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Professionalism and person-centredness: developing a practice based approach to leadership within NHS maternity services in the UK

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Abstract

This paper, based on data taken from in-depth interviews with senior midwives and obstetricians and conducted as part of a critical ethnographic study, argues for a greater appreciation of person-centred, value-led midwifery practice. The paper begins with a discussion of the way midwifery practice is shaped by encoded and embodied knowledge. The paper subsequently focuses on an emergent practice based leadership using an adapted Aristotelian conceptual framework derived from MacIntyre (2007). Professional dissonance is highlighted as a difficulty experienced by repositioned managers who are also expected to be leaders in their field. Using data gathered from in-depth interviews it is contended that establishing person-centred care might be better achieved through the development of practice based leadership (rather than solely by adherence to organisational requirements). This type of leadership could potentially nurture a professional environment that promotes qualities, such as agency, commitment and high levels of competence among midwives. Such leadership is central to UK government priorities and is applicable to a global practice development agenda.

Key words: midwifery, person-centred approach, MacIntyre, professionalism, professional dissonance, autonomy

Introduction and background

The purpose of this paper is to explore some of the tensions which arise between interpretations of midwifery as a practice understood holistically (person-centred) and as a profession which is largely shaped by technical competence. The paper is based on some of the findings from a critical ethnographic study involving in-depth interviews with senior midwives and obstetricians. The paper focuses on midwifery in the National Health Service (NHS) in the United Kingdom (UK) but is of relevance to professionals working in a range of health and social care contexts, nationally and internationally, where organisational and hierarchical forms of managerialism (Davies, 2004) have significantly shaped professional practice. The paper also draws attention to the importance of an emerging but widely unrecognised form of practice-based leadership (West et al., 2015) which has resonance with servant leadership where values and beliefs emanate from the leader (Woodward, 1994; Russell, 2000). Such leaders foster positivity and are able to influence beliefs and behaviours within the workforce (Girvin, 1996; Russell, 2000). Thus effective clinical leadership is crucial to childbearing women's experiences of maternity services (Fielding, Richens & Calder, 2010), workforce engagement (Byrom & Downe, 2010), clinical outcomes (Phillips & Byrne, 2013; Murphy, Quillinan & Carolan, 2009) and organisational effectiveness (Burgess & Currie, 2013; Ham, 2003; Renfrew et al., 2014).

Returning to understandings of professional practice in the NHS there is continual emphasis on quantifiable targets, efficiency savings and rationalisation of service delivery. At the same time, practice regulation and governance (Davies, 2004) prioritise control and surveillance (Mander & Murphy Lawless, 2013) and compliance

(Hollins Martin & Bull, 2006), which encourage and privilege technical competence (Hunt & Symonds, 1995; Hannah, 2014). From a midwifery perspective, the culture described above has contributed to a change of emphasis from 'embodied knowledge' (tacitly held by a midwife) to 'encoded knowledge' and increased use of protocols, guidelines and directives (Parsons & Griffiths, 2007; Brown, 2008, p.350). A reliance on 'guideline-centred care' (Kotaska, 2011, p.97) is difficult to reconcile with the requirement to place person-centred practice at the heart of midwifery (Hall, 2013; Hunter, 2004; Nicholls & Webb, 2006). For example, research has shown that women value care from midwives who provide informed choice and includes them in clinical decision-making processes (Care Quality Commission [CQC], 2013; Davies, Daellenbach & Kensington, 2011; Fahy, Foureur & Hastie, 2008; Kirkham, 2010; Moloney & Gair, 2015; Walsh, 2010). Above all, women value and rely upon embodied knowledge (Kirkham, 2004).

