An ethnography of midwifery work patterns during organisational redesign

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Abstract

Despite a substantial increase in midwifery research since the early 1990s, there remains a lack of available research into the everyday practice of midwives. In general, hospitals are striving to reduce costs and increase efficiencies, so many hospital-based midwives are being exposed to hospital restructuring processes. The primary purpose of my research was to learn about the work patterns of hospital midwives during organisational redesign. A large Brisbane hospital, as part of its hospital-wide organisational redesign plan, merged two postnatal wards to create a new, larger unit. With this amalgamation, the ward midwives were exposed to several service delivery changes. Midwifery work patterns during this organisational change revealed a milieu characterised by a culture of busyness. The impact of change introduced ritual and personal elements that influenced midwifery work patterns.

Introduction

Although the growth in midwifery research has been substantial in the last couple of years, Robinson and Thompson (1996, p 6) claim that many aspects of everyday midwifery practice are still under-researched. The primary purpose of my research was to learn about the work patterns of hospital-based midwives during organisational redesign. Ethnography was considered the most appropriate research method to use, as it allowed me to explore, explain and formulate a cultural description of hospital-based midwives during organisational redesign. The major goal of this research was to undertake a journey into the daily world of contemporary hospital-based midwives to explain their work culture and learn from their experiences.

I began the research process in earnest in July 1997 and finished in June 1998. The research was performed in the postnatal ward of a major tertiary teaching hospital

in Brisbane where, as part of an overall restructuring plan in July 1997, two postnatal wards and their staff merged to form one large postnatal unit.

Organisational redesign in health care delivery has, in the latter half of this century, become a reality throughout the world (Tonges 1989; Flarey 1995; Sovie 1995; Silberzweig & Giguere 1996). Contemporary hospital-based midwives are practising their profession in an increasingly budget-conscious era. There is an ever-increasing expectation to redesign work practices so as to produce enhanced, cost-effective and efficient practices of care. What has worked in the past will not necessarily work in the future (Comack, Brady & Porter-O'Grady 1997), therefore there is a need to re-engineer systems/processes, and to streamline and simplify current organisational practices (McManis 1993).

Despite the copious literature now available on re-engineering, restructuring and redesigning, there is a lack of research available to ascertain the behavioural effects during the re-engineering process. A snapshot of the changing structure of organisations shows, for example, an increasing trend to transform into a flattened structure, which is less bureaucratic, hierarchical and consequently more empowering for employees (McLaughlin 1990; Barger & Kirby 1995). While flatter structures generally result in fewer managers, the depth and scope of job expectations often increases (McLaughlin 1990). Changes in job scope and practice will inevitably cause 'change reactions'. The sheer magnitude and realisation that change will occur, not only to job roles but to almost all facets of the organisations' business, may affect employees' behaviour. Ultimately, organisational changes will affect all employees in one form or another. Therefore, knowledge and heightened awareness of organisational behaviour possibilities should be the norm prior to the implementation of changes.

For example, organisations contemplating alteration to pre-existing workplace situations need to consider the importance of corporate culture which has, at its essence, 'a general consensus of beliefs, mores, customs, value systems, behavioural norms' (Callahan, Fleenor & Knudsen 1986, p 9). Within each 'corporate' culture there are 'sub-unit' cultures. In a hospital-based environment, each ward is, in effect, a sub-unit culture, possessing its own value systems and customs (Siddiqui 1997).

Kramer & Schmalenberg (1977), in their ground-breaking work with graduate transition programs, discuss the term 'reality shock' which occurs when an individual moves from a familiar subculture to a new subculture, with resulting loss of confidence and competence. Their theory relating to the transition experience from one culture to another can be adapted to any setting or circumstance. A productive way to resolve this conflict between old and new cultures is simply to become bicultural. Biculturalism 'means being as competent and effective in the new subculture as in the old' (Kramer & Schmalenberg 1977, p 9). There are, however, a series of competencies and knowledge required to achieve biculturalism. For example, being familiar with the stages of 'reality shock' can enable an individual to use the experiences within each stage positively, so that competence and a reduction in conflict will generally occur.

Other steps involved in becoming bicultural include:

- the assessment and development of behaviours necessary to achieve pre-established goals
- knowledge of pre-existing values within the work culture
- learning how to identify values which are grounded in everyday speech (culture speak)
- regular feedback and self assessment, and
- knowledge pertaining to conflict and its resolution (Kramer & Schmalenberg 1977).

One of the primary aims of being bicultural is to be able to become interpersonally competent in the new work subculture. Knowledge of the steps involved in attaining bicultural behaviour may assist hospital midwives to become more adaptable to the change process occurring in hospitals.

