CHAPTER 5

Time and Midwifery Practice

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> To practice the science of medicine and analyse and treat the disease the physician distances himself or herself in time from the patient and treats the patient as allochronic, in another time.... To practise the art of healing the physician meets the sufferer in his or her own time, as a coeval.
>
> —Frankenberg (1992: 10–11)

Introduction

The idea that the practice of midwifery is both an art and a science has long been promoted, as demonstrated by the title of a textbook written for advanced midwifery practitioners (Silverton 1993). However, in the above quote, Frankenberg has suggested that the practice of science and the art of healing involve radically different approaches defined by different notions of time, approaches so different as to be distinct and separate.

In the arena of childbirth the distinction that Frankenberg drew between medicine and healing might readily reflect the ideological difference between obstetrics and midwifery; the one focuses on real or potential problems, whilst the other supports a physiological process. Therein lies one of the major tensions in current midwifery practice. The remit of midwifery is the promotion of normal childbirth, with practitioners being upheld as its 'experts' or 'guardians', and the concept of salutogenesis being adopted as a theoretical frame for the development of midwifery knowledge (Downe and McCourt 2008). Nevertheless, the push towards the hospitalization of birth for reasons of safety (DHSS 1970), and more recently the imperative to embrace the hegemony of evidence-based

medicine (Enkin 2006; NMC 2008) has served to strengthen the 'science of midwifery', to the detriment of its art.[1]

Such issues emerged as a major theme in a doctoral ethnographic study of caseload midwifery, a radically different form of midwifery practice implemented within a National Health Service (NHS) maternity service in England. In this chapter I focus on how issues to do with time were seen to influence the nature of midwifery practice and how dramatically this impacted on care provision. Caseload midwifery effectively denied Frankenberg's thesis by embracing both the art and science of midwifery practice but the tensions that were generated, both within the organization and at a personal level, were seen to have their roots within conflicting notions of time.

Background

Recognition of public dissatisfaction with NHS maternity services and the centralization of birth led to a major review concerning the maternity services in England and Wales (HoC 1992). Women had felt as if they were subjected to a conveyer-belt system, whilst midwives found that, despite their ethos of autonomy, the reality of their work was domination by the medical model of care. The recommendations of The Expert Maternity Group (DoH 1993), accepted as government policy in 1994, promoted the normality of birth and sought mechanisms for supporting this model, including the recognition of midwives as the appropriate main care providers.

Caseload midwifery practice was developed as a form of care delivery that implemented these recommendations. Although similar to the way independent midwives worked, this was a radically new organization of midwifery practice within the NHS, and the ramifications of implementing it within an existing maternity service were unknown.[2] In this model, each midwife, instead of being allocated to an area of the service, such as a hospital ward, cared for an annual caseload of forty women; this included care and education throughout the antenatal period, assistance with the birth, and subsequent care of mother and baby up until twenty-eight days postnatally (Stevens 2003). Rather than being based within a central hospital, the midwives worked with the women, where and whenever required. This necessitated them being available twenty-four hours a day and working in a range of different environments, including women's homes, general practitioners' surgeries and the maternity hospital. The use of mobile phones, and the avoidance of being tied to work at specific times, such as is the case with a clinic, facilitated such flexibility and enabled the midwives to 'make the job work for them'. Being organized into partnerships within groups of six to eight full-time equivalent midwives enabled the midwives to support each other and provide cover for 'timeout', holidays and sickness.

In this model, midwives were being given greater personal responsibility than they had previously experienced within the NHS, although no more than they were trained for and which the ethos of midwifery supported. Concerns were raised that midwives would be both unable and unwilling to work this way. The partnership and group structure were mechanisms by which support, cover and peer review of practice were facilitated but would this be enough to enable the midwives to function effectively, to work safely and efficiently and not become overtired, stressed or burnt out? A robust evaluation was built into this service development, one arm of which sought to explore and identify the implications this held for the professionals (Stevens 2003).

Ethnography as Evaluation

Ethnography has not been an approach commonly adopted for evaluative studies: it has been seen to take too long and the findings are frequently framed as thick descriptions that enrich an understanding of a situation but preclude any quick answers. However, whilst other parts of the evaluation sought answers through more traditional quantitative and qualitative methods, it was recognized that exploring the implications for professionals was unknown territory. Any form of positivist enquiry would invariably frame the responses and limit the opportunity to understand the situation from the perspective of those being studied. An ethnographic approach was thus adopted as being most suited to the needs of this situation. Good ethnography, in terms of its validity, can only be achieved when the participants feel confident enough to behave in their usual manner and respond openly and honestly to the probing queries of the researcher. Thus it is advantageous if the researcher can minimize their impact on both the study setting and the participants, and is perceived as presenting no threat to the participants; such criteria are met when the researcher has experience of working within the field but is unknown to the study site, as in practitioner-researcher situations such as this study.