The requirement in midwifery to be technically competent (Nursing & Midwifery Council [NMC], 2015) and the use of 'encoded' knowledge alone can create 'caring robots' (McCourt & Stevens, 2009) who use the relative safety of an algorithm (check list) approach to their midwifery work. Similarly, uncritical 'obedient technicians' prefer to follow protocols and guidelines and pass responsibility for clinical decision making to other work colleagues (Deery, 2010). This can become disempowering for women and midwives. Childbearing women on the receiving end of such care have reported uncaring and disconnected relationships with midwives (Dykes, 2005; Fielding et al., 2010; Kirkham, 2010). Thus, when person-centred care is subordinated to a technocratic approach (Davis-Floyd, 2001) and compliance with managerial targets there are real practical implications for maternity services (CQC, 2011; CQC, 2013)

not least that midwives and obstetricians may be favouring a technocratic approach in the belief that it improves outcomes for women and babies. Recent investigations into NHS failures have emphasised that a lack of person-centred care and a preference for target driven practice can compromise the essential knowledge base necessary for sound clinical competence (CQC, 2011; Francis, 2013; Kirkup, 2015) and innovative clinical practice.

Repositioning and professional dissonance

This study was undertaken at a time when some senior midwives (and obstetricians) had been repositioned as managers. There was also an expectation that they would be seen as leaders *and* be clinically active (Divall, 2015; Ham, 2003). This also meant becoming accountable for the implementation of clinical guidelines, directives and targets purportedly to ensure excellence and a standardised service (Bolton, 2005; Hollins Martin & Bull, 2010; Hyde & Roche-Reid, 2004; Stanley, 2006). Repositioning senior midwives has further contributed to an undermining of person centred care in midwifery because many midwives are now tied to outcomes, measurement and technical rationality and are unable to critique or counter its claims (Currie & Lockett, 2011; Ritzer, 1993). As will be seen the data highlight a culture of conflicting expectations, loss of professional identity and demands in maternity services that were impacting negatively on senior midwives' abilities to lead and support the professional development of midwives.

Practice-based leadership offers the potential to develop midwifery professionalism in the face of current pressures of managerialism (Hugman, 1991; Buchanan et al., 2013)

which give rise to organisational cultures described above that encourage midwives to defer responsibility and decision making to their co-workers. The solution may lie in developing a greater focus on a more sustainable, value-led practice orientated towards collaboration, commitment and professional development (Walsh, 2007; McAra-Couper et al., 2014).

Conceptualising practice differently – internal and external goods

MacIntyre (2007) conceptualises practice (according to an adapted Aristotelian model) as a coherent set of activities that have evolved cooperatively and cumulatively over time by a community of engaged practitioners who work collaboratively. A practice, from this perspective, is conceived of broadly and may include any of the following: playing a musical instrument, learning a foreign language, farming, carpentry, intellectual pursuits, and caring. For MacIntyre, what counts above all is that the practice is pursued primarily to achieve rewards that are internal to the particular practice. In midwifery, the internal goods of practice are derived from being the best possible midwife one can be – arguably achieved pursuing person-centred practice which includes appropriate technical expertise. While the initial stages of learning in any practice inevitably involve learning from those who are more experienced and paying close heed to guidelines, the development of practice need not be limited to compliance but might, instead, over time, incorporate opportunities for making contributions to the development of practice. Seen this way, engagement with practice is no longer merely about submission but offers the potential for creativity and personal growth. Equally, with genuine identification with their roles, midwives are likely to

become more person-centred (to women's physical, social and emotional needs) as well as respectful of their own agency and autonomy.

MacIntyre (2007) acknowledged the importance of 'external goods' which are the rewards derived from engaging in a practice but which are, nevertheless, not intrinsic to the particular practice itself. The external goods of practice normally include rewards such as money, status, job security and so on. In other words, rewards which can be obtained through any number of practices or activities. In this paper an extended interpretation of MacIntyre's understanding of external goods is applied to include the requirements of organisational professionalism, for example financial budgets, risk management procedures and other forms of surveillance. While these may be important to the smooth running of the organisation, they generally emphasise compliance with organisational requirements rather than the creative development of practice. Attempting to motivate midwives by measurements of performance which are external to practice may promote compliance, but at the cost of promoting traits such as distancing, cynicism and obedience (Austin, 2011; Hollins Martin & Bull, 2006). As MacIntyre argues, the internal goods of practice must be prioritised in order to prompt the necessary engagement required for excellence.

