Consequently, the health care practitioner's right to clinical decision making would be curtailed through clinical governance, with amendments to statutory regulation enforcing changes to professional behaviour.[64] This enthusiasm for regulatory change was articulated by Tony Blair:

> 'The professions know that they have to make professional regulation, swifter, tougher and more open if it is to regain public support- the essential foundation on which all regulation depends…patients have a right to expect that the person who treats them is up to the job. Government has a duty to ensure that they are.'[65]

The 1999 Act thus signalled a move away from self-regulation towards further state intervention, justified in the name of ensuring patient safety.[66] This nevertheless led to some suspicion of the legislation, with some health care professionals viewing this as a means for the manipulation of healthcare organisations who did not perform in accordance with state and public expectations.[67] Indeed Baroness Cumberledge commented during the debate on this legislation that:

> 'One of the great challenges in the NHS is trying to unite the professional tribes. I believe at a stroke the Government has succeeded in doing that. However, it is a pity that the professions have united against these clauses.'[68]

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[63] Poole n2 above.

[64] Blair A., National Health Service Address 2nd July 1998 as cited in *Modernising Regulation-The New Health Professions Council: a consultation document* (Department of Health; London, 2000) at 6.

[65] Blair A., 50th Anniversary Conference Address on the National Health Service (1998).

[66] As will be seen below, this included changes to the Nurses, Midwives and Health Visitors Act 1997; n58 above: c 8 s.60: the health care professions regulated by this section were broad and included those regulated by the Pharmacy Act 1954; the Medical Act 1983 and the Dentists Act 1984.

[67] HL Deb vol. 597 col. 1836 4th March 1999.

[68] ibid at 1833.

Here, the Labour administration appears to move away from alliances with healthcare professionals towards control and censure through regulation. Notwithstanding the rhetoric of New Labour, in this move the state becomes progressively more authoritarian in nature.[69]

3.2.2 Risk Management

The 1999 Act enabled the New Labour administration to build on the reforms of the previous administration, which had devised risk management as a means of managing issues in service provision that had led to patient dissatisfaction and claims of negligence and litigation. In chapter two it was seen that during the 1990s, the cost of clinical negligence had continued to increase unremittingly.[70] This had contributed to a focus on risk management strategies and the establishment of the National Health Service Litigation Authority (NHSLA) and the Clinical Negligence Scheme for Trusts (CNST) that attempted to address the problem.[71] One of the latter's functions was to produce national risk management standards.[72] However, whilst the aim of the scheme is laudable in terms of seeking to improve risk management strategies and learn from adverse events to the benefit of all concerned within the maternity services,[73] it

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[69] Poole n2 above.

[70] National Health Service Litigation Authority (NHSLA) *Ten Years of Maternity Claims: An analysis of NHS Litigation Authority Data* (NHSLA; London, 2012a); National Health Service (NHS) Executive *Clinical Negligence Costs* (NHS Executive; London, 1995) FDL (96)39: this report identifies that the total cost of claims to the NHS in 1975 was approximately £1 million, this figure had increased to around £200 million by 1996.

[71] The creation of the NHSLA and CNST were discussed in the previous chapter where it was established that it the NHS Litigation Authority (NHSLA) was established on 20 November 1995 to indemnify English NHS bodies against claims for clinical negligence. It is a Special Health Authority and as such a division of the National Health Service. It is not an insurance company. Initially, its only purpose was to manage the Clinical Negligence Scheme for Trusts (CNST), a risk-pooling system in respect of clinical claims occurring as a result of incidents on or after 1 April 1995 for NHS Trust members and their employees (NHSLA *Fact Sheet* (NHSLA; London, September 2009).

[72] Walshe K., The development of risk management in Vincent C *Clinical Risk Management: Enhancing Patient Safety* 2nd ed. (British Medical Journal (BJM) Books; London, 2001):45-60; National Health Service Litigation Authority (NHSLA) *NHSLA Risk Management Standards 2013-2014* (NHSLA; London, March 2013a); National Health Service Litigation Authority (NHSLA) *Clinical Negligence Scheme for Trusts: Maternity Clinical Risk Management Standards v.1* (NHSLA; London, March 2013b): the NHSLA has reviewed its approach to risk management standards and clinical maternity standards and as a result from 2014 the new CNST standards will focus on outcomes and not simply processes. Successful assessment against these standards demonstrates commitment to risk management and patient safety but additionally attracts discounts to insurance premiums including level1 – 10%, level 2- 20% and those achieving level 3 receiving a 30% discount http://qualitygovernancesolutions.co.uk/committee-structures.html (accessed 04/04/2015).

[73] Bartholomew A., Learning Lessons from Claims *Clinical Risk* 17(2011):85-87.

operated through the introduction of financial incentives that aimed to provide the motivation needed to develop clinical risk management within the NHS.[74] This can create tensions between quality care provision, government targets and financial restrictions.[75] The use of incentives can potentially mean that the development of governance structures may become perceived as an end in themselves rather than as a means to achieving quality of care and patient safety. These points of tension between the use of incentives and a 'target setting' culture, and alternatively what pregnant woman and midwives believe to be best in terms of the woman's care, is again visible in the empirical data discussed in subsequent chapters.

3.3 An Organisation with a Memory and the National Patient Safety Agency (NPSA)

A focus on the management of risk as a key aspect of ensuring patient safety was also clearly visible in other policy initiatives.[76] In this context patient safety is defined as 'freedom for a patient from unnecessary harm or potential harm associated with health care',[77] with the assessment of risk related to the likelihood of being subjected to significant damage or injury.[78] Notably, the policy document, *An Organisation with a Memory* (2000) acknowledged the problems of errors in medical treatment and emphasised the significance of learning from mistakes.[79] The following year the National Patient Safety Agency (NPSA) was created to implement its recommendations, with the aim of improving patient safety.[80]

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[74]ibid.

[75]Som C.V., 'Quantity' v. 'Quality' dilemma of health staff in NHS UK: Does Clinical Governance Provide a solution *Clinical Governance An International Journal* 14 (2009) (4):301-314.

[76] Department of Health (DoH) *Building a safer NHS for patients: Implementing an organisation with a memory* (HMSO; London, 2001a).

[77]Council of the European Union, European Council Recommendation on patient safety, including the prevention and control of healthcare associated infections, *2947th Employment Policy and Consumer Affairs Council Meeting* (Press Office; Brussels, 2009) http://www.consilium.europa.eu/Newsroom (accessed 02/07/2013).

[78] Stevenson O., *Elder Protection in Residential Care: What can we learn from Child Protection?* (Department of Health; London, 1999).

[79] Department of Health (DoH) *An Organisation with a Memory* (HMSO; London, 2000b).

[80] DoH ibid above; National Patient Safety Agency (NPSA) *Seven steps to patient safety: the full reference guide* 2nd Ed. (NPSA; London, August 2004): the functions of the NPSA became part of NHS England in 2013.

The complex nature of healthcare provision means that inevitably errors will occur periodically. 'Good people will make mistakes' and outcomes on occasion may be less than perfect.[81] Nevertheless, the requirement for reporting systems and performance reviews within risk management, which attempt to identify inadequate actions or mistakes made by clinicians, are not always effective.[82] There is often little enthusiasm for reporting errors or adverse events by healthcare practitioners particularly where the service user has not been affected, which may lead to an incomplete picture in terms of risk management and quality care.[83] It was this set of concerns that informed the introduction of the NPSA. This organisations function was to collate and analyse evidence from NHS organisations, staff, patients and carers, and utilise information from a variety of global reports to identify risks and, in doing so, prevent harm to patients from adverse events in clinical practice.[84]

Human error and individual failures lead to adverse events in approximately 15 per cent of circumstances.[85] However, when procedures are developed to address errors in healthcare, there is frequently an emphasis, in management terms, on the individual rather than the

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[81] Bark P., Psychological aspects of patient safety in Tingle J., Bark P., Patient *Safety, Law Policy and Practice* (Routledge; London, 2011): 64-84 at 72.

[82] Toft B., The Failure of Hindsight *Disaster Prevention and Management* 1(3) (1992): 213-217: Toft suggests that errors in health care made by individuals often involves the focus on individual performance the so called 'naming, blaming and shaming' approach.

[83] Wallace L.M., Boxall M., Spurgeon P., Organisational change through clinical governance: the West Midlands three years on *Clinical Governance: An International Journal* 9(1) (2004):17-30; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: this sets out standards of quality and safety and replaces existing regulations. These regulations also additionally introduce the requirement of the Duty of Candour. This duty requires health and social care providers to be open and transparent with service users about treatment and care they have received, including when outcomes are poor. It applies to health service bodies and aims to address the concerns identified in the *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009* Volume I (Francis R., (Stationary Office; London, 2010), the follow on report by Francis R., *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (The Stationary Office; London, 2013), and the *Berwick Review into Patient Safety* (Berwick D., *Berwick Review into patient safety* Department of Health (DoH) (DoH; London, 6th August 2013)) which will be discussed in the concluding chapter of the thesis.

[84] Berwick ibid.

[85] Reason J.T., Human error: models and management *British Medical Journal* 320 (March 2000):768-770; Wilson J., Tingle J., *Clinical Risk Modification: A Route to Clinical Governance* (Butterworth-Heinemann; Oxford, 1999): these authors identify that 85% of adverse events are caused by organisational failures.

organisation.[86] This would appear to support some clinicians' fears that risk management is at times a restrictive measure, existing in tension with clinical judgement and decision making. The management of risk in these circumstances may also be seen as a system which seeks to blame the individual healthcare professional,[87] frequently as a result of their being 'autonomous' and in control of decision making.[88] Here, the healthcare practitioner is required to be responsible for the management of particular events as a result of their expertise.

The problem in these situations however lies with the perception of risk that the healthcare professional possesses which may increase their anxiety and so generate actions and behaviours which avoid blame but which may not provide quality care.[89] Indeed, Clements argues: 'that one man's defensive medicine is another man's risk management,'[90] a view it would seem that is shared by the NHSLA that, as was discussed above, implement CNST schemes and produce clinical risk management guidelines for NHS Trusts across England.[91] However, the difficulty with such perceptions are that they do not address the health care professionals misconceptions in relation to what might constitute poor practice in legal terms, choosing instead to concentrate on implementing punitive measures should identified targets not be reached. As a consequence of this 'blame culture', errors may not to be addressed effectively, as strategies for resolving these failures do not acknowledge that broader, more complex institutional issues have as significant an impact on mistakes in practice as individual clinical errors.[92]

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[86] Reason J.T., Understanding Adverse Events: human factors *Quality in Health Care* 4(1995):80-89; Wilson J.H., Principles of clinical governance in Wilson J.H., Symon A., *Clinical Risk Management in Midwifery: The right to a perfect baby* (Books for Midwives; Oxford, 2002):1-14: Wilson suggests that remedial action in terms of addressing errors in healthcare focuses on the individual in 98% of occasions and only addresses organisational failures 2% of the times.

[87] Reason J.T., Carthey J., de Leval M.R., Diagnosing 'vulnerable system syndrome': an essential prerequisite to effective risk management *Quality in Health Care* 10(Suppl11) (2001):ii21-ii25.

[88] Langer E.J., *The psychology of control* (Sage; London, 1983).

[89] Titterton M., *Risk and Risk Taking in Health and Social Welfare* (Athenaeum Press; Gateshead, 2006) : 49-62

[90] Clements R 1991 Litigation in Obstetrics and Gynaecology *British Journal of Obstetrics and Gynaecology* 98(1991):423-426 at 424.

[91] n 71

[92] Reason J., Beyond the organisational accident: the need for 'error wisdom' on the frontline *Quality Safety and Health Care* 13(suppl11)(2004):ii28-ii33: Reason suggests that organisational accidents may be characterised by

It is noteworthy that the aim and function of the NPSA is consistent with other industries (for example the aviation industry) where there is a high level of risk and where the potential for failure is generally well recognised.[93] In these organisations, staff are educated at all levels to have the confidence and tools to deal with failure and, as such, safety and reliability become a 'dynamic non-event.'[94] In this situation, organisational change rather than a 'blame culture' is the dominant model.[95] Conversely in the NHS, whilst there has been some improvement in reporting incidents in recent years,[96] clinicians still appear to be apprehensive about risk management believing that it is still mainly concerned with failure rather than achievement and the reduction of errors rather than improving care provision and practice.[97] This apprehension also emerged in the empirical data discussed in chapter four, where for some midwives, the care they were able to offer to pregnant women at times appeared to be in tension with risk management strategies.

3.4 The Creation of NICE and the Growth of Clinical Guidelines

With these reforms in place, Blair moved next to create two new institutions that aimed to resolve disparities in care by facilitating the process of clinical governance.[98] This involved the introduction of new systems of management and increased accountability, which it was hoped

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the Swiss Cheese model of accident causation whereby the slices of the cheese represent successive layers of defensives, barriers and safeguards. In an ideal world Reason argues the defensive layers would be intact. However in reality they are like a Swiss cheese, full of holes. These gaps occur as a result of weaknesses and failures which are created both by unsafe acts on the part of clinicians and as a result of earlier decisions by those who regulate and manage the system.

[93] Weick K.E., Organizational culture as a source of high reliability *California Management Review* 29(1987):112-127: the industries where high reliability occur include air traffic control centres and nuclear power plants. These organisations have characteristics which are similar to healthcare in that they are complex, at times are intensely interactive and they perform demanding tasks often under extreme pressure.

[94] Ibid: in these circumstance Weick suggests that 'non-events' do not attract undue attention.

[95] Black N., Medical litigation and the quality of care *Lancet* 335(1990):35-37: in these circumstances clinicians may avoid both procedures and service users who they believe carry a high risk of litigation and medical negligence claims.

[96] NRLS n48 above.

[97] Titterton n89 above 88-95.

[98] The National Institute for Clinical Excellence (NICE) (Establishment and Constitution) Order No 220 (Stationary Office; London, 1999); National Health Service Act 1999 s. 19 (2).

would produce cultural transformations within the NHS.[99] The organisations were to be known as the National Institute for Clinical Excellence (NICE) which is now known as the National Institute for Health and Care Excellence,[100] and the Commission for Health Improvement (CHI) which has lately become the Care Quality Commission (CQC).[101] Whilst NICE would be responsible for devising guidelines and promoting clinical audit, the CHI/CQC would guarantee quality of care across the NHS through the monitoring of performance at institutional level.[102]

It was imagined that the newly constructed CHI would have as its main role to carry out analysis of the management of care provision and would make these reviews publicly available,[103] ensuring public accountability and transparency for care was established and maintained. In the Health Act 1999, the CHI was tasked with examining performance at local level in relation to clinical governance.[104] This theme was developed in the Labour reform document the *NHS Plan* in 2000, which attempted to describe the reasons for poor performance within the NHS, suggesting these included a lack of consistent standards across the

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[99] Poole n2 above.

[100] The National Institute for Clinical Excellence (NICE) became the National Institute for Health and Clinical Excellence in 2005 as a result of The National Institute for Clinical Excellence (Establishment and Constitution) Amendment Order 2005. Following the Health and Social Care Act 2012 the organisation became known as the National Institute for Health and Care Excellence and changed from being a special health authority to an executive non-departmental public body (ENDPB). The organisation has retained its abbreviated name NICE throughout these changes.

[101] The Commission for Health Improvement was a non-departmental organisation which was funded by the Department of Health. The CHI was the first organisation to audit and assess the performance of the NHS in England. It carried out its role until 2004 when its functions were incorporated into the Healthcare Commission. As a result of the Health and Social Care Act 2008 the role of regulating health care provision undertaken by the Health Care Commission together with the Commission for Social Care Inspection and the Mental Health Act Commission were subsumed into the current regulatory organisation, the Care Quality Commission (CQC) which was established in 2009. The CQC is an executive, non- departmental public body of the Department of Health. The CQC is accountable to the Public; Parliament and the Secretary of State for Health.

[102] ibid.

[103] Health and Social Care Act 2003 s. 19 (1)(a-e): in 2003 the CHI's powers were extended as a result of the s.2 (12) & (13)(1-4) which enabled it to inspect any aspect of the NHS; was be able to recommend to the Secretary of State for Health when "special measures" should be taken to improve failing performance; and was to establish an Office for Information on Healthcare Performance and to publish an annual report on the state of the NHS.

[104] ibid.

organisation and disenfranchised service users.[105] The *NHS Confederation Report* in 2001, additionally argued that the reasons for poor performance could be extended to incorporate the lack of management of treatment areas, poor dialogue and general engagement with health care professionals, ineffective management and an excessive eagerness for organisational change.[106] These claims demonstrate the subtleties and complexities of the culture of the NHS.

The Labour Government anticipated that the question of safe care would be performance managed through the distribution of NICE guidelines which would be adhered to by all staff across the NHS.[107] Reliance on such guidelines is a significant strategy of clinical governance, which enables the measurement of the effectiveness of care against identified standards.[108] This interpretation was developed further by Sir Michael Rawlins the Chairman of NICE who, whilst implicitly referencing the *Bolam* standard of care for professional negligence law,[109] suggested that: 'NICE guidelines are likely to constitute a responsible body of medical opinion for the purposes of litigation'.[110] This links the provision of NICE guidelines to the reduction

[105] Department of Health (DoH) command paper *The NHS Plan: a plan for investment, a plan for reform* (HMSO; London, 1st July 2000a) Cm 4818-1.
[106] National Health Service (NHS) Confederation *Why Won't the NHS Perform Better?* (NHS Confederation; London, 2001): the NHS Confederation is the membership organisation whose partners are those institutions who commission care within the NHS. Within the Report it was concluded that much more time had been spent on outlining the cure to problems in the NHS than had been spent on determining what those issues were.
[107] n 98 above.
[108] Vincent C *Clinical Risk Management: Enhancing Patient Safety* 2nd ed. (British Medical Journal (BJM) Books; London, 2001); Secker-Walker J., Donaldson L., Clinical Governance: The context of Risk Management in Vincent C., ed. *Clinical Risk Management* (BMJ; London, 2001): 61-73; Timmermans S., Berg M., *The Gold Standard: The challenge of evidence based medicine and standardisation of health care* (Temple University Press; Philadelphia, 2003) at 22: Timmermans and Berg in this instance describe clinical guidelines as procedural standards which have the capacity to change the views of actors, adjust interactions of accountability and accentuate or understate 'pre-existing hierarchies'.
[109] Bolam v Friern Hospital Management Committee [1957] 2 ALL ER 118 at 587: McNair J when summing up in Bolam stated that a doctor ' is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men'. As such a doctor or other health care professional following the guidelines will be able to rely on that fact to argue that he has not fallen below the relevant standard of care if accused of being negligent.
[110] Taylor J., Tough Talk from the NICE man *Med Economics* (November 2003):44-46.

of clinical negligence claims,[111] in a manner similar to those of risk management strategies which were discussed earlier.

Clinical guidelines furthermore offered an important mechanism by which care could be standardised care across institutions and settings.[112] The Blair administration anticipated that the standardisation of care would improve outcomes and, as a result, the Health and Social Care Act 2003 entrenched this principle in legislation.[113] This was followed by the policy document, *Standards for Better Health*, in 2004 which outlined seven areas or 'domains' including clinical and cost effectiveness; and safety and governance amongst others.[114] As an aspect of the standard related to clinical and cost effectiveness, clinicians and NHS organisations were expected to provide care that was consistent with NICE guidelines.[115]

Clinical guidelines in this context are part of what is termed 'scientific-bureaucratic medicine,' which promotes evidence based medicine and attempts to ensure that clinicians practice in accordance with guidelines that provide therapeutic measures in identifiable conditions.[116] Guidelines are regarded as texts that encapsulate outstanding practice, and are based on the best available scientific research and expert opinion.[117] Many NICE guidelines are commissioned through one of its four National Collaborating Centres (NCCs).[118] The NCCs

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[111] NRLS n50 above; Samanta A., Samanta J., Gunn M., Legal Considerations of Clinical Guidelines: Will NICE make a difference? *Journal of the Royal Society of Medicine* 96(2003):133-138.

[112] Timmermans S., Berg M., A world of standards but not a standard world: towards a sociology of standards and standardisation *Annual Review of Sociology* 36(2010):69-89.

[113] Health and Social Care (Community Health and Standards) Act 2003 c.43 s.46.

[114] Department of Health (DoH) *Standards for Better Health* (DoH; London, 2004b).

[115] Talbot-Smith A., Pollock A.M., Efficiency and standards in author's ed. *The New NHS: a guide* (Routledge; London, 2006): 104-135.

[116] Berg M., Problems and promises of the protocol *Social Science and Medicine* 44(8) (1997): 1081-8.

[117] Fawcett J., Evaluating use of clinical guidelines: a crucial component of evidence based practice *Journal of Advanced Nursing* 65(4) (2009):5; Spyridonidis D., Calnan M., Opening the black box: A study of the process of NICE guidelines implementation *Health Policy* 102(2011): 117-125; National Institute for Health and Care Excellence (NICE) *About clinical guidelines* (NICE; London, 2013a).

[118] National Institute for Health and Care Excellence (NICE) *Developing clinical guidelines: national collaborating centres* (NICE; London, 20th January 2012): the National Collaborating Centre (NCC) has 4 NCC's: National Clinical Guideline Centre (NCGC); National Collaborating Centre for Women's and Children's Health (NCC-WCH); National Collaborating Centre for Mental Health (NCCMH); and the National Collaborating Centre for Cancer (NCC-C). These NCC's help to develop clinical guidelines and quality standards by utilising the expertise of the

establish a working group (normally an independent Guideline Development Committee) which consists predominantly of clinical experts, service users and their representatives with relevant experience and nominated registered stakeholders.[119] In these circumstances, the expert knowledge of the professional is employed to guide the process of guideline development which will be utilised to inform practice more broadly. At NHS Trust level, NICE guidelines should form the basis on which local guidance is constructed. Whilst guidelines might thus be perceived as having a clear role to play in disseminating knowledge of best practice and promoting it, they also sit in tension with the ability of the clinician to have the discretion to practice in a contingent and individualised manner.

Here, it is noteworthy that whilst the neutral phrase, 'guideline', might suggest voluntary participation by clinicians, in practice increased managerialism in the NHS has meant that clinical decision-making and autonomy have tended to be replaced by an emphasis on guideline compliance.[120] Clinical guidelines are part of a wider compliance system that attempts to identify errors and instil professional responsibility.[121] Accountability is achieved through the identification of decisions (which may be poor) and possible errors in practice, which are linked to specific individuals, who then may be targeted for specific performance management.[122]

Royal medical colleges, professional organisations and service users and carer groups. http://www.nice.org.uk/aboutnice/howwework/developingniceclinicalguidelines/nationalcollaboratingcentres/national_collaborating_centres.jsp (accessed 27/04/ 2014).

[119] National Institute for Health and Clinical Excellence (NICE) *Developing clinical guidelines: guideline development groups* (NICE; London, April 30th 2009): the Guideline Development Group reviews the evidence and considers comments on the draft guideline before making final recommendations as to the content of the completed guideline. The panel aims to ensure that stakeholder comments in particular have been closely considered and responded to. This group monitors adherence to NICE guidelines.
http://www.nice.org.uk/aboutnice/howwework/developingniceclinicalguidelines/guidelinedevelopmentgroups/guideline_development_groups.jsp (accessed 27/4/ 2014).

[120] Harrison S., The politics of evidence based medicine in the UK *Policy and Politics* 26(1) (1998): 15-31.

[121] Taylor n110 above.

[122] Grinyer A., Risk, the real world and naïve sociology in Gabe J., *Medicine, Health and Risk: Sociological Approaches* (Blackwell; Oxford, 1995):31-51.

Throughout the Blair administration the issue of compliance with the regulatory framework was articulated in policy documents such as *Trust, Assurance and Safety - the Regulation of Health Professionals in the 21st Century*,[123] and the enquiries which were undertaken to examine failures in care.[124] All of which emphasized the need to ensure that standards of care and clinical governance at national level were achieved through closer inspection of health care professionals and their roles. As a result the Health and Social Care Act in 2008,[125] developed governmental control of the healthcare professions through the Council for Healthcare Regulatory Excellence (CHRE).[126] The function of this organisation was to ensure that healthcare regulators were fulfilling their duty to promote and protect the wellbeing of the public.[127] Altogether, whilst these regulatory changes were championed in the name of safe and consistent services, they also serve to reduce the clinical autonomy that professional elites with their expert knowledge in healthcare have previously enjoyed.[128] In this sense, the Third Way notion of partnership appears somewhat elusive: rather than empowering health care professionals, as key stakeholders, professional discretion appears undermined, or at least, very tightly constrained.[129]

Within the maternity services, clinical guidelines reflect an evidence-based foundation for care provision, based on the assumption that the best opportunities for good outcomes can be

[123] Department of Health (DoH) *Trust, Assurance and Safety - the Regulation of Health Professionals in the 21st Century (*DoH; London, 2007d*).*
[124] Department of Health (DoH) *Safeguarding Patients – the Government's response to the Shipman Inquiry's fifth report and the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries* (DoH; London, 2007a); Department of Health (DoH) *Learning from tragedy, keeping patients safe: Overview of the Government's action programme in response to the recommendations of the Shipman Inquiry* (Department of Health; London, 2007b).
[125]Health and Social Care Act 2008 s. 113.
[126] The CHRE was created from the existing Council for the Regulation of Healthcare Professionals (CRHP) which was formed as a part of the provisions in National Health Service and Health Care Professions Act 2002.
[127] n 125 above at s.114.
[128] Grinyer n 122 at 34: here an 'expert' is defined as managers and policy makers who are responsible for compiling and constructing official information and regulations. Grinyer states that they may not have scientific or medical knowledge but in the process of devising safety programme for use in health care may define themselves as 'experts 'in risk and safety.
[129] Poole n2 above.

derived from population calculations, which are then applied to individual women who access care.[130] Although this approach has obvious merit in driving improvements in care, it can also create problems where there is limited room for the exercise of clinical discretion or individual patient choice. Notably, it can result in generic guidelines with a 'one size fits all' approach, which may not be suitable for all pregnant women and which therefore has the potential to undermine rather than to enhance care. The employment of such 'codified knowledge' through evidence based practice guidelines, at the same time as attempting to provide standardisation of care, may also exist in tension with the embodied knowledge of the individual woman.[131] Again, these tensions emerged clearly in the empirical data discussed in subsequent chapters.

3.5 The Nursing and Midwifery Order 2001

The New Labour Government was also closely concerned with issues relating to poor performance and competence of healthcare professionals. Consequently, it proposed reform of healthcare professional regulation,[132] relying on its powers under the Health Act 1999.[133] This enabled it to introduce the Nursing and Midwifery Order 2001.[134]

The 2001 Order was much broader than earlier nursing and midwifery legislation and, in line with New Labour policy, foresaw substantial changes to the relationship between the state, the individual and the public.[135] As was seen in chapter two, the previous Conservative Government constructed the professional as being an integral part of the problem of the welfare

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[130] Wilson and Symon n 11 above; Sackett D.L., Rosenberg W., Muir-Gray J., Evidence based medicine: what it is and what it isn't *British Medical Journal* 312(1996):76-89.
[131] Levy V., How midwives use protective steering to protect informed choice in pregnancy in Kirkham M., ed. *Informed Choice in Pregnancy* (Palgrave; Basingstoke, 2004):57-69; Polanyi M., *Personal Knowledge: Towards a post-critical philosophy* (Harper-Torch books; New York, 1962).
[132] DoH n105 above: this document sets out plans for the reform of the NHS and sets three test for regulatory bodies: being smaller with greater patient and public representation; being faster and more transparent; and having meaningful public accountability in the health service.
[133] n 58 s.60: the health care professions regulated by this legislation were broad and included those regulated by the Pharmacy Act 1954; the Medical Act 1983 and the Dentists Act 1984.
[134] The Nursing and Midwifery Order 2001 no.253.
[135] Poole n2 above.

state and the NHS, and encouraged the public to distrust the 'self-serving' professional elites who provided care.[136] In order to address this perception, the challenge for the Blair Government was to ensure that the public interest was represented in the various elements of healthcare provision, including the regulation of the healthcare professions themselves. Public accountability was seen to be essential, as it was thought that this would lead to greater transparency in regulatory practices and better communication both for registrants, employers and the broader community.[137]

3.5.1 The Nursing and Midwifery Council (NMC) and Fitness to Practice Provisions

The Nursing and Midwifery Order 2001 created a new regulatory authority, known as the Nursing and Midwifery Council (NMC),[138] which replaced the previous regulatory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). The function of the NMC was explicitly recognized for the first time as being 'to safeguard the health and well-being of persons using or needing the service of registrants.'[139] Additionally, the 2001 Order stipulated that the membership of the new Council should be composed of both registrant and lay members, in contrast to the old system whereby the UKCC and its committees were made up entirely of professionals.[140] A more robust and evenly balanced lay membership was believed by the Blair Government to be crucial to the new Council, as it was

[136] Clarke J., Gewirtz S., Hughes G., Humphrey J., Guarding the Public Interest? Auditing Public Services in Clarke J., Gewirtz S., McLaughlin E., eds *New Managerialism New Welfare?* (Open University Press; London, 2001): 250-266.

[137] J M Consulting *The Regulation of Nurses, Midwives and Health Visitors. Report on a Review of the Nurse Midwives and Health Visitors Act 1997* (JM Consulting Ltd; Bristol, 1998): this organisation was a private company who specialised in business and management consultancy and who were commissioned by the Department of Health in 1997. The report evaluated the 1997 Act and recommended that new legislation was essential to address public safety issues and areas of weakness in the 1997 Act.

[138]n 134: part 2 Article 3(1); Article 3 (9): provides that the NMC has four statutory committees which are the Investigating Committee, the Conduct and Competence Committee, the Health Committee and the Midwifery Committee.

[139] ibid part1 Article 3 (4)&(15): where the NMC's remit was to create and uphold standards of conduct and performance it was obliged to confer with a variety of different organisations including the lay public whilst executing its role.

[140] Nurses Midwives and Health Visitors Act 1979 s.1 (4).

suggested that patient wellbeing could only be achieved through the involvement of lay members. [141] These strategies are consistent with Third Way reasoning which, as has been highlighted throughout this chapter, considered co-operative partnerships between government, the individual and the healthcare professional as being necessary to generate improvements in the provision of care.

One of the core functions of the NMC relates to fitness to practice procedures which enable the regulator to screen its membership and in so doing, ensure that the professions it regulates remains selective.[142] In the 2001 Order questions of competence and misconduct were to be dealt with by the Conduct and Competence Committee who were to manage all such issues for registrants.[143] Panel membership of fitness to practice hearings, was to include a combination of both unqualified and professional personnel who would receive training and direction on how to perform their role as panel members.[144] Although the professional personnel was to include a registrant and/or a registered medical practitioner;[145] there were no specific requirements in relation to the qualifications, experience or competence of the lay member, who has responsibility in part for determining whether or not a registrant is a safe practitioner. As such the NMC is reliant on the panel members having sufficient guidance with which to tackle complex and challenging practice issues.

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[141] HC Deb vol. 360 Col. 437 08 January 2001.

[142] HL Deb vol. 629 Col. 1495 13 December 2001.

[143] Nursing and Midwifery Council website states: that the Conduct and Competence Committee considers cases where a nurse or midwives fitness to practice is alleged to be impaired due to: misconduct, lack of competence; a criminal offence, a finding by any other health or social care regulator or licensing body that fitness to practice is impaired or a barring under the Safeguarding Vulnerable Groups Act 2006, The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 or the Protection of Vulnerable Groups (Scotland)Act 2007 (Nursing and Midwifery Council; London, 1st March 2010). http://www. nmc-uk.org/About us/The Council/Committees-of-the-Council/Midwifery-Committee (accessed 14/08/ 2011).

[144] Nursing and Midwifery Council (NMC) *Nursing and Midwifery Council: Annual Fitness to Practice Report 2011-2012* (NMC; London, September 2012b).

[145] n 134: part 5 Article 24 (b) &(c).

The 2001 Order was enacted against a background of broader developments in the rights of citizens through the Human Rights Act 1998.[146] This was part of a more extensive undertaking by the Labour administration to democratise services and nurture service user participation.[147] However, the 2001 Order's fitness to practice provisions appear to exist in tension with registrant's rights in relation to human rights legislation. In the case of *Tehrani v. UKCC* [2001] these rights were clarified and it was established that the registrant had the right to a fair and public hearing.[148] Other judicial reviews which have considered decision making during fitness to practice hearings since *Tehrani*,[149] have demonstrated that articles contained in the European Convention on Human Rights,[150] which the Human Rights Act 1998 gives direct effect to, are still on occasion apparently being misunderstood or contravened despite court clarification. This has led to registrants being removed from the register, only to be reinstated later when the decision has been overruled.[151] One of the difficulties that was identified was that of obtaining a fair and impartial hearing within a reasonable time.[152] Indeed, in 2011, UNISON when asked to comment on this situation stated: "Nurses and Midwives continue to wait a significant (and often unacceptable) amount of time for their case to be heard and concluded." [153]

[146] Human Rights Act 1998.
[147] Carpenter M., A Third Wave, Not a Third Way? New Labour, Human Rights and Mental Health in Historical Context *Social Policy and Society* 8(2) (2009): 215-230.
[148] Tehrani v. UKCC [2001]IRLR 208: in this case the Court of Sessions held that as a public authority, the council is subject to s.6(1) of the Human Rights Act 1998 which states that: "It is unlawful for a public authority to act in a way which is incompatible with a Convention right". Article 6(1) of the Convention, which is now incorporated in Schedule 1 to the Human Rights Act 1998, provides that: "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law ".
[149] [2001] IRLR 208
[150] Council of Europe *European Convention on Human Rights* (Council of Europe; Strasbourg; 1950).
[151] Colton v The Nursing and Midwifery Council [2010] NIQB28: In this case Article 6 of the European Convention on Human Rights which relates to the 'right to a fair trial' was said to have been violated and it was claimed that the fitness to practice panel had acted unlawfully by proceeding with the hearing in the registrant's absence.
[152] n 144 above.
[153] House of Commons Health Committee *Annual Accountability hearing with the Nursing and Midwifery Council: Seventh Report of Session 2010-12* (The Stationary Office; London, July 2011).

It is suggested that the reason for the protracted length of time taken to investigate and conclude complaints occurs in part as a result of the mounting numbers of complaints received by the regulator.[154] The NMC has seen a 102 per cent rise in referrals related to poor practice, with a 14 per cent increase in the period from 2013-2014.[155] Whilst the NMC is neither able to provide an adequate explanation for this increase in referrals nor to differentiate in its data between referrals made in relation to midwives or nurses,[156] it has attempted to manage this problem by reviewing its conduct and competence procedures including the composition of fitness to practice panels.[157] As a consequence of some of these amendments, the NMC has removed the need for a panellist to be an experienced practitioner with an understanding of the same area of practice as the registrant, formally referred to as the 'due regard' panel member.[158] However, recent reviews of the NMC fitness to practice mechanisms have continued to highlight concerns in relation to these problems, despite the changes made by the regulator.[159]

The NMC's ability to ensure that fitness to practice procedures are robust emerged within the empirical data as a particular area of concern. This will be discussed in more detail in chapter five.

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[154] ibid at 50: evidence given by UNISON the largest public sector union in the NHS, indicated that in May 2011 the NMC had 3,698 cases but only 544 at the substantive hearing stage.

[155] House of Commons Health Committee *Oral evidence: 2015 accountability hearing with the Nursing and Midwifery Council* (The Stationary Office; London, 13th January 2015) at 847.

[156] ibid at 7.

[157] Nursing and Midwifery Council (NMC) *Council Agenda for 26th May 2011 (Open Session)* (NMC; London, 26th May 2011).

[158] ibid.

[159] Professional Standards Authority for Health and Social Care (PSA) *Annual Report and Accounts and Performance Review Report 2013/14* Volume 11 (The Stationary Office; London, 26 June 2014) Vol 11: the Professional Standards Authority for Health and Social Care replaced the Council for Healthcare Regulatory Excellence (CHRE) as a result of the Health and Social Care Act 2012 S. 222. This Authority monitors the regulatory bodies which regulates health professional in the UK and social care in England.