However, practitioner–research has been viewed with scepticism, thought of as entailing an inherent subjectivity because the researcher is unable to theoretically disentangle themselves from their work (Field 1991). Also, maintaining research awareness within a familiar setting and not inadvertently imposing their own 'world-view' are inherent difficulties which demand constant reflexivity from an ethnographer. This is comparable to the debate within anthropology about 'research at home' (Lipson 1991). Hammersley (1992) pointed out that the self-knowledge demanded of all ethnographers is not immediately given, and that people can deceive themselves and may even have an interest in self-deception. In being appointed to undertake this ethnography, my experience as a practising midwife meant that, to the maternity services, I was an 'insider', familiar with the setting, jargon and expected

behaviour. However, long-term overseas experience, working with and for people who held very different views to myself, had forced me to confront my own views, assumptions and training. These experiences proved central in achieving the 'anthropologically strange' stance advised by Hammersley and Atkinson (1995: 9). Serendipitous circumstances allowed fieldwork to continue over a period of almost four years, which facilitated an understanding of both the initial implementation phase and its subsequent development into a more settled service. During this time, throughout the week I lived on-site in the 'nurses' home', so was able to participate in the life of the hospital twenty-four hours a day. I also worked for two days per week as a clinical midwife on the Delivery Unit, which sensitized me to the culture of the maternity service and many of the issues experienced by hospital midwives.

Data collection and analysis were undertaken in an iterative process: in response to the issues which emerged a range of data collection methods were used, including individual and focus group interviews with each of the key groups involved, where I sought to understand their unique perspectives, observation of practice, survey questionnaires and some documentary analysis. The findings from each group were considered in relation to each other and to the wider service delivery. It was at this stage of the analysis that the issue of time emerged as a dominant theme and the ways in which it controlled both the quality of care and midwifery practice became apparent.

Frankenberg's (1992) quote aptly highlights a fundamental difference between institutional birth and that facilitated by caseload midwifery practice. This chapter explores the different approaches to time that were observed within the hospital and caseload practice, and develops an understanding of how issues concerning 'time' were used as mechanisms for controlling childbirth. Such perspectives, although found to be fundamental to the nature of midwifery practice, are deeply embedded in the social life of the service and are unlikely to be tapped by positivist inquiry. This highlights the value of the ethnographic approach, enabling identification and exploration of this theme.

Concepts and Uses of Time

Time is often thought to be a universal concept, one of the few immutable truths that help provide stability in an increasingly complex world. Nevertheless, many writers have shown this assumption to be fundamentally incorrect (Thompson 1967; Whitrow 1989; Priestley 1964; Hall 1959). Diverse notions about time have been identified, and the ways it is constructed, used and interpreted may hold widely differing connotations, both between and within societies (Griffiths 1999). The ways in which time is conceptualized and used can communicate powerful messages. In English, time has been externalized, made tangible, a commodity that can be 'bought' and 'sold', 'saved', 'measured', 'wasted',

or 'lost'. It is compartmentalized, allocated for work, leisure and sleep, and it is used sequentially; it is valued objectively and personally, carefully guarded, and individuals becoming angry if 'their' time is unnecessarily wasted (Hall 1959, 1976), ideas that, it will be seen, are interwoven within hospital work. An understanding of how time was conceived within the hospital and within caseload practice reveals underlying notions that influence the nature of the services provided. However, as both were situated within the *durée* (Giddens 1987) of daily life, this must first be addressed.

The way time is conceived of and used in modern society has been strongly shaped by the influences of religion and technology. Judaeo-Christian beliefs stress the notion of irreversible time; 'switched on' at creation and to be 'turned off' in the future. Meanwhile, the Protestant work ethic (Weber 1976), placed a high value on the industrious use of time for spiritual rather than material rewards. Such notions, reinforced by puritan preachers and social reformers, were subsequently internalized during the Victorian era (Thompson 1967), promoted with the 'professionalization' of midwifery (Heagerty 1997), and remain in the ideas of some that nursing and midwifery are vocational work. As discussed in Chapter 1 (this volume), the industrial revolution had a profound effect, with time's 'inexorable passage' being stressed by mechanization that altered the rhythm of people's lives, negating seasonal or cosmological distinctions of time and reducing the element of personal control over work. The need for the synchronization of labour meant increasing attention was given to time, with people being paid by the hour not the task. Work itself became a distinct period of time, and time became a currency not to be 'passed' but 'spent' (Thompson 1967). Today, universal education inculcates a time discipline on all. 'Economic' time tends to dominate life, patterning its stages through infancy, learning, earning, retirement, each year (work and holidays) and each day, clearly dividing it into work and personal time – mentally if not physically. Diaries are no longer used to record events but to remind and structure them. The upsurge in the use of the Filofax and personal organizers, and development of various training courses, suggests that 'time management' has become an economy in itself. However, such concepts and their consequences are not universal and less industrial societies have been shown to hold very different notions of time. For all practical purposes 'task-orientated' time is the major framework (Giddens 1987; Priestley 1964); work is adjusted to the task not the time spent, and there is minimal demarcation between labour and social activities.

Although occurring in societies dominated by culturally specific notions about time, childbirth carries its own (universal) time – a physiological time. The mother commonly 'slows up' towards the end of pregnancy and may experience changes in sleep patterns. To a greater or lesser extent the expectant mother is being eased into having to use her time in a different way to meet the demands of a newborn that has yet to be socialized into a 'daily routine'. Labour commences with no reference

to what may be socially convenient, and the woman is delivered into motherhood at a pace over which she has minimal conscious control. For millennia, 'traditional' birth attendants have supported and accompanied women during this transition, rarely attempting to control or subvert the timing of events that were physiologically inherent. This situation has changed radically in many societies (Davis-Floyd and Sargent 1997). In an age where time has become inherently scheduled and commodified, it is not surprising to find such control being extended to the arena in which childbirth is now placed.