Crucially, midwives are more likely to acquire a sense of responsibility that extends beyond becoming a compliant technician when they can have genuine identification with their roles (Hunter & Warren, 2013). Person-centredness is far less likely to emerge in professional contexts characterised by patriarchal tradition and technical capacity (Hunt & Symonds, 1995; Kirkham, 1999; Sandall et al., 2009). Indeed, person-centred care is contingent on relationships which are fundamentally

democratic and respectful of all parties. Notwithstanding this, the equal requirement for medical and technical expertise is essential whilst also recognising that person-centred care involves appropriate and mindful integration into practice. Not all women using maternity services will require or need high levels of emotional and social support; person-centredness is respectful of women's agency and autonomy whilst stressing a relational (rather than a paternalistic or maternalistic) approach which is sensitive to differing needs and expectations.

Methodology

Critical ethnography explores the complexity of cultures, informing routines and rituals, and must, according to Madison (2005, p.6-7), consider the politics of positionality that take account of the researcher's own power, privilege and biases. RD has extensive experience of working clinically as a midwife in busy labour ward environments and in birth centres and midwife-led units. Current and past experiences, values, feelings, knowledge, interpretations and responses, as well as the way events influenced RD, were all recognised as part of the data gathered during in-depth interviews, focus groups and periods of observation. Immediately after data collection methodological and reflective notes were recorded in a research diary which was often referred to when re-reading transcripts. This enabled RD to question personal and professional prejudices and how these might influence what was happening in the study (Finlay, 2002; Finlay & Gough, 2008; Koch & Harrington, 1998). Researcher reflexivity in the form of 'thoughtful, conscious self-awareness' (Finlay, 2002, p.532) was therefore crucial to shaping the research study.

Previous research experiences have shown that critical ethnography can provide useful insights into the cultural phenomena within a maternity setting, where power, hegemony and organisational operation play such important roles (Dykes, 2005; Hughes, Deery & Lovatt, 2002; Rayment, 2011). Thus, critical ethnography can be understood as studying a culture in order to find an alternative and therefore seeks to identify how oppressive situations are (re)produced and reified within a research setting (Hammersley & Atkinson, 2007).

The research sites

The study was undertaken in three maternity units in the north of England where radical reconfigurations of services were taking place. Site A served a mixed rural and urban area with a South Asian population of 5.3%. At the time the study was undertaken the well-established midwife-led unit was located alongside the obstetric unit. A number of practice developments had been implemented at Site A, largely to promote midwife-led care, which had resulted in a diversification of care and the options available to childbearing women (Hughes et al. 2002; Deery and Hughes 2004). Site B had a newly established unit for midwife-led care that operated alongside the obstetric unit. This site served a city and a large rural area with a South Asian population of 23.3%. Site C served a small town with a multi-ethnic population of 49,700. Maternity services were mainly obstetrically-led but the feasibility of midwife-led care was being explored. Whilst there were many similarities between the units there historical and cultural differences that affected ways of working and working relationships. It will, however, be the similarities rather than the differences that will be considered in this paper. See table 1 for birth statistics of the three maternity units.

Insert table 1

Methods

The study was conducted in three phases (see Box 1) and comprised non-participant observation, focus groups and in-depth interviews in order to explore which cultural and organisational changes might assist further development of professionalism and person-centredness in maternity services. At the time organisational culture, reconfiguration of services and working relationships were becoming central to UK government development priorities. Some 'shadowing' of senior obstetricians was also undertaken. This paper reports some of the findings from in-depth interviews in phase 2 (see Box 2 for interview schedule questions). Ethical approval was sought and granted from the University Research Ethics Panel and from the NHS National Research Ethics Service.

