Walking the Line:  
Challenges of Research in Maternity Hospitals

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Abstract:
In the light of debates on research practices and the politics of location of researchers, this paper reports on the challenge of being a committed maternity services activist doing sociological investigation in the volatile and shifting environment of contemporary Australian maternity hospital workplaces. It argues that such action- and policy-oriented organisational research raises several significant issues – those concerning the management of researcher identity, the situated nature of knowledge and the difficult of articulating multiple voices effectively, and ethical questions associated with negotiating boundaries between ‘research’ and ‘change-oriented interventions’ into professional and organisational politics. The paper draws on qualitative research in maternity hospitals in which the research role included acting as a go-between across professional groups, especially the symbiotic yet deeply antagonistic professional cultures of midwifery and medicine. It explores the heightened emotions associated with these professional conflicts and their implications for managing my own identity and field role.

In recent years, the Australian maternity system, like that in some other Western countries, has been under significant critical review with policies recommending changes in models of care and in professional relationships (Reiger 2006; Lane 2006). Many hospitals have responded by implementing institutional restructuring, especially to increase the role played by midwives in antenatal care and to strengthen their authority vis-a-vis doctors in managing intrapartum care. Organisational cultures are less amenable to change than roles and management structures however. The challenge of developing
new norms of interpersonal and professional behaviour in maternity care is to replace traditional hierarchies with a more modern set of social relationships. In the light of debates on research practices and the politics of location of researchers, this paper reports on the experience of being a committed maternity services activist doing sociological investigation in the volatile and shifting environment of contemporary Australian maternity hospital workplaces. It argues that such action- and policy-oriented organisational research presented several challenges – of articulating multiple voices effectively, of negotiating boundaries between ‘research’ and ‘change-oriented interventions’ and of management of researcher identity.

**Studying changing maternity hospital cultures**

Workplace culture in contemporary hospitals, not only in Australia but in comparable western countries, has been in a state of significant upheaval in recent years. Change has been driven by several factors: the impact of neoliberal health reforms, requiring increased efficiencies, greater accountability and managerial power (Degeling, Maxwell et al. 2003); the consumer health movement’s critique of traditional medical authority, and changes in professional hierarchies as nurses and midwives also contest medical dominance. In several related research projects carried out in Victoria from 2002-5, I have explored how these interconnected factors are being played out in public maternity care units. The primary focus was on collaborative working relationships between midwifery and medical staff, but this quickly raised much wider issues than planned. Interviews with unit managers, senior doctors and one or more midwives from each of five suburban units provided a range of comparative material that encouraged me to investigate the role of state policy in facilitating change (Reiger 2006), and provided a basis for more detailed work in a small rural unit and in a tertiary hospital. At the rural unit, the introduction of a new team midwifery model was explored over a twelve month period, with the four midwives, unit and senior managers and four local general practitioners, interviewed at intervals over that time, along with initial interviews with several other midwives not in the team. Observation at some meetings and in the GP clinic, informal chats with manager and midwives and just ‘hanging around’ in the unit offered a fuller picture than interviews alone. Similarly, in the tertiary hospital, research included observational fieldwork in staff meetings, shift handovers and several antenatal
clinics and postnatal wards extending over almost two years from 2003-5, accompanied by interviewing and focus groups which included approximately 120 participants. This process, along with the fieldwork, produced a very rich and complex data set that was coded and analysed using NVivo (QSR 2003). Progress and lengthy final reports were given back to the organisations, and dialogue about implementation of recommendations has continued.

In undertaking these interlinked research projects, the research focus widened in order to understand contemporary hospitals as organisations and as workplaces. Widespread conflicts over authority, power and status in hospitals have been reported in Australia by Game and Pringle (1983) and by Wicks (1999). Tensions have been further exacerbated by economic rationalism leading to strains resented by workers on ‘the front line’ as Walby et al (1994) and Annandale (1996) have argued in the UK context. Organisational change and development in hospitals is acknowledged to be difficult, involving not just administrative structures but underlying cultures. In maternity hospitals in particular, longstanding professional rivalries between obstetricians and midwives further complicate the picture (Reiger 2005). As Pringle (1999) has pointed out, the power of obstetrics has been closely linked to its masculinity, although the gender, and also ethnic, composition of the profession is rapidly changing. Traditional gendered hierarchical relationships have, however, produced a demoralised and resentful midwifery culture which Mavis Kirkham (1999) has reported in Britain, and which has echoes in Australia (Brodie 2002). Attempts in recent years to change public hospitals away from obstetric-managed services and to expand midwifery roles to provide women with greater continuity of care have thus had to confront a widespread, though not uniform, culture of resistance and resentment, sometimes running aground on it. None of the resulting problems, nor ongoing medical dominance, are unique to any particular hospital, but they are played out within organisations with a specific history, culture and interpersonal dynamics.