Ideas about time are not homogenous to a society as individuals may favour particular notions. Also, in complex post-industrial society, people move between models during their daily life, being forced to acknowledge different attitudes and concepts relating to time simultaneously. For example: the demands for strict time control placed on factory workers contrasts with the generally more relaxed demands of family life; a similar difference was noted in my study within the hospital, between delivery unit and maternity ward. However, the dominant ideas become embedded within the culture of each society, both reflecting and influencing the ways in which people think and behave. This may have serious ramifications as concepts about time are relative to societies, dictating how individuals conceive their world and relate to each other. Problems occur when different sets of ideas about time clash – as when individuals move between countries or, as it is argued here, models of midwifery practice – forming the basis for 'cross-cultural' misunderstandings.

The ways in which ideas about time and its use can be internalized and affect behaviour have been most clearly developed by Hall (1959, 1969, 1976) and are helpful in understanding the different nature of caseload and hospital midwifery practice. Drawing from a number of disciplines, theoretical stances and empirical studies, Hall considered the notion of time and the ways this may influence a society. Using a comparative framework, he developed a thesis suggesting that time is not only a 'silent language … speaking more plainly than words' (1959: 23), as well as something which structures behaviour and judgements made about that behaviour (1969), but it also influences cognition and the manner in which societies relate to their physical world (1976). His ideas offer invaluable insights into ways of considering social situations. For example, the 'task-orientated time' of pre-industrial societies is closely related to Hall's notion of polychronic time. This is characterized by several things happening at once and Hall stresses the involvement of people rather than adherence to pre-set schedules (1976). These characteristics may be seen to apply to caseload midwifery.

Modern post-industrial ideas of time are summed up in his notion of monochronic time, and Hall (1976) stressed how use of this directly affects attitudes and behaviour. Undertaking activities separately and sequentially implies implicit and explicit scheduling. This involves according priority to people and functions, and so forms a classificatory system ordering life which is so integrated that it appears logical and natural, although it is not

inherent in natural rhythms. Prioritization implies a valuation, and thus the use of time acquires an implicitly recognized code: for example, a call at 2 A.M. has more serious connotations than one at 2 P.M. The segregation of activities enables total concentration but 'decontextualizes' them and people may become disorientated if they undertake several activities at once. Relationships are intensified but then temporally limited, as in business meetings or hospital appointments, which are private but of fixed duration. Failure to observe time limits implies an intrusion on another's schedule, and may be considered ill mannered or egocentric. Such ideas resonate strongly with the hospital maternity service and help explain negative reactions observed in my study towards caseload practitioners who worked within a polychronic timeframe.

In appreciating the changes faced by the caseload practitioners, an understanding of the way time was conceived and used within the hospital is important. Having come from this system the midwives would have internalized it to some extent. However, they were forced to rethink and develop different ways of using time in caseload practice.

Hospital Time: An Uneasy Alliance

Implications concerning the way time and space are used and controlled within institutions like hospitals have been highlighted by studies such as Frankenberg (1992), Foucault (1973), Goffman (1968) and, in particular, Zerubavel (1979). A predominant feature of such work is an appreciation of the relationship between the control of time and status and power within the institution. For Frankenberg (1992), time itself and the way it was used and controlled formed a definitive element in the practice of healthcare and healing. Even though the majority of clients in maternity care are healthy women who could give birth successfully without medical intervention, it is managed institutionally within such a system. This relationship may hold particular implications for a maternity service that has been directed to provide mothers with increased choice and control in the care they receive (DOH 1994). How then was time used by the maternity service in this study and in what ways did the new model of care influence the caseload practitioners' ability to practise the art and science of midwifery?

The hospital maternity service necessitates the merger of three, potentially competing, time frames: physiological time, institutional time and the personal time of 'normal' daily life:

- Serving the needs of childbearing women, the *raison d'être* of the service is guided by the physiological time of gestation, labour and the demands of the neonate. The service has to be constantly available, twenty-four hours a day, 365 days a year.
- Serving the needs of many rather than the individual forces a rationalization and consequently the development of 'institutional time', which is described in this chapter.

- The service is provided by, and for, individuals who live in a world external to the hospital, and whose personal time is governed by the complexities of 'normal daily life' and the notions of time described previously. Work in, or visiting, the hospital is but one component in their lives.

In this study it became apparent that within the hospital these time frames formed an uneasy alliance, resulting in a particular patterning to the day and to the organization of work within it. Whilst tensions between physiological and institutional time were most apparent on the delivery unit, the potential for conflict between institutional and personal time occurred throughout the hospital, in all departments and wards. Although core staff working rotational duties or 'shift work' provided the twenty-four hour baseline service, institutional time gave the appearance of the patterning of activities of 'normal daily life'. Most categories of staff worked a modified 'office hours' regime; afternoon and evening visiting gave a social element to the day; and night time was a period of quiet, reduction in noise and lighting being used to encourage 'patients' to rest. Nevertheless, it could be extremely busy at night, and a reversal of the natural day/night, work/sleep dichotomy was imposed by bright lights being kept on. This subversion of 'normal-daily-life' time by institutional time was not remarked on by staff and generally accepted by 'patients'. Time was less tightly controlled over weekends and bank holidays when routine work was avoided and a more relaxed atmosphere prevailed.

The division of time and labour in the shift pattern of work was aimed at ensuring an appropriate number of appropriately skilled staff was available when most required, although this does not succeed in practice since labour and birth cannot be scheduled in the manner of work shifts (Audit Commission 1997). Additionally, a clearly hierarchical pattern was discernable. The association of flexibility and control over one's time being inversely related to status and power within a hospital has been highlighted by Zerubavel (1979), and was similarly noticeable here. Night periods were covered by more junior staff, supported by senior or specialist staff working an on-call system; the most senior staff, consultants and managers, were rarely seen at night unless called specifically for an emergency situation – their presence indicated that something was seriously amiss.