Insert Box 1

Insert Box 2

All interview and field note data were transcribed verbatim. The data presented are derived from one of the aims of the study – to explore which cultural and organisational changes might assist the delivery of more effective and efficacious care in three maternity units. Preliminary analysis identified key phrases and themes (Boyatzis, 1998). Emergent themes were identified and, as analysis progressed, reconsidered

and, in some cases, modified. The data presented has been taken from eight interviews with senior midwives who had managerial and leadership roles (and in all cases at least 15 years' professional experience) and with three obstetricians. Pseudonyms have been used to protect the identities of the participants.

Findings

The findings are discussed in four sections: senior midwives as enforcers who are experiencing professional dissonance within their roles; change inhibiting practice focused developmental work; a midwifery preference for a 'control and command' model and a preference to work in a culture where midwives can defer responsibility and avoid being accountable.

Senior midwives as enforcers

A frequent tendency towards professional isolation was noted with senior midwives who often saw themselves as enforcers indicating a perceived shift in their professional identity. Eve, who had more than twenty years' experience saw her role primarily in terms of translating managerially imposed aims to the midwives 'on the ground', ensuring their compliance with policies. Eve had experienced service reconfiguration on a large scale and explained that she often encountered resistance towards organisational objectives from frontline midwives. As a result, Eve appeared to pay a personal cost when mediating between midwives and management,

I think it's harder than it ever was. I've been in management in the NHS a long time and people will always say 'oh things go full circle we're bringing that back in, we're doing this, we're doing that', but I think from my perspective there's a lot of target-driven stuff. The NHS has always had targets but I think they're more focused... it's a different kind of targets that we're looking at, you've got CNST. [Clinical Negligence Scheme for Trusts], you've got risk-management, you've got the complaints and all those have to be turned round in a certain time.

Many of the pressures that Eve was experiencing related to the organisational demands of performance management that defined her working life in terms of negotiating street-level bureaucracy (Lipsky, 1980). As pointed out in Lipsky's (1980) seminal work, 'bureaucracies' provide an organisational setting in which workers experience a combination of increasing caseloads, inadequate resources, the unpredictability of clients and uncertainty about the best way to approach their work with clients.

Eve and Susan experienced stress when they attempted to engage with midwives whilst reconciling their needs with the requirements of their own managers who remained focused on the implementation and achievement of organisational targets.

You do feel like the meat in the sandwich...I've got a senior position...seven midwives beneath me...I should be able to devolve a lot to them for their own development as much as anything but I'm not able to because I know the pressure that they are under. (Eve)

Well...having taken this dual role on it's been a big change...I feel like the jam in the sandwich 'cos you've got your staff – one layer of bread, you're there to support and the other layer is management and I feel like a buffer to pass everything down. (Susan)

Eve and Susan's words are reminiscent of previous research (Deery et al., 2010) indicating when managers are unable to integrate their personal and professional values into their managerial role they experience professional dissonance. That is, holding simultaneously two, often conflicting, sets of values, namely the professional values of midwifery in which the managers have been educated and practised, and the values of the target driven NHS (Deery et al., 2010). Straddling this unhappy divide and the professional dissonance that this created led to competing interests and personal unease for repositioned senior midwives (Deery, Kirkham & Hughes, 2010; Walsh, 2007). Participants in Divall's (2015) research exploring midwifery leaders' narratives of identity described this situation as 'being between a rock and a hard place' (p. 1065).

Change inhibiting practice focused development work

Louise, a midwifery manager with 25 years' professional experience, including five years in a senior position, spoke at length of the reluctance of many midwives to

embrace change, even if this was directed at providing person-centred services in a newly reconfigured organisational context. In common with other interviewees, Louise explained that midwives were often paralysed by fear of change in a way that could be injurious to the quality of service. Regretting the lack of opportunities to engage in practice-focused developmental work, Louise explained,

... you know, your everyday sort of 'fire fighting', you spend a lot of time doing like the risk management stuff, the incidents, the complaints, all taking priority because of timescales *and yet that nice sort of developmental stuff that you get a lot of satisfaction out of has gone...*[our emphasis]

The type of support that Louise alludes to is related to the development of practice and was not simply about promoting her own wellbeing from an individual perspective. Referring to a more senior colleague, Susan explained,

'...there's one [colleague] who agrees to everything, no substance at all, well two [colleagues], they'll agree to anything, you know, and that's not what I want ...I want real support'.