3.5.2 Additional Specific Midwifery Provisions in the 2001 Order

3.5.2.1 The Midwifery Committee

The Nursing and Midwifery Order contains other provisions that applied exclusively to midwifery. These include a Midwifery Committee,[160] with the role of providing advice to the NMC on matters related to the regulation of midwifery but not issues of misconduct.[161] The Committee's work includes the production of regulation regarding suspension procedures and continuing education requirements for qualified midwives.[162] Whilst this provides welcome recognition of the special status and specific interests of midwifery, it is noteworthy that this body was to have merely an advisory role, with the NMC free to discount any advice with which it disagreed. Indeed, the RCM have argued, that in practical terms, within the wider organisation of the NMC, the Midwifery Committee appears to have a minimal role and that midwives are underrepresented and marginalised at senior level within the NMC generally.[163] These concerns are given additional weight in light of recent Law Commission recommendations which will be discussed in more detail in chapter seven.[164]

3.5.2.2 Statutory Supervision of Midwives

The 2001 Order also outlines stipulations for the statutory supervision of midwifery, which has been a consistent feature of midwifery regulation since the first Midwives Act in 1902 (as

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[160] n134: part2 Article 16 (2a) & (2b): states that within the Midwifery Committee the majority of the membership of the Committee should be practising midwives but does not provide specific instruction as to the identity of other committee members.

[161] The Nursing and Midwifery Council (NMC) (NMC; London, 24th March 2010): state on their website that the Midwifery Committee advises on any matter affecting midwifery, i.e. policy issues affecting midwifery practice, education and statutory supervision of midwives, responding to policy trends, research and ethical issues affecting all registrants.
http://www. nmc-uk.org/About us/The Council/Committees-of-the-Council/Midwifery-Committee (accessed 14/08/ 2011).

[162] n 134: Article 42 (a) & (c).

[163] n 134 at 48.

[164] The Law Commission (LC) *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England Law Com No 345* (Law Commission; London, April 2014).

discussed in chapter two). The statutory requirements include provisions for how the Local Supervising Authority (LSA) should function and the qualifications that were deemed necessary to be a supervisor of midwives, as well as providing the LSA with the power to suspend a midwife from practice.[165] As such the LSAs have a broad range of powers with regards to midwifery registrants within the 2001 Order, which operate alongside the NMC's general fitness to practice requirements. This would suggest a belief that, as in all previous statutes since the Midwives Act 1902, the practice of midwifery necessitates extra regulation in order to function effectively. The nursing profession is not subject to the same statutory supervisory procedures within the 2001 Nursing and Midwifery Order. Nevertheless, when discussing the revalidation of nursing in June 2011, the House of Commons Health Committee recommended that the NMC consider extending statutory supervision to the nursing profession as statutory supervision of midwives was seen as 'a tried and trusted means of assuring the quality of midwifery practice.'[166] However, this official view of statutory supervision, may be changing.[167] It is therefore interesting to note that this ambivalence regarding the merits of statutory supervision at policy level was mirrored in the empirical data discussed in chapters five and six.

3.6 Conclusion

This chapter has set out the current regulatory framework for midwifery practice, contextualising it within broader New Labour reforms to the NHS. These reforms resulted in

[165] n 134 above: Article 43(1) states: each LSA shall (a) exercise general supervision in accordance with the rules made under article 42 over all midwives practising in its area; (b) where it appears to it that the fitness to practise of a midwife in its area is impaired, report it to the Council; and (c) have power in accordance with the rules made under article 42 to suspend a midwife from practice; (2) The Council may prescribe the qualifications of persons who may be appointed by the LSA to exercise supervision over midwives in its area, and no one shall be so appointed who is not so qualified. (3) The Council shall by rules from time to time establish standards for the exercise by LSAs of their functions and may give guidance to LSAs on these matters.

[166] n 153 at 13

[167] The proposed reforms to statutory supervision will be discussed in more detail in the concluding chapter of this thesis.

important clinical governance and risk management strategies, as well as introducing a range of other changes that have impacted on the regulation of midwifery. Blair's response to the perceived crisis within the NHS was firmly grounded in his Third Way philosophy, which involved the fostering of partnerships between the state, the individual and society more broadly. This, it was believed, would increase economic efficiency, reduce the cost of welfare and improve the provision of care in the NHS.[168] The individual and the healthcare professional were encouraged to actively participate and take responsibility for decisions made about the provision of care.[169] Managers would facilitate the aim of the state to improve the safety and quality of care, through systems of clinical governance, which would monitor and evaluate the outcomes of care and take an active approach to risk management. Whilst these schemes may be seen as a 'rolling out of the state', it is significant that intervention is increased through regulatory mechanisms such as clinical governance and risk management, with responsibility for motivating change delegated to a local level.[170] Rose and Miller describe this as 'action at a distance'.[171]

Within the strategy of clinical governance lies the production and employment of clinical guidelines that utilise evidence and science to formulate practice instructions and to standardise care.[172] However, the deployment of clinical guidelines and risk management plans can create challenges both for those accessing services and those providing it. The question of risk may be laden with difficulty for the individual pregnant woman seeking assistance, which may generate the need for unanticipated decision making to ensure that there is compliance with

[168] Poole n2 above.
[169] Poole n2 above.
[170] Peck and Tickell n19 above.
[171] Rose N., Miller P., Political Power beyond the state: problematics of government *British Journal of Sociology* (2010): 271-303 at 278.
[172] Grinyer n122 above.

treatment plans.[173] Similarly clinical guidelines, which are based on population data,[174] may create pressures for the pregnant woman to follow certain care pathways that are not always suitable for all women and, which may generate outcomes that are not satisfactory to either the service user or service provider.[175] In such circumstances, however well intentioned, the regulatory framework can potentially undermine decision-making for both the pregnant woman and the midwife as they negotiate routes through the maternity care system, thus affecting the delivery of safe quality care.

During his time in office, Blair similarly undertook reform of healthcare professional regulation. Once again, in keeping with Third Way ideology, this reform was to include increased state and public involvement with healthcare professional regulation, moving away from the traditional model of self-regulation. This restructuring involved lay membership of regulatory authorities such as the Nursing and Midwifery Council, which is accountable for the 680,858 nursing and midwifery registrants on its register.[176] It was hoped that this would benefit the public interest and strengthen professional accountability, particularly in relation to questions of conduct and competence. However, both the NMC's fitness to practice procedures and the specific statutory supervision of midwives have been subject to serious criticism and debate.[177] As mentioned above, these will be explored in more detail in chapter seven.

The regulatory framework that governs the practice of midwives in the UK is multifaceted and complex. Whilst it has resulted from a range of well-intentioned policy initiatives, the strategies used to resolve the questions of quality, safety, poor practice and competence sit in tension

[173] Ruhl n41 above.
[174] Wilson and Symon n11 above.
[175] Downe S., McCourt C., From being to becoming: reconstructing childbirth knowledge in Downe S., ed. *Normal Childbirth: evidence and debate* 2nd ed., (Churchill-Livingstone; London, 2009).
[176] Nursing and Midwifery Council (NMC) *Annual Report and Accounts 2013-2014 and Strategic Plan 2014-2017* (NMC; London, 23rd October 2014c)
[177] Law Commission n164 above; Baird R., Murray R., Seale R., Foot C., Perry C., *Kings Fund Review of Midwifery Regulation* (Kings Fund, London, 2015).

with, and may at times run the risk of undermining excellence in care provision for pregnant women. As explained earlier, the current study embodies the perspective of one specific group of actors, whose views are poorly represented in the existing literature: midwives. Chapters four, five and six of the thesis will thus draw on their experience of working within the regulatory framework laid out above, in order to investigate their views on whether the current regulatory framework that governs midwifery practice supports or undermines the protection of the public.

4. Midwifery Perceptions of Clinical Governance and its Impact on Midwifery Practice

4.1 Introduction

The previous two chapters highlighted how clinical governance strategies have been widely implemented across the NHS in an attempt to standardise care and so offer patients a safe quality service. However, these strategies do not come without difficulties, particularly for the pregnant woman and those assigned to facilitate her journey through the maternity services. When reflecting on these regulatory schemes, one midwife, who was representative of many participants in the study commented:

> 'Clinical governance has made everything very black and white…But when you start thinking about it, it seems quite ridiculous that...…"well you're either this or you're this" and there's nothing that's a bit in the middle, actually that's what midwifery is, more often than not, the bit in the middle, keeping somebody as normal as possible, or its facilitating a high risk woman to still enjoy some degree of normality in her pregnancy.' (Susan, NHS, 6-10 yrs.)

Here the challenge of working with clinical governance strategies whilst attempting to provide care which is consistent with the traditional model of midwifery practice is clear. This theme was repeated throughout the data on clinical governance and is one which will be examined in detail in this chapter.

The analysis of the political reforms that were implemented by both the New Labour Government and its Conservative predecessors in the two previous chapters, established that increasing number of claims for clinical negligence has been a problem for a number of years. In the early 1990s, John Major's administration endorsed risk management as a means of addressing the issue of litigation in the NHS,[1] and founded the NHSLA in 1995 to manage negligence claims across the NHS. It was this organisation that would produce risk

[1] Department of Health (DoH) *Executive Letter: Risk Management in the NHS* (HMSO; London, 1993): 111.

management standards to enhance the provision of care.[2] At the same time, Major's Government was also extending the neoliberal concept of the patient as a consumer who had choice in his or her care.[3] This was a principle much favoured by his predecessor Margaret Thatcher throughout the 1980s, where New Public Management (NPM) strategies encouraged a shift in the focus of service provision away from healthcare professionals towards the patient, a move which it was believed, would be facilitated by the managers of the service.[4] Within the maternity services, this commitment to choice was expressed in the policy document the *Changing Childbirth Report* (1993), which emphasised the concept of woman centred care and suggested that the pregnant women should be actively involved in the care they received.[5] The statutory title of the midwife is derived from the Middle English word meaning 'with woman'[6] and is enshrined in statute.[7] As part of this role, the midwifery profession has traditionally viewed advocacy and partnership with the woman as being integral to its core function. As such the role of the midwife would seem to be aligned with the notion of woman centred care. However, as was seen in chapter two, the rights of patients, and the pregnant woman accessing maternity services, in terms of standards of care and choice,[8] were often in tension with other aspects of service provision, which may in part be the reason why litigation claims have increased in recent years.[9]

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[2] National Health Service Litigation Authority (NHSLA) *NHSLA Risk Management Standards 2013-2014* (NHSLA; London, March 2013a).
[3] Department of Health (DoH) *The Patients Charter: Raising the Standards* (HMSO; London, 1992).
[4] Department of Health (DoH) *Working for patients* (HMSO; London, 1989) cm 555; Le Grand J., *Motivation Agency and Public Policy: Of Knights and Knaves, Pawns and Queens* (Oxford University Press; Oxford, 2003a) at 26.
[5] Cumberledge J., *Report of the Expert Maternity Group: Changing Childbirth* (HMSO; London, 1993).
[6] Webster's On Line Dictionary defines the term midwife as follows: Middle English midwife, from Anglo-Saxon *mid* with (akin to Greek ...) + ... woman, wife http://www.encyclo.co.uk/webster/M/64 (accessed 21/07/2013).
[7] Nursing and Midwifery Order 2001.
[8] DoH n3 above
[9] Pratt R., Morgan S., Hughes J., Mulhall A., Fry C., Perry C., Tew L., Healthcare Governance and the modernisation of the NHS: infection prevention and control *British Journal of Infection Control* 3(5)(2002): 16-25.

In chapter three, following the election of the New Labour Government, the problem of an increasing NHS litigation bill and the perceived falling standards in care were to be addressed by an expansion in risk management strategies. As a result, healthcare reform was considered necessary and would include the introduction of the statutory 'duty of quality' in the Health Act 1999.[10] This was consistent with Blair's Third Way style of neoliberalism which extended some of the reforms of the previous neoliberal Conservative administration. For Blair, the management of risk in healthcare was an important element of his reform programme, which was acknowledged in the policy document *An Organisation with a Memory* in 2000.[11] Here, in keeping with Third Way tenets, there was to be more state intervention in healthcare in the form of clinical governance, which was to be administered by organisations such as the newly created National Institute for Clinical Excellence (NICE),[12] which would produce clinical guidelines for healthcare professionals to follow.

Chapter three demonstrated that these clinical guidelines were an integral aspect of Blair's clinical governance strategies which would help to reduce the risks to patients and standardise care across the service.[13] In doing so, clinical guidelines that were based on the best available evidence and expert opinion were considered as being essential for the provision of safe quality care.[14] However, the difficultly with standardised guidelines is that they may sit in tension with the practitioner's ability to make clinical decisions based on the individual needs of the patient, as compliance with the guideline is a requisite.[15] This is particularly challenging within the

[10] Health Act 1999; Timmermans S., Berg M., A world of standards but not a standard world: towards a sociology of standards and standardisation *Annual Review of Sociology* 36(2010):69-89; Brunsson N., Jacobsson B., *A World of Standards* (Oxford University Press; Oxford, 2000).
[11] Department of Health (DoH) *An organisation with a Memory* (HMSO; London, 2000b).
[12] The National Institute for Clinical Excellence (NICE) (Establishment and Constitution) Order No 220 (Stationary Office; London, 1999); National Health Service Act 1999 s. 19 (2): following the Health and Social Care Act 2012 the organisation became known as the National Institute for Health and Care Excellence but retained its abbreviated name NICE.
[13] Health and Social Care (Community Health and Standards) Act 2003 c.43 s.46.
[14] Spyridonidis D., Calnan M., Opening the black box: A study of the process of NICE guidelines implementation *Health Policy* 102(2011): 117-125.
[15] Taylor J, Tough Talk from the NICE man *Med Economics* (November 2003):44-46.

maternity services where the use of universal guidelines for the large number of women who access the service,[16] may leave little room for the needs of the individual.

As such the discussion in chapter three highlighted several significant issues, which are discussed in the literature regarding clinical governance frameworks and their impact on practice, including: whether there is a conflict between clinical governance and woman centred care and whether this has an adverse effect on quality care provision as a result; and whether clinical governance supports effective maternity care provision as the legislature intended. The current chapter whilst reflecting on these concerns, will also examine the role and effectiveness of risk management and clinical guidelines in order to determine whether, in the experience of the midwives in this study, these strategies promote or undermine the provision of safe effective care.

The empirical data for this study was produced by employing both quantitative and qualitative research methods. Quantitative data was gathered through the creation of a survey which was distributed to 192 registered midwives across the South East of England between May 2012 and March 2013 and which achieved a 70 per cent (n=132) response rate. Similarly, qualitative data was collected via semi-structured interviews with 20 midwifery participants who were working in the South East of England, and who had differing degrees of experience and levels of seniority.

The chapter will commence by examining the participants' general perceptions of clinical governance schemes to ascertain whether in the opinion of the midwives these methods offer quality care (4.2). Next it will go on to consider the themes that arose out of the data which related to risk and service user expectations (4.2.1), and clinical governance and its connection

[16] Office of National Statistics (ONS) *Statistical Bulletin: Births in England and Wales 2013* (ONS; London, July 2014).

with litigation (4.2.2). Following this, the discussion will move on to reflect on the relationship between clinical governance and the woman centred care policy implemented by the Major Government and continued by the Blair Administration (4.3). The chapter will then address the influence that clinical governance has on the normal processes of childbirth and the decisions that are made by pregnant women and midwives during pregnancy and childbirth (4.4 and 4.5).

4.2 Common Perceptions of Clinical Governance

As discussed above, chapter three established that clinical governance strategies were formulated as part of the New Labour Government reforms of the NHS. These reforms that were conveyed in the policy document *A First Class Service: Quality in the New NHS* (1999),[17] were motivated by the need to control and improve standards of care. In this context clinical governance strategies included the development of risk management schemes, and the production and employment of clinical guidelines.[18]

In the survey there was broad support for and confidence in clinical governance strategies from the participants, when asked their opinion of the ability of risk management strategies to reduce the likelihood of poor outcomes in maternity care.[19] 68 per cent (n=91) of participants were either very confident or confident about risk management strategies as a means of preventing poor outcomes in maternity care. However, 28 per cent (n=37) of midwives were neutral, with 4 per cent (n=6) unconfident about the safety of current care provision. When this neutrality was analysed in more detail through an examination of the comments that were provided with this question, several midwives raised questions about current care provision. One participant wrote: 'things will always go wrong despite risk management strategies but the "blame culture"

[17] Department of Health (DoH) *A First Class Service: Quality in the New NHS* (HMSO; London; 16th March 1999a).
[18] Timmermans and Berg n10 above.
[19] In this question the term "poor outcome" may be understood to mean an unfavourable result at the end of an episode of care which might relate to mortality or morbidity issues for either the mother or the infant.

and the threat of litigation does little to increase morale and standards' (NHS, >20yrs.). This comment, together with similar responses from others, reveals that some participants had anxieties about the safety of care, which clinical governance does not appear to address.

This unease about risk management within the survey was also apparent in the interviews. Whilst some participants were generally positive and commented that for them clinical governance was about 'keeping things as safe as possible really' (Jean NHS, 0-5yrs.); and 'being proactive and protecting the woman' (Mary NHS, 6-10 yrs.) others were less convinced. Here, risk management was not perceived as being wholly advantageous to care provision. For example Louise (NHS >20yrs.) remarked: 'I think that sometimes I feel are they written for the good of the patient or the midwife, or are they written to cover the establishment?' These sentiments were mirrored by those in the survey, where participants were asked whether the care women currently receive was safer than in the past and commented:

> 'Some elements are safer as a result of action implemented as part of governance but some factors e.g. staffing issues means that there are still risk issues' (NHS, >20yrs.).

> 'Care is certainly more evidence based, but pressures on the service can affect safety e.g. staffing levels' (NHS> 20yrs.).

> 'Risk is constantly being evaluated, however not everything is predictable in midwifery care therefore there will always be limitations to risk management' (NHS, 0-5 yrs.).

In these commentaries, the recognition of the improvements brought to the maternity services by governance are undermined by issues such as poor staffing levels that have a direct impact on patient safety and care provision.

These responses would suggest that participant's generally had confidence in clinical governance as an efficient mechanism in terms of quality care provision. However, closer analysis of the data from the survey and the semi-structured interviews revealed that,

notwithstanding this broad confidence, the respondents were uneasy about clinical governance and its effect on care offered to pregnant women. These reservations included: risk management and the broader societal perception of risk and its impact on the maternity services (4.2.1); and managing risk to avoid litigation claims rather than addressing the welfare of the pregnant woman and her baby (4.2.2).

4.2.1 Risk, Society and Service User Expectation

The discussion in chapter three highlighted that for the New Labour Government in the late 1990s the management of risk in healthcare was to be a significant part of the reform process in the NHS.[20] Here, the idea of risk is firmly centred on the possibility that there might be a poor outcome, rather than the certainty that there will be a poor outcome.[21] As a result, healthcare professionals are required to assess and manage risks to patients. Thus, in accordance with Third Way ideology, the pregnant woman and healthcare professional are obliged to work in partnership to enable good outcomes with limited risk.[22]

During the semi-structured interviews the concept of societal awareness of risk and its influence on health care provision, particularly with respect to maternity service provision was explored. This was undertaken in an attempt to establish, in the opinion of participants, what effect risk has on clinical governance strategies. June (NHS, >20 yrs.) reflects on the impact of risk management on midwives, service users and society in general and proposes:

> 'I think suddenly the whole thing of risk management has made us feel that it should never happen, so that the thing that we're scared of should never happen, and that bothers me because actually, however good your risk management is, sometimes an adverse incident occurs. So …whatever you do as a midwife, whatever you do as a mother, as a woman sometimes things just happen, and my worry with having a big

[20] Beck U., The Politics of risk society in Franklin S., ed. *The Politics of Risk Society* (Polity Press; Cambridge, 1998) at 12.
[21] Adam B., Beck U., Van Loon J., *The Risk Society and Beyond: Critical Issues for Social Theory* (Sage Publications; London, 2007) at 2.
[22] Ruhl L., Liberal Governance and Prenatal Care: Risk and Regulation in Pregnancy *Economy and Society* 28(1) (1999):95-117 at 96.

> industry called "risk management" is that society feels that we can get rid of risks and we can make everything lovely and nice and that babies never die….. And so I think there is a societal expectation that things never go wrong, so if they do someone is to blame and I think it can become a bit of a witch hunt and I think that can affect midwifery practice because then you are petrified of the adverse outcome.'

Tocophobia is defined as an extreme fear of birth that affects some pregnant women,[23] and may be influenced by societal and cultural issues such as the media and the internet as well as the woman's familial networks.[24] However, in June's discussion it is not only pregnant women who may experience fear and anxiety within pregnancy and childbirth, midwives also feel these emotions as a result of their apprehension that something will go wrong during the birth. Kate (NHS, >20yrs.) demonstrates this anxiety when she says:

> 'We've had three or four major incidents that have affected lots of the staff. So although we practice.....there's always that worry and that feeling that "I'm glad it's not me and luckily I wasn't there.'

Susan (NHS, 6-10yrs.) links these anxieties to societal panic and suggests:

> 'Everything is sensationalised in this country now. So as parents we're terrified to let our children out because we're frightened to death that they're going to be abducted by a sex offender. Which is so not going to happen in the scale of things, and it's kind of that whole thing with midwifery that in the scale of things, why is it that the fear of litigation is then stopping or terrifying professional women from doing their job?'

The perception of endemic risk was discussed in chapter three where it was seen as a striking feature of western culture.[25] However, the difficulty with this societal awareness of risk is that the term can be interpreted differently by different actors and as a result what might seem a

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[23] The Collins Online Dictionary defines tocophobia as follows: an abnormal fear of childbirth or the fear of becoming pregnant, (Greek *tokos* childbirth + -phobia) http://www.collinsdictionary.com/dictionary/english/tocophobia accessed (24/08/2013).

[24] Jordan R.G., Murphy P.A., Risk Assessment and Risk Distortion: Finding the Balance *Journal of Midwifery and Women's Health* 54(3) (May/June 2009):191-200.

[25] Beck n20 above; Scott A., Risk or Angst Society in Adam B., Beck U., and Van Loon J., eds, *The Risk Society and Beyond: Critical Issues for Social Theory* (Sage; London, 2007) at 39.

tolerable level of risk to some may not be the same for others.[26] Within the maternity services, in an attempt to ensure safe outcomes and manage risk there is a 0.1 per cent doctrine with an emphasis on the uncommon poor outcome.[27] Here, many healthcare professionals when offering care to pregnant women, treat the 1:1000 unfavourable event as a certainty and do not remember the 999:1000 episodes when care outcomes are good, or the 99.9 per cent doctrine.[28] Quality midwifery care should predominantly be about the 99.9 per cent doctrine, which might explain why risk management for the participants' is problematic. The midwives in my study stressed that there was a tension between quality care provision and risk management which has the potential to be self-limiting for them as a result of their apprehensions of the improbable risk occurrence. As such, on at least some occasions, the midwives' fear of risk would appear to be preventing the delivery of safe, effective care. As Susan (NHS, 6-10yrs.) comments:

> 'Unreasonably lots of midwives are terrified about "what if I haven't done it right?" And it's not even if catastrophically mum or baby dies. But you know "what if she doesn't like the fact she's ended up with a caesarean section?" Complaints and looking at things, people are scared to death of it…Everybody's terrified of what somebody else will see or say about their practice.'

For Susan, the risk society and the blame culture were interconnected, so that the management of risk, regardless of whether it produces a good outcome or not is associated with the fear of criticism and complaints if service user expectations are not met. This perception of risk and risk management strategies within society generates the expectation that health care provision within the maternity services will produce good outcomes through an experience which was as the service user envisaged. There is a collective expectation, that by attempting to manage these

[26] Symon A., *Risk and Choice in Maternity Care: An International perspective* (Churchill Livingston; London, 2006) at 2.

[27] Dahlen H., Undone by fear? Deluded by trust? *Midwifery* 26 (2010):156-162: the origins of this doctrine are credited to Dick Cheney (46th Vice President of the United States of America) as a result of his comments following the terrorist attacks in America on September 11th, 2001 when he suggested that: "If there is even a 1% chance of a terrorist act occurring we must treat that as a certainty".

[28] ibid.

challenging problems they will somehow be contained and life and health care will be safer. Tanya (NHS, 11-20 yrs.) elaborates on this concept of societal expectation and remarks:

> 'Things are becoming more complicated because of technology and expectation…and therefore things aren't as acceptable as they were, so for example if you look at the 1950s there was an expectation by women that they would lose babies, there would be that stillbirth factor within pregnancy and birth. However today that is not the woman's expectation I don't believe, I believe that they think that that should be a rarity.'

Tanya considers risk through the lens of technology and advances in medical care and suggests that as a result, society broadly expects that childbirth will be safe and systems, including regulatory frameworks, will be put in place to ensure the well-being of the mother and baby. In western culture where risk-aversion is widespread, an adverse outcome such as a stillbirth may be seen as a failure of medicine and technology to control an unpredictable event.[29] This societal expectation of a favourable outcome, regardless of the circumstances, does not appear to take into consideration the official statistics. These figures demonstrate that currently, whilst there has been a fall of 7.7 per cent in the total number of stillbirths recorded in the UK from 2012 to 2013, in 2013 there were still 3,288 stillbirths or 4.7 per thousand total births.[30] Samantha (NHS, >20yrs) draws attention to this unrealistic societal expectation and says:

> 'I'm going to say this because I think it. I say this vaguely at the Trust, but you know babies die. The Trust goes mad when babies die, the Trust risk management and governance, they go mad, but actually babies die, for no reason…nothing that anyone could have done, they die. It's sad and we need to look at it, I'm not saying we shouldn't look at it but they die. Alternatively we had a case where we missed a high risk Down's case,[31] and we missed it. The knock on effect for that woman, if we've missed that and she does have a Down's baby, which we don't know yet and is unlikely to happen, but if we missed it, is phenomenal…and yet because the baby didn't die, nobody's shouting…We did the big investigation...and I keep thinking "Why?" And it's because it's emotive, people are reacting emotively to the death of a baby which they don't come across very often.'

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[29] Jordan and Murphy n24 above.

[30] ONS n16 above.

[31] NHS Choices website states: Down's syndrome is a genetic condition that typically causes some level of learning disability. Around 775 babies are born each year in England and Wales with this condition http://www.nhs.uk/conditions/downs-syndrome/Pages/Introduction.aspx (accessed 05/08/2015).

The current perception and approach to risk in childbirth has created an environment where the fear of litigation has flourished,[32] and this might be the underlying concern in Samantha's scenario. This concept was also acknowledged by other participants' who were of the opinion that society had unrealistic expectations of childbirth and sought recompense when outcomes were not as expected. As a result, managers within the NHS particularly at executive grade appear to be trying to minimize the risk to the organization by implementing defensive rather than proactive clinical governance procedures. Some of the participants appeared to believe that the shift in the wider public's attitude towards the management of risks associated with pregnancy and childbirth has led to a proliferation of risk management strategies that create challenges in terms of care provision. Several of the participants were concerned that risk management generated an increase in claims for clinical negligence, particularly when outcomes were not as anticipated.

4.2.2. Clinical Governance and its Relationship to Litigation

Clinical governance strategies attempt to ensure safe and effective care provision whilst reducing the cost of claims for clinical negligence, a point that was discussed in the previous chapter.[33] Here, it was identified that the issue of litigation and the insurance scheme put in place to administer claims against NHS Trusts in England, known as Clinical Negligence Scheme for Trusts (CNST), was significant for Trust management and the clinicians who provide care. The challenge of how to address the problem of the increasing number of claims of clinical negligence in obstetrics, and its link to CNST was also a recurrent theme for several of the respondents. Many participants connected the failure to accomplish a safe outcome, including the prevention of stillbirth, to litigation claims. In the survey, one participant

[32] Royal College of Midwives (RCM) *Assessing and Managing Risk in Midwifery Practice* (RCM; London, 2003) at1.
[33] National Health Service Litigation Authority (NHSLA) *Fact Sheet 2: Financial Information* (NHSLA: London, June 2012b).

typically remarked: 'I feel that some aspects of risk management focus on the potential of a client to claim and reduce the likelihood of a pay-out rather than the sole focus being that of the woman.' (NHS 6-10yrs.).

This unease was mirrored by participants in the interviews:

> 'It's not about the woman's care; it's how to reduce litigation' (Lilly, NHS, 0-5yrs.).

> 'When I think of risk, I quite often think about CNST and the fact that it is about getting your insurance [premium] lowered and achieving…the status for the Trust, which often then appears to be a tick box exercise…and it isn't about true risk which I find frustrating, because it's not proactive, it's often reactive. So if you're going for a level of CNST, the months prior to that people are trying to get training up to date, they're trying to get things like notices up and it is questionable whether they are effective, but if it meets the needs of CNST that's ok…I find it quite frustrating.' (Tanya, NHS, 11-20 yrs.).

When the participants were questioned about risk management, many similarly spoke in terms of cost, NHS budgets, big pay outs and insurance policies. Here, Tanya (NHS, 11-20 yrs.) observes:

> 'It should be to protect the public, to ensure that experience, that contact, with the services is as safe as possible. Then there is litigation and insurance….so the better you are at risk the less your insurance costs because litigation is costly…….and you have to think about...what can you do to reduce the risk occurring, how does litigation affect that, what are the implications of paying out all that money?'

For some of the midwives there was tension between the purpose of risk management in the context of NHS budgets and financial cost and the care given to women. Claims for clinical negligence within maternity services are currently amongst the highest in the NHS,[34] and a

[34] Department of Health (DH) *Maternity Services in England* (DH; London, 8th November 2013a): the report states that the cost of maternity care to the NHS was around £2.6 billion in 2012-13, equivalent to £3700 per birth. The total cost represents approx. 2.8% of health spending, about the same proportion as a decade ago. As in other parts of the NHS, litigation in maternity care is rising, the number of claims has increased by 80% in the 5 years to 2012-13. Nearly a fifth of spending on maternity services is for clinical negligence cover; National Health

substantial problem for the state.[35] Risk management strategies have many functions in the maternity services including the provision and improvement of quality care and should not be considered purely as a method for addressing claims for clinical negligence.[36] Many of the participants, whilst recognising that risk management had the potential to produce enhancements to care, were apprehensive that the risk management agenda was more about meeting these government and NHS Trust targets in terms of monetary costs rather than providing safe, quality care to women. Lilly (NHS, 0-5 yrs.) in a comment that was representative of many, suggests:

> 'I think it's there to look at how we can reduce risk so reducing litigation…. It's about bringing the insurance policies down, isn't it? Everybody knows…everybody knows that it's all about the money. It's not about the care as such. I don't think people will spend that much money sorting out, you know, different ways of managing risk…but it's not about the women's care. It's how to reduce litigation.'

Here, it emerged that participants believed that the emphasis on reducing the cost of litigation to the NHS, as a key focus of clinical governance creates tensions between service provision and the service user. In the following section this will be considered further with regard to the tension between: clinical governance and first the woman centred care agenda (4.3); and second normal childbirth (4.4.).

Service Litigation Authority (NHSLA) *NHS Litigation Authority: Report and Accounts 2014/15- Fair Resolution* (HMSO; London, 16th July 2015) at 20.

[35] Dixon C., Costs and Clinical Negligence *Law Society Gazette* (21/08/2015): in this article Dixon suggests that clinical negligence provisions in terms of the government budget is second highest behind the cost of nuclear decommissioning. http://www.lawgazette.co.uk/analysis/comment-and-opinion/costs-and-clinical-negligence/5050646.article (accessed 28/08/2015).

[36] Symon A., The Midwife and the legal Environment in Wilson J.H., Symon A., eds. *Clinical Risk Management in Midwifery: The Right to a Perfect Baby?* (Books for Midwives; Oxford, 2002):37-55.

4.3. Clinical Governance and the Commitment to Support Woman Centred Care

In chapters two and three, it was established that the woman centred care policy introduced by the *Changing Childbirth Report* (1993),[37] was continued by the Blair Government in subsequent policy initiatives such as *The New NHS: Modern and Dependable* (1997),[38] and *Maternity Matters* (2007).[39] This concept may be envisaged as epitomising the service user voice in terms of maternity care provision.[40] Clinical governance strategies that employ standardised care and guidelines,[41] conversely appear to support the historically favoured paternalistic stance towards care provision that was considered in chapter two.

In the survey, some participants commented that clinical governance appeared to be in conflict with prioritising woman centred care and that this presented challenges in practice. One remark which was typical of many respondents' comments was:

> 'It seems that we practice with 'one size fits all' policies and procedures which could result in providing *women* centred care as opposed to *woman* centred' (NHS, 0-5 yrs.).

Laura (Ind., >20yrs.) in the interviews continues this theme by saying:

> 'It's not the thing about what's safe for this woman in front of you; you're giving what's safe for the bulk of people. Because that's what the guideline says, so that's not protecting the public.'

Here, it is the emphasis on service provision and the standardisation of care that creates difficulties in terms of safety for the individual woman requiring care. Other participants referred to the loss of uniqueness and individualism that was generated as a consequence of the

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[37] Cumberledge n 5 above.

[38] Department of Health (DoH) *The New NHS: Modern Dependable* (HMSO, London; December 1997).

[39] Department of Health (DoH) *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service* (DoH; London, 2007c).

[40] Deery R., Kirkham M., Supporting Midwives to Support women in Page L.A., McCandlish R., eds. *The New Midwifery Science and Sensitivity in Practice 2nd Ed.* (Churchill Livingstone; Edinburgh, 2006) at 125.

[41] Timmermans S., Berg M., *The Gold Standard: The challenge of evidence based medicine and standardisation of health care* (Temple University Press; Philadelphia, 2003) at 22.

processes associated with clinical governance, and the obstacles that these created for the pregnant woman:

> 'You are making everybody the average person, so you're saying that everybody with a certain condition will fall into a category, there's no individual consensus there…and their experiences are impaired.' (Tanya, NHS 11-20 yrs.).

> 'some people who are in a high risk category are maybe not given as much of a chance ... women that are in a higher risk group are often induced early when perhaps there possibly hasn't been the need.' (Ruth, NHS, 6-10yrs.).

In these examples, the woman who has apparent underlying health problems loses her opportunity to have individualised care based on her own specific needs. This occurs because of the regulatory requirement to follow risk management strategies that prescribe standardised care for women.[42] This point was discussed in chapter three, where it was established that this places the woman at risk of intervention and poor outcomes, as a result of offering care which is based on population data rather than on the individual woman accessing care.[43] Jean (NHS, 0-5 yrs.) provides an example of an incident in practice where the loss of connection with the service user is evident:

> 'We had a woman that wanted a homebirth. She didn't meet the criteria for a homebirth. She wanted hypno-birthing.[44] She didn't want VEs [Vaginal Examinations]. She didn't want monitoring [of the fetal heart]. She didn't want any of that... The two midwives that went out to her were in a very stressful situation because she had meconium[45] everywhere and refused to go [into hospital]…she put herself in the pool really early. So then she was getting cold and there was meconium everywhere. She refused to go in. It was a very, very stressful situation that those midwives were put in and even involving the supervisor midwife didn't help. They finally got her in, but almost under

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[42] Health Act n 10 above; n 12 above.

[43] Downe S., McCourt C., From being to becoming: reconstructing childbirth knowledge in Downe S., ed. *Normal Childbirth: evidence and debate* 2nd ed., (Churchill-Livingstone; London, 2009).

[44] Walsh D., Preparation for Childbirth in author's ed. *Evidence and Skills for Normal Labour and Birth: A Guide for Midwives* 2nd ed. (Routledge; London, 2012): 13-22: Walsh suggests hypno-birthing originated in the USA and employs the use of language as a primary method to reduce anxiety and pain during the birthing process. This technique also involves deep relaxation through breathing and visualisation.

[45] Meconium is faecal matter which is produced by the fetus and is present in the fetal intestinal tract. It is normally passed via the rectum in the first few days of life. The presence of meconium stained liquor in labour may be indicative of fetal distress and as such the labour becomes high risk in terms of fetal wellbeing.

> the thing of, "We can't tell you your baby is safe." It got to that kind of really angst situation but they got her in. And then, she was supposed to be monitored. She ended up with a [caesarean] section and her baby was very, very, poorly.'

In this situation the loss of connection causes stress and anxiety for both the woman and midwives; and although the woman attempts to determine what is in her own best interests the outcome is not the one she anticipated. In this situation, had the connection between the woman and midwife not been lost, it is possible that the woman could have been persuaded to allow the midwife to follow the guidelines, and as a result the outcome might have been better.

Jean (NHS, 0-5 yrs.) concludes:

> 'I think that [situation] was quite difficult because our job is to reduce risk, to keep people safe, you know. The way those midwives had to practice went against everything they knew. They were dealing with what they knew was an unsafe situation. They had no control over it. And I think that was really difficult.'