Although notionally serving the needs of twenty-four hour physiological time, hospital time imposed a strict schedule. The day was divided and defined by the clock in the organization of duty rotas, clinic schedules and appointments, ward rounds, operation lists and in-patient meal times. These determined where people should be at specific times of each day and helped ensure all necessary tasks were undertaken. In this way, time served to regulate and create order out of complex and, given the numbers of people involved, potentially chaotic situations. Adherence to these 'demands' generated the impression of efficiency and organization,

even though it was not possible in practice to match staff levels in a shift system with the less predictable patterns of labour and birth.

The midwives themselves noted how different perceptions of time dominated different departments within the hospital. The Outpatient Clinic comprised two three-hour, sharp bursts of intense activity each day. These fitted relatively easily into the 'normal-daily-life' time of staff and attendees, acknowledgement of which was emphasized by the importance placed on punctuality, highlighted by waiting-time audits, even though in practice women waited long periods for very time-limited visits. The in-patient wards attempted to establish a 'normal-daily-life', 'physiological time' twenty-four hour rhythm to the day, although this was moderated by ward routines, set meal times, rest times and the regulated social contact of restricted visiting times. It was also sharply divided by the fast turnover of admissions and discharges, and the accompanying administration created intense work pressure for staff even though this was of a relatively non-urgent nature.

Perceptions of time, and the way it was used, proved very different on the Delivery Unit, where all births took place; it was here that the potential for conflict was most apparent. Providing a constant level of cover, the difference between night and day was appreciable only by a reduction in the number of staff seen on the unit. The use of bright lighting, particularly when busy, defied diurnal variations. However, physiological time cannot be overruled with the same ease, and inter-professional conflicts of understanding and approach around this emerged as the 'active management' of obstetrics versus the 'waiting' of midwifery (see also chapters 3 and 4, this volume).

To some extent the timing of work was initiated and ordered by physiological time – such as the spontaneous onset of labour – although institutional time was superimposed with work created by elective caesarean sections and inductions of labour. However, it was rare for physiological time to be allowed to proceed without some element of control. Even physiological labours progressing 'efficiently' and 'normally' were monitored by the clock; constant assessment of contractions in terms of frequency and duration, routine monitoring of the fetal heart, and regular assessments of progress helped tie the labour to chronological time. This was reinforced by a formal, supposedly research-based time frame imposed on the process of labour through the use of the partogram (Rosser 1994; see also Chapter 3, this volume). Further control of physiological time was both symbolized and actuated by 'the board' in the Delivery Unit office

In common with other maternity hospitals in England (Hunt and Symonds 1995), 'the board' contained the basic information relating to each woman admitted to the Delivery Unit; as such it provided a visual representation of the current clinical workload of the unit. It was the responsibility of the midwife caring for a woman to update the board as appropriate. This enabled the obstetricians and the sister in charge of the unit to be kept fully informed of an individual's condition, particularly the

progress of her labour, without disturbing the mother or midwife caring for her. A report of a 'delay in progress' on the board would be watched carefully by the obstetricians who then proactively involved themselves in care management, before the midwife called for assistance.

Thus, the board, or more specifically the interpretation of the information presented on it, was seen to have a direct impact on behaviour and the subsequent workload of the unit. In many ways it provided a lynchpin for the working of the unit and a medicalized, 'management' approach to labour. This was symbolized in the information that was considered to be relevant to the board, and actuated through the 'progress reminders' it constantly presented. As such, the board became the focus for some tension between caseload midwives and the obstetricians and the sister, particularly when the midwives failed to maintain the information on the board, or to behave, as expected.

> The doctor came in and was looking down to see who was fully[3], who was pushing and who wasn't pushing and why not – and noticed that someone had been fully for a good length of time and why hadn't they delivered? (hospital midwife interview)

The controlling influence of the board was clearly recognized and frequently subverted by some of the hospital midwives, although the subversion tended to remain hidden and so did not challenge the established ordering of events. The unique physiological timing of a woman's labour may differ from the guidelines established by the authoritative knowledge (Jordan 1993) defining 'safe' limitations to the stages of labour. Noting events, such as the start of the second stage, on the board, 'sets the clock ticking' (a term used by midwives and mothers alike) and a mother not delivered within the allocated time would soon receive medical assessment. However, some midwives prevented such interventions by delaying tactics that avoided 'starting the clock' by, for example, not confirming the start of second stage when suspected and if maternal and fetal well-being were assured.

Many of the midwives complained about obstetricians watching the progress of labour too assiduously, being too interventionist and expecting women to be examined vaginally at two-hour intervals so as to monitor progress. Such regularity was not indicated in the procedures manual nor, in personal experience, imposed by the obstetricians. However, during personal clinical practice, an experienced sister advised me to undertake such regular examination 'as the doctors expected it', a situation also experienced by others:

> Here, if the doctor doesn't come and knock, in two hours the sisters will – they are pushing the doctor to ask how things are progressing. To get a breather I give in. OK, come and knock. (focus group, hospital midwives)

In the hegemonic medical model, labour is not a safe time for mother or baby, and judicious intervention is indicated when there is a delay in the process. Although disputes over what constituted 'delay' were recognized,

medical guidelines concerning appropriate time frames were followed. Perceived delays in progress were quickly noted and intervention was recommended, a system not just dependent on obstetricians' actions but internalized and practised by senior midwives.