This aligns with previous research suggesting that midwives seek developmental and robust support (Deery et al., 2010; see Kirkham & Stapleton, 2000). While midwives clearly value supportive relationships with their colleagues, they appear to value in particular those relationships that are developmental to practice (Deery, 2005). Personal wellbeing and a sense of solidarity are thus enmeshed in the rewards gained through 'doing a good job'. This resonates with MacIntyre's (2007) conceptualisation

of how the pursuit of the internal goods of practice is associated with excellence in practice and collective forms of wellbeing. What is noteworthy, here, is that a general lack of personal identification with practice among some midwives appears to be undermining important organisational objectives, for example, the target of raising the number of 'normal' births which are managed by midwives without referral to obstetrics. This points to an often overlooked relationship between personal agency and organisational efficiency, namely that the former is ultimately undermined in a culture which allows little scope for authentic engagement and practice development. June, who had managerial responsibilities explained,

I'm concerned about the rise in the caesarean section rate, 24, 25 per cent I feel is high and I feel if other units can achieve a lower caesarean section rate then we can ...so I'm terribly disappointed that, having a midwife-led unit, the normal birth rate is not rising (June).

June is drawing attention to the fragility of person-centred practice that can so easily yield to unwarranted medical interventions in women's labours (Mander, 2007), sometimes without their consent (Deery, 2010). Put differently, some midwives are unable to deconstruct a medicalised way of working and are only able to practise by making decisions through proxy with their co-workers. This can be one of the consequences of working in an organisation that focuses on litigation costs, performance monitoring, accountability and audit (Brown, 2008; Deery & Fisher, 2010; Kostaka, 2011). June's words above are highlighting a culture which is not conducive to autonomous working and where some reflection on practice could facilitate midwives to closely examine their assumptions and expand their thinking.

Preference for a 'control and command' model

Some of the senior midwives interviewed agreed that midwives were often too eager to transfer responsibility by unnecessarily referring women to obstetric-led care (see Deery, 2010). As one of the interviewees stated,

Some midwives are too eager to transfer, it is right that we should recognise deviation from the normal, and once a woman becomes high-risk she needs intervention... but sometimes we are too eager to transfer because yesterday a woman was transferred from the midwife-led unit... With support she would've done it on her own without an epidural. It's just a bit sad (Kate).

Kate's words are highlighting that practice development could have helped to build confidence and broaden midwifery practice enabling the midwife described above to become involved in professional decision making processes and enhancement of maternity the services.

One interviewee Lola had been involved in an initiative to set up a midwife-led unit. Rather disappointingly, the culture in which she worked remained prone to hierarchical working. Lola's words suggested that she often felt 'out of her depth' and unable to facilitate professional development as she found midwives unprepared for autonomous work (see Deery, 2010). Indeed, in a cultural context in which the reconfiguration of services towards midwife-led care was in its infancy the midwives tended to prefer a more traditional 'control and command model'. As the research

progressed Lola took up a post with managerial responsibilities and found herself embroiled in a culture that was 'top down' and 'not facilitative'. Her attempts to promote the type of person-centred care associated with midwifery were rejected by both the midwives and obstetricians. In relation to her own managers, she explained,

'I suppose [it's] because they're looking after themselves, but I would've expected more support from the more senior staff'.

Lola's comments regarding senior management are perhaps an indication that the latter were equally constrained by organisational requirements (the 'jam in the sandwich') or, alternatively, that there was a disconnection between managers and midwives.