Individual women may have different agendas and philosophies in the terms of safety in childbirth, which the discussion in chapter three established, are often dependent on their own perceptions, beliefs and experiences.[46] This is apparent in Jean's challenging narrative where the midwives and the pregnant woman have different views of safety that clinical governance strategies do little to resolve.

Jean's example of providing care to a pregnant woman would also appear to be contrary to the tenet of woman-centred care expressed in the National Institute for Health and Clinical Excellence (NICE) (2007) guidelines.[47] These require healthcare professionals and the maternity services to provide 'supportive one-to-one care' and for the service user's opinions

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[46] Edwards N., Safe Birth: Everybody's Business *Aims Journal* 20(3) (2008b):18-19.
[47] National Institute for Health and Clinical Excellence (NICE) CG55 *Intrapartum Care: Care of healthy women and their babies during childbirth* (NICE; London, 2007).

on care to be 'sought and respected'.[48] In Jean's scenario attempts were made to compel the pregnant woman into the narrow categories that were deemed by the maternity services to be in the woman's best interest and the 'safest' option, although the pregnant woman herself disagreed. It also did not support the best interests of the woman as she herself saw them, which ultimately may have had an impact on the outcome of care. Whilst it is possible that the woman was mistaken in what she considered to be her own best interest, the guideline for individualised, woman centred care (as outlined above) that is thought to be pivotal to quality care provision here seems to be overshadowed.[49] Thus, there appears to be tension between the duty of beneficence that health care professionals have to their patients[50] and the respect for the woman's autonomy, whereby she is an equal partner in a therapeutic venture,[51] able to contribute to decisions made about her care. The legal and ethical right of the competent pregnant woman to be autonomous in relation to decisions about her care is well established.[52] In Re MB,[53] Butler- Sloss LJ stated:

> 'A competent woman who has the capacity may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In the event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests, objectively considered, does not arise'

In Jean's narrative the conflict between the clinicians and the pregnant woman as a result of these different principles is clear. This emphasises the challenge that confronts the midwife as she attempts to facilitate safe outcomes for the woman and her baby whilst simultaneously

[48] ibid at 7. This guidelines was current when the data for this study was collected. This guideline was updated by NICE in December 2014 (National Institute for Health and Care Excellence (NICE) *Intrapartum Care: Care of Healthy women and their Babies during Childbirth* (NICE; London, December 2014)) but still contains the recommendations that women be respected and that one-to-one care is offered to labouring women.
[49] n 47 above.
[50] Beauchamp T.I., Childress J.F., *Principles of biomedical ethics* 6th ed. (Oxford University Press; Oxford, 2009).
[51] ibid.
[52] Re M B (An Adult: Medical Treatment) [1992] 2 FLR 426.
[53] ibid.

recognising the woman's autonomy. The result of this is that decisions are made that are not compatible with the clinical judgement of the clinician who is providing care. Whilst such situations are inevitably difficult, the key question for current purposes is whether and to what extent they are helpfully addressed by clinical governance strategies.

Several participants' in the interviews reflected on this issue. The following comment from Cathy (NHS, 0-5yrs.) is typical:

> 'A woman I suppose would like to see a midwife as someone that is there for her, to accommodate her and support her choices in pregnancy and birth. And we are as midwives, we've got the other side of it where we are governed by rules and guidelines and risk assessments. So we sometimes have to talk to women about all of that and I think sometimes it can put a bit of a barrier between us…because I think [women] as individuals they just see themselves and what they would like…sometimes I don't think they fully take into account the risks to their baby or to themselves and they think "I'm just having a baby, you know it's normal, why can't I just do things I want to do in the normal way."'

In these conditions it would appear that the underlying issue with clinical governance through clinical guidelines is that they are endorsed by professional definitions of safety which may be at variance with woman-centred care. The outcome, as Cathy suggests, is that there is a negative effect on the midwife- woman relationship such that the trust that is a requisite for a functional relationship is limited or, as demonstrated in Jean's scenario, seemingly lost altogether.

As part of the discussion in chapter three it was seen that clinical guidelines may be perceived as a tool to enable the clinician to determine what is best for the pregnant woman based on the category of risk that the woman is allocated to.[54] Women who are deemed to be low risk are filtered towards one care pathway whilst those who are categorised as high risk as a consequence of health issues are channelled down a different pathway.[55] However, some

[54] Downe and McCourt n 43 above.
[55] National Institute for Health and Care Excellence (NICE) *NICE Pathways: Antenatal care Overview* (NICE; London, 2013b) http://pathways.nice.org.uk/pathways/antenatal-care (accessed 05/10/2013).

respondents suggested that this method of providing care presents difficulties for women and health care professionals alike. Here, Lynn (NHS, 6-10 yrs.) comments: ‘I think the low risk bubble that women slot into has got so small, and the high risk group has got huge’, whilst Lilly (NHS, 0-5yrs.) says:

> ‘I think actually the higher risk women probably get less care than the lower risk women…the lower risk women, especially at a home birth for example, you get two midwives...and you’ve got one-to-one care…the 2nd midwife’s not actually doing anything other than being a buddy and documenting. And basically, it’s between her [the pregnant woman] and her partner…[but] she’s got that full care of those midwives there. Whereas the high risk woman on the acute site…there’s only one midwife and you could be looking after three high-risk women. Well, you can’t have one-to-one care if one midwife is looking after three women. So I think actually the higher risk you are, the less care you’re getting…so allocating them to a high-risk group in that particular instance is actually…I think it’s more detrimental to the outcome, definitely.’

The challenge of trying to care for women with medical problems in the acute hospital setting was also noted in the survey comments. The following observation is characteristic of these remarks: ‘Too busy, short staffed increasing number of high risk women, lack of support, equipment not good enough, too much pressure when caring for [high risk] women on LW [labour ward].’ (NHS, 0-5 yrs.).

It would therefore seem that the issue of quality care provision and safety in relation to women who have high risk pregnancies emerges as being particularly problematic. Safety cannot be assured in any birthing location.[56] Nonetheless, for the participants in my sample, women who are high risk appear to receive a substandard service due to lack of resources and staffing problems.

Amy (NHS, >20yrs.) discusses the issue of staffing and argues that:

> ‘An Independent midwife would have different answers to my answers. But what I would say to you is she’s dealing with a very small clientele. We’re dealing with a much bigger clientele with very, very, diverse problems, very high risk complex pregnancies, and really difficult socio-economic problems. And with that comes all

[56] Steen M., *Supporting women to give birth at home: a practical guide for midwives (Routledge; Oxford, 2012).*

> sorts of risks that they probably won't see. And we have to do the best for the majority I think. And you can't unfortunately have everybody managed as an individual in the NHS. We've got to have a broad policy, a broad procedure that will protect the majority.'

According to Edwards the development of risk management within the NHS whilst protecting the organisation is not advantageous for either the clinician or service user, for whom it may intensify the possibility of risk and poor outcomes. [57] Kirkham describes such comments as those made by Amy as reflecting a 'Teflon-coated [style of] management',[58] which does little to cultivate responsibility, and which may create further problems in terms of safety.

Amy however, does not accept that risk management can create potential problems for the individual woman and maintains:

> 'We wouldn't have somebody that doesn't fit in. And every woman is either going to be low risk with no problems whatsoever or high risk. The only women who don't fit in to those groups are the people who don't want to fit in…and they have a choice not to. You know, we can't force any of this on anybody…it is all well and good us having statute laws, guidelines, clinical governance, risk management; we have to expect that some [women] don't want to fit in to that box. And neither should they if they don't want to. So, I can't see that there is anybody really who doesn't fit in, apart from those that don't want to fit in.'

Within this, standardised care compels women down different routes of care; where only a minority of women will not 'fit into the box', creating a tension between the service and the service user. In this quotation the emphasis on the woman who does not conform to standardised care has a negative connotation. Although Amy recognises that the woman has a choice, the subtext is that women should want to comply with the service that is offered to

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[57] Edwards N., *Birthing Autonomy* (Routledge; Oxford, 2005); Edwards N., Safety in birth: the contextual conundrums faced by women in a 'risk society', driven by neoliberal policies, *MIDIRS Midwifery Digest* 18(4) (2008a):463-70 at 466.

[58] Kirkham M., The Maternity Service Context in author's ed. *The Midwife-Mother Relationship* 2nd ed. (Palgrave Macmillan; Basingstoke, 2010):1-16.

them, since it is the service which ultimately knows what is in the best interests of the pregnant woman, rather than the woman herself. Jean (NHS, 0-5 yrs.) supports this and says:

> 'I think as long as women know that you're on their side and you're doing the best for their baby, then they have to accept what you're doing. And the majority, 99.9%, you won't get any problems with. There will always be one person that wants to break every rule there is.'

In both Amy's and Jean's opinion women can have what they want provided it mirrors what the service is willing to offer. Those women who 'do not fit in the box' are thus, perceived as troublesome as they wish to resist this authoritarian form of care and make their own decisions. As a result in these circumstances the pregnant woman may experience a loss of connection with the midwife, which will have an impact on her care and the overall satisfaction with that care which might generate complaints as a consequence. This is emphasized by Paula (Ind. 11-20yrs.) who argues:

> 'Risk assessment doesn't work [because] you're trying to fit women into one very narrow parallel so that you don't get sued. Women do not easily fit into that parallel and therefore, they want to sue. So, it's like two ends of the spectrum all the time, they're fighting against each other rather than working with women…if you could work in a system where there's one midwife looking after one woman, that one midwife could give individualised care. She's less likely to get sued. But they can't give individualised care because they have to look after a huge spectrum of women, squashing them into narrow parameters based on the constraints of risk management.'

Paula's comments are illustrative of other participants who thought that clinical governance was counter-productive to care provision and which resulted in a loss of connection between the woman and midwife. All of the participants raised the subject of individualised care in their narratives. In the examples above whilst Amy is regretful but pragmatic about the lack of individualised care that the majority of pregnant women receive, Paula is more vehement in her assertion that it is this aspect of care which should be pivotal in order to achieve better outcomes for the service user.

The concept of quality care and successful outcomes is ultimately dependent on a functional partnership between the midwife and woman.[59] In the data the changing relationship between the midwife and the pregnant woman which was triggered in part by risk management strategies, was seen as reducing the ability of the midwife to be 'with woman'.[60] Amanda (NHS, 11-20yrs) for example comments:

> 'I think it [risk management schemes] can potentially cause problems for women and for midwives. If someone is high risk it limits their options. You don't want to give them certain options, for example, you don't really want them to have a home birth...and if they make that choice then there's lots of input to try and help them see that they shouldn't have made that choice..."no you don't really want home birth, you need to see a supervisor of midwives to discuss [this]" rather than exploring why they want a home birth, why they would deem that that's safe, and trying to find out what their perception of it is…trying to put some mechanism in place that makes it as safe as possible for the woman …and then sometimes risk is not based on something that you could argue is right. If someone's had 6 births and never had a PPH [post-partum haemorrhage], why are they suddenly deemed to be a high risk of a PPH? There's no evidence that supports that, it's very historical. Risk assess them…you say "well high risk no home birth" [and the woman will argue] "well I had 5 of my children at home why are you now saying I shouldn't have my 6th child at home?"'

Attempting to restrict patient choice through limiting their options is problematic in terms of the professional behaviour expected by the regulatory body who stipulate that information provision is a necessary element of decision making.[61] Amanda suggests that it is risk management and the labelling of women that produces this reaction. Mary (NHS, 6-10yrs.) has an explanation for this midwifery behaviour and says:

> 'These are young, fit, healthy women who are able to make good informed decisions. Things like the internet, books and magazines that are out there give women an idea about what they want and I think as midwives we try to facilitate that and when things go wrong, risk management draws everything back to "well, this is what you should be doing, so why didn't you do that?" without taking into account the woman saying "I don't want to be continuously monitored"...you have to look at what the woman's saying, you have to act in her best interest. You have to be autonomous and you have

[59] Gould D., Quality Care is more than a set of processes *British Journal of Midwifery* 17(4) (2009):210.
[60] n 6 above.
[61] Nursing and Midwifery Council (NMC) *The Code: Standards of Conduct, performance and ethics for Nurses and Midwives* (NMC; London, 2008a). This NMC Code was current when the data for this study was collected. The NMC has since published a revised Code in 2015.

> to be her advocate. Although she might not want to be monitored or have an examination, however, we have to say "we do it because of this, this and this."'

Here, there is a tension between the midwife and woman in terms of how the best interests of the pregnant woman are determined. In such situations it is arguably the fetus who is being treated as the patient and it is the pregnancy that is monitored and assisted from the fetal perspective rather than that of the woman.[62] Decision making should occur in an equitable environment where the woman is enabled rather than disabled to make choices which are pertinent to her regardless of professional definitions of safety.[63] Mary's account indicates the complex nature of decision making when providing care to pregnant women which impact on her ability to access woman centred care. Mary's narrative also highlights the importance of the midwife woman relationship, particularly in terms of communication and advocacy, which as was outlined above are considered integral skills for the midwifery profession.

Kate (NHS, >20yrs.) reiterates the value of good communication skills to the midwife woman relationship and comments:

> 'If you've got the woman at home, the midwives are usually quite anxious about that. They can acknowledge that this is the woman's choice and they're going to stay at home with the woman, if the woman wants to stay at home …because the risk of something happening, they [the midwives] feel is greater, so they feel they shouldn't maybe allow the woman to stay at home…you can try and negotiate with the woman that they will come in if there's a problem, then it might make the midwives feel more secure. And the communication should be better between the woman and the midwife...not alienating their clients…you still need that relationship with the midwife…because otherwise the women are not going to call if they don't have support from the midwife.'

In the *Saving Mothers Lives Report* (2011) communication between healthcare professionals and the pregnant woman was recognised as central to effective care.[64] Moreover in this Report

[62] Arney W., *Power and the Profession of Obstetrics* (University of Chicago Press; Chicago, 1982).
[63] Cumberledge n5 above.
[64] Draycott T., Lewis G., Stephens L., *Saving Mothers Lives: 8th report of the Confidential Enquiries into Maternal Deaths in the United Kingdom* (CMACE) (Centre for Maternal and Child Enquiries (CMACE); London, 2011)

poor communication between healthcare professionals and the women receiving care was linked to the provision of substandard care.[65] Pregnant women who access maternity services in the UK have diverse needs and expectations which embrace not only the desire to have safe, effective, individualised care, but also the requirement to be listened to in a manner which supports excellence in care. Unfortunately, it would appear that in some instances the maternity services are only listening to the voice of the service user when the requirements that the service user vocalises echoes the mandate of clinical governance strategies. This may have a negative impact on the midwife-woman relationship, and influence the care quality aspiration as a result.[66] As has been highlighted throughout this section, in the views of some midwives, clinical governance strategies undermine the provision of care in some situations, such that care is then neither safe nor woman centred.

The question that arises therefore, is whether the provision of clinical governance strategies for the general pregnant population justifies the loss of the connection between the woman and midwife that may occur in some cases. The findings emphasize that the loss of connection between the midwife and woman is highly problematic, particularly for those women who are deemed to be high risk and require specialist treatment in a facilitative environment.

Communication in the context of the CMACE Report may be understood to include verbal and non- verbal interactions including guidelines, plans of care as well as discussions between service users and practitioners providing care.

[65] ibid.

[66] Cumberledge n5 above.

4.4. Clinical Governance and Normal Childbirth

In chapter two, the scientific, medical model emerged as the dominant approach to care for pregnant women during the twentieth century, which was supported by successive governments through policy documents such as the *Cranbrook Committee Review* (1956) and the *Peel Report* (1970).[67] The medical model of care supported the 'active management' of labour,[68] which it was argued would benefit the service and the pregnant woman.[69] However, these claims were made without substantive evidence,[70] and were in contrast to the more traditional method of care offered by midwives which may be characterised as being supportive and woman centred.[71]

The discussion in chapter three demonstrated that with the growth in risk management strategies, implemented by the New Labour Government, the gap between these two models of care widened, as attempts were made to control the provision of care in an effort to reduce risk and ensure safety. As discussed earlier, although woman- centred care continued to be espoused by the Blair administration,[72] clinical governance strategies necessitate the adherence to guidelines which recommend that labour and birth be managed rather than facilitated. As a result, neither the woman accessing care nor the clinicians who provide care may be certain about the normal physiological processes that facilitate birth for the majority of pregnant women and how to safely assist them.[73]

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[67] Ministry of Health Chairman Lord Cranbrook *Report of the Maternity Services Committee* (HMSO; London, 1959); Standing Maternity and Midwifery Advisory Committee (Chairman Peel J.,), *Domiciliary Midwifery and Maternity Bed Needs* (HMSO; London, 1970).
[68] O'Driscoll K., Meagher D., Boylan P., *Active Management of Labour* (Mosby; London, 1993).
[69] Goer H., Active Management of Labour: Not the answer to dystocia *Birth* 20(1993):99-101.
[70] Tew M., *Safer Childbirth? A Critical History of Maternity Care* (Free Association Books; London, 1994).
[71] Hunter B., Midwifery 1920-2000: The reshaping of a profession in Borsay A., Hunter B., ed. *Nursing and Midwifery in Britain Since 1700* (Palgrave Macmillan; Basingstoke, 2012): 151-174.
[72] DoH n39 above.
[73] Robertson A., Are Midwives a Dying Breed? *The Practising Midwife* 5(7)(August 2002):16-17: Robertson defines physiological birth as a process through which labour and the delivery of the infant are facilitated rather than managed by care providers with an emphasis on the pregnant woman's innate ability to birth her baby without intervention.

Against such a setting, the issue of exactly what is meant by safe care provision and the woman's perception of it is complex and relates not only to the physical care that is provided to her, but to her psychological and social needs, which also have a profound effect on the birth physiology.[74] Here, as in chapter three, the use of clinical governance and guidelines that are constructed on the basis of medical evidence have the potential to disrupt the normal physiological processes of labour and birth, which may ultimately lead to intervention and medicalization of childbirth.[75]

For some participants, this was also revealed in the sense that clinical governance strategies reduced their ability to utilise their knowledge and experience of the diverse aspects of labour and of childbirth. One midwife wrote: 'I feel that it has become very medicalised and the belief and trust in women's ability to birth is fading...with a few of us battling to save it!!!!' (NHS, 0-5 yrs.).

Another observed:

> 'Choice, continuity and control for women are words only used in lip service. Some midwives, very few, manage to give a brilliant service under the circumstances. They work hard to support women, but interfering with the birth process has led to an increase in the operative and instrumental delivery rate, and this cannot be safer for mothers or babies. The fear ensures that the mother is undermined, and many women are left feeling that something is hugely missing confidence-wise, as they begin parenthood…if the process is left alone more, more women will birth normally, and will be happier, more confident and healthier mothers.'(Ind. > 20yrs.).

These remarks are representative of many others made in the survey and demonstrate the concern that clinical governance strategies are undermining the confidence that women and midwives have in the normal processes of birth which creates problems for them both. Throughout the interviews, respondents repeatedly reported reservations about the use of

[74] Foureur M., Creating Birth space to enable undisturbed birth in Kahy K., Foureur M., Hastie C., ed. *Birth Territory and Midwifery Guardianship* (Elsevier; Edinburgh, 2008).
[75] Bassett K., Iyer N., Kazanjian A., Defensive medicine during obstetric care: a by-product of the technological age *Social Science and Medicine* 51(2000): 532-537.

clinical governance strategies including guidelines, their interpretation and importantly their place in care offered to pregnant women who were having a normal physiological birth. Participants for example remarked: ‘guidelines can help with complexity yes, I think sometimes in [the] normal [birth] no’ (Amanda, NHS, 11-20 yrs.), and Lynn (NHS, 6-10yrs.) commented that:

> ‘a guideline would reduce your midwifery intuition if you like…in normal labour, you’ve got a guideline, this happens, that happens you know, four hours later you do this, two hours later you do this and you think “but this is normal labour, for a low risk woman, why are we saying in four hours she must do this, and in two hours she must do this?” Because we’re actually talking about human beings and human bodies work in different ways, to reach the same goal ideally, but you know, that lady might do something different to that lady, but does that mean that that lady’s body is not working as efficiently? So I do think that it reduces the normal parameters, therefore medicalising women.’

For these midwives, clinical guidelines have an effect on the pregnant woman and the midwife such that it is difficult for the woman to be considered “normal” in the wider context of pregnancy and birth, which limits her opportunity to have a normal physiological birth free from medical intervention.

Amanda (NHS, 11-20yrs.) offers this example of providing care for a woman having a normal physiological labour:

> ‘I didn’t do a VE [vaginal examination] because the woman didn’t speak English…There were definite physiological signs [she was progressing]…so I didn’t do a VE that was deemed to be scheduled 4 hours after the last one, because I didn’t believe I could get informed consent…and so I took that decision. However when I went out of the room and I was asked how was she progressing I was asked what’s the VE, I said “I haven’t done one”. I then had to justify it [my decision] to a doctor and I said to the doctor, “actually she’s within the scope of normality, she hasn’t got any medical problems...She might be in an acute site however she’s under my care as the lead midwife caring for her and that’s the decision I’ve made”...and that’s a tension…and some midwives might think “actually I need to go back and do that VE.” Because the doctor is saying it’s unsafe not to know that she’s progressing [using the results of a vaginal examination], how do you know she’s progressing?’

Fahy et al. suggest that midwives are the "guardians" of the birthing environment and consequently need to empower the woman's sense of safety during the process.[76] In her quotation Amanda is faced with a dilemma when attempting to cater to the woman's psychological needs and her sense of safety which appears to be somewhat different to another clinician working alongside her in the acute hospital setting. As such the recommendation to perform an intimate, but arguably unnecessary, vaginal examination has the potential to create additional problems for the woman whilst providing the information that the guidelines state is necessary to deliver safe care. For Amanda as "guardian of the birth environment", being confident and having an understanding of the physiological process of birth is important and she says in this regard: "If you're looking inside the realms of normality for midwives, really their education and subsequent learning should give them confidence."

In the next passage Jean (NHS 0-5yrs.) provides another example of a woman who had a poor obstetric history but who wanted to have a normal birth in a Midwifery Led Unit:

> 'So I had to look at the evidence that was in front of me…if we can normalise her labour we can achieve a better outcome…so I had to use my skills of knowing normal, knowing the physiology, and being aware of things I could do that would improve the situation…we knew that she'd had one shoulder [dystocia],[77] and that she automatically has a higher chance of having another shoulder [dystocia] even if it is a normal-sized baby because it could maybe be down to her pelvis size which we can't change…so as long as she delivered before 41 weeks, she could actually still go into the MLU [Midwifery Led Unit]…she was happy to do as many things as she could to enable her to have a normal delivery in the MLU. We knew that she could have a homebirth…she could choose to stay at home…but she wanted to be in an MLU next to the hospital…so using that knowledge, not ignoring that knowledge but not being totally forced into one corner because of it, not judging all her pregnancies by one experience.'

[76] Fahy K., Parratt J., Foureur M., and Hastie C., Birth Territory in Bryar R., and Sinclair M., 2nd ed. *The Theory of Midwifery Practice* (Palgrave Macmillan; Basingstoke, 2011) at 225.

[77] Fraser D.M., Cooper M., *Myles Textbook for Midwives* 15th ed. (Churchill Livingston; London, 2009) at 629 states: the term shoulder dystocia is generally used to describe the failure of the shoulders to negotiate the pelvis spontaneously after the birth of the head. The anterior shoulder becomes trapped behind or on the symphysis pubis, whilst the posterior shoulder may be in the recess of the sacrum or above the sacral promontory, thus impeding delivery. The incidence of shoulder dystocia is uncommon being between 0.37-1.1percent.

Midwifery Led Units (MLU),[78] have been developed throughout the UK as part of the "normal birth" campaign and have been judged to be as safe as birth in an acute obstetric unit.[79] Nevertheless, the admission criteria for these units are often restrictive and any woman who has had previous medical or obstetric problems may find it difficult to gain entry,[80] as Jean's example reveals. In this instance admission guidelines have the potential to limit the woman's birth options and deny her the opportunity of a normal physiological birth in the place of her choosing. Here, it is important that Jean has confidence in her own skills and knowledge to facilitate woman centred care and did not merely accede to the guidelines. As a consequence the pregnant woman was able to have the experience she felt was appropriate for her.

Laura (Ind. >20yrs.) also explores the issue of normal labour and the lack of coherent guidelines with which to support labouring women who are wanting to have a normal physiological birth. She provides this account as an illustration of the challenge this presents to midwives and women alike:

> 'This might not even be a NICE guideline but it's a good example of a midwife who was supporting a woman having a water birth and she hadn't recorded the temperature of the water throughout the labour. Now it wasn't that she wasn't checking the water but she didn't record it. Now the act of not recording or recording it doesn't make it any safer, it's about what you do about the temperature. So that's about back covering, both for the institution and the practitioner etc., but it's not about good practice. You know, good practice is that the midwife is there, she is attentive, she is looking after the woman, she's taking on board the whole situation and using her judgement and intelligence to assess, so for example in a labour it's really important that the temperature is what the woman wants. Come the birth, if it's going to be born under water it needs to be around the woman's temperature, so it's really important that midwives don't get into a way of thinking that "blimey, every 3 hours I must record this temperature" because you will get some midwives who will then think "As long as I record the temperature and as long as it's at the woman's temperature…36, 37, it's

[78] Department of Health (DH) n34 above: this report states that there were 152 midwifery led units in England in June 2013 an increase of 65 from April 2007. Midwifery Led Unit's (MLU) are the so called "alongside" facilities for women who opt for a hospital birth but who do not wish to have medical intervention such as epidural analgesia and which are staffed by midwives.

[79] National Perinatal Epidemiological Unit (NPEU) *The Birthplace Cohort Study: Key Findings* (University of Oxford; Oxford, 2011).

[80] NICE n47 above s.1.1.1 planning place of birth states: that if she [the woman] has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications during her next birth, she should be advised to give birth in an obstetric unit.

> ok". It's not ok if the woman wants to be quite cool in labour, you might be doing her damage by doing that.'

Although she is hesitant, Laura correctly identifies that it is a national guideline produced by NICE (2007) that requires practitioners to monitor water temperature when facilitating a water birth and that may, in some circumstances, be contrary to the requirements of the labouring woman.[81] Indeed, Laura's emphasis is on the temperature being written down or recorded as indicated in the instructions in the guidelines which is a distraction from the main role of enabling the woman's physiological birthing experience. Another midwife, Lucy (NHS, 11-20yrs.) outlines this conundrum with clinical guidelines in normal midwifery practice and reasons:

> 'Should our midwifery training that we have provide us with our own guidelines? Because we know well enough physiologically what's happening, why do we need to refer to a guideline to tell us what to do next?'

The NICE (2007) guidelines discuss the management of normal labour and recommend that clinical intervention is unnecessary in such circumstances.[82] However these guidelines,[83] also prescribe management for observation, monitoring and assessment of labour which are at times rigid and may be considered to medicalise the normal physiological processes of labour. Consequently for Lucy and Laura the importance of knowing, understanding and having confidence in these innate biological activities is essential, as it can support and empower the labouring woman to birth unimpeded.

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[81] NICE n47 above at s. 1.4.5 states: for women labouring in water, the temperature of the woman and the water should be monitored hourly to ensure that the woman is comfortable and not becoming pyrexial. The temperature of the water should not be above 37.5°C.

[82] NICE n47 above at 5: clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well. This advice is continued in the current 2014 NICE guidance.

[83] NICE n 47 above.

4.5 The Impact of Clinical Guidelines on Decision Making in Midwifery Practice

Effective decision making within midwifery practice is an essential element of care provision and is a central tenet of regulation for the profession.[84] However, as was seen in chapter three, the Health Act 1999 and the implementation of clinical governance schemes breached the boundary between health care management and clinical decision making, which created challenges for practitioners, and which signified the curtailment of professional judgement and the enforcement of changes to professional behaviour.[85] As part of this regulatory reform, it was envisaged that clinical guidelines would be employed to facilitate the provision of care which is safe and of an acceptable standard.[86]

In the survey participants were questioned about whether they felt that clinical guidelines guaranteed safe care. When questioned 69 per cent (n≠93) of respondents were either very confident or confident that clinical guidelines ensured safe care. However, the data also revealed that 25 per cent (n≠34) were neutral about the link between safe care and clinical guidelines. Once again the remarks from midwives who signalled that they were neutral about care being safer now than in the past were examined in more detail in an attempt to understand this neutrality. Whilst some participants did not hold strong views about the present safety of care, several others were more apprehensive. One midwife, who was representative of these respondents observed: 'Medicalisation (under the guise of safety) carries its own risks- hence my neutrality' (NHS, 11-20 yrs.). For these participants, their neutrality occurred as a result of being uncertain about the impact of these strategies rather than simply not having an opinion about the influence of clinical guidelines.

[84] NMC n61 above.

[85] Pollock A.M., *NHS plc: The privatisation of Our Health Care* (Verso; London, 2004) at 121; Blair A., National Health Service Address 2nd July 1998 as cited in *Modernising Regulation-The New Health Professions Council: a consultation document* (Department of Health; London, 2000) at 6.

[86] National Reporting and Learning System (NRLS) *Patient Safety Resources* (National Health Service Litigation Authority (NHSLA) *Learning from Maternity Claims* (NHSLA; London, 10th January 2014).

Equally when the replies from the midwives who indicated that they were neutral about the concept of safe care and clinical guidelines were analysed, there appeared to be concern about the culture of care within the NHS and the medicalisation of childbirth. These factors have impacted on the participants perceptions of the link between safe care and clinical guidelines. One midwife expressed a view that was typical of those offered by many participants, when she wrote: ‘The guideline is only as beneficial as those who use it, it depends on their willingness to engage with the guideline, their understanding and how they empowered feel’ (NHS, 11-20 yrs.). Thus the ‘neutrality’ that was initially identified, appears to belie real fears for at least some midwives, about care provision and the effect that clinical governance strategies have on that care.

Only one respondent, Paula (Ind., 6-10 yrs.) was very unconfident about the influence of clinical guidelines on safe care provision and whether or not care was safer now than in the past. However as the number of independent midwives in the study was small it is not possible to state whether or not this participant is representative of the wider community of independent midwives.

Within the survey participants were also questioned about the impact that clinical guidelines had on a midwife’s ability to make autonomous decisions. Here, 49 per cent of respondents (n≈66), indicated that the clinical guidelines had a positive impact on, whilst 28 per cent (n≈38) felt that they had either no impact of a negative impact on decision making, and a further 22 per cent (n≈30) were unsure about the influence of guidelines on midwifery decisions. This concern about the effect of clinical guidelines on decision making, which had the potential to produce defensive practice, was mirrored in the interviews. For example Laura (Ind. >20 yrs.) comments:

> ‘They [midwives] are frightened of doing something that’s going to come back and they’re going to get in trouble for, so I think it’s dumbed down professional midwives taking responsibility for their practice, and they have slipped down a notch and will just

> do whatever is deemed they've got to do, they'll do it rote, they'll do it monkey like fashion and they'll stop thinking. Because they think they're safe because this is what for example the NHS Trust guideline might say, so if I do everything that the guideline says then I'll be safe. Yes I'll be safe. Being safe means I won't get into trouble, not that the woman's safe.'

However, the Nursing and Midwifery Council (NMC) stipulates that the midwife is accountable for their 'acts and omissions' that incorporates decision making. [87] As such the regulator does not support the defensive strategy that Laura suggests exists in practice. Laura argues that it is the guidelines themselves that are the cause of the difficulties and states:

> 'People are thinking that they've got to follow the guidelines, because that's going to protect the public and keep them safe and they're not thinking intelligently about the individual in front of them and the clinical situation in front of them.'

She continues:

> 'Your experience and the individual woman etc. or the research may tell you something different to what the guideline says. So then there's a challenge …you're being torn apart, do I follow the hospital guideline or I do something different, because actually I've just read the latest research, or I looked after a woman last year and my goodness I remember what happened to her when this happened … so it doesn't support midwives to make those professional decisions at the time, in real time it doesn't support them.'

The problem encountered in practice as a result of restrictive clinical guidelines was also recognised by other participants:

> 'I think [the guidelines] have taken away from the autonomy that midwives have because we can't go outside of the guidelines.' (Cathy, NHS; 0-5 yrs.).

For Cathy, prescriptive guidelines detract from the midwife's ability to use her decision making skills. In the data, clinical guidelines deskill the midwife by depriving her of the ability to cultivate expertise in decision making, which as a result, will have a negative influence on

[87] NMC n61 above.

future care provision. Midwives, often feel inhibited by guidelines,[88] and feel that they have little option but to follow the advice given in guidelines, as failure to do so might invoke criticism or litigation or both,[89] which seems to support the suggestion made in chapter three that 'NICE guidelines are likely to constitute a responsible body of medical opinion for the purposes of litigation.'[90]

For other midwives the perception of guidelines was that they interfered with their ability to provide effective care during pregnancy and labour. For example Lucy (NHS, 11-20yrs.) commented:

> 'We need our guidelines and we need our…national or local [guidelines] as a bench mark, even though they may not be right. And we see it in practice all the time, you know, it's the woman whose not quite fully [dilated],[91] well we'll say she's got an anterior lip[92] because we need to give her that little bit more time, so that's what it's made us do, is actually lie…Yes because you know that if that woman had a little bit more time she would probably get to fully…and have a completely normal delivery. Whereas if we go now and say "no she's fully, or she's had her 2 hours", we'd better get a ventouse or forceps and all the intervention that it creates.'

In Lucy's comments, having confidence in the birthing process enables her to be 'creatively compliant' with the rules and guidelines in an attempt to ensure the physiological processes of labour are facilitated and the medicalization of birth avoided. Creative compliance may be defined as 'the practice of side-stepping rules and navigating regulations without breaking their formal terms.'[93] In Lucy's scenario, some midwives are less than truthful when asked about the progress of labour, as they are aware that to state honestly the actual circumstances of the

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[88] Symon A., *Obstetric Litigation from A-Z* (Quay Books; Salisbury, 2001).
[89] Better Regulation Task Force (BRTF) *Avoiding Regulatory Creep* (BRTF; London, 2004).
[90] Taylor n 15 above.
[91] Fraser and Cooper n 77 above at 464 states: cervical dilatation is the process of the opening of the os uteri which will permit the passage of the foetal head. Dilatation is measured in centimetres and full dilatation is equal to approximately 10cms.
[92] Fraser and Cooper n 77 above: The term "anterior lip" refers to the presence of a small part of the os uteri which remains prior to full dilatation of the cervix.
[93] Baldwin R., Cave M., Lodge M., *Understanding Regulation: Theory, Strategy and Practice* 2nd ed. (Oxford University Press; Oxford, 2011) at 70.

labour might involve the implementation of the so called 'cascade of intervention',[94] whereby the labouring woman will be exposed to medical procedures designed to keep the labour to within the prescribed time limits. Several midwives mentioned the need to be 'flexible' in their approach to guidelines and Lilly (NHS, 0-5yrs.) is characteristic of these opinions when she says:

> 'if you don't reach that certain point within that certain time you then bring in the whole medical management. And that's when things can go wrong.'

These time lines are part of an interventionist approach to labour,[95] which are currently utilised in UK maternity units as a method of addressing financial and staffing issues.[96] Many of the midwives in the study, indicated that when a labouring woman is experiencing normal physiological birth, guidelines which are written for the average woman can be counterproductive. Here, the participants suggested that guidelines are often circumvented by ingenious covert behaviour in order to avoid unnecessary intervention and the problems that intervention causes for some labouring woman. As no pregnant woman is average, to attempt to make pregnant women fit into such a pattern can be contrary to her interests.[97] This however is the situation that exists in many maternity units and which is the rationale that participants give for evading the directions given in the guidelines in certain circumstances. These findings may be contrasted with Parker and Lawton's (2000) study, which was discussed in chapter one, where midwives when questioned about fictional situations were disapproving of actions which

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[94]Mold J.W, Stein H.F., The cascade effect in the clinical care of patients *The New England Journal of Medicine* 314 (1986) (8): 512-514.

[95]Philpot R., Castle W., Cervicographs in the management of labour on primigravidae1: the alert line for detecting abnormal labour J*ournal of Obstetrics and Gynaecology of the British Commonwealth* 79(1972):592-8: the cervicograph was developed in the 1970s as an attempt to provide guidance for untrained African women living in remote areas who were at risk of obstructed labour which was associated with a high risk of maternal mortality.

[96]Walsh n 44 above.