The possibility of complications encouraged an immediate time orientation and it was recognized that the pace of work on the unit would, at times, quickly change. As one midwife commented 'they work in hours down there' referring to the wards 'whilst we work in minutes up here!' The peaks and troughs of work that are inherent in childbirth and the maternity service generate a clash between the rhythms of nature and those of the institution. At times staff had to remain on duty when there was little work to do; at other times the pressure of work was so relentless and staff so limited they quickly became exhausted and worried about safety levels being compromised. A seemingly constant fear of litigation served to increase the stress of these periods.

Implications for Midwives and Midwifery

In providing a twenty-four hour service to a large number of women, the institution developed a momentum of its own. This seemed to have an inherent logic to it, which was then internalized and reinforced by the staff. In accepting employment, hospital midwives gave complete control over the timing of their work to their employers, who set the shifts and rotas on a three-week cycle and thus exercised a high degree of control over their personal lives. Midwives could submit requests for particular duties to their employees but these were not necessarily granted; a few subverted this control by occasionally reporting sick when a requested day off had been refused. Acknowledging the Sapir-Whorf hypothesis (Sapir 1985; Whorf 1971), the accepted use of the term 'days off', rather than 'days on', linguistically reflected the domination institutional time had over the midwives' personal time. Personal life was arranged around the needs of the hospital, often to the detriment of the individual – particularly those with young children – as witnessed in tensions generated over cover scheduled for school holidays, Christmas and New Year. The majority of midwives grumbled about personal difficulties incurred but appeared to accept this as 'part of the job'. Institutional time was accepted as the 'norm' for midwifery work.

Not only did the hospital midwives have very little influence over when they actually worked, whilst at work they had minimal control over the place and content of their working time. Meal breaks were taken when allocated rather than chosen to suit the workload situation; not infrequently in the Delivery Unit, the relentless demands of crisis situations precluded meal, coffee and even toilet breaks. Although Hall (1959, 1976) described notions of 'modern' time as being scheduled and prioritized, within the hospital the midwives were frequently required to undertake many tasks at once, juggling the competing demands of a busy unit, incessant telephone calls, crying babies, concerned relatives and clinical emergencies. Not in ultimate control of such situations, the

midwives were forced to be reactive rather than proactive and exhibited the disorientation identified by Hall (1969).

The tightly defined boundaries of the midwives' time generated a short-term focus that forced them into an immediate-task orientation, akin to a Fordist division of labour (Godelier 1988) where activities are broken down to their component parts and undertaken separately. The rotational nature of midwives' duties limited the possibility of them caring for the same woman on their next shift; thus, it became almost irrelevant for the midwives to develop an understanding of the mother's situation – the wider context of the care they provided. The philosophy of continuity of care (similar care provided by all staff) was acknowledged as being ideal, but so was the reality of conflicting advice given by different professionals.

Given the relatively short duty span in the context of longer care requirements, midwives were unlikely to complete care provision; they had to leave when it was time to go off duty rather than stay and complete the activity, such as assisting with a birth. Thus time divisions, rather than completion of a task, becomes the guiding focus of work. This did not sit comfortably with the midwives and many would 'stay behind', or miss meal breaks, even when a relief was available, if this was at an inappropriate time for the mother. However, such practices were not encouraged. For example, one midwife reported how a sister 'refused to allow' her to stay on duty for the delivery of a mother she had been looking after all evening because she was expected back on duty the next morning.

Hospital midwives were contracted to work 37–and-a-half hours per week with a specific holiday entitlement. Payment for extra hours worked was not available, except in exceptional circumstances, and midwives were expected to 'take back' time when the unit was quiet by going off duty early. However, the reality of understaffing and increased workloads meant that they were rarely able to do this. Several senior midwives were 'owed' many hours, which they recognized they would never be compensated for. True commoditization of their time had failed, ironically resulting in the institution 'stealing' an employee's time because they had focused on completing the activity for which they were employed rather than the time 'allowed'. The use of time within the maternity hospital took on symbolic valuation and, most importantly, developed a momentum that appeared unalterable. Scheduled time became predominant, internalized and accepted as the normal, sensible way of 'doing things'. This held important implications for the way midwifery care was delivered and for the midwives as individuals. Such notions were challenged by caseload midwifery practice.

Time and Caseload Midwifery

Caseload midwifery practice (CMP) required a radically different orientation towards time. The new style of practice challenged the notions previously

developed within the hospital service, forcing midwives to redefine their concepts about time and its use. In 'giving back' control over time to midwives, the maternity service implicitly acknowledged the control it exercised over those remaining in the conventional service, a feature that was apparently not overtly recognized. The different orientation towards the use of the caseload midwives' time was structurally defined within their contract. They were employed to undertake broadly specified activities (or responsibilities) rather than provide a set number of midwifery-care hours. Operationalization of this requirement was at the discretion of the individual midwife, and fixed additional payment, irrespective of actual 'unsocial' hours worked, facilitated their flexibility. This strategy effectively de-commodified the midwives' time. It also removed the pressure to complete an activity within a specific time, such as before going off duty.