While fear of litigation may well be a factor undermining some midwives' confidence, there are clearly other factors at play, not least workload issues (Lipsky, 1980). However, challenging as these factors are, it is likely that they could be attenuated if greater emphasis were placed on professional development. This would require the involvement of experienced and senior midwives working in more practice-related roles where they could nurture professional development and teamwork (Martin & Waring, 2012). Developing collegial collaboration and practice and fostering a caring culture among midwives would provide a good starting point for the delivery of person-centred care. As things stand, there are few opportunities for this type of development. Instead, senior midwives are engaged in ongoing and relentless organisational work which tends to result in a culture which is generally neglectful of wellbeing. Georgina, a recently promoted midwife described the frustrations,

I just can't believe that there's so much paperwork. With the high technology and computers and so on these days, you'd think that paperwork wouldn't be a problem. I should be 'on the shop floor' where I'd be able to motivate because I know I'm a good motivator...to get midwives going again.

The maternity services offered on the sites where this research was undertaken had the potential to provide opportunities for autonomous, innovative practice and skill development facilitating midwives to channel their keenness and commitment. However consultation and ownership were not fostered and bureaucratic forms of clinical practice often emerged.

'Taking on the mantle' and being accountable

According to the interviewees' accounts, there is a readiness among some midwives to use technical aids to justify their own personal disengagement,

But sometimes the midwives pressure the doctors that there is an abnormality. I mean when the midwife tells you that she'd prefer to work on the central labour ward because then she can look at a CTG [cardiotocograph] monitor that's sad, sad, sad, sad... so it's relying again, they're still in their comfort zone. This has always been the case... they're quite happy to look at the CTG, write on it, write in the notes, go to the station, sit and chat... (Lola)

Organisational and hierarchical forms of control, including those related to risk management, may act as potent pressures on midwives, managers and obstetricians to comply with the managerial line, thereby undermining human agency and moral responsibility (MacIntrye, 2007). A culture of hyper-accountability restricts initiative and encourages a reliance on task based approaches rather than embedding these appropriately within more holistically developed practice (Hannah, 2014). The obstetricians shared this view. Rachel, a consultant obstetrician explained,

I think a lot of community midwives are not sufficiently confident to reassure patients when the patients should be reassured. And again, it's understandable. If you get something wrong 'the system comes down on you like a ton of bricks'; so you are better to just push it onto someone else to make that decision. So I think that there are more women coming into the hospital system that could easily be managed at home.

Similarly, Graham, a senior obstetrician argued that obstetricians were still,

'seeing a good number of women who we shouldn't be seeing, who should be seen by midwives, managed solely by midwives.'

Graham was surprised that more midwives were not 'so enthused to take on the mantle' but later referred to the organisational barriers that had contributed to the present culture, explaining that 'people' (midwives and obstetricians) had become accustomed to working in 'silos'. The obstetricians generally took the view that the

training of midwives was producing technicians rather than professionals. As Rachel put it,

I'm not being derogatory but in many things they are technicians, and there's always a problem when a technician believes they know more than an engineer. I don't blame the midwives, more often than not it's their training and the training has to decide what we want of midwives.

Rachel's comment takes us to the main question underpinning this paper – whether midwifery should be seen as a practice understood holistically or whether it should be task-based and conducted by 'caring robots' and obedient technicians (see Deery & Hunter, 2010; McCourt & Stevens, 2009; O'Connell & Downe, 2008). Current organisational structures and hierarchies are promoting the latter by positioning midwives (some willingly, others not) as instruments of organisational aims at the expense of enabling them to develop practice in all its dimensions. The human dimension is replaced by an apathy with women sometimes viewed less positively in terms of their personhood and birthing ability and more as a body that is a potential liability.

The organisational processes that create these tensions are ones that legitimise rationalisation, standardisation and accountability over agency, discretion and judgement. Value-based understandings of professionalism have ceded to normative discourses 'from above' which socialise and reshape individual identities around organisational requirements (Burgess & Currie, 2013; Evetts, 2011; Flynn, 2002;

Muzio & Kirkpatrick, 2011). Understandings of autonomous professional practice are reduced to the ability to follow logical rule-following (McKee et al., 2013).