[97]Wilson J.H., Symon A., *Clinical Risk Management in Midwifery: The Right to a Perfect Baby?* (Books for Midwives; Oxford, 2002) at 159.

did not comply with guidelines.[98] The findings in my study appear to suggest that regardless of how they respond to hypotheticals, in practice, midwives are very capable of creative compliance, should the need arise.

An interesting point which was made by several participants was the notion of midwives researching and devising guidelines for situations in practice where no other clinical evidence or written recommendations existed. In these circumstances there appears to be a different understanding of what is meant by a 'guideline', which is more akin to an individual action plan for the midwife and women who are working together on a shared endeavour. June (Ind. >20 yrs.) provides a clear example of how individual guidelines might support decision making and woman-centred care. In the following detailed quotation June describes a situation where she provides care to a woman who has a complicated obstetric history, and who wants a home birth after having had a previous caesarean section, against conventional advice:

> 'So I put together my own guideline for her labour because at the time I was working independently...I didn't want to use a hospital guideline for VBAC (Vaginal Birth After Caesarean Section)I wanted to make my own, so I used recommendations from the Royal College of Obstetrician and Gynaecologists (RCOG) VBAC Green Top guidelines… I did a lot of research on how to keep her as safe as possible…and did a guideline that was in my head…she knew the guideline as well, so that on the day when she went into labour, we were very clear about things that I would be doing during the first stage of labour …how I would be asking her about pain...we talked about time limits for…first and second stage [of labour] because we thought that that was important [as] we were out of the hospital. I looked at some of the guidance on time limits and put that into my own guideline...and yes, we felt comfortable working together…and if she deviated from that then we would transfer in. And in the end she did, …we had fetal distress in the second stage, and we transferred in and …it was very clear, we discussed that at any point fetal distress would be a "we'll be transferring in", there's no question about that…and because she trusted me there was no discussion…we'd worked together on this guideline and she was happy with it, I was happy with it...She ended up with a ruptured uterus and ruptured bladder…so I had an investigation and the one thing that the Supervisors [of Midwives] who looked at my care in the investigation were very impressed with was that I had a guideline and that it was very clear and that we'd worked to that guideline.'

[98] Parker D., Lawton R., Judging the use of clinical guidelines by fellow professionals *Social Science and Medicine* 51(2000): 669-677.

Likewise, Louise (NHS, >20yrs.) recalls an incident where a woman had opted for a home birth, despite contra-indications (a previous caesarean section and twins in the current pregnancy), causing numerous problems for staff who were giving care to her. Louise notes:

> 'You know there are times when you have to bypass the guidance, but usually it's the woman and her wishes that give you the autonomy to do that…[in this scenario] there weren't any guidelines so we had to go along with the pregnancy and labour, we did some research beforehand, and we prepared as best we could, we got some very bizarre advice at times…about putting a [urethral] catheter in, and then trying to push litres of water into this woman's bladder to keep the baby up and out of the way while we transferred her in…God knows how we would have managed to do that practically ...but we did some research, we talked it through with the woman, she was very aware of the pros and cons of twin delivery anyway, and she was determined to stay at home…in a way it was quite reassuring that she felt we were quite capable of looking after her as well at home where she felt secure.'

In both scenarios the midwives are confronted by requests for home births in situations more commonly reserved for the acute hospital setting,[99] and where the recommendation for birth is via caesarean section.[100] Within these examples the pregnant women have made informed decisions about the place where they wish to give birth and as a result need midwives who are able to provide care for them in these circumstances. In such cases the regulations stipulate that the midwife has a duty of care to the pregnant woman,[101] and must ensure that she delivers care that is within her scope of practice.[102] Although both births were outside the scope of practice for these midwives, they did however endeavour to ensure that the women had care which was safe and effective and in doing so met the regulations set out in the midwives' *Rules and Standards*.[103]

[99] Royal College of Obstetricians and Gynaecologists (RCOG) *Green-top Guideline No. 45:* Birth after previous Caesarean birth (RCOG; London, 2007).
[100] NICE n47 above.
[101] Nursing and Midwifery Council (NMC) *NMC Circular 8- Midwives and Home Birth* (NMC; London, 2006a).
[102] Nursing and Midwifery Council (NMC) *Midwives Rules and Standards* (NMC, London, 2012a).
[103] ibid.

In the illustrations, as a result of the pregnant woman's decision to have a home birth, the midwives prepared for the births by developing their own "guidelines", which were devised after extensive research, and which were followed during both labours. In June's example the outcome of the birth resulted in a supervisory investigation following complications during the labour. However both the woman and the regulatory authority were satisfied that the care that was given was appropriate, as required by the NMC standards,[104] and the NICE guidance.[105]

For the participants in these situations there was a need for effective communication and collaboration with the pregnant women so that each understood the other in terms of the provision of care. June deliberates on the trust that was developed as a result of the intricate labour plans that were made, whilst Louise is reassured by the woman's trust in her skill as a midwife. In each of these situations the midwife and woman worked together in partnership to support each other's decision making in difficult circumstances. As was highlighted in chapter three, woman-centred care is an important aspect of government policy. However, it is arguably a strategy that is not always well supported by another aspect of government policy: the use of standards and guidelines. This is in contrast to discussions above which highlighted the restrictive nature of clinical guidelines, particularly in terms of decision making. Both June and Louise's narratives demonstrate that for decision making in practice to be effective, clinical guidelines need to provide guidance which supports the decision making process rather than undermining it, as it is only in these circumstance that quality care will be provided.

4.6. Conclusion

Clinical governance strategies have been responsible for a fundamental change in the provision of care in the UK over the past three decades. Within this chapter we saw a range of reactions

[104] ibid.
[105] NICE n47 above.

to this change from midwives, which may be summarised utilising Dickens and Cook's concept of clinical guidelines which suggests that they may be seen as both a "shield to defend practitioners who comply with them and as a sword with which to attack those who fail or refuse to follow them".[106] Some participants viewed clinical governance and clinical guidelines as broadly supportive of clinical practice and provide a protective shield as Dickens and Cook describe.

However, a number of the participants perceived clinical guidelines as a legal sword,[107] suspended over their heads, and liable to fall on them if they do not follow the guidelines. This is regardless of whether the directions are appropriate for the individual woman, or whether the instructions will ultimately produce a good outcome. This may be preventing them from offering care that is safe and effective. This ignores the advice from the NMC that midwives are 'personally accountable for actions and omissions in your practice and must always be able to justify your decisions',[108] even in the event of unsound guidance in clinical guidelines.[109] The legal sword that the midwives fear will be employed to attack them if they do not follow the advice contained within clinical guidelines is therefore double edged, as failure to provide effective care could also incur legal sanctions from the regulatory body. Confidence and ability to exercise discretion and judgement in using guidelines is thus key.

For other participants, the negative 'sword' effect of the clinical guidelines was spoken of in terms of litigation and criticism by the service user. This perception of guidelines being utilised by women to instigate complaints and litigation when they are unhappy with the care provided, was a common theme when reflecting on the impact of litigation on midwifery practice. In

[106]Dickens B.M, Cook R.J., The Legal Effects of Foetal Monitoring guidelines *International Journal of Gynaecology and Obstetrics* 108(2010): 170-173 at 171.
[107]ibid.
[108] NMC n61 above at 1.
[109] Foy R., Grimshaw J., Eccles M., Guidelines and Pathways in Vincent C., *Clinical Risk Management:* 2nd ed. (British Medical Journal Books; London, 2001):283-300.

some instances, participants were unwilling to take responsibility for care provision because of the fear of poor outcomes. The data thus establishes that defensive practice can have a limiting effect on service provision for both the service user and the midwife. In these circumstances women have difficulty accessing safe, effective care as a result of the midwife who is unwilling or unable to offer care which is anything other than defensive. This is particularly challenging for the woman who has or develops a health related problem and becomes 'high risk' in terms of risk management strategies. Service provision for women with complex medical conditions should focus on identification of risk and effective management, which should in turn ensure safe quality care.[110] However as defensive practice was a significant issue for many of the participants, this issue needs to be addressed if care is to be as safe and effective as the legislature intended.

The subject of defensive practice and claims of litigation was one of a number of concerns identified by several of the participants. Jean (NHS, 0-5yrs.) amongst others, spoke of this when she told the story of providing care to a woman in challenging circumstances:

> 'She would be the sort of woman that actually would then go through the litigation process; I could see it, because …she had no realisation that anything she was doing was wrong. I'm all for people having their own environments and taking as much control over things as possible, but I think when a midwife is saying, "We need to do this and this is why we need to do this," and a mum is ignoring you because she thinks she knows best…but a midwife was trying to work within guidelines as much as possible and trying to do what was right, and she was just being battled with, you know….there was not a balance of power…everybody had a different agenda unfortunately. The midwives' agenda was to keep the mum and the baby safe. And you would think the mum's agenda was to keep herself and her baby safe… she would say it was, but they went about it two different ways…and I knew when the baby was in [the] special care [baby unit], she was not happy about this, not happy about that.…and it was very difficult to say to that woman, "You're to blame for this."…how they got her into [the caesarean] section at the time they did, I don't know, but that was somebody who was fighting against every safeguard that we have to keep the mum and baby safe. She was battling and breaking the rules …and she was a very intelligent,

[110] Schofield H., Safety in obstetric critical care *Best Practice & Research Clinical Obstetrics & Gynaecology*, 22(5) (2008):965-982.

> articulate woman who knew she knew best. So this wasn't somebody that was ignorant and they just wanted to get their way. She believed what she was doing was best really.'

Jean highlights the many challenges faced by women and midwives in the modern maternity services. These difficulties include the tension between clinical governance strategies and the duty of beneficence on the one hand, and woman-centred care and the duty to respect the pregnant woman's autonomy on the other. Whilst participants recognise that clinical governance strategies help to provide standardised care for the majority of women, there are also some individual situations where clinical guidelines were seen to impede rather than support quality care provision. In these situations, as Jean demonstrates, the potential for conflict between the pregnant woman and the clinicians is amplified.

The following chapter will move on to consider the midwives perceptions of the regulatory body the Nursing and Midwifery Council (NMC), exploring whether it is seen as effective in achieving the statutory aim of protecting the public.

5. The Nursing and Midwifery Council: Insights of Midwifery Registrants

5.1 Introduction

> 'In terms of the fees I think the NMC is a waste of money… for me as a person I don't think you get value for money, no... I can't see where my money is going…when I go and spend £70 on shopping I know what that is being spent on, that it's being spent on food to feed my family for a week, that it's being spent on clothes to keep me warm, to pay my bills. With the NMC it's almost like I'm giving somebody some money and I don't know what is being done with that money…I'm having to pay to do the job I love…if I pay my council tax I know that my council tax money is going to public transport, the police and education, I know where it's going to…not every single penny…but a rough idea. With my registration fee I haven't got a clue where any of the money goes.' (Lynn, NHS, 6-10 yrs.).

The unpopular rise in the annual amount that registrants pay to remain on the NMC register, have been implemented in order to increase the resources available to the regulatory body to address the significant number of historic fitness to practice cases that have not been dealt with by them. The regulator has justified these fee increases in the context of ensuring patient safety.[1] However, this is clearly not evident to Lynn who perceives the NMC to be remote and bureaucratic. This was a theme which was repeated throughout the discussions with participants, and which will be discussed in more detail below.

The Nursing and Midwifery Council (NMC) was created as a result of the Nursing and Midwifery Order 2001.[2] The formation of the NMC was part of broader policy changes to the regulation of health care professionals (as highlighted in chapter three), which it was envisaged would address societal and governmental concerns related to quality care provision and unsafe

[1] Addison M., Nursing and Midwifery Council (NMC*) NMC Council make the difficult decision to increase the annual registration fee to £120* (NMC; London, 2014): The increase was agreed by Council members despite an e-petition by registrants which had over 100,000 signatures and which was against the fee increase. This increase will mean that the annual registration fee has risen by approximately 55% in recent years.

[2] The Nursing and Midwifery Order 2001 no.253 part 2 Article 3(1) states: there shall be a body corporate known as the Nursing and Midwifery Council (NMC).

practitioners.[3] Consistent with neoliberal ideology and in a quest for greater transparency, the regulation of healthcare professions was to be carried out with the participation of lay members, who might represent the interests of the wider society.[4] This, it was imagined, would ensure competent and collaborative management of healthcare and the healthcare professions.[5] Influenced by these principles, and with a strong focus on ideas of accountability and personal responsibility,[6] the NMC was created with the aim of protecting the public.[7] The current chapter focuses on whether, in opinion of the participants in this study, it is successfully fulfilling that role.

The chapter will therefore explore the midwives general perceptions of the NMC (5.2) after which it will reflect on whether from the participants' perspective, the NMC is functioning effectively (5.3). The chapter will then go on to consider the influence that the fear of removal from the NMC's register has on midwives (5.4), before examining whether the NMC is ensuring safe practice and competent practitioners (5.5). Following this discussion the chapter will analyse the shifting relationship of statutory supervision of midwives to the NMC (5.6).

5.2 General Perceptions of the NMC

The law is a complex system of structures and processes, which are at times varied and somewhat contradictory.[8] The discussion in chapter two reflected on the purpose of regulation and highlighted that it may generally be considered as the determined effort to change the

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[3] Blair A. National Health Service Address 2nd July 1998 as cited in *Modernising Regulation-The New Health Professions Council: a consultation document* (Department of Health; London, 2000) at 6.
[4] Professional Standards Authority for Health and Social Care (PSA) *Fit and Proper? Governance in the Public Interest* (PSA; London, March 2013).
[5] Rose N., *Powers of Freedom* (Cambridge University Press; Cambridge, 1999); Calnan M., Rowe R., Trust relations and changing professional governance: theoretical challenges in Kuhlmann E., Saks M., *Rethinking professional governance: international directions in healthcare* (The Policy Press; Bristol, 2008).
[6] PSA n4 above.
[7] n 2 above.
[8] Ewick P., Silbey S., *The common place of law: stories from everyday life* (University of Chicago press; London, 1998) at 17.

actions of individuals in order to produce broadly identified outcomes.[9] In chapter three, Black argued that for regulation to be effective it must be accepted by the community that is being regulated.[10] Within the survey, when given a variety of choices about the aim of legislation, many midwives, (75 per cent (n≈100)) felt that it protected the public and improved standards of midwifery practice, whilst 66 per cent (n≈88), believed that it increased patient safety. Here, the participants were broadly supportive of the need for legislation and healthcare regulation.

This support for regulation in the context of the relationship between the midwife, the legal framework and the NMC was also revealed as being important to participants. In the survey some respondents were positive about the connection between themselves and the law, for example:

> 'The presence of the NMC ensures respect for the law that governs midwifery practice…respect and understanding of professional accountability.' (NHS, >20 yrs.).

> 'It improves patient care and ensures that we adhere to training requirements, guidelines etc.' (NHS, 0-5 years).

> 'It encourages personal responsibility for practice.' (NHS, 6-10 yrs.).

These sentiments were also echoed by some of the participants in the interviews:

> 'We should be accountable for the care we provide to people…the reason why we have Acts of Parliament and these rules is that you have guidelines…everything we do has a path that we follow…providing boundaries…it's about putting people at the forefront when providing care.' (Lynn, NHS, 6-10 yrs.).

In all of these narratives there is a recognition of the importance of the regulatory framework and its influence on the practice of midwives. The law is perceived as a device through which

[9] Black J., Critical Reflection on Regulation *Australian Journal of Legal Philosophy* 27 (2002a):1-36 at 26.
[10] Black J., Regulatory Conversations *Journal of Law and Society* 29 (1) (March 2002b): 163-96.

practitioners are enabled to perform their roles whilst ensuring acceptable levels of control over them and their activities.[11] The presence of regulation and the regulatory body within midwifery practice is thus seen as a helpful structure that will aid the midwife in the provision of care.

The aim of the 2001 Nursing and Midwifery Order is to safe guard the health and wellbeing of the public.[12] This is to be achieved by various means including the provision of standards,[13] and the investigation of alleged poor practice and fitness to practice hearings,[14] for registrants whose practice has been questioned. In both the survey and interviews participants were asked whether they felt confident that the NMC was effective in ensuring safe practice. Within the survey 71 per cent (n≈95) of respondents were confident that the NMC was broadly effective in ensuring that midwifery practice was good. This was reflected upon by some of the participants in the interviews who articulated that the production and implementation of standards for practice assisted with the provision of safe care:

> 'They set up the standards…they are shaping the profession in terms of defining what are the key things that ensure who will be able to be entered onto the register as a midwife.' (Nina, NHS, 11-20 yrs.).

> 'They have their standards so everybody knows what is expected of them as a midwife.' (Karen, NHS, 0-5 yrs.).

> 'The NMC is effective because if there is unsafe practice then it would be the NMC and the *Code of Conduct* that would be brought into play…it's the standard by which you are measured.' (Lynn NHS, 6-10 yrs.).

[11] Scott C., Accountability in the Regulatory State *Journal of Law and Society* 27(1) (March 2000): 38-60.
[12] n 2 above: see chapter three for further detail.
[13] n 2 above (5)(2)(a): the Order states that the regulator will establish the standards of proficiency it considers necessary for safe and effective practice.
[14] n 2 above Article 21(1b).

Here, the utilisation of professional standards by the regulator are perceived as being similar to clinical guidelines, which as was discussed in chapters three and four, are devised and implemented in order to ensure uniformity and safety in the provision of care.[15] As such for some participants the function of the regulatory framework was perceived as being supportive of the role of the midwife.

However, other midwives were less confident about the effectiveness of the NMC to safeguard the public. Within the survey data 22 per cent (n=29) of respondents were neutral, whilst 5 per cent (n=7) were unconfident and, 2 per cent (n=2) were very unconfident about whether the NMC was able to ensure safe practice. This finding was mirrored in the interviews:

> 'The NMC needs to function better. It needs to sort out doing fitness to practice properly…it makes me feel that if they're not dealing with something as important as professionals that are perhaps unsafe to be in practice promptly and efficiently how are they dealing with everything else?' (Amanda, NHS, 11-20yrs.).

> 'I don't think they are fully effective in their role…there have been issues with the NMC and I don't think they are fully ensuring safety.' (Megan, NHS, 11-20 yrs.).

These remarks are characteristic of the frequently repeated concern regarding the NMC's ability to manage its core function of fitness to practice competently.[16] Thus, despite some positive responses from midwives, the data nevertheless revealed that the participants had concerns about the NMC as a regulator. This unease, which will be discussed below, was focused on first the NMC as a dysfunctional organisation (5.3); second the fear of being

[15] Timmermans S., Berg M., A world of standards but not a standard world: towards a sociology of standards and standardisation *Annual Review of Sociology* 36(2010):69-89.

[16] n 2 above part 5: the legislation specifies arrangements for the criteria and process in relation to allegations of poor health or conduct; the investigation of registrants as a result of allegations; as well as how and in what manner Conduct Hearings should be undertaken. In determining such matters the regulatory body is obliged to consult with its own statutory Conduct and Competence Committee and Health Committee as appropriate.

removed from the NMC register (5.4); third procedural problems related to fitness to practice (5.5); and lastly its relationship with statutory supervision of midwives (5.6).

5.3 A (Dys) Functioning Organisation?

The Nursing and Midwifery Order 2001 stipulates that the NMC is accountable for its own actions and those of its member registrants to the Privy Council, the Department of Health and the Professional Standards Authority (PSA) (formally the Council for Healthcare Regulatory Excellence, CHRE).[17] In chapter three, the new regulation which was introduced, required that the function of the NMC would be to safeguard and be answerable to the public who access the services of the NMC's registrants.[18] Nevertheless, reviews by the CHRE/PSA have called into question the ability of the NMC to accomplish its statutory role.[19]

Within the data many participants were also apprehensive about the NMC's ability to function properly:

> 'For a professional body, it's almost an embarrassment…there have been criticisms…the NMC haven't been doing what they were supposed to.' (Samantha, NHS, >20yrs.).

> 'The NMC didn't have a clue what their function was.' (Laura, Ind. >20yrs.).

> 'There have been government concerns about the way that the NMC have been managing…I think that the criticisms might be valid.' (Nina, NHS, 11-20 yrs.).

[17] Health Act 1999 s.60; n2 above: Article 50 & Article 52: these articles require the Nursing and Midwifery Council to publish annual reports and to keep proper accounts which should be disclosed to the current administration. There are annual hearings held by the Health Select Committee on behalf of Parliament which examine the work of the regulator.

[18] House of Commons Health Committee *5th Report of Session 2013-14: 2013 accountability hearing with the Nursing and Midwifery Council* (Stationary Office; London, 3rd December 2013).

[19] Council for Healthcare Regulatory Excellence (CHRE) *Special report to the Minister of State for Health Services on the Nursing and Midwifery Council* (CHRE; London, 2008); Council for Healthcare Regulatory Excellence (CHRE) *Performance Review report: Changing regulation in changing times 2010/11* (The Stationary Office; London, 28th June 2011); Council for Healthcare Regulatory Excellence (CHRE) *Strategic Review of the Nursing and Midwifery Council: Final Report* (CHRE; London, 3rd July 2012).

The NMC regulates 680,858 nurses and midwives in the UK of which are approximately 40,000 midwives.[20] In a large organisation of this type,[21] the importance of ensuring effective leadership, management and accountability is seen as being key to good governance.[22] However, for the participants a tension exists between the statutory aim of the regulation and the ability of the regulator to manage the organisation so that the statutory objective could be facilitated effectively:

> 'I read some things about the NMC and thought "oh dear"…it was basic things about failure to communicate, poor management et cetera…it's very worrying.' (Amy, NHS, > 20 yrs.).

> 'Partly it was management wasn't it, needing to get their own house in order.' (Lucy, NHS, 11-20 yrs.).

> 'They are clearly an organisation that don't function particularly well….let alone the fact that they are regulating nurses and midwives…I think the culture in the organisation doesn't facilitate the very valuable aim of protecting the public…I worry that whatever changes occur…they just never seem to quite work.'(June, Ind. > 20 yrs.).

In these accounts there is an acknowledgment of the importance of the legislative objective but there is also pessimism that the NMC will be able to oversee such significant work. Tanya (NHS, 11-20 yrs.) in her discussions develops this concept and suggests:

> 'All they are is a repository for the laws and regulations…they could be called anything and do anything the way they are…they are office people…there is a legal requirement to have a place, a company, a building full of people…they are almost like a holding company, they're people who put things together, they are office people, they are not skilled practitioners.'

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[20] Nursing and Midwifery Council (NMC) *Our Register: An NMC Fact Sheet* (NMC; London, February 2014a).

[21] Nursing and Midwifery Council (NMC) *Annual Report and Accounts 2012-2013 and Strategic Plan 2013-2016* (NMC; London, 2013c): this documents highlights that there were on average 441 members of staff at the NMC in 2013 and that it had an income of £73.355 million which included fee income of £52.080 million, a grant from the Department of Health of £2O million, which was provided in order to address fitness to practice issues and investment income of £1.275 million.

[22] Cabinet Office *Corporate governance in central government departments: Code of good practice 2011* (HM Treasury; London, July 2011): this document outlines principles of good practice which are acknowledged as enablers of good governance in business and which the NMC have recognised in their own reports and literature. These principles include effective leadership, effectiveness, accountability and sustainability.

For Tanya, the difficulties experienced by the NMC occur as a result of lack of knowledge about clinical practice and the registrants' role by those who carry out the regulatory processes. This problem occurs as an outcome of the implementation of systems of New Public Management (NPM) throughout the health sector over the past thirty years that was outlined in chapters two and three. This has led to the creation of managers and administrators who might not have expert knowledge of practice,[23] but who nevertheless organise and control the procedures for the regulation of midwives. Even though these developments are in accordance with government policy for shared regulation,[24] and increased participation by non- health care professionals,[25] they do nonetheless generate challenges in terms of the effective management of the NMC.[26]

Some participants believed that this lack of efficiency creates further challenges for the regulator. Kate (NHS, > 20yrs.) for example suggests:

> "I think they've lost the confidence of the public and the profession partly because of the problems they've had and the changes in leadership."[27]

Thus whilst the aim of 2001 Order was to ensure public protection, as a result of management issues within the NMC, its ability to be an effective regulator who can safeguard the pregnant woman is perceived by the midwives in this study to be greatly reduced.

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[23] Courpasson D., Managerial Strategies of Domination: Power in Soft Bureaucracies *Organisation Studies* 21(1) (2000): 141-161 at 153; Grinyer A., Risk, the real world and naïve sociology in Gabe J., *Medicine, Health and Risk: Sociological Approaches* (Blackwell; Oxford, 1995): 31-51 at 34.

[24] PSA n4 above.

[25] Baldwin R., Cave M., Lodge M., Self-regulation, meta-regulation, and regulatory networks in author's ed. *Understanding Regulation: Theory, Strategy and Practice* 2nd ed. (Oxford University Press; Oxford, 2012): 137-164.

[26] Council for Healthcare Regulatory Excellence (CHRE) *Strategic Review of the Nursing and Midwifery Council: Interim Report* (CHRE; London, 10th April 2012) at 6: this review states that these imbalances had been widespread throughout the NMC for many years.

[27] ibid: in this report it is identified that the NMC lacked clear consistent direction, had unbalanced working relationships at a senior level which included sometimes dysfunctional relationships between the Chair and the Council, the Chair and the Chief Executive and the Chief Executive and the staff, and inadequate business systems.

5.4 The Fear of Removal from the Register

The discussion in chapter two established that in accordance with self-regulation principles, one of the functions of healthcare regulators is to hold a register of its members. This function is part of the provisions of the 2001 Order.[28] As was mentioned above, the NMC holds a large register, which is the biggest register of healthcare professionals globally.[29]

In the data it was evident that several participants were concerned about the authority of the NMC on them as individual registrants. In the survey, whilst 37 per cent (n≠49) of respondents felt that the fear of removal from the NMC register created a positive effect on care provision, other participants were less convinced. 26 per cent (n≠ 35) of participants thought that it had a negative impact on practice, whilst 47 per cent (n≠50) believed that it either had no impact or were uncertain of the impact. Equally when the midwives were asked to give examples of how this fear might impact on practice the responses were noteworthy:

> 'Midwives especially newly qualified midwives can feel that they are held to ransom, there is a huge issue around autonomy and responsibility linked with having worked hard for three years, and as a result may decide to "just go along with the norm", and not challenge practice or guidance that may not be in line with best practice because it's easier not to challenge and possibly be referred to the NMC.'(NHS, 11-20 yrs.).

> 'Midwives will document absolutely everything to cover themselves which takes time away from being with woman. The old saying that "if it's not written/ recorded it didn't happen" has damaged midwives autonomy.'[30] (NHS, 11-20 yrs.).

> 'There is a risk of practice by stealth, a risk of dishonesty with either yourself or the supervisor.'(Ind. > 20yrs.).

> 'It generates protective practice…to the detriment of being "with woman"…the true essence of midwifery.' (NHS, 0-5 yrs.).

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[28] n 2 above: s.5(1)
[29] n 20 above.
[30] National Health Service (NHS) Professionals *CG2 – Record Keeping Guidelines Clinical Governance V3* (Department of Health; London, March 2010) at1: this document states that the approach to record keeping that courts of law adopt tends to be that 'if it is not recorded, it has not been done'.

These comments were representative of the broad range of views expressed by respondents to the survey, and which were echoed by midwives in the interviews:

> 'I would say that it [the regulatory framework] makes midwives cautious.' (Nina, NHS, 11-20yrs.).

> 'I think we see removal from the register as losing our job, and not having money and not being able to pay the bills.' (Mary, NHS, 6-10 yrs.).

> 'We're protecting ourselves most of the time…it makes you defensive…midwifery isn't midwifery anymore, things have changed.' (Cathy, NHS, 0-5yrs.).

> 'Defensive practice…that's what it's all about, we don't practice how we feel we should…midwives are toeing the line because they are frightened of losing their registration... and that's your livelihood isn't it?' (Lucy, NHS, 11-20yrs.).

In these narratives the common thread is one of concern regarding the power of the regulator to remove registrants from its register,[31] and the impact on practice that this anxiety creates for midwives, which is epitomised as defensive practice.

Defensive practice may be defined as practice that the midwife employs in order to shield themselves from the risk of blame and punishment.[32] In chapter four it was highlighted that the NMC does not support defensive practice.[33] It is therefore interesting that many participants appear to believe that the authority of the NMC is generating overly cautious and protective practice which may not be in the interest of the pregnant woman.

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[31] n 2 above.

[32] Black N., Medical litigation and the quality of care *Lancet* 335(1990):35-37; Clements R., Litigation in Obstetrics and Gynaecology *British Journal of Obstetrics and Gynaecology* 98(1991):423-426

[33] Nursing and Midwifery Council (NMC) *The Code: Standards of conduct, performance and ethics for nurses and midwives* (NMC; London, 2008b): the Code states that the midwife is accountable for their "acts and omissions" which incorporates decision making. Nursing and Midwifery Council (NMC) *The Code Professional standards of practice and behaviour for nurses and midwives* (NMC; London, 2015b): In the latest version of the Code accountability is not explicitly discussed in this manner.

Comparable to the findings in chapter four, the defensive practice that is produced as a corollary of the fear of removal from the NMC register is multifaceted. It may include: limiting decision making, avoidance of caring for women in challenging situations, and undermining midwifery confidence in their own competence:

> 'I wouldn't want to do anything which would jeopardise my registration…it's like big brother watching you…every decision I make, every time I sign something I think I could potentially go to the NMC.'(Jean, NHS, 0-5 yrs.).

> 'Everything you do your accountable for …we're very much a stick orientated profession…it's very much a case of "watch out" because you're accountable, rather than "isn't it fantastic that you're accountable because of all the knowledge you have"…and that "stick" impacts on the decisions you make.'(Samantha, NHS, >20 yrs.).

> 'Being aware of the NMC has caused me to act differently…there are some decisions that I don't want to make on my own, so I'll involve other people.'(Lucy, NHS, 11-20 yrs.).

In each of these quotes the possibility of referral and removal from the NMC register is an influential component in terms of decision making in practice. Other narratives draw attention to additional difficulties that the fear of removal evokes for participants. For some midwives it is the responsibility of caring for women with complex needs which emerged as being problematic in this context:

> 'We all know midwives who avoid stressful situations, we all know midwives that don't go into the room when the emergency bell goes off.' (Louise, NHS, >20yrs.).

Whilst several midwives spoke in terms of being anxious about making errors in practice:

> 'When I was working on the wards I adapted my practice so I wouldn't get into trouble.' (Mary, NHS, 6-10 yrs.).

> 'Midwives always talk about how stressed and worried they are…and that they don't want to make a mistake…and that there will be big trouble for making a mistake…I

> have heard midwives say "I might be removed from the register if something goes wrong."'(Kate, NHS, >20 yrs.).

> 'The first thing they say when it's been highlighted that they've been doing something wrong is "I will lose my registration wont I"? Of course the vast majority of them don't…but I do think that that's what they think when they're in trouble.'(Amy, NHS, >20 yrs.).

Although the fear of being removed from the NMC register appeared in the discussions to be limiting for many of the midwives, it is interesting that both Amy and Kate identify that the perceived fear in relation to errors and mistakes made in practice is disproportionate to the number of midwives who are removed from the register.[34] This might suggest a lack of understanding of the regulatory process. Throughout, the view of the regulator was of a remote authority who was controlling and punitive in its approach.[35] This image of the NMC created a negative impact on practice for the participants whereby decision making and confidence were limited, and which thus has the capacity to undermine the provision of care. As such, an assumption that accountability produces quality service provision,[36] appears problematic. For many participants, awareness of their accountability to the NMC was viewed as an obstacle to efficient midwifery practice.

In the following section the concept of the provision of safe care and the regulatory procedures for managing concerns about registrants will be examined as these emerged in the data as being significant for the participants. This section will consider whether in the view of participants the NMC's fitness to practice procedures ensure competent practice.

[34] Nursing and Midwifery Council (NMC) *Nursing and Midwifery Council: Annual Fitness to Practice Report 2012-2013* (NMC; London, October 2013d): this report states that 0.2% or 1,347 nurses and midwives who were referred to the NMC received some form of sanction in the period covered by this report.

[35] Allsop J., Jones K., Protecting patients: international trends in medical governance in Kuhlmann E., Saks M., ed. *Rethinking professional governance: international directions in health care* (Policy Press; Bristol, 2008): 15-27.

[36] Weissman H., Accountability and Pseudo- Accountability: A Nonlinear Approach *Social Service Review* (June 1983):323-336.

5.5 Are Fitness to Practice Procedures Facilitating Safe Practice?

The NMC's fitness to practice decision making processes were examined in chapter three. This discussion established that there have been historic management issues associated with these procedures which have meant that allegations of poor practice were not dealt with in a timely manner.[37] These issues were also of concern to participants:

> 'If we talk about protecting the public how can it be right that it takes 5, 6, 7 years for cases to come up before a fitness to practice panel, that's not right and that's not protecting the public.'(Samantha, NHS, >20yrs.).

> 'It's not acceptable that people wait for years…they could go on working, maybe in a different area and practice unsafely.'(Amy, NHS, >20yrs.).

> 'It makes you worried that either there are staff that need to be back in practice or that there are staff that are in limbo.'(Amanda, NHS, 11-20 yrs.).

Here, addressing alleged poor practice in a timely manner is seen as being important for the registrant and the service user, particularly in terms of service provision. As the primary function of the NMC is to maintain a register of competent individuals the issue of the timing of investigations and fitness to practice hearings is somewhat problematic in terms of which registrants may practice, when and under what circumstances. Indeed, as noted in chapter three, the tardiness of some of these hearings, has been the considered as potentially in breach of human rights norms.[38] In the *Accountability Report* (2013),[39] (which was current at the time

[37] House of Commons Health Committee *Annual Accountability hearing with the Nursing and Midwifery Council: Seventh Report of Session 2010-12* (The Stationary Office; London, July 2011).
[38] In chapter three it was established that, in accordance with Article 6(1) of the European Convention on Human Rights which is now incorporated in Schedule 1 of the Human Rights Act 1998, provides that: 'in the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law…'
[39] House of Commons n18 above: this report states that the length of time taken by the NMC to conclude fitness to practice cases has been a persistent concern for the Health Committee. From 2015 the NMC intends to reduce the target for resolution of fitness to practice cases to 15 months. The report notes that if the target time is to be reduced to 12 months that changes to NMC legislation is required which will necessitate close liaison with the Department of Health.

the data was collected) which was presented to Parliament indicated that the NMC had made some progress in reducing the number of old fitness to practice cases, however it still remained a significant issue.

Participants were equally concerned by decision making procedures at fitness to practice hearings. Some midwives suggested that the decision making process was rigorous:

> 'The evidence must be quite strong for them to come to the decision they've come too…they've got their guidelines to follow…so it must be robust.' (Jean, NHS 0-5 yrs.).

> 'I don't think the decision is made lightly…they wouldn't take someone's registration away unless they felt that they were dangerous in practice.'(Karen, NHS 0-5 yrs.).

However others were less convinced about fitness to practice decision making processes. Samantha (NHS, >20yrs.) for example was troubled about the issue of timeliness and decision making in her comments:

> 'When it takes 2 to 5 years to get from the incident to fitness to practice…the whole process is compromised…the case reviewers or administrators change…so every panel you go to the people change…and then they ask you for all the same information…the fact that they've had it maybe three times or more…it would make more sense to have the same administrator who knows the case…it doesn't make organisational sense to me…and they make some odd decisions as far as midwifery goes.'

These observations relate to personal experience that Samantha has had with the organisational management of the NMC where there has been a high staff turnover in recent years which has had a substantial effect on competence procedures.[40]

Several more participants were apprehensive about the lack of practice experience of panellists at fitness to practice hearings and how this influenced decision making. Some commented on decisions being made without reference to the context of practice:

[40] House of Commons n18 above.

> 'I have big concerns about them…I've been to one hearing and read the transcript of another…they either stick to the NICE guidance and say "this midwife didn't do this, this and this" or they don't have a clue what normal practice is…they seem a bit of a kangaroo court…which hugely bother me because then you're at the mercy of the people on the day…I'm not sure how fair that is… particularly when it's about specifics of care, I think midwives can get hauled over the coals for specifics when maybe it's actually that their philosophy doesn't quite fit with what's considered main stream.' (June, Ind. >20yrs.).

> 'I've seen fitness to practice panels which were very scary where they quite literally looked at what was written in the rules and stated that the midwife had broken those rules without taking anything else into consideration. It was so far removed from the ward…from what was going on.' (Mary, NHS, 6-10 yrs.).