**From maternity activist to researcher**

It was into a somewhat fraught health sector therefore that I moved after many years of examining the historical development of Australian maternity care and the
professionalisation of midwifery (Reiger 2001a, 2001b). As a founding member of the advocacy organisation, the Maternity Coalition, I had also spent more than a decade working in the community with consumers and with midwifery colleagues, most of whom were independent practitioners working in homebirth settings. To then investigate professional cultures in public hospitals involved a complex process of ‘walking the line’—on the one hand between maintaining an activist’s commitment to change in the maternity care system, which itself gave me legitimacy with many midwives and indeed managers, and on the other, seeking to be accepted as an authoritative social science researcher, especially in an organisational environment more familiar with positivist research, especially clinical trials.

As the interrelated projects, like much policy-oriented research, were developed somewhat hastily in consultation with managers seeking urgent change strategies, there was little opportunity to consider the research fully in the light of theoretical debates on reflexive research practices and organisational ethnography and the ethics and politics of research (e.g. Marcus 1998; Coffey 1999; Mason 2002). Aiming to undertake good qualitative research on the basis of a feminist framework and a ‘postmodern sensibility’ (Denzin and Lincoln 1998), required negotiation of the ‘slippery pole’ between seeking some ‘truths’ (but not Truth) about observable reality and recognising a multiplicity of positions, power and voices (Ramazanoglu 2002). Having spent over a decade working on campaigns to de-medicalise childbirth, though not myself within the more radical homebirth movement, and taking a position largely critical of the medical profession, I now felt at times that I was over on the ‘dark side’, in the midst of obstetrically-dominated terrain. Furthermore, I was stuck in the middle of a highly conflicted field, struggling to hear both sides’ points of view.

The following discussion reflects on the challenges faced, particularly in terms of my own personal identity work, negotiating what Coffey terms the ‘ethnographic self’ (Coffey 1999). As Coffey argues, the researcher’s self is central to the research process as we are embodied and emotional participants in fieldwork settings, and the quality of the social relationships we establish depends on our crafting of interpersonal relationships (Coffey 1999: 54-7). In these hospital contexts, riddled as they were with tensions arising out of economic and political factors and professional rivalries, my multiple identities as
social scientist/activist/mother facilitated my research role as potential mediator of professional conflicts. Furthermore as many anthropologists report, the fieldwork experience changed me, including aspects of my thinking about birth – a development which I have found challenging as a woman and an activist.

**Researcher as mediator**

In view of the initial research focus on professional relationships between midwives and doctors, I was not surprised to find participants complaining about the other profession. In one suburban unit visited early in the research program, the tension between the senior obstetrician and the midwifery manager was palpable. Having spoken to the doctor first, I was aware of his position of power as he clearly expected me to accept his interpretation of the issues, including the need to ‘bring the midwives into line’. He knew nothing of my background. By contrast, the midwifery manager had already met me in community settings, and, after closing the door and not feeling confident to tape the interview, poured out her grief about the strain of increasing medical dominance that midwives were under as a result of a merger with another hospital. As the fieldwork and interviews in other settings progressed, the impression grew stronger that my role as researcher was akin to that of a counsellor charged with listening to the parties in a committed but quite dysfunctional marriage—both midwives and doctors wanted to make their professional relationship work but by and large they could not hear each other’s point of view and had little opportunity or skills to do so. Considerable personal angst emerged in many interviews showing that staff tensions lingered long after specific incidents or overt conflict. Just as even a good marriage can become a battleground, the overall sense became that of a professional ‘guerrilla war’ of varying levels of intensity across maternity services more widely.

**Hearing midwives’ concerns**

At both rural and metropolitan tertiary sites, midwives sought to use my research role to advance their arguments in ways to which doctors might listen. They reported frustration and resentment that some doctors did not treat them with due professional and personal respect and wanted their skills better recognised, their role in advocating for women accepted and the philosophical differences in approaches to birth discussed on the basis
of both evidence and experience. The ways in which their experience was situated within the gendered everyday ‘relations of ruling’, to use Dorothy Smith’s term (Smith 1992, 2005), of medically managed units became clear as they discussed the constraints on their professional judgement and practice, and the emotional pain resulting from interprofessional tensions. My role as researcher regularly came to involve validating their feelings.

Although working relationships between midwives and doctors vary across units, they are most strained in those in which midwives make greater claims to professional autonomy. My relationships with midwives in a rural team or a city birth centre were built on our shared frame of reference that ‘birth is not an illness’, whereas midwives in a ‘high risk’ city unit were generally more suspicious of me. Their greater anxiety about birth was more readily understood though when I sat in on handovers in their workplace. As an embodied participant, I too was caught up in the dynamics of the unit as I heard not only staff accounts of very sick women and babies, but encountered the sights and loud sounds of labouring women. My ‘ethnographic self’ thus had to be flexible to manage the diverse situations and relationships, including those with doctors.