Discussion

The data reported suggests that there is a need to develop an authentic value-based professionalism in midwifery. There is a growing body of research in health, sociology and psychotherapy which suggests that genuine emotional attachment to work is associated with greater professional commitment, enhanced responsiveness to service users and higher levels of emotional wellbeing among practitioners (Deery & Fisher, 2010; Fisher & Byrne, 2012; Hunter & Deery, 2009; Orbach, 2008; Rayment, 2015). What these authors suggest is that emotional attachment can give rise to a superogatory commitment, that is a commitment which goes beyond the call of duty (Bauman, 1995; Fisher & Byrne, 2012; Sayer, 2011). Emotional attachment understood this way is not necessarily reducible to relationships with individuals (although an interest in people is a necessary component for person-centred care) but it refers primarily to a feeling that something matters at a deep level. In other words, midwives see their work as valuable in itself and are thus personally motivated to strive towards excellence. From this perspective, emotion is not a reactive or passive force but is linked to intentionality and to active agency (Ashman, 2008; Fisher & Byrne, 2012).

In highlighting the importance of authentic emotional engagement, this paper offers an alternative view to the type of emotional labour identified by Hochschild (1983). Hochschild (1983) used the term emotional labour to describe commodified emotion

work performed in the interests of an organisation: often this involved presenting an appropriate face (Hunter & Deery, 2009). In contrast, this paper draws more directly on Bolton's (2005) term 'philanthropic' emotion work which, she argued, is based on a largely authentic sense of engagement. While this type of emotional commitment has generally not been associated with ambitions for excellence within professional settings, it may have an important and yet under-acknowledged role to play in this respect. In order to interrogate the link between authentic emotional engagement and excellence in practice an adapted Aristotelean model of practice based on the indivisibility of cognition and emotion.

From instrumentalism to practice

MacIntyre's (2007) model of practice recognises that person-centred care requires a complex combination of skills, expertise, responsibility, and engagement with others in the pursuit of value-led practice. Developing practice from this perspective requires 'more than a friendly algorithm to run through' (O'Hara & Leicester, 2012, p.6); it involves social processes which enable practice to be co-constructed, rather than prescribed from above. Put differently, it is based on the assumption that excellence cannot be achieved in environments characterised solely by hierarchical working.

The development of excellence in practice requires authentic engagement experienced independently of heteronomous constraints. In other words, excellence is achieved when agents have opportunities to be the authors (rather than merely the instruments) of the purposes they pursue (Fisher & Lees, 2015; MacIntyre, 2007). What this means is that 'power-over' styles of working need to yield to collegial working

relationships focused on the co-production of practice which benefits the whole of maternity services. From a Macintyrean perspective midwives could view themselves as a 'community of practice' (Lave & Wenger, 1991) responding to each other with the same values, (for example, dialogue, responsiveness, collaboration, co-construction) which they can enact in their practice with childbearing women. A community of practice approach based on collaborative, rather than confrontational working, is an essential component of professionalism having the potential to enhance a person centred approach and to do that in a way that is true to the philosophies underlying midwifery practice.

Enacting these aspirations requires a great deal of time, commitment and practice development. The data in this study suggest that there is a desire to change ways of working and creatively develop practice. Some of the midwives did not appear to exercise personal responsibility even when this was possible and might have ensured a better birth experience for women. Senior midwives stated that they were constantly faced with organisational restrictions that hampered their desire to engage with, and support midwives on the frontline. One positive starting point to address this situation might begin with an organisational acknowledgement that a new type of leadership is needed, one that is based on a congruency between values and actions (Stanley & Sherratt, 2010) and not 'subservience to managerial aims, reconfiguring...professional identities in line with organizational and policy priorities' (Martin & Waring, 2012, p.372).