The regulation of the health care professional has as its focus patient safety,[41] and as such fitness to practice hearings play a significant role in ensuring the protection of the public. Nevertheless, for these midwives, there emerges a perception of limited understanding on the part of fitness to practice panellist members of the provision of care within the clinical environment. This reflects a view that codes and guidelines are used to enforce conformity and regulate the behaviour of professionals,[42] without acknowledging that the environment within which care is offered might also influence the actions of the professional.

Some participants went further, suggesting that government strategy for the NHS and the maternity services was in part responsible for this type of decision making within fitness to practice hearings. Two participants made specific reference to endemic underfunding:

> 'I witnessed a hearing…and I remember thinking "that person hasn't gone to work that day intending to harm that baby"…there are always other things involved…it was a busy shift…when you take a person out of the situation and pull them apart you can almost sympathise with the situation, the dilemma that they're in. The NMC has got a difficult job…I think they're carrying the can for the government not putting enough money into the NHS…we know how understaffed units are…wards running with just one midwife…there isn't enough staff, there isn't enough beds and it's dangerous. I

[41] Spencer-Lane T., Safeguarding the public by regulating health care social care professionals: lessons from Mid-Staffordshire and the Law Commission Review *Journal of Adult Protection* 16(1) (2014): 52-59.
[42] Yeung K., Dixon-Woods M., Design-based regulation and patient safety: A regulatory studies perspective *Social Science and Medicine* 71(2010):502-509.

> think in the bigger picture, that funding has got a lot to do with it.' (Lucy, NHS, 11-20yrs.).

> 'I think it's the government passing the buck…they don't put money into the system but they still want everybody to have the same standard of care and you can't do it…so they think "Let's pass the buck to the NMC because practitioners are not doing their jobs effectively."' (Lilly, NHS, 0-5 yrs.).

Here, the impact of neoliberal policies that focus on reduction of welfare budgets and the curtailment of public sector spending,[43] together with the quest for quality care,[44] are seen to have a direct influence in fitness to practice hearings. The NMC is tasked with examining the registrant's actions in practice, which may have been affected by other factors beyond the control of either the regulator or the regulated, without recognising the effect of the external issues on the practitioner's behaviour. Decision making in these conditions may thus be flawed and not supportive of either the public or the registrant, albeit that this may only be representative of midwives in my study and not of the broader population of midwives working in the U.K. Further, as we see next, significant concerns were also expressed regarding the qualifications of fitness to practice panel members.

In chapter three the discussion highlighted that (New) Labour policy emphasised increased public participation as an essential aspect of professional regulation.[45] One consequence of this policy was the inclusion of lay public members on NMC fitness to practice panels and their encouragement to take an active part in the decision making process as a means of increasing

[43] White M., Neoliberalism and the rise of the citizen as consumer in Broad D., Antony W., eds. *Citizens or Consumers? Social Policy in a Market Society* (Fernwood Publications; Halifax NS, 2000): 56-64.
[44] Health Act n17 above: 18 (1) Duty of Quality states: it is the duty of each Health Authority, Primary Care Trust and NHS Trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals.
[45]Arestis P., Sawyer M., Neoliberalism and the Third Way in Saad-Filho A., Johnston D., eds *Neoliberalism: A Critical Reader* (Pluto Press; London, 2005); Department of Health (DoH) *Shifting the Balance of Power within the NHS – Securing Delivery* (HMSO; London, 2001b); Department of Health (DoH) *Involving Patients and the Public in Healthcare* (HMSO; London, 2001c).

professional accountability to the public.[46] The inclusion of the public in matters of healthcare professional regulation is also thought to enhance the relationship between the practitioner and the service user,[47] by encouraging society to use its public 'voice' to positively influence the provision of care.[48]

The employment of non-professionals as fitness to practice panellists was explored in the interviews. Several participants were unaware that these panels included lay members:

> 'I didn't know that they included the public…but I would have thought that that would help them to be fairer, more reasonable, a bit like a jury…they would come with a different perspective.' (Ruth, NHS, 6-10 yrs.).

> 'I didn't know…but I wouldn't be surprised, because there is normally a lay person on most panels now because they're neutral, independent people.'(Jean, NHS, 0-5 yrs.).

> 'I wasn't aware that they had lay members…but I can appreciate why, because if the NMC is there to protect the public it would only be fair to have the public represented.' (Nina, NHS, 11-20 yrs.).

In these extracts the inclusion of the public is associated with impartiality and equanimity in decision making. In these circumstances, lay members are perceived to be a mechanism to enhance accountability in order to ensure the evolution and development of care between themselves and the healthcare professional.[49] However, other participants were more doubtful about the efficacy of lay members on fitness to practice panels:

> 'You need people that are completely objective, but how can you be objective when you're hearing a case where harm has been done to a patient by a practitioner…you immediately want to blame the practitioner and say "it must be the practitioner, because it wasn't the patient."' (Lucy, NHS, 11-20 yrs.).

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[46] n 2 above.
[47] Department of Health (DH) *Trust Assurance and Safety: The regulation of health professionals in the 21st century (*Department of Health; London, 2007d).
[48] Hirschman A., *Exit, Voice and Loyalty: Responses to Decline in Firms, Organisations and States* (Harvard University Press; London, 1970); Paul S., Strengthening Public Accountability: Can 'Exit' and 'Voice' help? *Economic and Political Weekly* August 31 1991:78-84.
[49] Weissman n36 above.

> 'If they have no medical knowledge, no midwifery knowledge…if they're drawn from a wide range of the public they wouldn't have a clue what was done, why it needed to be done, and the order we follow things as a midwife…they might not necessarily understand why something was done…and this would impact on their decisions.' (Lynn, NHS, 6-10 yrs.).

> 'I'm concerned that in midwifery cases you might get somebody who's had no experience of childbirth…so how can someone like that be representative of the lay side of things on a childbirth issue? How can they understand what's quite often complex decision making…I would suggest it would be beyond them…if you're going to have lay people…they should be well qualified and come from organisations that represent lay members around childbirth issues…that would be useful.'(Laura, Ind. >20yrs.).

Here, the lack of understanding and, on occasion, limited personal experience was perceived to be difficult particularly in relation to decision making. As was indicated in chapter three, the NMC provides training and guidance on fitness to practice issues.[50] However, given the complex nature of errors in practice, it is unclear whether this training programme is sufficient. It is thus unsurprising that some of the midwives expressed concern regarding the potential for problems to occur in the decision making processes within these panels that might undermine patient safety and accountability.[51]

5.6 Statutory Supervision of Midwives: A Shifting Relationship with the NMC

For the midwives in this study, the relationship of statutory supervision to the NMC emerged as being important. At the time the data was collected the issue of whether the provisions within the 2001 Order,[52] which permit the Local Supervising Authority (LSA) to be able to suspend a midwife from practice should be retained, or whether this function should be returned to the

[50] Nursing and Midwifery Council (NMC) *Nursing and Midwifery Council: Annual Fitness to Practice Report 2011-2012* (NMC; London, September 2012b).
[51] Yeung and Dixon-Woods n42 above.
[52] n 2 above: Article 43(1): these provisions were discussed in chapter three.

regulator were being considered, as a consequence of the *Morecombe Bay Inquiry* (2010).[53] Statutory supervision of midwives will be examined in detail in chapter six, where it will be demonstrated that whilst participants have reservations about local supervision procedures they are nevertheless concerned about the proposed changes to the statutory framework.[54] Some of the midwives thought that a local relationship within a working framework was the most effective way of managing practice concerns:

> 'If there is an issue the LSAMO [Local Supervisory Authority Midwifery Officer] will come to the Trust and talk to the midwife, the supervisor of midwives (SoMs) investigating her, it's a more collaborative approach. I think what we've got in place now is good…I don't think suspension is something to be taken lightly so maybe by the time it gets to the NMC we've been through all the stages and the NMC should have the final say.'(Mary, NHS, 6-10 yrs. Supervisor of Midwives (SoM)).

> 'The LSA should make the decision to suspend somebody because I think they work closely with us…I don't think I've got a relationship with the NMC as such.' (Cathy, NHS, 0-5 yrs.).

These observations support a collegiate style of regulation which is thought to present greater uniformity in terms of specialised decision making which should facilitate accountability.[55]

In many other narratives, participants discussed the changes in terms of the recent concerns about the performance of the NMC which was believed to potentially increase problems with fitness to practice decision making:

> 'I haven't got a lot of faith in the NMC as its not demonstrating that it's clearly dealing with its remit at the moment…so maybe local supervision is therefore a good process…I'm not filled with great confidence that a midwife who shouldn't be practising until something's been investigated won't slip through the net and carry on practising.' (Amanda, NHS, 11-20 yrs.).

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[53]Fielding P., Richens Y., Calder A. *Final Report: Review of Maternity Services in University Hospitals of Morecombe Bay NHS Trust.* (University Hospitals of Morecombe Bay; Morecombe Bay Inquiry, 2010): this inquiry was held after a series of five unconnected serious untoward incidents at Furness General Hospital in 2008.

[54]Parliamentary and Health Service Ombudsman (PHSO) *Midwifery supervision and regulation: recommendations for change* (The Stationary Office; London, December 2013); Nursing and Midwifery Council (NMC) *Independent review of midwifery regulation: terms of reference* (NMC; London, 2014b).

[55] Baldwin Cave and Lodge n25 above at 342.

> 'I don't know that the NMC is in a position to make decisions about suspending midwives from practice…I think the local system where the LSAMO makes the decision is quicker…I think if the NMC were left to make decisions about suspension, that midwife could carry on and make another error… the NMC shouldn't have that power because they would take too long.' (Kate, NHS, >20 yrs. SoM).

For these midwives, regional regulatory mechanisms were the key to supporting accountability and safety in practice.

Several participants thought that if the regulator took control of this aspect of the regulatory process that this would increase the potential for procedural difficulties, particularly in terms of fitness to practice which would further effect midwifery accountability:

> 'If the NMC were in control I think there will be more midwives who are suspended…because it's different looking at something on paper, and then I think there will be a massive back log…I don't want to be practising for a year and then be told "Oh by the way you've now been suspended because of something you did 18 months ago"' (Lilly, NHS, 0-5 yrs.).

> 'From what I've seen at the NMC…we'll all be suspended…it's better kept at a local level because midwifery is completely different to medicine and nursing…and I think local supervision wards off that whole NMC stuff…if supervision is done right…I've seen the NMC in action… fitness to practice hearings can be like a Kangaroo court.' (Paula, Ind. 11-20 yrs.).

In these dialogues, Lilly and Paula identify that the direct involvement of the regulator rather than resolving problems, may create challenges for midwives and the midwifery profession which do not increase safety in practice.

Some participants identified that the perceived remoteness of the regulator who lacked understanding of midwifery matters was also problematic in terms of the proposed changes. Indeed, Mary (NHS, 6-10 yrs. SoM) maintained:

> 'I don't think there are any midwives left at the NMC, so how can somebody who's not a midwife make decisions based upon midwifery practice when it is so different to nursing.'

In order to enhance and support practitioner accountability several interviewees suggested that suspending a midwife from practice should be a collective decision:

> 'It needs to be a joint decision…it's a very powerful decision to make…scarily powerful…to withdraw a midwife from practice…it needs to come from all sides, management, supervision and the NMC.' (Lucy, NHS, 11-20 yrs.).

Whereas, other participants argued that the solution lay with ensuring that local regulatory mechanisms were effective:

> 'The NMC doesn't know these midwives…they are a governing body who sit in a different part of the country and don't know that midwife…I feel that if the Trust, management and supervisors of midwives do their role properly that's much more positive than being sent to the NMC...it should be a far better mechanism, keeping it local as much as possible.'(Megan, NHS, 11-20 yrs.).

> 'It's like centralising the government isn't it? The more you take it away from the local community the more damage it does generally…you need to get things as close to where the working environment is as possible to have the best outcome…the NMC should be like a governing shield that makes sure that local supervision works.'(Jean, NHS, 0-5 yrs.).

In these dialogues the function of the NMC is perceived to be one of reinforcing local regulatory processes. Here, fitness to practice issues need to be managed in a proactive manner, such that practitioner competence and accountability is assured through local procedures which are fit for purpose.

The data reveals that although the participants have concerns about statutory supervision and its ability to ensure that accountability and safety in practice are guaranteed, they were nevertheless uneasy that the NMC would be able to effectively fulfil this function, should the

proposed changes be implemented.[56] Additionally, there was unease that the current regulatory framework was not fit for purpose. The regulator was perceived by some participants to be too remote, whilst for others, fitness to practice panels did not have the relevant expertise to understand the midwives' clinical working environment and, thus ensure a fair hearing.

5.7 Conclusion

The regulation of the health care professions has experienced fundamental changes over the past thirty years. This has occurred in part as a consequence of high profile malpractice cases,[57] with the resultant loss of trust in the professions. This, together with successive governments focus on neo-liberal policy objectives has created the situation whereby the traditional model of self- regulation has been replaced by more state and public involvement in matters of health care regulation.[58] In this chapter the role of the regulator has been analysed, utilising the data to explore the participants' perceptions of the NMC.

Although there was general support for the purpose of regulation in terms of the protection of the public, many participants were critical of the functioning of the NMC and its ability to ensure patient safety. These concerns focused on whether or not the regulator was truly effective given the number of problems it had, which included the administration within the organisation, the lack of understanding of its core function and the management of fitness to practice cases. When discussing knowledge of fitness to practice proceedings many of the

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[56] Baird R., Murray R., Seale R., Foot C., Perry C., *Kings Fund Review of Midwifery Regulation* (Kings Fund; London, 2015): the findings of the review (which were published after the data in this study was collected) has recommended that the ability to suspend a midwife from practice should be the function of the NMC and not the LSA. This will be examined in more detail in chapter seven.

[57] R v Allitt [2007] EWHC 2845 (QB); Foster J. *Mother tells of baby's death: the ward 4 murder trial* (Guardian Newspaper: London, 23rd March 1993); Department of Health (DoH) *Safeguarding Patients – the Government's response to the Shipman Inquiry's fifth report and the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries* (DoH; London, 2007a)*;* Department of Health (DoH) *Learning from tragedy, keeping patients safe: Overview of the Government's action programme in response to the recommendations of the Shipman Inquiry* (DoH; London, 2007b).

[58] PSA n4 above; Peck J., Tickell A., Neoliberalizing Space *Antipode* 34(2) (16th December 2002):380-404.

participants believed the NMC to be a remote regulator of whom they seemed fearful. Whilst most participants were acutely aware of their own accountability and responsibility to the regulator, this cognizance appeared to create additional challenges that further impacted on the care provided to pregnant women. This was characterised by Karen (NHS, 0-5 yrs.) who recounted this experience in practice:

> 'I don't think these panels ensure good practice…there is probably a more effective way of doing it within the Trust…I think midwives are scared because it's the unknown…it's something you hear about, something that's talked about in practice occasionally…there were a couple of midwives who went to fitness to practice hearings…it was like a nice day out for them…and when they came back it would be "guess what this one did, guess what that one did"…and you listen and think…"It's scary…what if you find yourself in that situation"…'

In this account whilst there is some transparency in the fitness to practice hearing in that they are open to the public, reports of events at these hearings reinforces fear and apprehension. Here, midwives fearful of losing their hard won registration and the threat to job security that this would entail, resort to providing care which is guarded and restrained, but not necessarily in the best interest of the pregnant woman. As such it transpires that far from promoting safe care these systems of accountability, possibly weaken and undermine the provision of quality care.

The theme of accountability was developed further in the context of referrals to and management of alleged poor practice by the NMC. Several participants connected these issues to broader unease about lack of government funding of the NHS, which it was thought had the potential to produce unsafe practice. Laura (Ind. >20yrs.) makes this comment which summarises the concern that many midwives have:

> 'The fitness to practice panels can lead to miscarriages of justice I would say, any systems failure within the maternity services should be a clear referral to the CQC [Care Quality Commission] to investigate. It's quite obvious to me, I'm about to tell the CHRE[now the PSA] because we [the Independent Midwives Association] feed back to their annual review…and it dawned on me when I was thinking about what the NMC

> core function was, and I don't believe the NMC have been clear about it. It should be about getting rid of the Beverley Allitt's of this world, not getting rid of the Mary, Jo and Jane who are struggling to do their best and are caring midwives who may have made an incorrect clinical decision on occasion, we all do, we always will, we do our best not too, but we will. It's not about persecuting those midwives until they're driven to the point of suicide to make them pay for it. It's about supporting them, and unless they do then they're not going to have the midwifery profession left, end of story and then women will really be unsafe, and will all have caesarean sections, and end up having complications with the next pregnancy and more mothers will die.'

Within this narrative the importance of effective management and funding of the NHS is seen as a pivotal factor to the provision of care. Here, Laura, as did other participants, suggests that financial constraints within the NHS, result in practitioners attempting to provide care in difficult fiscal circumstances that may lead to NMC referrals when outcomes are poor. In these circumstances the regulator was perceived to be penalising individual practitioners for failures within the wider system. This, in conjunction with ineffectual management structures within the NMC,[59] meant that registrants felt further alienated from the regulator and were all the more unsure about its core function and role.

A further concern raised by participants about the management of alleged poor practice and fitness to practice hearings was the recent proposals to change the structure of statutory supervision.[60] These recommendations were viewed as problematic by participants, who saw a local approach to the management of adverse events and incidents involving alleged poor practice through the Local Supervising Authority as more beneficial in terms of resolving fitness to practice cases than a remote regulator. This was considered to be particularly important given the current problems that the NMC had in addressing fitness to practice cases. Midwives in this study were of the opinion that current proposals,[61] could further aggravate an already difficult situation with regards to fitness to practice, which may affect the care offered

[59] CHRE n19 above.
[60] Baird et al. n56 above: the proposals will be discussed further in chapter seven.
[61] ibid.

to pregnant women. Their views on statutory supervision will be more fully considered in the next chapter.

6. Current Perceptions of the Statutory Supervision of Midwifery

6.1 Introduction

Statutory supervision of midwives has frequently generated polarised opinions within the midwifery profession, whereby some midwives are enthusiastic proponents, whilst others have viewed it as a pursuit to control midwives.[1] Within the interviews, some participants were positive towards statutory supervision:

> 'It's about promoting optimal practice.' (Lilly NHS, 0-5 yrs.).
>
> 'Supervisors are there to support and help and guide and protect.'(Megan NHS, 11-20 yrs.).

However, others were less confident about the purpose of supervision suggesting:

> 'It's very destructive…I don't think it's functional.' (Laura Ind.>20yrs.).
>
> 'It's a bit of a policing activity.' (Lucy NHS, 11-20yrs.).

Here, the nature and purpose of statutory supervision and the relationship that exists with those it is attempting to regulate are highlighted in these accounts. These concerns emerged as being important for some midwives in this study and will be discussed in this chapter.

The statutory supervision of midwives has been an integral and unique part of midwifery regulation since the first Midwives Act was enacted in 1902.[2] In chapters two and three, supervision was seen to be an influential part of the way in which the midwifery profession is governed in the United Kingdom. It has been seen by successive governments as a key component of the regulatory framework designed to ensure the protection of the public in terms

[1] Henshaw A., Clarke D., Long A.F., Midwives and supervisors of midwives' perceptions of the statutory supervision of midwifery within the United Kingdom: A systematic review *Midwifery* 29 (2013):75-85. See further chapter two.
[2] Midwives Act 1902 c17 (England and Wales).

of safe and effective care provision whilst supporting the woman centred agenda.[3] Lately however, questions have been raised about the effectiveness of statutory supervision and whether it is fit for purpose within current maternity service provision.[4] These concerns and the proposals to address these problems were explored at the end of chapter five. In this discussion, it emerged that participants were uneasy about the prospect of Local Supervising Authorities (LSA's) and supervisors of midwives losing the ability to implement local procedures following allegations of poor practice, with the Nursing and Midwifery Council (NMC) taking back overall control of its core regulatory function of fitness to practice, given the poor performance of the regulator in the recent past.

In chapter six, statutory supervision will be examined in more detail with the aim of determining whether, from the participants' perspective and experience, supervision enables the midwifery profession to provide safe effective care to pregnant women. It will be seen that there was broad support for statutory supervision of midwives from the participants both in the survey and in the semi-structured interviews. However, when the midwives' views were considered in more depth, it emerged that the interviewees were apprehensive about aspects of statutory supervision and its impact on midwifery practice. These concerns centred on the following themes: the provision of safe care in practice (6.2); practitioner accountability (6.3); woman centred care and the public choice agenda (6.4). These three themes will be analysed in detail in this chapter.[5]

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[3] Cumberledge J., *Report of the Expert Maternity Group: Changing Childbirth* (HMSO; London, 1993); Kirkham M., The Maternity Services Context in Authors Ed. *The Midwife- Mother Relationship* 2nd ed. (Palgrave Macmillan; Basingstoke, 2010): 1-16; see further chapter three.

[4] Parliamentary and Health Service Ombudsman (PHSO) *Midwifery supervision and regulation: recommendations for change* (The Stationary Office; London, December 2013).

[5] In this chapter a distinction will be made between those participants who are supervisors of midwives (SoM) and those who are not, therefore SoM will be included after the individual participant information to indicate those who have this additional midwifery qualification.

6.2 Supporting Safe Care in Practice?

In the survey, when participants were asked about their understanding of the purpose of statutory supervision of midwifery 91 per cent of respondents (n≠122) agreed that the rationale for statutory supervision was to protect the public and ensure high standards of midwifery practice. This response may be the outcome of the drive towards providing more information to midwives about the aim of supervision which had been identified as necessary in earlier research,[6] and that has resulted in the publication of literature and information on the topic.[7]

Around six per cent (n≠8) of respondents in the survey were of the opinion that statutory supervision was a mechanism for the policing of midwifery, echoing a view found in previous research.[8] In an interview the nature of supervision for some midwives was articulated by Mary (NHS 6-10 yrs. supervisor of midwives (SoM)) who remarked:

> "Maybe midwives feel that they're being bullied or that they're being picked on. I can only talk about having been at a meeting and overhearing about a midwife who had been on supervised practice and then another issue cropped up, something completely different about her attitude. The midwife made a complaint saying that she felt that the supervisors were bullying her and that they weren't viewing the issue independent of what had happened previously. And maybe that's part of the 'old girls club' of supervision…midwives will say "what have you heard at the old girls club? Now what's going on, who are they talking about this time, go on give us the gossip, you must hear some juicy stuff"…there is an aspect that midwives still view it as "the chosen ones" group.'

Apprehension about the purpose of statutory supervision of midwives and its ability to ensure safe practice was clustered around several core concerns: the (non)-expert supervisor (6.2.1); the impact of the supervisory relationship on the provision of care (6.2.2) and whether the annual supervisory review ensures safe and competent practitioners (6.2.3). Each of these

[6] Stapleton H., Kirkham M., Supervision of Midwives: England 1996-97 in Kirkham M eds. *Developments in the Supervision of Midwives* (Books for Midwives; Edinburgh, 2002):61-92.
[7] Local Supervising Authority Officers (LSA) National (UK) Forum *Modern Supervision in Action: a practical guide for midwives* (Nursing and Midwifery Council (NMC); London, January 2008).
[8] Stapleton and Kirkham n6 above.

factors was felt to have an impact on whether statutory supervision ensures the provision of safe effective care provision and each is considered in turn below.

6.2.1 The (Non)-Expert Supervisor

The Nursing and Midwifery Order 2001 sets out the requirements for the statutory supervision of midwives, this includes: the requirement that every midwife should be allocated a supervisor of midwives, how these supervisors of midwives are to be appointed and what their role and responsibilities will be.[9] Here, supervision may be perceived as the ability to monitor another's work with discernment such that the supervisee may be able to utilise the knowledge and expertise supplied by the supervisor.[10] Other aspects of the supervisory role consists of the facilitation of safe practice,[11] or the provision of professional support.[12] As such, the NMC also require that the midwife has twenty four hour access to a supervisor of midwives, who she can contact for advice and guidance should the need arise.[13]

When this system of support is functioning effectively as a result of the supervisor of midwives who has comprehensive understanding and proficiency in particular birth scenarios, participants reported that supervision gave them confidence in these potentially challenging situations. One midwife, Jean (NHS, 0-5 yrs.) described this incident:

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[9]Nursing and Midwifery Order no.253 Article 43(1) states: each LSA shall (a) exercise general supervision in accordance with the rules made under article 42 over all midwives practising in its area and (c) have power in accordance with the rules made under article 42 to suspend a midwife from practice; (2) The Council may prescribe the qualifications of persons who may be appointed by the LSA to exercise supervision over midwives in its area, and no one shall be so appointed who is not so qualified. (3) The Council shall by rules from time to time establish standards for the exercise by LSAs of their functions and may give guidance to LSAs on these matters.

[10] Holloway E., The Essence of Supervision in author's ed. *Clinical Supervision: A systems approach* (Sage; London, 1995): 1-9.

[11] North West Local Supervising Authority *Supervisors of Midwives Resource Pack* (University of Manchester; Manchester, 2010).

[12] Kirkham M., The History of Supervision in The Association of Radical Midwives ed. *Super- Vision: Consensus Conference Proceedings* (Books for Midwives Press; Cheshire, 1995):1-9

[13] Nursing and Midwifery Council (NMC) *Midwives Rules and Standards: Part 4 Supervision and reporting* (NMC; London, 2012a) Rule 9 (d) states: all practising midwives within [the LSA] area have 24 hour access to a supervisor of midwives whether that is the midwife's named supervisor or another supervisor of midwives.

> 'I got my supervisor involved, because she's the VBAC [vaginal birth after caesarean][14] person, to put a plan together. She was there for a totally positive reason. And when we did that delivery....I've never done a VBAC at home. Not many midwives have done VBACs at home. And I wanted a supervisor there for me. Even though the second midwife that was coming had been a midwife for 10 years, she'd never done a VBAC at home…so we got the supervisor who was our matron at the hospital at the time and she came out, she didn't need to do anything…everything was straightforward. But we had her literally there as a presence, we felt it was important that the women had a home birth and I had the confidence of somebody that had done a VBAC and had been a midwife for 30 years.'

Here, the accessibility of expertise from the supervisor of midwives supports both the midwife and woman during potentially difficult times in practice.

However, whilst the 2001 Order provides the supervisor of midwives with significant powers, many participants raised concerns about her/his effectiveness where she/he does not have sufficient relevant expertise, experience or skill. The disparity in the competence of the supervisor of midwives was recognised by several of the participants as being influential in terms of safety:

> 'There are some supervisors of midwives who are exemplary and others who are not.' (Amy NHS, >20 yrs. SoM).

> 'It depends on the individual supervisor, they're all trained the same but it's how they use those skills and that knowledge.'(Megan NHS, 11-20yrs.).

Whilst the NMC has identified competencies to ensure that the supervisor of midwives has skills which are of an acceptable standard,[15] the experience of a number of the participants would suggest that such skills are not always present. As a consequence of the changing nature

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[14] Al-Zirqi I., Stray-Pedersen B., Forsén L., Vangen S., Uterine rupture after previous caesarean section. *British Journal of Obstetrics and Gynaecology* (BJOG) 117(7) (2010):809-820: A vaginal birth after caesarean section (VBAC) is considered to be problematic as a consequence of the potential for rupture of the uterine scar during labour. The incidence of uterine scar rupture during labour following a previous caesarean section is thought to be 8 times higher after trial of labour than at repeated elective caesarean section.

[15] Nursing and Midwifery Council (NMC) *Standards for the preparation and practice of supervisors of midwives* (NMC; London, October 2006b).

of midwifery practice, midwives have by necessity needed to develop competence and expertise in areas previously unfamiliar to them.[16] In these situations, the current 24 hour access to support provision,[17] was undermined for a number of participants due to the lack of clinical expertise and assistance that the supervisor of midwives was able to provide:

> 'Supervisors are meant to be an expert in everything, well they're not…as midwives we're made to feel we have to be able to do everything…if you had supervisors who had some degree of expertise you would know how to use them. They're meant to be these expert midwives; well I would suggest that some of them aren't expert in certain areas at all.'(Amanda (NHS, 11-20yrs.).

> 'there's no point having a fantastic labour ward midwife supervising a community homebirth midwife, that's just not helpful because, the things I use my supervisor for is her knowledge and to be able to talk things through with her so there's no point if she's not got an area of expertise that's shared.' (June Ind. >20yrs.).

In Amanda and June's quotations the current NMC generic recommendations are somewhat problematic.[18] In situations where particular expert knowledge and assistance is required by the midwife, the supervisor of midwives might be unable to provide the level of expertise needed due to their own lack of skill and competence and this can create challenges to the provision of care.

6.2.2. The Influence of Individual Supervisory Styles

Every supervisor and supervisee has different expectations of the supervisory relationship.[19] This was evident in the discussions with the interviewees. Some participants reported positive relationships which were based on mutual respect:

[16] Duerden J., Supervision at the beginning of a new century in Mander R., Flemming V., eds. *Failure to Progress: the contraction of the midwifery profession* (Routledge; London, 2002a):78-98.
[17] NMC n13 above.
[18] NMC n13 above: Rule 8 states: (a) A supervisor of midwives must be a practising midwife and (b) meet the requisite standards of experience and education for the role of supervisor of midwives set by the Council from time to time. Rule 9(d) states: all practising midwives within (the LSA) area have 24 hour access to a supervisor of midwives whether that is the midwife's named supervisor or another supervisor of midwives.
[19] Holloway n10 above: 41-55

> 'My supervisor of midwives is proactive and supportive…she doesn't interfere with my practice, we have a relationship of trust that she knows that if I've got a problem I will contact her.'(Laura, Ind. >20 yrs.).

> 'She's been very supportive…she's very good at giving me advice…she wants me to improve my practice.'(Lilly, NHS, 0-5 yrs.).

Within this complex relationship, the ability to have confidence in each other's ability was recognised as an important part of a functioning reciprocal relationship, mirroring the findings of earlier research.[20] Further requisite characteristics of an effective supervisory relationship were outlined by participants including the need for the supervisor of midwives to be: 'visible and approachable.'(Mary, NHS 6-10 yrs. SoM); 'less coercive and a good listener.' (Paula, Ind. 11-20 yrs.) and, 'interested in the people they are supervising, being helpful and accessible.' (Louise, NHS >20 yrs.).

Nevertheless, for some midwives their experience of the supervisory relationship was less than positive:

> 'you hear dreadful stories about midwives being bullied by their supervisor when there is power on one side and not the other…I think the potential for a power imbalance is huge.'(June, Ind. >20 yrs.).

> 'I think the supervisor is seen in quite a negative way…it's seen by some as a parent-child relationship.'(Lilly, NHS 0-5 yrs.).

> 'There are some supervisors who've been around a long time who might be scared to jeopardise the relationship between the supervisor and supervisee and who don't address potential issues when there are mumblings about a midwife's practice and about their attitude…it's not until an incident happens that real definitive action is taken.' (Mary NHS 6-10 yrs. SoM).

[20] Hunter B., Berg M., Lundgren I., Olafsdottir A., Kirkham M., Relationships: the hidden threads in the tapestry of maternity care *Midwifery* 24(2008):132-137

In June's account the difficulties that can develop as a result of the hierarchical nature of the supervisory relationship are acknowledged, whilst both Mary and Lilly draw attention to the problems that occur when the relationship is perceived to be dysfunctional or where the stated purpose is either misunderstood or forgotten. Far from supporting safe practice, these issues appear to undermine it for these midwives.

Several participants developed this notion of the defective relationship further:

> 'When it is dependent on who the supervisor of midwives is it is then sometimes you think…"she doesn't like me so I won't speak to her.'(Susan, NHS 6-10 yrs.).

> 'Some midwives don't like their supervisor of midwives. I would find it hard taking criticism from somebody I didn't like or didn't respect…a lot of midwives think the supervisor of midwives is there to pick holes and then the midwife thinks "why do I need to go and see her?"'(Lilly, NHS, 0-5 yrs.).

In these representative examples, the ability to access advice and guidance,[21] is lost when there is tension in the supervisory relationship, which may subsequently effect the care offered to women. As a result the potential benefits of the statutory supervisory system is invalidated by the inability of midwives or their supervisors to acknowledge and resolve these obstacles.

Some midwives indicated that problems arose in the supervisory relationship as a consequence of how supervisor of midwives were originally selected:[22]

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[21] NMC n13 above

[22] NMC n13 above: Rule 8 Supervisors of Midwives: Rule 8(1) states that in order to ensure that supervisors of midwives meet the above requirements the LSA will publish their policy for the appointment of any new supervisor of midwives within their area and maintain a current list of supervisors of midwives. Rule 8 (2.1): eligibility for appointment as a supervisor of midwives states: that to be appointed as a supervisor of midwives in accordance with article 43(2) of the Nursing and Midwifery Order 2001, a person shall be a practising midwife and have three years' experience as a practising midwife of which at least one shall have been in the two year period immediately preceding the first date of appointment. Rule 8 (4) for a subsequent appointment as a supervisor of midwives states: a person shall be a practising midwife and have practised as a supervisor of midwives within the three year period immediately preceding the subsequent appointment date. Rule 8(1) states: that in order to ensure that supervisors of midwives meet the above requirements the LSA will publish their policy for the appointment of any new supervisor of midwives within their area and maintain a current list of supervisors of midwives.

> 'The process of selecting supervisors seems to be very much everyone votes for them,[23] but what's that based on? They like them…Well you can like someone, they're really lovely but they're not very good and I'm not sure they're the best midwife.'(Amanda, NHS, 11-20 yrs.).

> 'Maybe it comes back to the selection of supervisors…they are nominated nowadays…but they're always the leaders, the person that puts their head above the parapet…well wrong reason.'(Lucy, NHS, 11-20 yrs.).

Later in her interview Lucy expanded this further:

> 'supervisors of midwives are nearly always the people that are in management…there's definitely a tension, you cannot do one and then the other…if your managing that person you can't supervise them…it's too conflicting…your supposed to support a midwife as a supervisor of midwives, but as a manager your approach is "you haven't toed the line".'

Other participants identified similar issues when midwives held the dual role of manager and supervisor of midwives:

> 'The problem I have is that my line manager is my supervisor…If your supervisor of midwives is different to your line manager…she wouldn't have the agenda of finance or anything else.'(Jean, NHS, 0-5 yrs.).

> 'It's quite difficult to go to a supervisor of midwives because they're often managers, and I'm not sure they're very good at splitting their role.'(Ruth, NHS, 6-10 yrs.).

[23] Smith S., Local Supervising Authority (LSA) Midwifery Officers National (UK) Forum *Policies for the statutory supervision of midwifery: nomination, selection and appointment of supervisors of midwives* (LSAMO Forum UK; London, March 2013a): this document states that notices inviting nominations for the role of supervisor of midwives should be displayed within the LSA area. Applicants may apply for the role and undertake the supervisors of midwives education programme through the following route: peer nomination, self-nomination or nomination by others such as supervisors, midwifery educationalists or midwifery managers. Nominations must be from more than one peer or colleague and the candidate will need to provide a supporting statement of evidence to demonstrate their suitability for the role. Potential candidates must also have endorsement from the local supervisory team. Following expressions of interest or nomination a closed ballot may be held amongst local midwives to ensure that the midwife is familiar with local practice and is known to local midwives. Midwives who have been successfully nominated will be invited to an LSA selection panel interview which will be chaired by the LSAMO and which might also include; a supervisor of midwives in practice, a preparation of supervisors of midwives (POSOM) course leader and a service user representative. The interview process should ensure that all candidates have an equitable opportunity. Successful candidates will attend an NMC approved POSOM course in accordance with Rule 8 of the LSA standards (NMC 2012). Successful completion of the programme does not automatically ensure appointment as a supervisor of midwives. New supervisors of midwives will receive support from the local supervisory team and a period of established preceptorship which should be for a minimum of three months in accordance with Rule 8 of the LSA standard (NMC, 2012).

The traditional perception of supervision may be that of professional supporter.[24] However, as was discussed in chapters two and three, as a result of increased managerial responsibilities over the last four decades, problems may arise which have the potential to effect the quality of care provided. As such the added role of manager may create difficulties for both midwife and supervisor of midwives,[25] which are not easily addressed.

Several participants explored ways to improve how the supervisor/ supervisee relationship is constructed:

> 'It should be a completely flat structure, based on respect and peer support.'(June, Ind. >20 yrs.).

> 'My current supervisor of midwives knows me, she has worked with me in the last year, whereas my last supervisor of midwives was never seen in practice...I hadn't worked with my last supervisor of midwives, I felt that she didn't really know me.'(Lynn, NHS, 6-10 yrs.).