**Doctors’ tales**

As a social scientist, I was to some extent accepted by medical staff in the tertiary unit and by the rural GPs, but only a few knew of my background. One senior doctor became alarmed when I mentioned the ‘maternity reform’ movement, saying, ‘see that makes us the enemy!’ So while some doctors, primarily men, were complacent about medical authority, others were defensive and required reassurance that I did not prejudge them. As some doctors became more confident in talking to me, once I had been around enough, they used the opportunity to complain about their medical colleagues as well as some midwives. They wanted to make their views known to them but could not find ways to do so, then seeing the research as an important opportunity for this. Even senior medical staff said they rarely shared their ideas and experiences with anyone else in spite of the concerns that they felt, such as about lack of effective medical leadership. Attendance at professional development meetings provided invaluable insight into obstetric culture, including its professional narrative and internal power plays, but
required negotiation of identity as I struggled to decide if and when I could ask a question or make a comment. Not only interviews but observation and informal discussion brought out the seriousness with which medical staff took their highly individual sense of medical responsibility, and considerable grief when a mother or baby died. They saw their profession’s historical role in terms of ‘saving’ women from childbirth danger and were hence puzzled by midwives’ and birth activists’ stress on lessening medical intervention.

Complex ethical issues arose as I built close bonds with several participants, leaving me wondering about the judgements I was making in pushing some of them to justify their views, or commenting when asked about staffing appointments. Ethnographic methodologist, John Van Maanen has commented about the amount of ‘symbolic violence’ that frequently occurs in research settings as people are ‘coaxed, persuaded, pushed, pressured, and sometimes almost blackmailed into providing information’ (Van Maanen 2002). Could I really justify some of my interventions on the grounds of the larger objective of changing maternity care? Yet I too was also changed during the research process.

The changed self

In negotiating the ethics of listening and articulating multiple voices, my identity became integral to the research process. That I was both a maternity activist and a mother (who also became a grandmother during the research) was valuable in establishing bonds and trust, especially with midwives. Even doctors though seemed to find it reassuring that I was doing the research in the interests of women and babies rather than advancing a professional agenda. As many accounts of ethnographic or long term observation in an organisational context make clear, the researcher both becomes part of the dynamics of the setting and changes in the process (e.g. Coffey 1999). Entering the ‘field’, as anthropologists put it, thus occasioned a significant shift from ‘hating hospitals’ to feeling comfortable and at home in at least a couple of them as workplaces. I increasingly came to identify with the hospitalised maternity environment, even whilst maintaining the line that such a place was, by and large, not the best place to have a baby—at least unless you needed high level care. My own subjectivity was affected by learning more about birth complications and by sharing the grief felt after a baby’s death or other poor outcome,
processes that heightened my own anxiety as my granddaughters were being born! Does my increased understanding of the personal and professional dilemmas faced by professional staff impact on my activist role therefore? I certainly try now to mediate across the sector, even if it entails risking homebirth advocates’ reservations about my deserting the cause.

Conclusions

The research process reported here involved locating myself in the field not as a disinterested observer but as one committed to changing maternity care. As Dorothy Smith (2005) argues, institutional ethnography concerns exploring social relations and processes which in this case meant the intense interpersonal and organisational emotional dynamics embedded in the underlying culture of maternity care settings. As a researcher, it was rewarding to hear from midwives particularly that they had felt ‘heard’ in the research process and to be taken into their confidence by several doctors who shared many aspects of their frustration with colleagues and their organisation. The challenge became not only how to maintain enough critical distance and sustain my complex identity or ‘ethnographic self’ but also how to ‘leave the field’ as anthropologists say. The difficulty of researchers extricating themselves from the emotionally rich and complex relationships forged in fieldwork has had some attention in the methodology literature (e.g. Snow 2001) but in this case was complicated by my ongoing involvement in the childbirth movement. While I remain an outsider to the organisational and professional cultures, my background identity and Maternity Coalition involvement provided an ‘insider’ status as well. Doing critical social research into the politics of maternity care, as played out in specific hospital sites, clearly required a form of praxis based on 'thinking globally' but 'acting locally'. My knowledge of international midwifery developments, obstetric contacts and ability to provide information about initiatives elsewhere became a politicized research strategy. Furthermore, while the massive amount of knowledge acquired, including personal stories and details of organizational and industrial conflicts, can now be used only indirectly to inform my resumption of a more explicit activist role, a two-way process emerges as central. Just as careful negotiation of my change-oriented ‘ethnographic self’ was critical to the success of the research process, a changed researcher can contribute
to the wider social movement.

Footnotes

1 Fuller details of the research are available from the author than can be reported here. The ‘Constructing collaboration: professional identities and cultures in maternity care’ research has been funded by a La Trobe University Faculty grant and collaborative grants between La Trobe University and two hospitals. My thanks go to the many midwives in particular, but also doctors and others, who have shared their experiences with me, and to my research assistants, Elisabeth Speller, Bonnie Simons and Annie Dennis.

References