Methodology

Ethnography was the chosen methodology for this research question because such an approach portrays the way of life/culture of a group of people. Hammersly and Atkinson (1995, p 1) state that, in reality, ethnography simply involves the researcher participating 'overtly or covertly, in people's daily lives for an extended period of time'. Morse and Field (1996, p 21) claim that ethnographers 'learn from' people rather than studying people. Ethnography was the appropriate choice of methodology as a means of observing through field work the work patterns, behaviours and interactions in the cultural work setting of hospital-based midwives during organisational change.

Setting

The study setting for this research is a 43-bed maternity ward situated in a large metropolitan hospital in Brisbane. The ward was established in July 1997 following the merger of two postnatal wards as part of a major hospital reorganisation plan. Staff from both wards also merged, swelling numbers to a total of 55. The newly amalgamated ward consists of two large corridors (wing and main) emerging from a right angle situated at the top of the ward. Patient rooms (mostly two-bedded), treatment areas, the nurses' station (on the main corridor), dirty utility rooms, storerooms and cleaning cupboards flank either side of both corridors.

Sample

In order to engender deeper insight into the ward culture, purposeful sampling of key participants was undertaken. A mix of five core full-time and part-time midwives were identified after a period of participant observation and were subsequently asked to participate in the study.

Data collection

The data collection instruments used to perform the fieldwork in this research included the researcher; participant observation and semi-structured interviews.

Fifteen field sessions of participant observation were performed. All shifts (that is, early shifts, late shifts and night shifts, including weekends) were captured. In addition, slices of specific shifts were targeted (for example, 'early' morning, and 'late' morning to 'early' afternoon). This facilitated an overview of high and low clinical dependency hours. Field sessions varied in length from two to six hours' duration and all sessions were transcribed and typed within 24 hours of the field work (to aid recall and accuracy).

Semi-structured interviews for this research commenced at the completion of the 15 active field sessions. Five taped interviews were completed, lasting approximately one hour each. All interviews yielded over 7000 words of typed transcript (performed by the researcher to increase familiarity with the data). All transcripts were signed and dated as true records by each key participant and returned to the researcher. One key participant requested to keep a copy of the transcribed interview.

Data analysis

Initial perceptions, followed by observation for patterns in thought and behaviours, are crucial steps in the process of ethnographic analysis (Fetterman 1989). Phase 1 (overview analysis) was conducted in this manner. During Phase 2 (closer analysis) more immersion in the data was performed. Host validation of the 15 field sessions was checked with each of the key participants during the face-to-face interviews. During Phase 3 (coding analysis) the search for themes/categories/pathways was undertaken. Finally, Phase 4 (organisational analysis) involved the construction of a typed/handwritten organisational map (measuring one metre by half a metre) depicting the three main analytical dimensions and their interpretive strands. Factors of rigour were constantly reflected upon to ensure trustworthiness.

Rigour in qualitative research is present when the two elements of trustworthiness and a decision trail are present (Holloway & Wheeler 1996). Each of my participants read, signed and dated their interview transcripts. I asked the five key participants during interview to comment on the themes and observations that I had unearthed during the 15 field sessions. By immersion and subsequent organisation of my data into four phases, including a final organisational chart, I was able to capture a decision trail for audit purposes.

An information sheet was prepared and displayed in the ward. To maintain confidentiality and anonymity for key participants, assurances were given verbally and in writing (the informed consent) that data would not be attributable or identifiable to any of the involved participants. All data were stored and maintained in a locked facility.

Findings

The examination of work patterns of hospital-based midwives during organisational redesign involved the analysis and interpretation of ethnographic data. The complexity of the cultural setting produced large quantities of data, however three main analytical dimensions with individual interpretive strands were located. A hospital-based maternity ward is a dynamic and constantly changing environment, and midwifery work patterns support a variety of mother-and-baby activities in a postnatal ward. Following data analysis, three dimensions that captured the essence of midwifery work patterns during organisational change were identified:

- the contextual dimension
- the ritual dimension, and
- the personal/interpersonal dimension.

Additionally, midwifery work patterns revolve around and are expressed according to these dimensions through specific interpretive strands – milieu, changes, prioritising, mother–midwife partnering, biculturalism and team relationships.

Contextual dimension

Postnatal midwifery work patterns are constant through day, evening and night shifts. The ward milieu provides the frame through which midwifery work patterns are conducted. Interpretation of data in this study revealed a milieu characterised by a culture of busyness. However because several changes occurred with the ward merger, a fuller explanation depicting the liaison between milieu and changes will be given in the second defining component of the contextual dimension – changes. The ward milieu is linked to the cultural busyness, therefore further insights into ward milieu, ward changes and midwifery work patterns may demonstrate the connecting threads in the contextual dimension.