These comments demonstrate that partnership working and assistance are fundamental to a supervisory association which is facilitative and effective.[26]

For other participants the key to an effective supervisory relationship was how the midwife and the supervisor of midwives were brought together:

> 'Midwives choose their own supervisor of midwives,[27] and I think "well that's an interesting choice"…do you chose a supervisor of midwives that will challenge you and some midwives do, whereas with some midwives you think "you've chosen her for an easy life."' (Mary, NHS, 6-10 yrs. SoM).

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[24] Holloway n10 above: 11-40: Holloway suggests that there are five functions of supervision which include support and sharing, advising, modelling, consulting, monitoring and evaluation.
[25] Kirkham n12 above.
[26] Butterworth T., Faugier J., *Clinical Supervision* (Chapman Hall; London, 1992) at 12: these authors note that supervision should foster discussion amongst professional practitioners in order to develop skills and competence.
[27] NMC n13 above: Rule 12 (1) guidance (6) states: a midwife should be able to choose their supervisor of midwives if they know them or one will be allocated to them by the LSA if they do not know one. If the relationship is not beneficial to both parties either midwife or supervisor can request a change.

> 'I suppose with your supervisor of midwives you don't want it to be someone that no one else wants to have to deal with.'(Amanda, NHS, 11-20yrs.).

> 'Choosing your supervisor is important…you can chose someone that shares your philosophy in practice, someone you like and respect and get on with and I'm not quite sure that's easy to do.'(June, Ind. >20 yrs.).

Within these narratives the act of choosing the supervisor of midwives enables the midwife to be more accepting of someone who she has been involved with selecting, which as a result is seen to have a positive influence on the working dynamics of the relationship.[28] Therefore, whether or not statutory supervision is perceived as a mechanism for the provision of safe effective care would appear in part to be dependent on the relationship that exists between the supervisor and the supervisee. When the relationship is functioning well, partnership working has the potential to ensure that the delivery of care is as effective as possible. However, when there are difficulties in the relationship, then the ability to assist with the provision of optimal care may be compromised.

6.2.3 The Annual Supervisory Review: Is it fit for purpose?

The annual supervisory review is a periodic evaluation of practice which is an additional element of the regulatory framework for midwives. It is seen by the regulator as an important element of the statutory supervision of midwifery which aims to facilitate quality care through the provision of competent practitioners.[29] Several midwives commented on the usefulness of the annual review:

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[28] Morton T., Alexander C., Altman I., Communication and relationship definition in Miller G., ed. *Explorations in interpersonal communication* (Sage; London, 1976): 105-125; Kurutac J., Supervision and non-NHS midwives: understanding a range of practices *British Journal of Midwifery* 19(7) (July 2011):459-462.

[29] NMC n13 above: Rule 12 2(b): stipulates that the practising midwife must meet with the named supervisor of midwives at least once a year to review the midwife's practice and in doing so identify any training needs they may have.

> 'It is quite helpful to have that nudge, knowing that someone will be looking with you at certain things…like note keeping…I found it really helpful.'(June, Ind. >20 yrs.).

> 'It ensures that we are up to date on our training…any skills we feel we're lacking, that has to be addressed.'(Jean, NHS 0-5 yrs.).

Nevertheless, other participants raised questions about the annual review process that were centred on the purpose of the meeting and whether or not it supported or undermined midwifery practice. Interestingly some of the participants who were also supervisors of midwives, mentioned the lack of consistency in the review process:

> 'When I spoke to a student supervisor of midwives who I was mentoring and who had been to see other supervisory reviews she talked about them as being a nice chat and a sign off rather than my reviews which push the midwife…they can't come in here and say "I've done another year thank you."' (Samantha, NHS, >20 yrs. SoM).

> 'There's a bit of poetic license with reviews…we have a set format which involves looking at mandatory training, auditing notes…I like to personalise the review so I don't always audit their notes…I like to see what's achievable for the midwife in the review…so it depends on the supervisor of midwives I would say.'(Tanya, NHS, 11-20 yrs. SoM).

Problems with the annual supervisory review were also remarked upon by participants who were not supervisors of midwives:

> 'The yearly supervision meeting can be more of a chit chat…from speaking to different colleagues I would say it depends on who your supervisor is as to what the point and benefit of the meeting is.'(Susan, NHS, 6-10 yrs.).

> 'The supervisor of midwives gathers information and ticks a box…but whether the midwife really did keep her practice up to date is a different thing.'(Nina, NHS, 11-20 yrs.).

Here, the quality of the annual review and whether or not it scrutinises the practice of the individual midwife and ensures safe practice is conditional on the interpretation of the

midwife's own named supervisor of midwives. This is despite the existence of prescribed LSA policy guidance and formats that aim to ensure broad consistency within the different LSA's across the UK.[30] Once again, the statutory supervisory structure for midwives, does not appear to be as reliable and robust in facilitating safe competent practitioners as it could be, as inevitably, any system is only as good as the individuals who are engaged to manage it.

When discussing the annual review, a number of participants had difficulty differentiating between the annual supervisory review and the appraisal process undertaken as part of the employment contract and felt that there was duplication in the two procedures:

> 'It's difficult to distinguish between the appraisal process and the supervision process…the paperwork tends to be very similar, I think you're ticking two boxes for the same things.'(Ruth, NHS, 6-10 yrs.).

> 'The annual supervisory meeting is a bit of a check list…when nurses go through their level of competence they do that with their manager. So one could argue that you're doing similar things but under different guises.'(Amanda, NHS, 11-20 yrs.).

The validity of the supervisory review is therefore questionable as a consequence of the duplication. For other participants the annual review was perceived to be more supportive of the service than the midwife:

> 'In doing appraisals and annual supervisory interviews the supervisor of midwives is doing the service a favour.'(Louise, NHS, >20yrs.).

> 'Midwives worry about the annual review because they're not confident in their practice…and if the wrong people are supervising and managing them and using their authority as a disciplinary measure rather than a supportive measure…well that's not how supervision should be, the SoM should be there to help you to improve your practice, to identify what you can do to improve your practice and to support you through what you've done in the past.'(Megan, NHS, 11-20 yrs.).

[30] Wallace V., Annual review of practice by a supervisor of midwives *Policies for the Statutory Supervision of Midwives* (Local Supervising Authority Midwifery Officers Forum UK; London, March 2013) http://www.lsamoforumuk.scot.nhs.uk/media/16944/annual_review_of_practice_by_a_supervisor_of_midwives_policy.docx.pdf (accessed 26/08/ 2014).

Here the annual review is perceived to be another aspect of the managerial framework which, as discussed in chapter two, is sometimes seen as a mechanism for the closer governance of midwives' practice.[31] Such a structure has the potential to be seen as punitive rather than facilitative. Where such a perception is dominant, it is unlikely that the annual review will enhance opportunities for the development of practice and competence, and thus will not support the provision of safe care.

6.2.4 Mechanisms for Addressing Concerns in Practice

As part of the regulatory framework for midwives, stipulations are made for the investigation of poor practice and procedures designed to resolve identified practice issues following the completion of the investigation.[32] These procedures include allocating a supervisor of midwives to lead the investigation and the subsequent development programme should it be required. This supervisor of midwives acts as the co-ordinator for the individualised practice plan with a team of professionals that includes: a supporting supervisor of midwives (who commonly is the midwife's own supervisor of midwives) and an academic assessor who will help the midwife address the practice issues identified in the investigation.[33] These are based on NMC requirements for competence.[34] During this period the midwife's development will be assessed, however the supporting supervisor will not take part in this assessment.[35] This programme also consists of protected clinical learning time and/or study time which should be

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[31] In chapter two it was seen that the dominant neoliberal policy in the 1980s resulted in an increase in management structures within the NHS. This enabled stricter control of the practice of health care professionals.

[32] Local Supervising Authority Midwifery Officer Forum (LSAMO) *Guidance for: Programme Lead Supervisors and Supporting Supervisors of Midwives leading a LSA Practice Programme* (LSAMO Forum; London, 2011) v3 (1): in certain situations it may not be appropriate or practical that the role of supporting SoM is the midwives own SoM and here an alternative SoM may perform this role. http://www.lsamoforumuk.scot.nhs.uk/policies-guidelines.aspx (accessed 19/09/2014).

[33] ibid.

[34] ibid.

[35] ibid.

supported by the NHS Trust where the midwife is working.[36] Whilst this has now changed,[37] at the time the data for this study was being collected, the processes that attempt to address concerns in individual midwives' practice were known as developmental,[38] and supervised practice.[39]

When questioned about their experience of developmental and supervised practice in the survey five per cent (n=7) of participants confirmed that they had completed a period of developmental practice whilst four per cent (n=5) stated that they had undertaken supervised practice since becoming a qualified practitioner. These participants were then asked whether they found the process to be beneficial: 57 per cent (n=4) were positive about developmental practice and 60 per cent (n=3) were positive about supervised practice, with 40 per cent (n=2) not.

Although these figures are small, it is noteworthy that participants also expressed reservations in the interviews:

> 'It depends on what the issue is as to whether the process is effective.'(Kate, NHS, >20 yrs. SoM).

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[36] ibid.

[37] Local Supervising Authority Midwifery Officer Forum (LSAMO) *Information for Midwives who are involved in a Supervisory Investigation* (Local Supervising Authority Midwifery Officer (LSAMO) Forum UK; London, November 2013): developmental and supervised practice processes have now been replaced by either a local action plan or a LSA Practice programme.

[38] North West Local Supervising Authority n11 above at 31: this document identifies that a midwife might need to be placed on a programme of developmental practice as a result of reflection by the midwife or as a result of a concern raised by a colleague, supervisor or the pregnant woman. The purpose of developmental practice is to enable the midwife to learn from the experience and so ensure that safety of the public remains the primary focus.

[39] NMC n13 above; Nursing and Midwifery Council (NMC) *Preparation of Supervisors of Midwives: revised edition* (NMC; London, 2002); Cro S., Bronsky Y., *Policies for the statutory supervision of midwives* LSA Review and Investigation Processes (Local Supervising Authority Midwifery Officer (LSAMO) Forum UK; London, November 2013): a midwife may be placed on a programme of supervised practice as a result of an investigation following an allegation of misconduct. The investigation should be carried out using a Root Cause Analysis tool which was developed by the National Patient Safety Agency. This tool is intended to identify areas of concern and to implement a plan of action which should help to prevent the reoccurrence of the problem. In cases of alleged misconduct the supervisor of midwives is required to conduct an investigation and should inform the Local Supervising Authority who will then determine what action should be taken. If it is determined that there has been an impairment of practice in accordance with the NMC standards for midwives, the midwife may be required to undertake a programme of remediation locally.

> 'It is difficult to know how robust the supervised practice process is.'(Amanda, NHS, 11-20 yrs.).

These excerpts are characteristic of a number of dialogues where concerns were raised about the procedures for addressing poor practice in particular, and whether these processes were performed in an efficient and robust manner.

For other midwives the process of decision making was unclear in relation to the identification and resolution of errors made in practice:

> 'I think sometimes it's the judgement call of the supervisor of midwives whose making that decision…two supervisor of midwives can think differently about one incident…I have seen some inconsistent decisions…where it's done more damage to the midwife.' (Jean, NHS, 0-5 yrs.).

> 'It only focuses on one aspect, and other things are forgotten.'(Mary, NHS, 6-10 yrs. SoM).

In these examples the process of establishing and determining how to manage alleged practice errors seems to be applied differently by individual supervisor of midwives, which may be as a result of the discretion that is permitted within the framework approved by the NMC.[40]

Additionally, when the midwife has a limited understanding of the legal nature of the practitioners' obligations to the regulator in the context of practice standards, difficulties can occur which appear to be compounded by statutory supervision. This is emphasized by Laura (Ind. >20 yrs.) who commented:

> 'Midwives are naïve about the process until they have to do it…I'm sure it could be used in a more constructive way…it is so punitive, I listen to the radio and hear of people who have done terrible things and they're given 120 hours community service…and there are fantastic midwives giving the very best care and they're sent to

[40] NMC n15 above: section 2 Domain 1: Professional Values 4 states that the supervisor of midwives must demonstrate the ability to support midwives to maintain their fitness to practise and provide safe and evidence-based care; NMC n13 above: Rule 10.

> do 300 hours of punitive things that has nothing to do with the event that originally raised the concern.'

For Laura there are essential weaknesses in the regulatory framework that for her lacks transparency and, which focuses on punishment rather than support, which consequently does not facilitate the provision of safe and effective care and may possibly undermine it. A number of the participants who had had experience of a supervisory investigation and had been placed on a programme of support in practice commented on their own lack of clarity regarding the investigation and the decisions made as a result of that inquiry:

> 'The investigation didn't find that I'd done anything wrong…I would understand if I had…but it was traumatic…the decision was still 'okay developmental practice'…it wasn't fit for purpose the developmental stuff, it was just a tick box exercise…even my own supervisor of midwives said so.'(Paula, Ind. 11-20 yrs.).

> 'I was a bit shocked because it wasn't anything I'd done as such…the incident that was investigated hadn't happened to me before so it wasn't something I could improve on…nobody told me how they made the decision… I wasn't expecting supervised practice.'(Cathy, NHS 0-5 yrs.).

These observations are remarkable, as they appear to be contrary to Local Supervisory Authority (LSA) guidance.[41] This guidance stipulates the importance of transparency and collaboration between the supervisor of midwives and the midwife during an inquiry into a midwives fitness to practice. Whilst these are just two cases, both Paula and Cathy's comments would seem to suggest that cooperation and openness in the supervisory decision making process may, at least on some occasions, be limited.

[41] Cro and Bronsky n39 above at 20: This document suggests that any LSA programme should address the concerns identified by the LSA investigation and should be relevant and address the matters giving rise to the finding of impairment of fitness to practice.

This situation was further compounded for other midwives as result of their own experience, or observations of colleagues who were required to complete either developmental or supervised practice programmes, following an investigation into their practice:

> 'It's as good as the individuals that are involved and it varies hugely and it's not particularly consistent…because everybody seems to have a slightly different way of how they do things…In my investigation…the supervisor of midwives had to give me something to do so she said she wanted me to go to a VBAC study day…even my own supervisor of midwives was appalled.'(June, Ind. >20yrs.).

> 'As a result of the supervisory investigation it was suggested that I spent a day with the midwife attached to CESDI,[42] it was trying to dream up something that would tick a box.'(Laura, Ind. >20 yrs.).

Further, participants who had not experienced this process were also unsure about whether it empowered the midwife undertaking the programme to improve her practice:

> 'If they want you out and they don't particularly like you, they will find a way…everybody slips up sometimes… you might have two midwives who've done exactly the same thing…one will go down the official route and the other one will get away scot free…you can't do it to one and not the other because you like that person.' (Lilly, NHS, 0-5 yrs.).

> 'It depends on the supervisor of midwives involved…as a midwife you should accept the decision and learn from it…but some midwives can't accept it…supervised practice is a serious thing…I know a midwife who has refused to do anything she's been advised to do whilst on supervised practice and has now been referred to the NMC…I don't think some midwives realise the whole process of supervision…it's never happened to them so they just don't understand.'(Louise, NHS, >20 yrs.).

> 'If there's something wrong with a midwife's practice or something's happened, you have to be very clear about what part of the NMC *Code of Conduct* has been broken…but the problem is that the *Code* is very woolly in lots of areas, you can almost blend it to fit…but you have to be very clear about what it is you need to supervise the

[42] The Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI). CESDI has now been joined with Confidential Enquiry into Maternal and Child Health (CEMACH) into one umbrella organisation known as MBRRACE-UK- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK. This organisation is responsible for providing information and data on Maternal and Perinatal mortality across the UK.

> midwife for…they have to have clarity because it is a very difficult thing to do supervision effectively.'(Lucy, NHS, 11-20 yrs.).

In contrast most participants who were supervisors of midwives were clear about the aims and objectives of developmental and supervised practice programmes:

> 'I think it enables the midwife and I have heard some midwives who've been on supervised practice speak very highly of what they have learnt and how they were able to identify their short comings and issues in practice.' (Mary, NHS, 6-10 yrs. SoM).

> 'Before I was a supervisor I thought it was punitive…I saw a midwife being punished for making a mistake that I probably thought was human error…having now known midwives that have been through the process and have valued the learning they've received…I see it as very supportive.'(Tanya, NHS, 11-20 yrs. SoM).

As such, there appears to be broad variations in the experiences and perceptions of the supervisor of midwives participants and the non-supervisor of midwives participants, in terms of how concerns were managed in practice. For the non-supervisors of midwives, the framework for managing alleged poor practice appears to be ambiguous and highly dependent on the individual supervisor of midwives responsible for carrying out the procedures.

In chapter five, it was seen that participants were doubtful that proposed changes in the relationship of statutory supervision to the NMC would enhance accountability and care provision. When these concerns are examined in conjunction with the ability of the LSA to suspend a midwife from practice and refer the practitioner to the NMC an interesting picture emerged. Whilst participants had reservations about local supervision procedures, they were nevertheless apprehensive about the proposed changes to the statutory framework,[43] which

[43]PHSO n4 above; Nursing and Midwifery Council (NMC) *Independent review of midwifery regulation: terms of reference* (NMC; London, 2014): when this data was collected the NMC had commissioned the Kings Fund organisation to carry out a review of statutory supervision. This review examined whether or not the ability of the LSA to suspend a midwife from practice should be removed from the LSA and returned to the regulator as it is with other health care professionals including the nursing profession which it also regulates. The results of this review were discussed in chapter five.

were discussed in chapter 5. These changes signify the end of the LSA's ability to suspend a midwife from practice, with this function being relocated to the NMC. In chapter five the planned shift of regulatory authority back to the NMC was not perceived to be beneficial, nor was it thought to improve accountability and the delivery of care by midwives in this study. Whilst I acknowledge that there may be other differing views to those offered in my study, it would appear that according to the participants, the flaws in both local supervision and national regulation in terms of fitness to practice procedures, cannot guarantee that midwives are competent and safe when caring for pregnant women.

6.3 Supporting Midwifery Accountability?

Within the regulatory structure, statutory supervision is perceived as the mechanism through which accountability is assured. This objective is said to be achieved through the provision of support and monitoring of an individual midwife's practice, with an emphasis on the development of skills and competence necessary to provide safe and effective care.[44] The NMC guidance contained within *The Code* states:

> 'As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.'[45]

This document additionally outlines other professional behaviour which is expected of a midwife including standards of confidentiality, team working, the management of risk and the provision of high standards of care and practice.[46]

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[44] NMC n13 above.

[45] Nursing and Midwifery Council (NMC) *The Code: Standards of conduct, performance and ethics for nurses and midwives* (NMC; London, 2008a) at 2: this version of the NMC Code was current when the data was collected for this study. A new revised NMC *Code* was published in January 2015.

[46] ibid.

In the interviews participants discussed their perceptions of accountability in terms of statutory supervision:

> 'Midwifery tends to be more autonomous…we take our roles and responsibilities pretty seriously…it might be a joint thing because of midwifery and supervision.' (Susan, NHS 6-10 yrs.).

> 'Supervision ensures that everybody is aiming for the same thing…there is that accountability, that oversight.'(Nina, NHS 11-20 yrs.).

In these narratives there is a clear link between accountability and supervision and the positive impact that this form of regulation has on midwifery practice.

6.3.1 Clinical versus Statutory Supervision

In the study, midwives were invited to compare statutory supervision with clinical supervision, the system commonly employed in the nursing profession. In the survey 69 per cent (n≒95) of respondents felt that not having statutory supervision had a negative impact on the nursing profession, with 19 per cent (n≒ 25) unsure and just eight per cent (n≒11) feeling that it had no impact at all. Further, 81 per cent (n≒109) of respondents stated that they felt that nursing should have statutory supervision. The increase in the number (by 12 per cent (n≒ 14)) of midwives who believed nursing should have statutory supervision as opposed to those who believed that the lack of statutory supervision had a negative impact is noteworthy. Here, participants appear more certain of the effect that the lack of supervision has on the nursing profession. This seems to suggest that for the majority of midwives in the survey, there is a perception that the provision of statutory supervision is advantageous for both midwives and nurses.

This positive perception of supervision was mirrored by some participants in the interviews:

> 'A nurse can make mistakes the same as a midwife…so the advantage [of supervision] would be knowing that somebody is there to support you should you need them.' (Karen, NHS, 0-5 yrs.).

> 'Supervision may make the [regulatory] structure more robust…it would make the lines of accountability clearer…nurses may just feel that additional support is useful to them.'(Nina, NHS, 11-20 yrs.).

In these examples it is the nature of the statutory framework which enhances the provision of care:

> 'They [nurses] only have a disciplinary rule which doesn't support the profession…the general public don't have recourse to the mechanism of supervision so they have to go straight to the NMC if they had any concern…there isn't a local mechanism.'(Kate, NHS, >20 yrs. SoM).

> 'Having been a nurse as well as a midwife…it seems that nursing need local action to address poor practice…it seems that there are so many nurses that are called to the NMC for such awful things, like client abuse, which might be helped by supervision.' (Tanya, NHS, 11-20 yrs. SoM).

However, a number of participants questioned the efficacy of statutory supervision particularly with regards to professional responsibility:

> 'Nursing have managed without statutory supervision up until now…I think to be honest clinical supervision should be enough.'(Louise, NHS, >20yrs.).

> 'What is the difference between statutory and clinical supervision? Do we need statutory supervision…maybe we just need clinical supervision. Statutory says we've got to have a supervisor, we've got to fill out an intention to practice, we've got to do dah, dah, dah, those are sort of administrative things …which you don't need a statute for. We could have a system that's there and that's what we have to do, but it doesn't have to be in law, it could be just an accepted part of being a midwife…So maybe we just need clinical supervision so we have a mentor, a peer who's going to challenge and support us…this would be more effective.'(Laura, Ind. >20 yrs.).

Here, clinical supervision is perceived to be more therapeutic,[47] and less rule based than its statutory cousin, indeed Mary (NHS, 6-10 yrs. SoM) noted that:

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[47] Deery R., Improving relationships through clinical supervision: 2 *British Journal of Midwifery* 7(4) (April 1999): 251-254.

> 'It's negative on midwifery because nurses have done well and when you look at NMC hearings you would expect not to see many midwives before fitness to practice panels…and these hearings are for common things which you would not expect to see.'

In these accounts, the ability to ensure that practitioners are responsible for the provision of safe care is not necessarily enhanced through statutory supervision as was previously recognised in the literature.[48] This is noteworthy given that in the survey data two thirds of participants were positive about statutory supervision, whilst a further four fifths thought that it should be extended to the nursing profession. As such these findings highlight the ambiguity with which statutory supervision is regarded by the midwives in this study.

6.3.2. Statutory Supervision and Decision Making in Practice

Clinical governance strategies, which were introduced to ensure high standards of care,[49] have been associated with statutory supervision for some time.[50] However, as was recognised in chapter four, clinical governance strategies can sometimes have the potential to negatively influence complex decision making in midwifery practice, particularly in terms of the normal physiological processes of birth. It is therefore important to explore whether supervision has a similar effect on decision making in practice, given its association with clinical governance schemes.

During the interviews, the participants spoke in terms of their own accountability and decision making in practice and how this was influenced by statutory supervision. For some this was very positive:

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[48] Kings Fund *Safe Births: Everybody's business. An Independent Inquiry into the Safety of Maternity Services in England* (Kings Fund; London, 2008); Department of Health (DH) *Midwifery 2020: Delivering expectations* (DH; London, September 2010b).
[49] Department of Health (D0H) *Clinical Governance: Quality in the NHS* (DoH; London, 1999b): see chapter three.
[50] Department of Health (DoH) *A First Class Service: Quality in the New NHS* (HMSO; London, 16th March 1999a); Duerden J., The New LSA Arrangements in Practice in Kirkham M., eds. *Developments in the Supervision of Midwives* (Books for Midwives; Oxford, 2002b): 129-148.

> 'As a supervisor of midwives you're giving the midwife the tools that make her safer.' (Samantha, NHS, >20 yrs. SoM).

> 'My supervisor of midwives challenges me, she doesn't back away from difficult questions, she listens carefully and she makes a decision whether I have to do something about it or not.'(Laura, Ind., >20 yrs.).

> 'If I've been to my supervisor of midwives …I could document I'd had a discussion with her and there would be a sense that this gives any decision I make legitimacy.' (June, Ind., > 20yrs.).

In these situations supervision is seen to support the supervisee in the process of ensuring accountability for practice whereby the supervisee is enabled through supervision to make sense of their own decision making in practice.[51]

Nevertheless, other midwives were uneasy about decision making within the supervisory process. For example Susan (NHS, 6-10 yrs.) said:

> 'How do I know what I'm doing is what I should be doing…You don't know, you only know about it if something really went wrong…that erodes the purpose of supervision and risk assessment, because the whole point is that you try and avoid something happening…if the only time when anything is flagged up is when it's gone really wrong, then that defeats the whole object of supervision.'

In Susan's account there appears to be a lack of confidence both in her own knowledge and the ability of statutory supervision to identify and address poor practice. Here, neither statutory supervision nor clinical governance strategies support her knowledge base. Thus, the provision of safe care, autonomy and accountability that the earlier participants identified as being an important part of decision making which occur as a result of statutory supervision, appear absent for Susan.

[51] Holloway n10 above.

6.4 Facilitating the Woman Centred Care Agenda?

As mentioned in chapter two, under the Thatcher Government's neoliberal ideology of the 1980s, public choice and healthcare consumerism became the dominant model.[52] This placed significant weight on 'woman-centred care' which was advocated in the policy document *Changing Childbirth Report*,[53] during John Major's administration. This policy outlines the importance of the pregnant woman having choice and control of her care,[54] and may be aligned to the historic focus of midwives of support and facilitation of the individual pregnant woman.[55]

However in chapter three, the discussion highlighted that woman centred care often exists in tension with clinical governance strategies which attempt to standardise care and, which may not therefore be seen as woman centred. In the data there emerged a complex picture in terms of statutory supervision and its association with the provision of individualised care for pregnant women, particularly in the context of whether statutory supervision supports the capacity for woman centred care.

Several of the midwives interviewed believed that statutory supervision assisted the pregnant woman and the provision of woman centred care:

> 'The supervisor of midwives is there to support the woman.'(Karen, NHS, 0-5 yrs.).

> 'Supervisors of midwives affect the careers of midwives and the woman's birth experience too and make it better…I think if I support the midwife then she supports the woman.'(Samantha, NHS, >20yrs. SoM).

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[52] Dunleavy P., *Democracy, Bureaucracy and Public Choice* (Harvester Wheatsheaf; London, 1991)*;* Butler E., *Public Choice-A Primer* (The Institute of Economic Affairs; London, 2012); Cumberledge n3 above.
[53] Cumberledge n3 above.
[54] ibid.
[55] Association of Radical Midwives (ARM) *The Vision* (ARM; Ormskirk Lancashire; 1986).

Here, there was an integral connection between the supervision of midwifery and the support it offered, and the historic emphasis on midwives being 'with woman' and facilitating their care rather than purely managing it.[56]

However, some participants were less confident that statutory supervision supported the pregnant woman especially in relation to the woman's ability to make decisions about her care. Within the data, for some midwives, there was a belief that statutory supervision appeared to support the provision and management of maternity services rather than the individual needs of the woman and the tenet of woman centred care.

In chapter four it was identified that, for some participants, the woman centred care agenda existed in clear tension with risk management strategies intended to ensure homogenised care to pregnant women across the NHS. In the context of statutory supervision, a number of participants raised similar concerns about the ability of midwifery supervision to support individualised care. This was considered to be particularly problematic when the woman's chosen plan for her pregnancy and birth was not compliant with service provision and current guidelines. Several midwives cited instances of tactics, employed by supervisors of midwives to persuade women to alter their plans for birth in order to conform to local service guidelines, whether or not these guidelines were based on current evidence.[57] Jean (NHS, 0-5 yrs.) recalled:

> 'I had a woman who didn't want to be transferred in…she was in labour and was determined that she was going to stay at home, although the labour was delayed.[58] So I

[56] Durham R., Women, work and midwifery in in Mander R., Flemming V., eds. *Failure to Progress: the contraction of the midwifery profession* (Routledge; London, 2002): 122-132.

[57] Symon A., The Risk Choice Paradox in author's ed. *Risk and Choice in Maternity Care* (Churchill-Livingston; London, 2006):1-12: as was identified in Chapter 3 evidence based guidelines are employed within the NHS in an attempt to ensure standardised care across the service. The difficulty however with such guidelines are that they are based on population data and do not take into account the needs and expectations of individual women.

[58] National Institute for Health and Clinical Excellence (NICE) CG55 *Intrapartum care: care of healthy women and their babies during childbirth* (NICE; London, 2007): this guidelines was current when the data for this study was collected. The advice in this guideline was that first labours last on average 8 hours and are unlikely to last over 18 hours. Second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours. The guideline does recommend that for women having their first baby it should be anticipated that the birth should take place within 3 hours of the start of the active second stage in these women and suggests that a diagnosis of delay in the active second stage should be made when it has lasted 2 hours. For women who have given birth

> phoned the supervisor of midwives and she agreed that the woman needed to come in and because I told the woman what the supervisor of midwives had said she changed her mind and went in.'

Whilst Paula (Ind. 11-20 yrs.) said:

> 'A pregnant woman who I had cared for in a previous pregnancy rang me and said "I've had a good relationship with my midwife and now they want me to be induced,[59] because I'm 41 weeks"…She was really upset by this plan and cried saying that her NHS midwife was coming round and had asked to bring the supervisor of midwives too…When she had gone into the hospital 4-5 days before for monitoring the obstetrician had spoken to her, the midwives had all spoken to her and the supervisor of midwives had spoken to her…they all spoke of the risks of still birth…and now the same supervisor of midwives wanted to come to her home to try to persuade her to be induced…if that's not coercion what is? The woman knew the evidence, although it's very old and outdated… she was well informed…I don't think the supervisor of midwives was protecting the woman, I think she was protecting the culture in which she worked…how can a supervisor of midwives think she is protecting a woman if she then goes against the midwife's rules which say there is no place for coercion…When does it stop being good care and information giving and become coercion and pressure?'

In Jean's scenario, the supervisor of midwives is seen to be supporting the midwife and adding extra authority to the voice of the midwife. Here, the woman when given further guidance is then enabled to make her own autonomous choice with regards to where she will birth her baby.

However in Paula's account there appears to be a disconnection between the midwives and the woman. For Paula, the supervisor of midwives is utilised as a controlling influence who unites with the midwife to persuade the pregnant woman to accept the guidance and recommendations

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before, the guideline recommends that birth would be expected to take place within 2 hours of the start of the active second stage in these women. A diagnosis of delay in the active second stage should be made when it has lasted 1 hour. In both instances women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent; National Institute for Health and Care Excellence (NICE) *Intrapartum Care: Care of Healthy women and their Babies during Childbirth* (NICE; London, December 2014): this guideline replaces the NICE 2007 guidance and now recognises that there is limited quality evidence in terms of the influence of a prolonged second stage on either maternal or fetal wellbeing.

[59]National Institute of Health and Clinical Excellence (NICE) *Induction of Labour: NICE guideline [CG70]* (NICE; London, July 2008): within this guideline women who experience a prolonged pregnancy are recommended to have an induction of labour between 41-42 weeks gestation in order to avoid the associated risks of still birth, and post-partum haemorrhage.

on offer. In such conditions supervision is employed to encourage the pregnant woman to adjust her plans, particularly in the home birth setting. Tanya (NHS, 11-20 yrs. SoM) comments:

> 'Supervision may be used with women who want to challenge the establishment… they might not meet the criteria for a home birth but they are adamant they've understood…The midwife might feel a little disconcerted, so supervision is used to support the midwife… You may never actually meet the woman, you may just have lots of discussion with the midwife.'

The language that Tanya uses when talking about the woman's autonomous decision making is important. She speaks of pregnant women who want to 'challenge the establishment', which results in the need for the supervisor of midwives to come to the assistance of the midwife. This suggests that, for Tanya, such choices are challenging and problematic and her comments would seem to be somewhat unsympathetic to the woman's own specific requirements. In her own words, Tanya's priority in terms of supervision is firmly focused on supporting the midwife. She also appears keen to tailor the pregnant woman's needs and expectations to the demands of the service. Albeit that current guidance for statutory supervision recommends that the supervisor of midwives should support both the midwife and the pregnant woman, whilst adhering to local NHS guidance.[60]

Other participants elaborated on the potential of statutory supervision to constrain rather than endorse woman centred care, with the supervisor appearing to support neither the woman nor the midwife. Lucy (NHS, 11-20 yrs.) suggested:

> 'The effect of supervision can be strangulation…where you're forced to use the guidelines…which might not be what the woman wants…that's not the proper care we should be doing is it? We should be giving holistic care…but when supervision is involved and care is strangulated because midwives are scared…then that's to the detriment of the woman.'

[60]Smith S., Provision of Supervisory Support in Challenging Situations *Guidelines for the Statutory Supervision of Midwives* (Local Supervising Authority Officers (LSA) National (UK) Forum; London, March 2013b): this documents highlights the need for the SOM to support both the midwife and the woman, but also states that plans of care should be developed that ensure that locally agreed processes are followed, which may include Trust guidelines.

Thus, whilst many midwives were positive about the effect of statutory supervision, some had significant reservations.

In these situations regulatory systems such as statutory supervision appear to be employed as a method of restricting the choices which are available to the pregnant woman and the care that midwives are able to offer. In these circumstances for some midwives in this study, the woman centred care policy that was consistent with the Thatcher style of neoliberalism and, which encouraged consumer choice, does not appear to be practical. Here, statutory supervision is used to insist on prescribed guidelines and service provision that has the potential to ignore individual needs and expectations.

6.5 Conclusion

Statutory supervision of midwives has been a central and unique part of the regulation of midwifery since the first Midwives Act was enacted in 1902. The stated function of this part of the governance framework is to ensure the provision of safe care to pregnant women. Within this chapter, analysis of participants' perception of statutory supervision has painted a complex picture. Whilst midwives were broadly supportive of supervision as a regulatory mechanism they were nevertheless unconvinced that it necessarily ensured safety and practitioner accountability in practice, or that it facilitated the woman centred care agenda.

Some participants were less than confident about some supervisors of midwives and their ability to provide midwives with expert knowledge in challenging circumstances. In these situations participants were apprehensive about accessing the (non) expert supervisors of midwives who lacked familiarity and competence to support them when caring for pregnant women who had complicated medical and social needs. Concerns regarding the competence and ability of the supervisors of midwives also influenced participants' views regarding the

annual review process. Here, some participants saw inconsistency and duplication in the process, which often happened as a result of the individual supervisor of midwives administering both the supervisory review and other appointment appraisals. At times, the annual supervisory review was seen as being punitive and authoritarian, undermining rather than supporting competent, safe practice.

The theme of accountability also emerged in the discussion of procedures for addressing poor practice. Whilst those participants who were supervisors of midwives felt that they were clear about the mechanisms to resolve practice concerns, participants who were not supervisors of midwives were less certain. This was particularly evident for those participants who had had their practice investigated and had undertaken prescribed remedial programmes as a result. This difference in the views between supervisors of midwives and midwives appeared to occur due to ambiguity about fitness to practice processes at local level which were administered by the LSA. Laura (Ind. >20yrs.) noted:

> 'I've become aware that the processes are never followed properly…because the supervisor of midwives don't know how to do an investigation and they are always flawed…I think you could challenge every single one on not following the process, never mind that the outcome is based on a flawed process. It's not safe.'

As such, whilst the participants who were supervisors of midwives believe that they understood these processes, it appears that the perception of those being investigated offers a different account. As a result outcomes may be questionable and unsatisfactory for the midwife whose practice is being scrutinized.

The analysis in this chapter further suggests that, at times, the supervisor of midwives constrained rather than facilitated the choice of the pregnant woman. This echoes the findings in chapter four, which traced a potential tension between the woman centred care agenda and clinical governance. In the current chapter, the supervisor of midwives was utilised on

occasion, to persuade the pregnant woman to conform to the provisions of the service commonly offered, rather than choosing options for care which might be problematic for the service to provide. Here, the supervisor of midwives was perceived as an authority figure who could supply information on issues of safety and risk to the pregnant woman and offer an authoritative and persuasive voice, regardless of whether the woman herself requested or wanted this further input.