A new type of leadership

Reconfiguration of maternity services at the three sites studied meant that some of the senior midwives were working in different areas of practice and across hospital sites. A lack of autonomous working, litigation, rising intervention rates and no control over work practices were some of the difficulties that mitigated against their aspiration to support midwives and lead further development of practice. In the context of this paper, it is of particular significance that clinical leaders have been identified as 'midwives with values' that are enacted in their practice. While still an underdeveloped area of research, the available evidence suggests that leadership based on a congruency between values and actions impacts positively on the working environment (Stanley & Sherratt, 2010). Unfortunately, value-based leadership of this kind receives little formal recognition in organisations which value managerial and hierarchical forms of leadership (Stanley, 2008).

While a detailed consideration of the benefits of value-based leadership are beyond the scope of this paper, the aim of such leadership is to relax its own authority in a symbiotic relationship with the development of others' practice. In other words, seeking the development of a distributed form of leadership (McKee et al., 2013; Turnbull James, 2011) to engage and value the contributions of midwives who seek to enhance the experiences of childbearing women and their colleagues. This would require authentic engagement with the internal goods of practice by midwives who *feel* responsible,

Leadership must be exercised across shifts 24/7 and reach to every individual: good practice can be destroyed by one person who fails to see themselves as able to exercise leadership, as required to promote

organisational change, or who leaves something undone or unsaid because someone else is supposed to be in charge (Turnbull James, 2011, p.18)

The extract above taken from Turnbull James (2011) may in some respects be harsh but nevertheless highlights the need for all midwives to feel a sense of responsibility. Arguably, this is precisely what is meant by distributed leadership. While this is unlikely to be achieved 'over night', a practice and value-led approach to leadership may offer a good starting place to combat the reluctance among some midwives to engage in developing their practice beyond defensive codified knowledge.

Conclusion

This paper suggests that hierarchical task-based boundaries are shaping practice. While senior colleagues are entrusted with responsibility (understood within the limited parameters of organisationally determined targets) those with less responsibility are expected to undertake the task-based care in ways that can undermine a sense of authentic engagement (Martin & Waring, 2012). While professionalism necessarily begins with the development of basic competence which is initially task-based (MacIntyre, 2007), a greater focus on the development of practice would provide scope for midwives to grow professionally beyond the initial stages of professional development. Midwives would be more likely to acquire embodied expertise that enables them to link technical skills into a holistic corpus of professional knowledge which can be applied flexibly within a range of idiosyncratic situations. This cannot be achieved by rational instrumentalism enforced by hierarchical structures but requires the development of a culture of collaborative practice based on a firm set of values and beliefs which prioritise the internal goods of practice (at least some of the time)

over compliance with organisational demands. Greater organisational acknowledgement of the importance of personal attachment to the values of practice is needed. In asserting this, there is still a need for organisational and hierarchical requirements.

Working within an organisational context clearly requires the integration of procedures and regulation into practice – external goods are also necessary goods (MacIntyre, 2007); indeed this research has revealed that these are not necessarily discrete categories. In common with other ‘people’ professions, midwifery will always necessitate navigating and reconciling, often imperfectly, organisational requirements with practice-based engagement and expertise. The point here is that within the context of organisational constraints, some space must be available for midwives’ agentic empowerment. Creating more opportunities for a form of clinical leadership that draws on some of the tenets of a MacIntyrean practice may contribute to the development of a culture in which midwives do not merely adhere to organisational requirements but strive to develop practice in ways that both exceed and creatively transform minimum standards. Until the value of doing so is acknowledged at global and organisational levels, person-centred care, is likely to languish as a result of the dominance of task-based approaches that devitalise midwives’ sense of self and professional engagement thus potentially affecting optimal clinical outcomes for women and their babies.

As Hannah (2014, p.3) states ‘there is a whole burgeoning apparatus of inspection, regulation and quality control designed to get the best out of a system already under strain’. This situation is concerning given the increasing global recognition that quality

maternity services (including who we are being as midwives) lead to optimal outcomes for women and their babies (Renfrew et al., 2014; Sandall, 2012).

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