Hospital Midwives	**Caseload Midwives**
Contracted for 37½ hours work per week	Contracted for care of 40 women per year
Commodified time – extra payment for 'unsociable hours'	Set extra allowance irrespective of time of day worked
Extra hours worked not paid	Not applicable
Clear divide between work and personal life	Work 'embedded' in personal life
Request particular days off	Negotiate free time with partner and group, or by managing own workload
Minimal flexibility to change duty	High level of flexibility
Work according to fixed duty rota	Work when needed by women
Work period intensely busy or quiet. Unable to take advantage of quiet periods. No balance reported.	'Long hauls' and quiet periods when minimal work. Can use to personal advantage. Reported to balance over time.
Work 'time' directed and controlled by hierarchy	Self-directed except where 'controlled' by labour and emergencies
Rota orientation – leave work when 'due off' – obstacles to staying	Activity orientation – finish work when activity completed
Current work has present orientation (task in hand)	Current work has future orientation (investment in future care provision)
Midwives' 'time' has a future orientation – immediate future work time known	Midwives' 'time' has present orientation – immediate future work time uncertain
Time is routinized, controlled, scheduled, de-personalized	**Time is purposeful, flexible, uncertain, personalized**

Figure 5.1: A comparison of orientations towards, and use of, time for midwives.

By altering the focus of work from time to activity, midwives worked when and as they determined or were required. Thus, although strict time scheduling of work is often associated with 'efficiency', they were able to use their time more effectively, no longer having to 'waste' it by going 'on duty' when it was quiet and no work was actually required, by having to duplicate work or to handover in mid activity owing to shift changes. Without close managerial direction, the midwives now 'owned' their time and were able to deploy it as they considered appropriate, spending as long or as short a time as they considered appropriate to achieve the activity in hand. One midwife, describing how she managed this situation, noted: 'I tend to do less visits over a longer time', that is, visits were of a longer duration. This presented them with enormous flexibility. Inevitably some variation in the way they structured their time developed. Some chose to start work early, others later in the day; some scheduled their routine work into a few long days whilst others planned for a more even spread.

Arranging cover at night and weekends was equally flexible. Some midwives preferred to remain available for their women, recognizing the limited chance of being called, whilst others opted for alternating night cover with their midwifery partner, preferring the higher chance of being called one night with the certainty of not being disturbed the other. Such flexibility enabled each midwife to negotiate with their partner a pattern of working that best suited their lifestyle. Moreover, as their lives and commitments changed, such patterns were relatively easy to alter and adapt.

> You actually have to plan better when you are working shifts. I find I plan on a weekly basis. Whereas before, when I was on the wards, you have to plan three weeks in advance because that's the way the rotas are done. (interview caseload midwife)

The midwives did not have total control over their time as they had to be available to respond to the needs of their women. Nevertheless, once they had developed their personal time-management skills and learnt to advise, or 'educate', their women appropriately they reported that interruptions at night were usually confined to labour and emergencies and proved to be minimal.

> At night? It's not very often. I would say on average a month I would get three. You can't put (a number on it). Or you may be contacted three times in one night! (interview caseload midwife)

Such reporting was verified in a study of the midwives' work diaries (McCourt 1998). Knowing the women who contacted them enabled the midwives to respond appropriately, not necessarily having to make visits but instead give advice or make an appointment. This contrasted with their colleagues in the conventional services where calls from 'unknown' women had to be treated with care; with no prior knowledge of particular

situations, most calls necessitated the woman being asked to come into hospital or being visited at home by the community midwives.

These two features, knowing the women and infrequent night calls, were symbiotic. Relating to their caseload midwife as a person rather than as a role, women were reported as saying they did not want to disturb them unless it was urgent. This appeared to be one of the most misunderstood features of caseload practice. In considering this model of care, both midwives and doctors understood the term 'on call' in terms of the hospital system in which, in their own experience, they were invariably disturbed. Alternative models, where they were 'available' yet rarely called, appeared incomprehensible.

As their time was not tightly defined or structured, and largely under their control, the caseload midwives were able to work within women's individual time constraints and their physiological time frame. With minimal previous experience of home births, the midwives reported finding that deliveries at home had a very different quality. They became more aware of the physiological rhythms of labour which, away from the constraints of hospital dominated time, were found to be very different from what they had previously considered as 'normal'. The midwives considered they learnt this by having to advise women during the early stages of labour and then caring for them through the active phase, rather than providing an eight-hour period of care isolated from the wider context of labour.

The caseload midwives tried to subvert the hospital time imposed on labour by their own strategic use of 'the board' in the Delivery Unit; as previously noted, this (open) refusal to comply with accepted procedure generated tension on the unit. Also, with a greater understanding of individual situations, they became more flexible in applying the unit's guidelines and protocols concerning labour. In describing a difficult delivery involving a long second stage, one caseload midwife explained that, because she was aware that the mother was unsure of the parentage of her child and was fearful of her baby's colour at delivery, she considered the delay was due to the mother psychologically holding back. In this situation the midwife considered that, while indications of the baby's well-being were satisfactory, support and understanding were more appropriate than speeding up the labour with hormonal stimulation.