This chapter has noted a range of instances where the management of the maternity services and the statutory supervision of midwifery existed in tension with each other, with such problems being exacerbated when the same person performed both roles. This was demonstrated in several participant's accounts, including that of Lucy (NHS, 11-20yrs.):

> 'Supervision is very positive…but there needs to be clear boundaries…If it's staffing its management, and if it's safety of mother and baby it's the supervisor of midwives …but this can be abused…supervisors need to ensure that managers protect the public by making sure that they provide the provisions to ensure appropriate care is given…as a manager it's your responsibility to make sure that the unit is managed. But sometimes this is difficult when the supervisor of midwives is the manager.'

Supervisors of midwives have a multifaceted role, where they are required to represent the interests of pregnant women, the midwife and the maternity services more generally, particularly in relation to clinical governance and risk management. As was discussed in chapter two the increase in managers across the NHS and the maternity services over the past thirty years has led to midwives with experience and seniority developing their careers within the NHS management structure.[61] The dual responsibilities for some of these supervisors of midwives was seen to cause confusion and the blurring of functions both for themselves, the midwife and the pregnant woman in terms of ensuring accountability and safety.

[61] Harrison S., Pollitt C., *Controlling Health Professionals: The future of work and organisation in the NHS* (Open University Press; Buckingham, 1994).

Many midwives in this study have indicated that they have had positive experiences, and have a high opinion of the value of statutory supervision. However, this chapter has also demonstrated that many participants have significant concerns regarding statutory supervision, with these being seen as having the potential to undermine rather than to support the wellbeing of the pregnant woman. Supervision can be valuable both in ensuring the safety of the public and in supporting the midwife practitioner. Nevertheless, in order to achieve these aims, there needs to be more clarity and definition about statutory supervision and the role of the supervisor of midwives.

The next chapter will draw together the themes from the empirical data and reflect on the influence that the current regulatory framework has on the provision of safe care for pregnant women.

7. Reflections on the Empirical Findings: Discussion, Recommendations and Conclusion

7.1 Introduction

The role of the state in the organisation and governance of the maternity services has been a significant one within this study. One midwife Laura (Ind. >20yrs.) in an interview remarked:

> 'I said to a politician recently that they'd better get maternity services right because God made nookie good, sex is good, sex is not going to stop happening, just because they haven't sorted out the maternity services, just because it's too big a problem for the government to sort out. I said to him "get thinking of some answers"….what can you say… sex is not going to stop because you can't sort out the maternity services, those babies will keep coming …… and we need to get it right.'

Here, the importance of having government policy that can provide a maternity service that is fit for purpose is seen as essential. Therefore, whilst drawing on the themes that have emerged in this study, the provision of safe quality care will be reflected upon in this last chapter.

Throughout the past one hundred years the regulation of the maternity services and the practice of midwifery has increased exponentially, reflecting shifting government priorities and ideologies. Over the last four decades, the predominant political doctrine has been neoliberalism in its different forms.[1] This philosophy has been extremely influential in terms of reforms to the welfare state, the NHS and healthcare provision, during this time. It thus offers the context to the current regulatory framework that governs midwifery practice in this study. Whilst this thesis has not attempted to provide a full response to the question of whether this regulatory framework supports or undermines the protection of the public, it has sought to cast new light on it by foregrounding the views of one set of important actors in the provision of maternity care: namely midwives.

[1] Peck J., Tickell A., Neoliberalizing Space *Antipode* 34(2) (16TH December 2002):380-404 at 389.

This final chapter will begin by acknowledging the limitations of this study and will make suggestions for possible future research taking these limitations into consideration (7.2). Following this, the discussion will go on to reflect on the key findings that emerged as pervasive concerns across the areas of midwifery regulation discussed in chapters four, five and six (7.3). These were: ensuring safe care in practice (7.3.1), accountability and decision making (7.3.2), and facilitating woman centred care (7.3.3). The chapter will next outline the proposed regulatory reforms that have been recommended since the data for this study was collected (7.4). Brief consideration of these reforms is necessary as a point of reference for the section in this chapter that sets out my own recommendations for change in light of the findings from the empirical research (7.5). This section will make some recommendations for forthcoming policy, which will be linked to the current ongoing government proposals for reform. Finally, the chapter will close with some concluding thoughts on the study in general (7.6).

7.2 Limitations of the Study and Suggestions for Future Research

The current study has offered a detailed exploration of the perceptions of the regulatory frameworks that govern the practice of a cohort of midwives practising in the South East of England between the period of May 2012 and March 2013. Whilst it has provided some insights into their experiences and has added to the small body of empirical research in this area it is recognised nonetheless as being incomplete. First, the study was small. The survey was distributed to 192 midwives, which achieved a response rate of 70 per cent (n=132), and twenty participants took part in semi-structured interviews. Within the sampling process, attempts were made to ensure that a wide range of qualified midwives working in the area were accessed in order that the findings should be representative of midwives in general.[2] However, the small

[2] Bryman A., *Social Research Methods* 4th ed. (Oxford University Press; Oxford, 2012):129-155.

sample size may impact on the generalisability of findings in relation to the wider population of midwives in the UK. Future research that incorporates a larger number of participants in a multi-centre study might facilitate the production of more robust results, which could be then be applied to midwives working in the UK more broadly.

Additionally, the small sample size of independent midwife participants can be seen as a limitation, as although the data appears to offer grounds for believing that independent midwives have a very distinctive perspective, I was nevertheless unable to make any authoritative claims as a result of the small number included in the study. The need to carry out further research in terms of the views of this group would seem therefore to be particularly relevant.

Second, with a regulatory framework that is continuously evolving, any study can only seek to represent the views of participants at any given point in time. The value of these findings may therefore wane as the framework changes, needing additional research to explore participant perceptions of new governance arrangements. The current study has nonetheless, offered a sustained focal point on the fundamental ideological drivers that have underpinned reforms over the last four decades. The identified focus on risk and quality care provision, together with public/private partnerships, which were discussed in chapters two and three, continue to play an influential role in motivating policy. As a result, this may mean that the findings from this study will continue to have some broad relevance notwithstanding the introduction of new, specific regulatory provisions.

Third, this study has concentrated on clinical governance and risk management in general terms, and explored midwives' views and opinions of only some specific aspects of those policies. As a consequence, it offers only a partial image of how these systems influence the care provided to pregnant women. A more in-depth examination of participants' experiences

and perceptions of the different aspects of clinical governance including: performance management, risk assessment, audit and monitoring might clarify how and in what ways these specific tools influence maternity care provision.

Finally, although the current study has investigated the opinions of midwives in relation to the regulatory framework it has largely ignored the voice of pregnant women, except in so far as their stories are told in the narratives offered by the midwifery participants. This approach is justifiable in the context of a small study, as it has given a voice to midwives, who are a hitherto under-researched group. Nonetheless, it is important to acknowledge that this is a limitation, and that future research that includes the perceptions of the service user would add another important dimension to the understanding and recognition of the impact of governance on the woman accessing care. This would be particularly helpful in terms of providing data that may be used to inform future reforms of the regulatory framework.

7.3 Key Findings: Emergent Themes

When analysing the views and opinions of the midwives who participated in this study three key themes emerged. These were: ensuring safe care in practice (7.3.1), accountability and decision making (7.3.2), and facilitating woman centred care (7.3.3). These will now be reflected upon in the following section.

7.3.1 Ensuring Safe Care in Practice

Across the three different strands of my research, the significance of the influence of the regulatory framework on the provision of safe care was clear for many of the midwifery participants. The midwives were generally supportive of the need for regulatory structures such as risk management, clinical guidelines and the statutory supervision of midwives, which were accepted as being necessary to protect the pregnant woman whilst supporting the midwife.

Nevertheless, the perception of what is meant by safe care similarly emerged as being complex and multifaceted.

In chapter three, it was established that the reform of the regulatory frameworks has often been made on the assumption that safety can be achieved through the standardisation of care.[3] In this context, clinical guidelines play an integral part in the treatment regimens for pregnant women accessing the maternity services. Within the empirical literature, clinical guidelines have been recognised as having the potential to enhance patient care.[4] Whilst this was not denied by participants, the current study has also revealed the extent to which the utilisation of guidelines based on the average pregnant woman were viewed as problematic. Midwifery participants did not consider pregnant women to be a uniform cohort and, as a result, on occasion guidelines were circumvented when they were judged to be incompatible with the individual woman's labour. Equally, there were times when midwives had to devise their own guidelines, which would help to facilitate safe quality care for the woman who had unique and complex circumstances. These findings are interesting as they illustrate how, in certain conditions, generic guidelines designed for the average pregnant woman, were not considered to be effective in providing safe care. This was true both in terms of supporting the normal physiological processes of labour and birth, and in situations that deviated from the normal course of events and that were challenging for the woman and midwife.

The data further highlighted inconsistencies between the regulatory schemes, which are designed to ensure safe care and the broader system of maternity service provision. It emerged that some participants were sceptical about clinical governance strategies, believing that their primary function was to reduce the cost of litigation to NHS Trusts. A heavy emphasis on risk

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[3] Health and Social Care (Community Health and Standards) Act 2003 c.43 s.46; Timmermans S., Berg M., A world of standards but not a standard world: towards a sociology of standards and standardisation *Annual Review of Sociology* 36(2010):69-89; Taylor J., Tough Talk from the NICE man *Med Economics* (November 2003):44-46.

[4] Thomas L.H., Cullum N.A., McColl E., Rousseau N., Soutter J., Steen N., Guidelines in professions allied to medicine (Review) *Cochrane Database of Systematic Reviews* Issue 1 Art. No.: CD000349 (2009).

management, for what was sometimes seen as the wrong reason of reducing costs and meeting government targets, was thought to have the potential to produce ineffective outcomes for the woman requiring care. This view of clinical governance supports and augments Som's (2009) research, which found that such strategies can have a negative influence on the overall outcomes of care, particularly when combined with competing demands such as financial constraints, care provision and service user expectation within the NHS.[5]

Concerns regarding the relationship between care provision and clinical governance in the context of limited funding were likewise seen in the current data. Some midwives suggested that women who were deemed to be high risk were less likely to receive quality care as a result of staffing problems, and the lack of resources in a financially restricted service. This concern also supports the findings regarding adequate staffing of maternity units noted by the *Kings Fund Report* (2011), which identified that there was some, albeit limited evidence to link staffing levels with outcomes of care.[6] The current study adds to the available evidence about the impact of staffing in maternity units by acknowledging that, for the participants, low numbers of expert staff are thought to be an important influence on the provision of safe quality care. These findings additionally support the *Kings Fund* recommendation for the 'effective deployment of existing staff'.[7]

In chapter five, when the discussion centred on the ability of the NMC to ensure safe care, many participants felt that the regulator had limited appreciation of the issues related to service provision. Funding was also a concern here, with the NMC being understood at times to be penalising individual midwives who attempt to offer care in challenging circumstances, for

[5]Som C.V., 'Quantity' v. 'Quality' dilemma of health staff in NHS UK: Does Clinical Governance Provide a solution *Clinical Governance an International Journal 14* (2009) (4):301-314.

[6] Sandall J., Homer C., Sadler E., Rudisill C., Bourgeault I., Bewley S., Nelson P., Cowie L., Cooper C., Curry N., *The Kings Fund Report: Staffing in Maternity Units, getting the right people in the right place at the right time* (The Kings Fund; London, 2011) at 9.

[7] ibid.

fiscal failings in the wider NHS. Further, the regulatory codes and guidelines which are issued periodically by the NMC, were seen by several participants as a device to enforce conformity, regardless of the consequence. It was widely felt that these rules and procedures did not recognise that behaviour and actions in practice are influenced by budget constraints and government policy, which taken together, have the potential to produce unsafe care. Whilst there is a paucity of existing empirical research on midwifery registrants' perceptions of the NMC, one key finding of this study is thus that the regulator was often understood to be remote and lacking familiarity with the practice of midwifery. This detachment was believed to have had a bearing on the NMC's ability to fulfil its statutory obligation of protecting the public.

In the context of midwifery regulation this study has, in addition, examined the statutory supervision of midwifery, which forms an extra layer to the regulatory framework for midwives practising in the UK. Whilst there have been studies that have investigated whether statutory supervision can be used as a method for facilitating quality care,[8] there was little in the previous empirical literature to suggest a positive correlation.[9] The current study casts further light on this aspect of the regulatory framework, finding that while many were positive, for others, statutory supervision appeared on occasion to be ineffective and failed to provide the appropriate support that midwives need, when caring for the pregnant woman in practice is challenging.

Participants' views on supervision were closely tied to their perceptions of the level of skills and personal qualities of the individual supervisor of midwives and this confirms the findings of earlier studies. For example in William's (1996) study it was found that the supervisor of

[8] Ball L., Curtis P., Kirkham M., *Why do Midwives Leave?* (Royal College of Midwives (RCM) and The Department of Trade and Industry Partnership Fund, 2002); McDaid C., Stewart-Moore J., Supervision: how can the gap be bridged? *Midwives: The official Journal of the Royal College of Midwives* 9(5) (2006):180-183.

[9] Henshaw A., Clarke D., Long A.F., Midwives and supervisors of midwives' perceptions of the statutory supervision of midwifery within the United Kingdom: A systematic review *Midwifery* 29 (2013):75-85.

midwives needed to possess a range of skills if adequate support was to be provided.[10] Mayes (1993) likewise drew attention to the significance of the supervisory relationship and the interpersonal traits possessed by the supervisor.[11] In the current study, these aspects were observed to enhance the connection between the midwife and the supervisor of midwives, revealing these key traits to be just as valuable to the effectiveness of statutory supervision in the modern maternity services as they were twenty years ago. In my study, the importance of the supervisor having detailed knowledge and expertise was emphasised. Here, the generic competencies which are prescribed by the NMC,[12] were deemed by some participants to be inadequate, as they do not accentuate the need for expert knowledge when events in practice are difficult. This situation was moreover compounded by the existing 24 hour access system where the midwife has the ability to be able to contact an 'on call' supervisor of midwives at any time.[13] Several participants suggested that this system did not offer adequate supervisory support, as the supervisor might not possess the requisite clinical expertise to be able to assist the midwife with the complex events that she might be trying to manage and, which therefore had the potential to impact on the outcome of care.

As with other areas of midwifery governance, the role of the supervisor of midwives was felt to be subject to organisational influences. Burden and Jones (1999) found that it was the perception rather than an actual conflict of interest that was problematic.[14] Stapleton and Kirkham (2000), who examined the supervision of midwifery in detail, additionally observed that for some supervisors of midwives there are 'institutional loyalties' which are at odds with

[10] Williams E.M.J, Clinicians' views of supervision in Kirkham M., eds. *Supervision of Midwives* (Books for Midwives press; Oxford, 1996):142-162.
[11] Mayes G., Quality through supervision *British Journal of Midwifery* 3(2) (July/August 1993):138-141.
[12] Nursing and Midwifery Council (NMC) *Standards for the preparation and practice of supervisors of midwives* (NMC; London, October 2006b).
[13] Nursing and Midwifery Council (NMC) *Midwives Rules and Standards* (NMC; London, 2012a) Rule 9 states: this might be the midwife's named supervisor or another supervisor of midwives.
[14] Burden B., Jones T., Midwives' perceptions of supervisors and managers *British Journal of Midwifery* 7(9) (1999):547-552.

their role as a supervisor.[15] In the current study, the dual role of supervisor of midwives and manager constricted rather than enhanced the supervisor/supervisee relationship for a number of participants, which had the capacity to weaken the aim of statutory supervision. These findings thus add further weight to the existing awareness of the tension that occurs for the supervisor of midwives who has managerial responsibilities, which may conflict with the role of professional supporter. As was seen above, this can create difficulties for both the supervisor of midwives and supervisee in terms of the provision of safe care in practice.

7.3.2 Accountability and Decision Making

In chapters two and three, the development of regulatory strategies of clinical governance and risk management was discussed. Whilst potentially offering a useful tool for healthcare professionals, these systems can also create challenges for healthcare professionals in terms of compliance with guidelines that reduces the ability to make clinical decisions based solely on professional judgement. Within the literature, it is recognised that compelling medical professionals to conform to clinical guidelines can be problematic, as doctors in particular fear losing professional autonomy.[16] When this question of compliance was examined previously, Parker and Lawton (2000) found that midwives were more critical and doctors more accepting when guidelines were contravened.[17] This was linked to professional decision making and autonomy that the medical profession value highly.[18]

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[15]Stapleton H., Kirkham M., Supervision of Midwives in England 1996-1997. In Kirkham M., ed. *Developments in the Supervision of Midwives* (Books for Midwives Press; Oxford, 2000): 61-92.
[16] Michie S., Johnston M., Changing Clinical Behaviour by Making Guidelines Specific *British Medical Journal (BMJ)* 328 (7) (2004):343-345; Harpwood V., *Medicine, Malpractice and Misapprehensions* (Routledge-Cavendish; Oxon, 2007).
[17] Parker D., Lawton R., Judging the use of clinical guidelines by fellow professionals *Social Science and Medicine* 51(2000): 669-677.
[18] ibid.

In the current study, midwifery compliance with guidelines was found to be more complex than the earlier research,[19] would seem to suggest. Here, tension was found to exist between clinical guidelines and decision making in relation to the normal physiological processes of birth. In these situations, some participants resorted to creative compliance so that unnecessary intervention in childbirth could be avoided. In other circumstances, strict adherence to clinical guidelines was viewed as a defensive mechanism that participants believed would prevent criticism and litigation. To a certain extent, these findings replicate Symon's (2000) research where midwives and obstetricians admitted to acting in a defensive manner in order to avoid claims of litigation, although Symon found that what represented 'defensiveness' was itself open to interpretation and related to issues such as: the use of more invasive investigations, the growing use of electronic fetal heart monitoring in labour and an increasing caesarean section rate.[20] Symon's study,[21] however did not examine the rigid compliance with clinical guidelines that midwives in this study highlighted as being a defensive mechanism, and thus the current study broadens the appreciation of defensiveness and the influence that it has on midwifery practice.

In chapter four, the concepts of accountability and defensive practice were seen to be linked. In the study, a number of participants appeared unwilling to take responsibility for the provision of care because of the fear that there might be a poor outcome for which they might be held to be culpable. This mirrors earlier research that explored why midwives ceased to practice in the UK, discovering evidence that some midwives feared condemnation and punishment if mistakes were made when providing care and left the profession as a result.[22] The findings

[19] ibid.
[20] Symon A., Litigation and defensive clinical practice: quantifying the problem *Midwifery* 16 (2000a):8-14; Symon A., Litigation and changes in professional behaviour: a qualitative appraisal *Midwifery* 16 (2000b): 15-21.
[21] ibid.
[22] Curtis P., Ball L., Kirkham M., Why do midwives leave? (Not) Being the kind of midwife you want to be *British Journal of Midwifery*, 14(1) (05 Jan 2006): 27 – 31.

from the current study emphasize that for those participants, who chose to remain, rather than leaving the profession, practicing defensively might be a way to avoid the criticism and penalties that they fear.

Additionally in chapter four it emerged that several participants were concerned by the perceived demand to follow clinical guidelines uncritically. In these circumstances, it was felt that the midwife was deskilled by these procedures, which consequently deprived them of proficiency and competence in decision making, and that had the capacity to have a negative influence on midwifery practice and the care offered to pregnant women.

The notion of accountability was also a key concern in the discussion of the NMC. Although the regulator has a statutory duty to protect the public,[23] official reports demonstrate that the NMC has performed inadequately in terms of fitness to practice processes, which has led to questions about its ability to be responsible for the practice of its registrants.[24] Whilst much of the literature,[25] and NMC guidance,[26] discusses concepts of accountability, there is limited empirical data on the impact of regulatory accountability from a midwifery perspective. In my study many participants had a heightened sense of cognizance of their own accountability to the regulator but were unclear about regulatory processes more generally. As a result, a number of midwives appeared to have a disproportionate fear of being removed from the register, which

[23] Nursing and Midwifery Order (2001) Part II s.3 (4).

[24]House of Commons Health Committee *5th Report of Session 2013-14 :2103 accountability hearing with the Nursing and Midwifery Council* (Stationary Office; London, 3rd December 2013); Council for Healthcare Regulatory Excellence (CHRE) *Strategic review of the Nursing and Midwifery Council: Final Report* (CHRE; London, 3rd July 2012).

[25]Baldwin R., Cave M., Lodge M., *Understanding Regulation: Theory, Strategy and Practice* 2nd ed. (Oxford University Press; Oxford, 2011): 338-355; Ayres I and Braithwaite J *Responsive Regulation: Transcending the Deregulation Debate* (Oxford University Press; Oxford, 1992); Gould D., Re-engaging with accountability *British Journal of Midwifery* 17(1)(January 2009):6; Savage J., Moore L., *Interpreting accountability: An ethnographic study of practice nurses, accountability and multidisciplinary team decision making in the context of clinical governance* (Royal College of Nursing; London, 2004); International Confederation of Midwives (ICM) *Professional Accountability of the Midwife: Position Statement* (ICM; The Hague, Netherlands, 2014).

[26] Nursing and Midwifery Council (NMC) *The Code: Standards of conduct, performance and ethics for nurses and midwives* (NMC; London, 2008a): This version of the Code states that the midwife is accountable for their "acts and omissions" which incorporates decision making. Nursing and Midwifery Council (NMC) *The Code Professional standards of practice and behaviour for nurses and midwives* (NMC; London, 2015b): in the latest version of the Code accountability is not explicitly discussed in the same way as it was in the previous version.

led to overly cautious decision making and self-protective practice particularly in challenging situations.

A lack of confidence in the regulator was demonstrated by many midwives who felt that the NMC was unable to fulfil its core functions, a point that echoed official reports.[27] Here, concerns arose about fitness to practice procedures, which included: the length of time taken to resolve alleged poor practice, the inclusion of lay members on fitness to practice panels and the general quality of decision making within fitness to practice hearings. Whilst some thought that lay membership of fitness to practice panels would enhance accountability, others were more doubtful. This apprehension focused on the judgements and decisions that were made by panel members (that was not limited to lay members), which did not appear to consider external maternity service issues that might impact on actions in practice. Consequently, decision making was not seen to be robust, and thus potentially impacted on the credibility of the NMC.

The question of whether the regulatory element of the supervision of midwifery should be administered by the NMC was likewise discussed in this study. For some midwives there was a perception that decision making by supervisors of midwives in relation to investigations about alleged poor practice, was at times inconsistent. This led to confusion for the supervisor of midwives and supervisee, which undermined the ability of statutory supervision to support accountability in practice. However, whilst midwives had these concerns about local statutory supervision arrangements, they were nonetheless disturbed by the suggestion that these regulatory procedures should be performed by the NMC.[28] Here, midwives were apprehensive about the NMC's ability to properly carry out these measures, in light of the acknowledged

[27] Council for Healthcare Regulatory Excellence (CHRE) *Special report to the Minister of State for Health Services on the Nursing and Midwifery Council* (CHRE; London, 2008).

[28] Baird R., Murray R., Seale R., Foot C., Perry C., *Kings Fund Review of Midwifery Regulation* (Kings Fund, London, 2015): the recommendations from this review will be discussed in more detail below.

poor performance of the NMC in managing fitness to practice procedures more broadly, and many thought that such a fundamental change would further affect accountability.

It is clear from the analysis in chapter six that participants were however divided on the question of statutory supervision in broad terms. Some felt that statutory supervision supported accountability through a collegiate style of regulation, which the midwives thought was more effective than that offered by the NMC. However, others suggested that clinical supervision should be sufficient. These findings support previous research, which concluded that independent midwives were critical of local investigatory processes that are utilised to address concerns about practice.[29] The current study builds on these older findings by drawing on the experience of both NHS and independent midwives, showing that the same scepticism was shared across both cohorts. It additionally revealed a general lack of familiarity and transparency with regards to the measures that are employed to support practitioner accountability and tackle areas of poor practice. The findings from this study moreover highlight that difficulties exist with statutory supervision, which mirror some of the earlier research,[30] which was undertaken prior to the most recent NMC recommendations.[31] The current findings indicate that there has been little alteration in the experience of participants with regards to supervision, despite the issuing of current standards from the regulator.

7.3.3 Facilitating Woman Centred Care

In the current study, the notion of woman centred care and being ‘with woman’ was seen as pivotal to the quest to provide quality care for the overwhelming majority of midwives. The woman centred care agenda, which seeks to encourage the pregnant woman to participate in

[29] Demilew J., Independent Midwives’ views of supervision in Kirkham M., eds. *Supervision of Midwives* (Books for Midwives Press; Oxford, 1996): 183-201.
[30] McDaid and Stewart Moore n8 above.
[31] NMC n 26 above.

decision making, focusing on her individual needs and expectations, has been part of government policy for over twenty years.[32] This policy is consistent with neoliberal tenets that endorses the patient as a consumer of healthcare. However, woman centred care may be perceived as being much broader and is coherent with the midwifery, 'with woman', philosophy of care which advocates support of the woman and the promotion of childbirth as a normal event wherever possible. Nevertheless, as has been demonstrated throughout this study, the provision of care for pregnant women is often complex and challenging. Woman centred care was important to participants, however, they did not appear to connect the NMC with the woman centred care agenda. The reason for this apparent lack of connection in the data was unclear, although it is possible that this might be a further indication of the limited appreciation of the work of the midwife that the participants believed the NMC had.

In chapter four, the difficulties that arose as a result of attempts to standardise care, were likewise seen to have an influence on the provision of woman centred care. Financial restrictions within the maternity service also contributed to tensions between clinical governance schemes and woman centred care policies, as was highlighted by Som (2009).[33] The current study offers additional insights regarding the competing policies within the NHS and their impact on the provision of care, such that the drive for individualised care often appears to be thwarted in favour of clinical guidelines and risk management. Here, some participants believed that the service user voice was typically only heard when it matched clinical governance strategies, generating challenges for both the pregnant woman and midwife. Clinical governance and risk management were perceived as encouraging the medical model of care, which many participants suggested facilitated *women* rather than *woman* centred care, contrary to government policy. This was felt to create a loss of connection between the

[32] Cumberledge J., *Report of the Expert Maternity Group: Changing Childbirth* (HMSO; London, 1993).
[33] Som n5 above.

service user and the service provider throughout the range of risk categories that women were allocated too.

In this study, quality care emerged as a sometimes elusive ideal, which was dependent on a functional relationship between the midwife and woman. These findings mirror research undertaken by Thompson (2013), which found that there was a gap between what women requested and expected, and the package of care the midwife was able to provide, and which recognised the importance of maintaining working relationships in difficult conditions.[34] This idea was developed by some participants in my study, who expressed their gratitude to women for restoring the midwives' confidence in their own skills and expertise, as a result of the woman's choices in care. These findings provide further awareness about the unique relationship that exists between the midwife and the pregnant women, which is often reliant on supporting each other's decisions in challenging and extraordinary circumstances.

When the midwife and woman are presented with difficult events and situations, the role of the supervisor of midwives has been described as pivotal to supporting each of them.[35] However, whilst some participants believed that supervision endorsed the woman centred care initiative, others were not as confident. Here, some participants felt that the supervisor of midwives was available as an authority figure who could ensure that the woman conformed to service provision, rather than facilitating individualised woman centred care. In Thompson's study (which was discussed above) the supervisor of midwives was identified as having an important role in assisting midwives, especially in relation to written plans that could be used to facilitate decision making for the midwife and woman when care deviated from that which was considered typical.[36] Thomson's study, whilst recognising that women wanted 'individualised,

[34] Thompson A., Midwives' experiences of caring for women whose requests are not within clinical policies and guidelines *British Journal of Midwifery* 21(8) (August 2013): 564-570.
[35] Smith S., Provision of Supervisory Support in Challenging Situations *Guidelines for the Statutory Supervision of Midwives* (Local Supervising Authority Officers (LSA) National (UK) Forum; London, March 2013b).
[36] Thompson n34 above.

non-institutionalised care,' did not explore the role of the supervisor of midwives in any depth in relation to woman centred care.[37] This reflects a broader gap in the literature, where beyond some occasional reference about the supervisor of midwives enabling midwives and women when making choices about care,[38] little empirical data was found that specifically addressed the question of how statutory supervision of midwifery impacts on woman centred care. The current study adds to this small body of empirical evidence, revealing that in some situations this aspect of midwifery governance rather than providing support appears to undermine attempts to offer individualised care as the woman centred care policy had anticipated.

These findings appear to indicate the need for reform of the regulatory framework that governs midwifery. However, before I come on to consider any policy implications that arise from my own study, it is necessary first to review developments in the years since my data was collected. These years have seen a number of important reviews with relevance to midwifery practice, each of which has envisaged the need for reform.

7.4 Proposed Regulatory Reforms since 2010

7.4.1 Reforms to Healthcare Regulation

Chapters two and three set out the regulatory framework that was in place up to 2010 when the study commenced. However, the regulatory framework that governs midwifery practice is an evolving structure and as such, it is important to consider the reforms and the proposals for future change, which have been made since this time. It will be seen that the criticisms made in these reviews serve to emphasize the same problems identified in my own study, thus providing further validation of the issues highlighted by the midwife participants. Providing

[37] Thompson n34 above at 569.

[38] Carr N.J., Midwifery Supervision and home birth against conventional advice *British Journal of Midwifery* 16(11) (2008): 743-245; Nursing and Midwifery Council (NMC) *NMC Circular 8- Midwives and Home Birth* (NMC; London, 2006a).

more detail of the recommendations made in these more recent reviews, will also allow me to place my own, tentative recommendations for change within this current, evolving policy context (7.5).

In 2010, a new Coalition Government was formed between the Conservative and Liberal Democrat parties. This merger saw the Liberal Democrats unite with the Conservatives in what was to become a progression of the Thatcher mission to ‘roll back the state’ (as was discussed in chapter two), through projects such as David Cameron’s ‘Big Society’.[39] Here, the Big Society may be envisaged as: first encouraging social enterprise, second having a public sector that incorporates new non-state providers, particularly in healthcare and education, and third viewing the role of the state as to advise or persuade society to change its behaviour and so create new societal standards.[40] Reform of the NHS was to be part of the Coalition strategy and was to be based on the core principles of freedom, fairness and responsibility. These reforms were articulated in the policy document *Equity and Excellence: Liberating the NHS*, which identified the need for healthcare providers to be accountable to patients whilst reducing bureaucracy and state control.[41]

This has echoes of first the Thatcher and then the Blair administration. Patients were to be encouraged to participate in decision making, and to have choice in service provision, who their consultant and general practitioner was, and in the treatment they received.[42] For the maternity services this choice was to be extended through the provision of maternity networks, which would promote consistency in standards whilst allowing local services to be developed in response to local needs.[43] Further, whilst it was suggested that NHS spending would be

[39] Lakin M., The ideology of the coalition: more ‘muscular’ than ‘liberal’? *British Politics* 8(4):476-490.
[40] ibid.
[41] Department of Health (DH) *Equity and Excellence: Liberating the NHS* (DH; London, July 2010a).
[42] ibid at 3.
[43] National Health Service (NHS) Commissioning Board *Strategic Clinical Networks: frequently asked questions (FAQ)* (NHS England, London, 2012) www.england.nhs.uk/wp-content/uploads/2012/11/scn-faq.pdf (accessed 19/09/2015).

increased in ‘real terms’,[44] public spending was to be drastically curtailed with local NHS institutions needing to achieve unprecedented budget reductions. Consistent with the Coalition tenets of freedom, fairness and responsibility, the individual would then be ‘freed’ to resort to family and private welfare providers for assistance rather than looking to the state.[45]

In terms of the regulation of healthcare, Cameron’s administration sought to reduce the influence of the state in the management of the NHS through the rearrangement of healthcare regulators including the Care Quality Commission (CQC) and Monitor. As a result of the enactment of the Health and Social Care Act 2012,[46] independent regulators would supervise the governance of the health service. Thus, whilst the CQC was now to be responsible for assessing the quality of health and social care services,[47] Monitor would focus on financial issues and ensure the efficient provision of health care services.[48] Similarly in the context of healthcare professional regulation the 2012 Act created the Professional Standards Authority for Health and Social Care (PSA), (which replaced the Council for Healthcare Regulatory Excellence (CHRE)),[49] another independent regulator, whose function it is to oversee and report on the performance of healthcare regulators, to set regulatory standards, and to advise government about the concerns raised in relation to the nine regulators it regulates.[50]

[44] DH n41 above.
[45] Gooby P.T., Stoker G., The coalition programme: a new vision for Britain or politics as usual? *The Political Quarterly* 82(1): 4-15.
[46] Health and Social Care Act 2012: also identifies that for the Coalition Government NICE quality standards would continue to support the government policy for health care and social care which aimed to provide the best possible outcomes for service users.
[47] Care Quality Commission (CQC) *About Us: What we do and how we do it* (CQC; Newcastle upon Tyne, 2013).
[48] Monitor *About Monitor: Making the health sector work for patients* (Monitor; London, July 2014).
[49] n 46 above s. 222.
[50] According to the Professional Standards Authority for Health and Social Care (PSA) website information: the nine healthcare professional regulators regulated by the PSA are: the General Chiropractic Council, the General Dental Council, the General Medical Council, the General Osteopathic Council, the General Optical Council, the General Pharmaceutical Council, Health and Care Professions Council, the Nursing and Midwifery Council and the Pharmaceutical Society of Northern Ireland https://www.professionalstandards.org.uk/ (accessed 19/09/2015).

In chapters three and five it was seen that official reviews of the Nursing and Midwifery Council (NMC) have highlighted fears about the NMC's ability to function effectively.[51] Since the data for this study was collected, a number of additional reports have been published that have assessed the ongoing performance of the NMC. The *PSA Review* (2013), indicated that several healthcare regulators including the NMC did not fulfil their statutory duties effectively.[52] This serves to provide additional external recognition of the concerns expressed by some of the participants in my study that the NMC was an ineffective regulator, who had difficulty, particularly in terms of fitness to practice, ensuring that its registrants were safe and competent. Further validation of these same concerns was provided by the 2013-2014 *Accountability Report* (2013),[53] which was presented to Parliament. This Report revealed that whilst there have been some improvements, there are still ongoing concerns with the NMC's ability to manage its core functions. The report draws attention to the length of time taken by the NMC to complete fitness to practice cases as a persistent concern for the Health Committee, noting that from 2015 the NMC intends to reduce the target for resolution of fitness to practice cases to 15 months.[54] The issue of timeliness and the ability to have a fair hearing was also raised by some midwives in my study, who were concerned about the NMC's ability to manage these processes, and the impact that this had on its ability to safeguard the wellbeing of the public. In the recent *2015 Accountability Hearing*, there still remains significant anxiety that

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[51] Council for Healthcare Regulatory Excellence (CHRE) *Special report to the Minister of State for Health Services on the Nursing and Midwifery Council* (CHRE; London, 2008).

[52] Professional Standards Authority for Health and Social Care (PSA) *Annual Report and Accounts and Performance Review Report 2012-2013* (The Stationary Office; London, June 2013).

[53] House of Commons Health Committee *5th Report of Session 2013-14: 2013 accountability hearing with the Nursing and Midwifery Council* (Stationary Office; London, 3rd December 2013): the report notes that if the target time is to be reduced to 12 months that changes to NMC legislation is required which will necessitate close liaison with the Department of Health.

[54] ibid.

the regulator is not performing this most important of its functions efficiently,[55] and this thus appears to additionally support the concerns of participants in this study.

The NMC, in an attempt to respond to its critics, likewise commissioned an independent external appraisal of the improvements it has achieved in relation to the *PSA Review* (2013).[56] The resulting *KPMG Review* (2014),[57] indicates that, whilst there has been some improvement in terms of stakeholder perception of the core function of the NMC, progress is still delicate and that a focus on good operational management is important. The *KPMG Review* commented on the lack of public and practitioner confidence in the NMC, and recommended closer links with external stakeholders and registrants as a method of improving confidence towards the NMC amongst these groups.[58] This focus on management and participation by stakeholders demonstrates the ongoing influence of neoliberal ideology in its different forms. Within this study, whilst some participants viewed contributions from external stakeholders such as lay membership on fitness to practice panels as positive, others were more doubtful and suggested that stakeholder participation should be targeted and include service user groups with experience of maternity services.

Nevertheless, the *KPMG Review* and the other official organisations who have scrutinised the regulator, help to emphasise some of the same concerns that were identified by several of the participants in this study, as discussed in chapter five (these included: ineffective fitness to practice processes, which led to the concern that the NMC could not ensure its main statutory

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[55] House of Commons Health Committee *Oral evidence: 2015 accountability hearing with the Nursing and Midwifery Council* (The Stationary Office; London, 13th January 2015) at 847.
[56] KPMG *External Review of Progress made by the NMC against the recommendations of the PSA's Strategic Review 2012: Final Report* (KPMG; London, 10th September 2014): KPMG are a global company which provides professional services to a range of clients. These services include audit and management consultancy.
[57] ibid.
[58] ibid.

objective of protecting the public). The *KPMG Review* moreover, encouraged the NMC to develop strategies to address the key issues that it identified in order for trust to be restored.[59]

In response to the concerns about the performance of several healthcare regulators (not exclusively the NMC) in key areas such as fitness to practice, the Coalition Government in 2011 instructed the Law Commission to review the current legal frameworks with the intention of drafting one new piece of legislation.[60] This statute would determine the central roles of the regulators, whilst enabling them to choose how they would implement these functions. This, it was hoped, would simplify the regulation of the healthcare professions,[61] as well as furthering the Coalition's goal of deregulating healthcare thus reducing the burden on the state. The 2014 *Law Commission Report*,[62] which was published as a result of the review, recommended that all statutory committees, including the Midwifery Committee at the NMC, should be abolished.

This is an interesting proposal given that many of the participants in this study perceived the NMC to be a remote regulator who had limited understanding of the role of the midwife, and as such the Law Commission suggestion that the Midwifery Committee at the NMC should be dispensed with, would perhaps be a cause for concern for participants in this study. However, as the Law Commission recommendation was not discussed with midwives in this study, their reaction to this proposal must remain speculation. Indeed, the *Law Commission Report* noted that it was the recommendation to abolish the statutory midwifery committee that generated the most opposition in the new draft proposals, but argued that the draft proposals should ensure 'a robust regulatory framework for midwives'.[63] Given the findings from the current study that

[59] ibid.
[60] Department of Health (DH) *Government Response to the NHS Future Forum Report* (The Stationary Office; London, June 2011b) at 54.
[61] ibid.
[62]The Law Commission (LC) *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England Law Com No 345* (Law Commission; London, April 2014).
[63] Law Commission ibid: Part 13(14) Recommendation 115 at 219.

were discussed above, and the concerns about the NMC that have been highlighted in official reports, it is nevertheless unclear how the Law Commission draft proposals in their current format will ensure this 'robust regulatory framework'. As such the recommendation to abolish the statutory midwifery committee, therefore seems to further emphasize the Royal College of Midwives' (RCM) concern about the voice of midwifery and its representation at the NMC.[64]

7.4.2 Reforms to Midwifery Regulation

In addition to these more general changes, further specific reforms have focused on the regulation of midwifery. In 2008 a series of five unrelated untoward serious incidents in the Morecambe Bay NHS Trust led to an inquiry into the service that it provided and the publication of the *Fielding Report* (2010).[65] The key findings from the *Fielding Report* included: an inadequate appreciation of clinical governance, limited understanding of the role of the supervisor of midwives, and a 'blame culture' within the organisation that added to the situation and, which produced poor standards of safety in practice.[66]

These findings are noteworthy in terms of the statutory *Duty of Quality* (as discussed in chapter three), which has been in existence since the enactment of the 1999 Health Act, and, which was intended to be a method of regulating the care provided to patients accessing the NHS.[67] The failings in the provision of care at Morecambe Bay highlighted by the *Fielding Report*, would

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[64] House of Commons Health Committee *Annual Accountability hearing with the Nursing and Midwifery Council: Seventh Report of Session 2010-12* (The Stationary Office; London, July 2011).

[65] Fielding P., Richens Y., Calder A., *Final Report: Review of Maternity Service in University Hospitals of Morecambe Bay NHS Trust* (University Hospitals of Morecambe Bay NHS Foundation Trust; Morecambe Bay, August 2010): following the disclosure that this report was withheld by the Chief Executive Officer of the Trust Tony Halsall from regulators and the public which would have enabled the identification of deficiencies sooner Monitor (the executive non-departmental public body of the Department of Health) have now implemented stringent disclosure rules for those Trusts seeking Foundation status in an attempt to prevent information being withheld in the future.

[66] ibid.

[67] Health and Social Care (Community Health and Standards) Act 2003 c.43 s.46; Health Act 1999 18 (1) Duty of Quality states: It is the duty of each Health Authority, Primary Care Trust and NHS Trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals.

appear to indicate that clinical governance strategies that attempt to improve standards of care across the NHS, seem to have had limited impact here. The concept of clinical governance as a method of ensuring high standards of care was likewise discussed in the current study, where although there was some support for these strategies, several participants were concerned that these arrangements, on occasion, failed to ensure the provision of safe effective care.

Following the *Fielding Report*, the *Parliamentary and Health Service Ombudsman (PHSO) Report* in 2013, identified that the failings in care at Morecambe Bay were linked to poor midwifery practice. The *PHSO Report* additionally drew attention to difficulties with statutory supervision and the regulatory role of the supervisor of midwives, which, it argued, had the potential to impact on the safety of pregnant women and their babies.[68] The *PHSO Report* also went on to state that this historic collegiate style of midwifery regulation had the capacity to insulate and protect those being regulated, which may result in regulatory inconsistency, confusion and the potential for conflict of interest.[69] Thus, in this instance, the regulatory strategies devised to improve the safety and quality of care for pregnant women did not appear to be functioning effectively. The *PHSO Report* findings were, moreover, echoed in this study in chapter six where the data displayed an ambiguity towards statutory supervision and its ability to provide safe effective care.

As a result of the concerns raised in these reports, (as discussed in chapter six), the traditional view of statutory supervision of midwives as a method of ensuring safety in practice has shifted. In 2014, the Kings Fund were commissioned by the NMC to carry out a review of the regulation of midwifery in the UK.[70] The central recommendation of the *Kings Fund Review*

[68]Parliamentary and Health Service Ombudsman (PHSO) *Midwifery supervision and regulation: recommendations for change* (The Stationary Office; London, December 2013).

[69] ibid at 4: this report states that the regulations permit the possibility of confusing the roles of supervision and regulation for midwives and the potential for conflict of interest; Baldwin, Cave, Lodge n25 above.

[70] Nursing and Midwifery Council (NMC) *Independent review of midwifery regulation: terms of reference* (NMC; London, 2014b).

(2015),[71] was that the NMC should have sole responsibility and accountability for the core function of regulation (namely fitness to practice processes). This is consistent with the *PHSO Report* recommendations, which suggest that reform of midwifery regulation will guarantee that accountability and safety concerns would be addressed.[72] The *Kings Fund* proposal was accepted at the NMC Council meeting in January 2015.[73] Following these changes, the responsibility for the regulatory element of the supervision of midwives (including fitness to practice issues) will be undertaken by the NMC. As such, this proposal will effectively eliminate the regulatory element of the supervision of midwifery once amendments are made to the existing legislation.[74]

The decision to alter the relationship between statutory supervision and the NMC was further reinforced by the *Kirkup Report* (2015), which emphasised concerns about the statutory supervision of midwives and its ability to ensure safe quality care.[75] It seems then, that the statutory supervision of midwifery is no longer the 'tried and tested' regulatory model of choice.[76] This shift in the regulation of midwifery is potentially troubling, given that whilst participants in the current study had concerns about statutory supervision, they were nevertheless apprehensive about the NMC's ability to protect the public as a result of inefficient fitness to practice procedures. Thus, it would seem that this move is likely to be unpopular with at least some midwives.

[71] Baird, Murray, Seale, Foot, Perry, n28 above.
[72] PHSO n68 above: 17-19.
[73] Nursing and Midwifery Council (NMC) *Nursing and midwifery regulator calls for supervision to be removed from its legislation* (NMC; London, 2015a) http://www.nmc-uk.org/media/Latest-news/Nursing-and-midwifery-regulator-calls-for-supervision-to-be-removed-from-its-legislation/
(accessed 01/02/2015).
[74] ibid.
[75] Kirkup B., *The Report of the Morecambe Bay Investigation* (Stationary Office; London, March 2015).
[76] House of Commons n 64 above.

Additionally, as a consequence of the *Kirkup Report*,[77] the Coalition Government ordered an urgent review of maternity service provision in England in March 2015, to ensure that these are developed in a safe, responsive and efficient manner.[78] This review is ongoing at the time this study was being completed, and as such the findings have yet to be published.

This section has highlighted that in the years since my data was collected, there have been a cluster of reports and recommendations that have identified significant concerns in terms of the delivery of safe care in the maternity services and the regulation of midwives. Much of what has been suggested in these reports echoes the concerns raised by participants in my study, most notably that neither clinical governance strategies nor the statutory supervision of midwifery, ensure the provision of safe effective care at all times. As a result, the recommendations from organisations such as the Law Commission, PHSO and the Kings Fund are that the regulation of midwifery, particularly in terms of statutory supervision and fitness to practice processes, needs to be reformed in order to more fully guarantee the protection of the public, and this will culminate in the removal of statutory supervision, amongst other reforms. The proposed changes to statutory supervision are nevertheless troubling, in light of my findings. I now turn to my own recommendations for future policy and reform.

7.5 Recommendations for Policy that Might Enhance the Provision of Care

In the course of this study it has been seen that the strategies employed to safeguard the health and wellbeing of pregnant women are multifaceted and complex. The study has demonstrated that, for the participants, the regulatory framework, which is designed to guarantee safe quality care, is not without difficulties. This is true of all the regulatory strategies studied here including clinical governance, risk management and the regulation of the healthcare

[77] Kirkup n75 above.
[78] National Health Service (NHS) England *Five Year Forward View* (NHS England; London, October 2014); National Health Service (NHS) England *Maternity Review: Terms of Reference* (NHS England; London, March 2015) at 1.

professions. I now move on to consider some proposals for reform. The limitations of my study, as noted above, mean that it is only possible to put forward some tentative ideas that might be worthy of future consideration.

7.5.1. A Renewed and Enhanced Commitment to Woman Centred Care

Clinical governance and risk management strategies serve many purposes, including safe guarding the pregnant woman who accesses care and the reduction of the cost of litigation to the NHS. The importance of these schemes to the maternity services was seen in both the findings in this study and in the *Fielding Report.*[79] However despite these regulatory arrangements, complaints and claims of clinical negligence continue to climb often as a result of dissatisfaction with care.[80] In this study the provision of individualised care to the pregnant woman through the policy of woman centred care has been seen as existing in tension with clinical governance strategies, with their focus on standardisation. This tension, was thought to be exacerbated by the present-day financial climate within the NHS, where budget cuts are common and resources are strained. In these circumstances, the policy of woman centred care with its emphasis on the individual pregnant woman seems to be a luxury that many NHS Trusts cannot afford. However, this would appear to be a somewhat questionable approach. A policy which revises clinical governance strategies so that they take into account the individual woman and her needs, might potentially be one method of reducing litigation costs, in so far as it would facilitate care that is safe and effective whilst meeting the expectations of the woman. This would be consistent with the *Duty of Candour* which requires health care professionals to have an open and honest relationship with service users accessing care.[81]

[79] Fielding n65 above.
[80] Harpwood n16 above.
[81] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the recent *Francis Report: one year on* (2014) the need for 'patient centred leadership' was documented.[82] This recommendation could be extended to the maternity services through the policy of woman centred care, which midwifery knowledge and skill would be ideally located to provide. At the beginning of this thesis the international definition of the midwife is given, together with an overview of the midwives scope of practice when offering care to pregnant women that states:

> 'The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the new-born and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.' [83]

This broad outline of the role of the midwife recognises the importance of focusing on the health and wellbeing of the pregnant woman and her baby, through the provision of care and support. The current study has highlighted that many midwives are enthusiastic and committed professionals who attempt to offer quality care to pregnant women, often in difficult circumstances. This interest in, and appreciation of, the importance of placing the service user at the centre of care might, for that reason, be translated into a sustainable maternity model, which given governmental support could possibly address the failings in care identified by the *Kirkup Report* (2015), which was discussed above.[84] In the document *Midwifery 2020* it was acknowledged that many of the proposals in the pioneering *Changing Childbirth Report* (1993), (including taking account of the individual woman's needs) have been reiterated in other policy documents from that time onwards but have never been completely put into

[82] Thorlby R., Smith J., Williams S., Dayan M., *The Francis Report: one year on* (Nuffield Trust; London, February 2014) at 8.
[83] International Confederation of Midwives (ICM) ICM International Definition of the Midwife (ICM; The Hague Netherlands, June 15 2011).
[84] Kirkup n75 above.

practise.[85] Here, articulate and robust midwifery leadership would seem to be key, both at national and local level, as this would help to facilitate the provision of safe quality care to pregnant women, whilst finally ensuring that the woman centred care policy recommendations were more fully implemented.

7.5.2 Effective Regulation: Understanding the Work of the Midwife

As discussed earlier, in January 2015, the NMC voted to accept the *Kings Fund Review* (2015) proposals,[86] to end the statutory element of the supervision of midwives. Since this time, the regulation of midwifery has been the subject of lively discussion in the midwifery literature.[87] Much of the debate focuses on how midwives will be regulated once statutory supervision is no longer part of the governance framework, and it is anticipated that there will be changes to the *Midwives Rules and Standards*, local fitness to practice in terms of supervisory investigations, suspension from practice and referrals to the NMC, amongst others. Recently, in July 2015 it was agreed by the Secretary of State for Health, Jeremy Hunt that the legislation governing midwifery regulation would change, however the timings and the procedures that will replace statutory supervision are as yet limited and unclear.[88]

Within this study, participants were concerned that the NMC was unfamiliar with the practice of the 40,000 midwives currently on its register. It is essential that in order for regulation to be effective that the regulatory authority has a detailed knowledge and appreciation of the role of

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[85] Department of Health (DH) *Midwifery 2020 Programme: Core Role of the Midwife Workstream Final Report* (DH; London, 2010c).

[86] Baird, Murray, Seale, Foot, Perry, n28 above.

[87] Lewis P., Freemantle D., Ireland J., The loss of midwifery supervision: to mourn or rejoice? *The Practising Midwife* 18(3) (March 2015): 12-16; Silverton L., The Future of supervision *The British Journal of Midwifery* 23(3) (March 2015): 160; Bennett P., A new era of supervision: a generation of midwives without supervision *British Journal of Midwifery* 23 (5) (May 2015): 360-361.

[88] Nursing and Midwifery Council (NMC) *Review of Midwifery Regulation: An Update on Midwifery Regulation* (NMC; London, 2015c): the main impact of this reform is that supervision will be taken of out regulatory legislation. This announcement also indicates that the Department of Health is currently making arrangements for supervision of midwives which is outside of regulation.

the midwife and the needs of the pregnant woman. In the post statutory supervision era a new governance framework could therefore include a midwifery specific regulatory authority to replace the current NMC. This would appear to be a plausible suggestion, given that the latest *PSA Review* (2015), has identified that the NMC's fitness to practice procedures, amongst its other functions, do not meet the required standards.[89]

The *PSA Review* (2015) expresses disappointment that recommendations from the *Law Commission Report* (2014),[90] have to date, failed to be introduced by the new Conservative Government.[91] The Review further suggests that there is a need for radical reform of health care professional regulation which, in its view, requires a more stringent approach than the current Law Commission proposals.[92] The implementation of a new midwifery governing body would therefore seem to support the PSA suggestions, and indeed would go further than the Law Commission recommendations, to address the concerns about the NMC, which has not performed effectively over a number of years.

Whilst it is not the role of the current thesis to set out the functioning of an alternative midwifery authority in detail, if such a body were not to be doomed simply to repeat the failings of the NMC, then a number of important lessons should be learnt from the analysis of the previous chapters. First it would need to ensure that regulation was responsive, and provide 'solutions which respond better than others to the plural configurations of support and opposition that exist [within the NHS].'[93] This could be achieved by utilising the knowledge and expertise of midwives, in combination with the pregnant woman's interest and experience. In meeting this goal, organisations such as the Association for Improvement in the Maternity

[89] Professional Standards Authority for Health and Social Care (PSA) *Annual Report and Accounts and Performance Review Report 2014/2015* vol. 11 (The Stationary Office; London, June 2015).
[90] The Law Commission n62 above.
[91] PSA n89 above.
[92] PSA n 89 above.
[93] Ayres and Braithwaite n25 above at 4.

Services (AIMS), which has a long history of lobbying for progress in maternity care on behalf of pregnant women, might possibly be utilised to represent the service user. This system would enable questions of performance and quality to be addressed in a pragmatic and efficient manner, and would be in keeping with the Law Commission recommendation for a 'robust regulatory framework.'[94]

Second, as the NMC is perceived as being remote and disconnected from the registrant and service user,[95] a reformed regulatory framework, which stipulates that the new regulator, together with the midwife and woman, should work more closely together in a collaborative partnership, would be more appropriate and effective. Such a new midwifery congress would be better placed to determine the codes and standards to govern midwives, as it would have the detailed knowledge of practice that participants in this study considered the NMC currently lacked. This might potentially more ably facilitate the protection of the public as the legislature intended. Although this would need to be verified by future empirical research.

7.5.3 Developing the Role of the Midwife in the Maternity Services

The *NHS Constitution* was published in 2013 and sets out the rights and responsibilities of the staff and public in terms of NHS service provision.[96] The *NHS Constitution* is a platform that endorses the engagement of the service user in a proactive partnership with the healthcare professional.[97] This enhanced partnership model could be especially useful in the maternity services. If it could be made fully effective, it might help midwives to move away from the defensive practice identified in this study, by active involvement of the pregnant woman in her own care, regardless of any underlying factors or risk categories. However, as this study has

[94] The Law Commission n62 above.
[95] KPMG n56 above.
[96] Department of Health (DH) *The NHS constitution: The NHS belongs to us all* (DH; London, 2013c).
[97] ibid.

also emphasised, current service provision is subject to financial constraints. As such, improved collaboration between the midwife and woman may not be possible unless there is a government commitment to further funding of the service and additional recruitment of midwives.

In recent years, instances of patient dissatisfaction with service provision have risen sharply. This study has highlighted that clinical governance systems can create challenges for midwives and pregnant women, particularly in relation to the allocation of risk and population based guidelines. One participant, Laura (Ind.> 20yrs) discussed these frameworks and linked them to the culture within the NHS.

> 'I think you become institutionalised into that way of thinking very quickly and if you don't leave [the NHS] you are seen as the "tall poppy" and you get bullied I would say. It takes a very strong person in the unit, and we all know them every unit's got those midwives that will say "now hang on" but eventually they leave don't they? They become teachers, they go into the community, they become independent midwives, and they go and practice abroad, all those other things because they love being a midwife and they're fantastic midwives but the institution does not support them or their good practice.'

This is a powerful statement which indicates that systems and strategies within the NHS often do not encourage midwives to offer care that is consistent with the ethos of normal birth. Here, midwives struggle with the competing influences within the maternity services and may become disillusioned. Nevertheless, the findings from this study have also revealed that midwives frequently have the skills and knowledge to ensure that care is safe and acceptable, both to the individual service user and to the maternity services, through the development of individual guidelines and plans of care. Midwives in clinical practice should be encouraged to develop this expertise and take a more participatory position in the improvement of care. This could be achieved by introducing policy that supports and values midwifery expertise. Behavioural changes could be achieved through a commitment to working more closely

together for and with the pregnant woman. As a result, midwives may develop renewed assurance in clinical decision making. Whilst this would need to be tested by future research, it is possible that this might mean that they would be less likely to behave in a defensive manner.

The decision has been made to remove statutory supervision of midwives from the regulatory framework. This makes it an appropriate time to review the support that midwives have access to in order to develop a structure which truly promotes quality care. Supervision is commendable when it safeguards the wellbeing of the pregnant woman through the reinforcement of good midwifery practice. Reform of midwifery supervision, away from the regulatory framework, could therefore include the deployment of dedicated midwives with the necessary expertise and skills to resolve the host of practice issues that frequently occur within the maternity services. This would be particularly useful in areas such as service provision and the woman centred care agenda, where specialist midwives could be more facilitative of both the woman and the midwife than has at times been previously observed. These influential lead midwives, some of whom might possibly be former supervisors, would need to possess the necessary skills to be able to liaise with management, midwifery staff and the wider pregnant population to determine how quality care is defined by the service user and the service provider.

Importantly, as this study has shown, independent midwives often have very distinctive views and abilities, and as such they too could be included and encouraged to participate in the provision of care to a wider population of pregnant women. Such plans would help to make sure that a new framework would be more robust than current arrangements. This would ensure that the service user and the midwifery voice are clearly heard, which would be to the benefit of the pregnant woman and her care.

Within this study the issue of adequate funding of the NHS generally and the maternity services in particular was raised by many participants. As such, for any future plans to be successful, the question of resources and the provision of adequate midwife numbers would need to be addressed, as it is perhaps only when these problems are resolved, that the quality of care that pregnant women have access to can ultimately be improved.

7.6 Concluding Thoughts

The purpose of this research study has been to offer new insights in answer to the question:

'*Do midwives believe that the current regulatory frameworks that govern midwifery practice support or undermine the protection of the public?'*

Reform of healthcare governance structures, has been motivated by concerns about the provision of safe care, through the management of risk, whilst ensuring accountability to Parliament and patients. This study has shown that, although broadly well motivated and offering potentially valuable prompts to better practice, in reality these strategies also have consequences that can, on occasion, distort the provision of optimal care. There is therefore no straightforward answer to this research question. Nevertheless, I hope that the current exploration of the views of midwives in relation to their working environment, and the context within which care is delivered, has made some contribution in response.

The profession of midwifery and the health and wellbeing of the pregnant woman has been a central aspect of my working life for more than twenty five years. During the course of this study, I have been able to critically discuss this research project and its findings with a wide audience. Consequently, my research has provided me with a unique opportunity to hear the views and opinions of midwives who are using the regulatory framework and to give them a voice. In particular, during the study I was invited to present my preliminary findings to the Kings Fund who were themselves undertaking the review of midwifery governance which has

been discussed in this thesis. Additionally, I have also presented my findings at both regional and national conferences where the focus has been on the regulation of healthcare and its relationship with the provision of quality care. Participation in these events has facilitated the discussion of my research question with other interested individuals and in doing so has permitted me to reflect on whether the regulatory framework supports or undermines the protection of the public.

It is clear within the research that the participants believe that clinical governance strategies and the legal frameworks that regulate the practice of midwives in the UK enables in part the provision of safe quality care. However, it is also apparent that, in the view of the midwifery participants, there are challenges in terms of the care offered to pregnant women that the regulatory frameworks do little to resolve. As such, this socio-legal study permits the articulation of the tensions that exist within these legal frameworks and as a result augments legal scholarship in this area. In the future I aim to disseminate parts of this thesis through the publication of papers in peer reviewed journals which have an emphasis on healthcare and governance. This will further increase the published empirical knowledge in the context of midwifery regulation, which as has been recognised in this thesis is limited. Accordingly, I hope that this research will make an original contribution to a number of important midwifery debates on the governance of the profession and the care offered to pregnant women.

Appendix One

Interview Participant Information Sheet

A Study of Registered Midwives' perceptions and attitudes towards professional regulation and legal frameworks and their impact on practice

Dear Colleague

You are invited to take part in a research study that aims to explore midwives' attitudes towards professional regulation and legal frameworks and the impact that these might have on midwifery practice. The research study is being undertaken as part of my Doctoral studies and aims to add an original contribution to existing knowledge in this area. Approval to conduct the study has been obtained from the University of Kent Research Ethics Advisory Group.

Please read the following information and please do not hesitate to contact me if you have queries and/or would like further information. Thank you.

The Purpose of Study

The purpose of this study is to examine the effectiveness of current midwifery regulation and legal frameworks including clinical governance and risk management.

Regulation of midwifery has changed in recent years in an attempt to address concerns about patient safety and claims for clinical negligence.

This research study has 3 main aims;

1. To describe midwives' training and years of experience
2. To describe midwives' experiences of midwifery regulation
3. To explore midwives' views on clinical governance strategies

It is hoped that the results of this research study will provide insight into midwifery regulation and clinical governance and to determine how these impact on midwifery care

Who is Taking Part?

It is hoped to enrol a number of Midwifery colleagues who have a wide variety of experience in this study. It is entirely your choice as to whether you wish to participate or not.

Your responses from the interview will be recorded and transcribed. The transcripts made after the interviews will be kept in a secure location during the research study. These will inform the findings of the study and may be quoted within the research report. All reported responses will be anonymous and confidentiality is assured. It is hoped that the research will be published in professional and academic peer reviewed journals. Readers of the published research report will not be able to identify participants in the research study when quotes from them are used in the research report. The transcriptions and audio files from the interviews will be destroyed once the study has been completed.

If you wish to withdraw from the study during the interview please say so at the time. If you wish to withdraw from the study at any time following the interview, please contact me and your transcribed responses will be deleted from the study without any detriment to yourself.

The results of the research study will be made available to you if you provide me with your email contact details. These will be kept securely and destroyed once the study has been completed and you have received a summary of the results

I very much hope that you will agree to take part in this study. If you have any questions that you wish to discuss further, please do not hesitate to contact me.

Yours sincerely

Jacqueline A Wier

J A Wier

Email: jw457@kent.ac.uk

Appendix Two

Informed Consent Form

A Study of Registered Midwives' perceptions and attitudes towards professional regulation and legal frameworks and their impact on practice

I confirm that I have read and understood the information provided about the study and have been given the opportunity to ask any questions about it: ☐

I understand that my consent to participate in the study is voluntary and that I am free to withdraw it at any time, without giving any reason: ☐

I understand that any information about me used in the study will be made anonymous before being written up: ☐

Name Date Signature

Name of Researcher Date Signature

J A Wier

I would like a summary of results

Email Contact details

Appendix Three

Interview Schedule

Briefing- define the subject, research question, purpose and content of interview

- General data on a separate form

Understanding of the purpose of legislation

The current Act of Parliament that governs Midwifery practice is the Nursing and Midwifery Order 2001. The stated aim of this legislation is the "protection of the public"

- What do you think this phrase means?
- Do you think it is effective in achieving this aim?
- Do you think it is a valid and achievable aim?

Prompt- Is there value in having a specific Act of Parliament which tells you to safe guard the public? Do you think that other professions should have similar governmental instructions? Do you think that the" protection of the public" provision has ever influenced you personally to practice in a certain way?

Clinical Governance

Clinical Negligence

- Do you think prompts women to make claims of clinical negligence?
- What factors do you think influence women when deciding whether or not to make a claim of clinical negligence?
- Do you think that midwives think about litigation when in practice
- Does the fear of litigation have an impact on your practice?
- Why does it have this impact?
- Can you give examples of how you have acted differently as a result of such concerns?
- Do you think that the fear of litigation has an impact on care provided to women?
- Do you think that the fear of litigation has an impact on the relationship you have with pregnant women when providing care?
- Have you ever been involved in a claim of clinical negligence?
- Did your involvement have any impact on your practice?
- Why do you think it had this impact?

Clinical Risk Management

- What do you think is the purpose of clinical governance in practice?
- Do you think that clinical guidelines help to ensure safe care in practice?
- Can you elaborate on why you think this?
- What affect do clinical guidelines have on decision making in practice?
- Have you had experience of clinical guidelines having an impact on decision making?
- Can you describe that experience?

- How did it affect the outcome for the woman?
- What do you understand by the term risk management?
- What do you think is the purpose of risk management in practice?
- Why do you think there has been an increase in risk management in practice in recent years?
- What impact do you think risk management has on midwifery practice?
- Do you think that allocating a pregnant woman to a particular risk group helps to promote safe care in practice?
- Do you think that the emphasis on risk in maternity services has an impact on the relationship between pregnant woman and the midwife?

Statutory Supervision of Midwifery

- What do you understand the term “statutory supervision” to mean?
- What do you think the statutory role of the Supervisor of Midwives is?
- Do you think that in general terms they are effective in this role?
- Do you think the role of the Supervisor of Midwives could be made to be more effective?
- Do you think that the Nursing profession should have statutory supervision like midwifery?
- What do you think are the advantages and disadvantages of having statutory supervision?

Developmental Practice

- Since qualifying as a midwife have you ever undertaken a period of developmental practice?
- If yes what impact did this have on your own practice? Was this a positive or negative affect?
- Do you think that the process of identifying which midwives may need developmental practice is fair and robust?
- Do you think that developmental practice is an effective way to support midwives in practice when concerns about practice are raised?
- Do you think that there are any challenges for midwives who are required to undertake developmental practice and those supporting them?

Supervised Practice

- Since qualifying as a midwife have you ever undertaken a period of supervised practice?
- If yes what impact did this have on your own practice? Was this a positive or negative affect?
- Do you think that the process of identifying which midwives may need supervised practice is fair and robust?
- Do you think that supervised practice is an effective way to support midwives in practice when concerns about practice are raised?

- Do you think that there are any challenges for midwives undertaking supervised practice and those supervising them?
- Do you think that supervised practice could be made more effective?
- Do you think that the Nursing and Midwifery Council as the regulator should have a greater role in facilitating supervised practice of midwives who are identified as having poor practice?

Nursing and Midwifery Council (NMC)

- What role do you think the NMC plays in ensuring good practice?
- Do you think that the NMC is effective in its role of ensuring the protection of the public?
- Are you aware that Parliament and the CHRE have been critical of the NMC in recent year?
- If so do you think this criticism is justified?
- Do you think decisions made by Fitness to Practice panels are fair and reasonable?
- Do you think they help to ensure good midwifery practice in the UK?
- What are the advantages and disadvantages of having lay members/ members of the public who have no knowledge of midwifery on Fitness to Practice panels?
- What impact do you think the fear of removal from the NMC register has on practice?
- Why do you think it has this kind of impact?
- Have the existence of the NMC / the possibility of being the subject of a Fitness to Practice proceedings ever caused you to act differently?
- If you answered yes to the previous question were your actions of a positive or negative nature?

Appendix Four

The Regulation of Midwifery Research Project

Questionnaire

Thank you for agreeing to complete this midwifery research project questionnaire. It is important to emphasize that no person participating in the study will be identifiable, the questionnaire does not ask for your name and all information provided will remain private and confidential. Your responses will inform the findings of my research study and may be quoted anonymously or through the use of a pseudonym so that you will not be identifiable within the research report. Consent to participate in this research study will be assumed through the return completion of the questionnaire.

This survey is divided into three sections;

Section 1:- About yourself

Section 2:- Midwifery Legislation

Section 3:- Clinical Guidelines

Thank you for taking part in this research

Section 1

Please tick the box which applies to you.

1. How long have you been qualified as a midwife?

0-5 years ☐

6-10years ☐

11-20years ☐

More than 20 years ☐

2. Where did you first qualify as a midwife?

United Kingdom ☐ Go to question 3.

Another European Country ☐ Go to question 4.

Outside the European Union (EU) ☐ Go to question 4.

3. If you qualified in the UK which training programme did you undertake to gain your midwifery qualification?

3 year undergraduate midwifery education (Direct Entry) ☐

78 weeks/ 18 month midwifery education (For qualified Nursing Registrants) ☐

4. Are you?

Female ☐

Male ☐

5. Who is your employer?

NHS ☐

Recognised Education Institute ☐

Independent/ Self Employed ☐

Other please specify ☐

6. If you work in the NHS what is your job grade?

Band 5 Midwife ☐

Band 6 Midwife ☐

Band 7 Midwife ☐

Band 8 Midwife ☐

Other please specify ☐

Not Applicable ☐

7. Are you a Supervisor of Midwives?

Yes ☐

No ☐

8. What is your highest academic qualification that you hold as a Midwife?

Diploma in Midwifery ☐

B.Sc. (Hons) ☐

Post graduate qualification ☐

Other please specify ☐

9. Where is your main area of clinical practice?

Hospital ☐

Community ☐

Section 2: Current Midwifery Regulation

10. Do you know the name of the Act of Parliament which currently regulates the Midwifery Profession?

Yes, please state the name here ☐

No ☐

Unsure ☐

11. What do you understand to be the aim of the legislation mentioned in question 10? (tick all that apply)

Increase patient safety ☐

Decrease claims of clinical negligence and litigation ☐

Restrict midwifery practice ☐

Protect the public ☐

Improve standards of midwifery practice ☐

Unsure ☐

12. How confident are you that the Nursing and Midwifery Council ensures good midwifery practice in the UK

Very Confident ☐

Confident ☐

Neutral ☐

Unconfident ☐

Very Unconfident ☐

13. What do you think the term "Statutory Supervision" means? (Please tick all that apply)

The policing of midwives ☐

Ensuring high standards of midwifery practice through support and monitoring ☐

Protecting the public ☐

Unsure ☐

14. What do you understand to be the legal responsibilities of the Supervisor of Midwives? (Please tick all that apply)

Investigating incidents in practice ☐

Supporting midwives to ensure standards of care are maintained and improved ☐

Referring midwives who might not be competent to the NMC ☐

Unsure ☐

15. The Nursing Profession does not have Statutory Supervision of Practitioners. What impact do you think this has on nursing care?

A Positive Impact ☐

No Impact ☐

A negative Impact ☐

Unsure ☐

16. In your opinion should the Nursing Profession have Statutory Supervision?

Yes ☐

No ☐

Unsure ☐

17. Since qualification have you ever been involved in an incident which has involved you receiving supported/ developmental practice?

Yes ☐

No ☐ Go to Question 21

18. If you answered yes to question 17, how did you find this process?

I found it beneficial ☐

I did not find it beneficial ☐

I found it neither beneficial nor unbeneficial ☐

I am unsure whether I found it beneficial or not ☐

19. Whilst receiving Developmental/ Supported Practice did you receive adequate support?

Yes ☐

No ☐

Unsure ☐

20. As a result of Developmental/ Supported Practice did your practice improve?

Yes ☐

No ☐

Unsure ☐

21. Since qualification have you ever been involved in an incident which has involved you receiving supervised practice?

Yes ☐

No ☐ Go to question 25

22. If you answered yes to question 21, how did you find this process?

I found it beneficial ☐

I did not find it beneficial ☐

I found it neither beneficial nor unbeneficial ☐

I am unsure whether I found it beneficial or not ☐

23. Whilst receiving Supervised Practice did you receive adequate support?

Yes ☐

No ☐

Unsure ☐

24. As a result of Supervised Practice did your practice improve?

Yes ☐

No ☐

Unsure ☐

25. How confident are you that Nursing and Midwifery Council "*Fitness to Practice"* investigations and hearings are fair and reasonable?

Very Confident ☐

Confident ☐

Neutral ☐

Unconfident ☐

Very Unconfident ☐

26. Do you think that the fear of removal from the NMC register has any impact on the ways in which individual midwives practice?

A Negative Impact ☐

No Impact ☐

A positive Impact ☐

Unsure ☐

27. Please give examples of the ways that this might impact on the midwives practice (optional)

Section 3: Clinical Governance

28. Do you think that in the last 5 years there has been any change in the number of claims for clinical negligence in Obstetrics/ Midwifery?

Increased Significantly ☐

Increased slightly ☐

Stayed the same ☐

Decreased slightly ☐

Decreased Significantly ☐

29. Do you think the fear of litigation has any impact on how you practice as a Midwife?

A positive impact ☐

No impact ☐

A negative impact ☐

Unsure ☐

30. Please give examples of the ways that this might impact on the midwives practice (optional)

31. Do you think that fear of litigation has any impact on patient care?

A positive impact ☐

No impact ☐

A negative impact ☐

Unsure ☐

32. Have you ever been involved in a claim for clinical negligence?

Yes ☐

No ☐ Go to Question 34

33. If you answered yes to question 32 what was the impact on your practice?

A positive Impact ☐

No impact ☐

A negative Impact ☐

Unsure ☐

34. Do you think that clinical guidelines have any impact on a midwife's ability to make autonomous decisions?

A positive impact ☐

No impact ☐

A negative impact ☐

Unsure ☐

35. How confident are you that clinical guidelines ensure safe practice?

Very Confident ☐

Confident ☐

Neutral ☐

Unconfident ☐

Very Unconfident ☐

36. How confident are you that the care that pregnant women receive now is safer than in the past?

Very Confident ☐

Confident ☐

Neutral ☐

Unconfident ☐

Very Unconfident ☐

37. Please feel free to comment on your answer to question 36 (optional)

38. How confident are you that risk management strategies reduce the likelihood of poor outcomes?

Very Confident ☐

Confident ☐

Neutral ☐

Unconfident ☐

Very Unconfident ☐

39. Please feel free to comment on your answer to question 38 (optional)

If you would like to participate in the semi-structured interview or receive a copy of the summary of results at the end of the research please contact me using the following email contact details:

jw457@kent.ac.uk

Thank you

J A Wier

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