Implications for Caseload Midwives

Such flexibility held distinct advantages for midwifery practice and mothers. Nevertheless, personal adaptation by the midwife was not necessarily easy or successful. This study indicated that it took between six to twelve months for midwives moving from the hospital service to settle into working this way, and that the most fundamental adaptation, although not overtly recognized, was likely to be to different notions and uses of time. Their lives were no longer clearly compartmentalized into the scheduled, tripartite divisions of Hall's (1969) monochronic time – work, social and domestic time, and sleep – as work became instead

embedded in the general passage of their lives in much the way Bourdieu (1963) described for Algerian peasants and Bohannan (1967) argued for the Nigerian Tiv. This lack of the compartmentalization of time may also be considered a feature of postmodernity, with the movement to more flexible patterns of working, in both time and space, indicated by the development of 'flexi-time' and home-offices. It is certainly a feature of the lives of some of those in more autonomous positions, such as senior corporate managers and senior professionals (Giddens 1987), and this was perhaps linked to the greater professional confidence and respect from obstetricians that the midwives began to experience (Frankenberg 1992).

This way of using time had a direct impact on the way the midwives viewed their lives, but it also held a certain ambiguity. Long-term planning was important for negotiating holiday time, and a balance to the caseload; it also incorporated the essence of 'investment' in their work discussed previously. However, short-term planning was less assured, forcing a more 'present' orientation and a need to be able to live with uncertainty. Although they would know 'due dates' for delivery and might have a sense of impending labours, they never knew when they would be called. Even when quiet, their busier colleagues might require support. The midwives recognized these patterns balanced out, that periods of intense activity would be followed by quiet spells. However, their appreciation of the quiet times was probably more retrospective than immediate, the exact duration of the quiet period only being defined once it had passed.

On a day-to-day basis the development of a forward orientation was limited as anything planned during 'available' periods could be disrupted by unexpected labours or emergencies. The ability to plan in certainty and enjoy the anticipation of particular social activities was determined by the support provided by their partners or group, and defined by whatever strategies for cover they had negotiated. The midwives' mobile phones became both the symbol and reality of this embedded work, freeing them to go wherever they wanted, as far as was reasonable and socially acceptable for the use of mobile phones, when they were officially 'available' but also interrupting such activities with the demands of their caseload. This extended into all aspects of their lives, with *coitus interruptus* being described laughingly by some as a new form of contraception. Adaptation to this 'embedded' more 'traditional' use of time was dependent on both personal characteristics and personal situation. It clearly suited those with a flexible and relaxed attitude towards work and life in general, proving more problematic for those who enjoyed living very structured lives. This different approach to 'work time' also made different physical demands on the midwives.

Time Clashes

Many of the difficulties the midwives experienced as caseload practitioners related to clashes experienced at the interface between their 'traditional', 'postmodern' concepts and uses of time and others' 'institutional' or

'modern' notions. These occurred in their domestic lives, with some of their clients, and when working in the hospital. Clashes that developed in the domestic domain were highly individual, and depended on particular circumstances. Being called when socializing with friends was difficult for some, whilst others said they experienced minimal problems in negotiating such situations. Most midwives commented on not being able to drink alcohol when they were 'available' to be called by women, but reported adapting to this. Midwives with stable and established live-in relationships appeared to experience less domestic tension than those with new or changing relationships. The greatest problems occurred when couples lived apart, particularly if separated by any distance. Tensions arose when visits together were interrupted by calls to work.

Two midwives reported finding childcare when working with a caseload considerably easier than with the shift pattern of work, but they acknowledged they benefited from flexible and supportive domestic arrangements such as the close proximity of supportive 'grandparents'. Others experienced greater difficulty, and reported feeling guilty when relying on friends to assist. This situation exemplifies one of the difficulties of using time in a more traditional way within a society that is structured and dominated by scheduled, industrial time. In traditional societies, childcare is commonly conceived of as the responsibility of the wider family, not just the mother. Where specialized childcare arrangements have to be adopted the uncertain nature of caseload practice can result in high fees or high levels of stress.

Although the reports were few, it became apparent that some clients experienced difficulty with the flexibility that was an integral part of the midwives' use of time. Living within a structured, scheduled time frame, their highly organized lives were disrupted when planned visits had to be cancelled at short notice (for example, when a midwife had to go and attend another mother's labour). One husband wished to lodge a formal complaint to the Health Trust, explaining how angry he had become when, having cleared time from his city occupation in order to meet the midwife, this visit was postponed at the last minute. He clearly considered his time had been 'stolen' by the midwife's inefficiency. In industrialized countries, punctuality is indicative of efficiency, although elsewhere aspects relating to respect, status or power are more heavily stressed (Hall 1959, 1976). Such clashes, unless recognized and tactfully handled, irritated clients who then interpreted the midwife's behaviour as disorganized or unreliable.

More serious difficulties developed when the midwives interfaced with the hospital service, where institutional time predominated. Problems were generated both in the way activities were undertaken and the negative stereotyping which developed from misunderstandings, a situation well recognized in cross-cultural misunderstanding relating to time (Hall 1959, 1969, 1976; Carroll 1990; Griffiths 1999). The interface in the Outpatient Clinic was reported as a constant problem by both groups of staff. The clinic was managed on a tight schedule and

the hospital midwives reacted sharply when caseload midwives did not appear as arranged or spent 'too long' with women, 'blocking' rooms and disrupting the 'smooth running' of the clinic. In the more relaxed atmosphere of the inpatient wards, the hospital midwives still complained that the caseload midwives were inefficient and disorganized, lazy and poor time keepers; they appeared at irregular times of the day and could not be relied upon to attend when planned, descriptions not infrequently applied to the same hospital midwives by the caseload practitioners. Both students and junior midwives noted how some hospital midwives phoned the caseload midwife for non-emergency queries at any time of day or even night. The perception was that as hospital midwives' shifts covered the hospital twenty-four hours a day so did the caseload midwives, and so it was felt appropriate to contact them at 3 A.M. for a minor query.

In the Delivery Unit, where time took on a shorter, more concentrated dimension, the relaxed attitude and flexibility of the caseload midwives proved particularly irritating to hospital shift-based staff if the unit was busy as described in Box 1:

8.30 A.M.
The unit is frenetically busy, staffing is difficult and there are a number of emergencies. Access to the telephone is constantly required.

One of the two phones is being used by a caseload practitioner to reschedule her day's work, having brought in a lady in labour. She is unaware of the intense irritation she is generating by her relaxed and humorous, although totally work-orientated, conversation. Her use of the phone lasted about ten minutes.

Nothing is said but strong 'looks' are exchanged between medical and midwifery staff.

Note: The caseload midwife's character was visually assassinated! A clear example of a 'time-clash'.

Source DU.observation study no.10 1997.

A second area of tension arose between the shorter periods of duty and longer duration of caring for a woman throughout labour, where caseload midwives received little help from hospital staff. Particularly in the early days, the hospital midwives considered it inappropriate to offer help, as the caseload midwives were responsible for their own caseload. However, they did not fully appreciate how long a particular caseload midwife had been on the unit, nor their previous workload prior to attending the labour. This withdrawal of support may have been fuelled by the caseload midwives' initial reluctance to 'update the board' in the unit (see above) because they did not wish to 'set the clock ticking' and end up being dominated by medical time and 'interference' unless they requested advice or support. As a result, obstetricians accused the sisters in charge of the unit of 'not knowing what was happening'. As a result, some of the sisters appeared to marginalize the caseload practitioners.

Time and Radical Change

Frankenberg (1992:16) suggested that 'revolutionary changes in health services … require that time itself is turned upside down', commenting how, in *Das Capital,* Marx exhorted workers to take charge of their own time. He also noted how a more egalitarian form of healthcare, defining carers and cared for as equal participants in the healing process, would neither need nor be able to treat the time of others as within its control. Practising with a caseload involved a radical change for midwives, not least in the way time was conceived and controlled, and this held fundamental implications for the midwives' work and lifestyle. The more reciprocal relationships established with mothers included mutual respect for each other's time and, with a less controlled patterning of their own time, midwives gained a greater appreciation of the physiological timing of labour.

Frankenberg (1992) remained pessimistic as to the viability of the change he had outlined, considering such relinquishment of power to be idealistic. Somewhat appositely he used the metaphor of childbirth when presenting this idea, suggesting that 'historical changes, like women in labour, still need midwives, even if for both they can most usefully be chosen from among their friends' (Frankenberg 1992:18). The nature of caseload midwifery practice appeared to support his views on revolution and egalitarian healthcare. As this study indicates, the fact that it has been successfully implemented, although only as a small scheme, and is subject to high levels of resistance and inter and intra-professional tension, undermines his pessimism but concurs with his valuation of 'friends', albeit 'professional friends'.

Conclusion

In analysing the adaptations carrying a caseload demanded of the midwives, it was apparent that particular structures that had become separated in 'modern' society became fused again. The 'role' and 'person' of the midwife became one, and the professional/client dichotomy became a relationship of mutuality where the expertise of both midwife and mother were valued. Such fusion presented a radical alteration to the way caseload midwives worked. However, perhaps the most fundamental fusion they experienced related to their use of time. This necessitated a deconstruction of the 'modern' way of compartmentalizing time, returning to a more 'traditional' way of conceiving and using it (Thompson 1967). Frankenberg (1992) indicated that a different use of time was involved in the practice of the science or the art of 'curing'. So it was in caseload midwifery. The different way of using their time enabled midwives to meet mothers on a level that acknowledged and facilitated the physiological timing of childbirth. Nevertheless, this change conflicted with institutional concepts of time and the way time was used by others, generating tensions.

Ideas about time, and the expectations generated by these, influence the way people live and relate to others. This understanding of the way time was used, both within the hospital and when carrying a caseload, helps give an appreciation of the very radical differences between the two models of practice studied here. It may also help explain some of the problems experienced, by all groups of staff, in responding to this social change. Those that work in the maternity services are part of a wider as well as local social world, and the implications of such change were wider than the immediate work context. The changes in uses of time observed in this study also implicitly challenged the related issues of hierarchy and gender in caring work, and ways of managing labour and birth.

Notes

1. There is a theoretical debate about the meaning of evidence, which is discussed in Downe, S. and C. McCourt, 2008. 'From Being to Becoming: Reconstructing Childbirth Knowledges', in S. Downe (ed.) *Normal Childbirth: Evidence and Debate*, 2nd edn. London: Churchill Livingstone, pp. 3–24. Here we refer to the relatively narrow definitions of 'science' and of 'evidence' that are used in practice in evidence-based medicine and regarded as authoritative knowledge. These hinge on viewing experimental research, particularly randomized controlled trials, and meta-analysis of trials, as the only really valid form of evidence. The concepts of evidence and science could be interpreted more widely, but this is not established in biomedicine.
2. Although described at the time as radically new, this was only within a short-term historical perspective. As discussed in Chapter 1 (this volume), this pattern of work was similar to that followed by most traditional midwives worldwide, and had been the norm for midwives in the U.K. until they became salaried employees with the advent of the NHS in 1948.
3. This is midwifery 'shorthand' for full dilatation of the cervix, which is considered to signify the beginning of the second stage of labour.

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