Changes

Sarah described the initial stages of the ward's amalgamation:

> *Oh just total disorganisation! I think two things – disorganisation, and no room for anything. Trying to crowd two wards full of stock, equipment, baby furniture, everything onto one floor, there was just no room for anything. The place is messy all the time – that's depressing, and everything had been so disorganised and so ill-prepared. It was just 'we're going to merge these two wards today, boom, let's do it!' And there was no preparation [pause]. I would still like to see a lot more communication happen, because we really weren't getting any, we didn't know what was going on. I'd love a little bit more aesthetic harmony so we didn't think that we were living in a nightmare the whole time.*

Several points are raised in Sarah's narrative. A disturbing milieu is evoked through emotional language: mess, crowding, lack of space, nightmare. The relationship between milieu and work practices is captured (mess, disorganisation, disharmony) as Sarah feels she is 'working in a nightmare the whole time'. A link between work and nightmare is exhibited through discontent and frustration with the lack of preparation and communication before and during the merger. A sense of chaos is evoked, due in part to the material crowding but also by Sarah's lack of knowledge and preparedness for the ward merger. Clearly there is a difference for Sarah between the culture of busyness in normal work patterns and the influence of physically-relocating-the-ward busyness. Porter-O'Grady (1996) strongly recommends involving employees at the 'point of care' in the planning and decision-making steps of organisational redesign. Sarah's remarks demonstrate that failure to empower employees may lead to dissatisfaction. Moreover, change resistance may ultimately ensue if lack of ownership persists.

Amy:

> *I think the two wards merging is good because Fourth Floor had good points. Third Floor had good points. Together they have better points. Third Floor, I thought, had a lot of efficient ways of running, and Fourth Floor was a very nice place to work, but now both of those good things are coming together [pause]. I don't mind coming to work every day [laughs] even though it's terribly heavy. And the changes, I've always been on the idea that I like my babies with their mothers. That for me has never been a change. A point that I find difficult to come to terms with is the caesar ladies. They have nowhere to turn and because it's so busy you are very limited in how to assist. I get over that by being prompt to answer the buzzers personally when I know that this is a caesar lady – I attend to the baby's needs and help her with the breast-feeding but that's as much as I can do. When she or the baby is unsettled, and if I have time, I take the baby with me while I write my notes. I can't do more than that. That's how I cope.*

Amy captures the positive aspects of both wards uniting. She displays bicultural tendencies (Kramer & Schmalenberg 1977) by remaining as effective as she can be in the new ward culture. Although she acknowledges the cultural busyness of the newly united ward, she nevertheless arranges and prioritises her pattern of work to remain as competent and effective as possible.

Kramer & Schmalenberg (1977) describe 'culture shock' as a feeling of disequilibrium when movement from a familiar culture to a new culture occurs. Every one of the midwives working in the newly merged postnatal ward underwent some form of contextual displacement. The midwives from the third floor ward left an understood and familiar environment, while the midwives on the original fourth floor ward also left behind (although not physically) an equally understood, familiar culture. Moreover, the new ward (as a direct result of the amalgamation) became a larger and busier unit. Larger, because the fourth floor originally had 23 beds, the third floor had 32 beds, and the newly amalgamated ward has 43 beds. Busier, because all the women who had

caesarean sections and medically complicated confinements are now placed in the new ward as opposed to previously being shared between the two old wards. Thus acuity and complexity of patient care increased substantially following the organisational redesign.

In this culture the contextual dimension containing the interpretive strands of milieu and changes has impacted on many of the midwives working in postnatal services. The link between milieu, changes and work patterns has been demonstrated through field notes and interview narratives depicting the cultural busyness and its link to the ward changes. In summary, the contextual dimension with interpretive strands of cultural milieu and cultural changes influence midwifery patterns in postnatal services.

Ritual dimension

Prioritising

Daily midwifery work patterns are conducted within a culture of busyness and a changing environment. As a direct result of the organisational redesign, midwives in their narratives place high value on, firstly, ritually prioritising their work patterns (in order to survive), and secondly, ritually promoting appropriate mother–midwife partnering allocation practices to achieve continuity of care.

Holly outlines some of her daily work patterns:

> *Well when I come on duty in the morning I organise my staff, the patient:staff ratio, what sort of skill mix. I go through the patients, sort out the discharges, the reviews for the doctors, the babies that have to be reviewed by the paediatrician. I'll go through all the charts of the new patients that I don't know. I get on the computer [pause] a quick round of all the babies just to make sure there were no jaundiced babies to put on the paed list, I'll go and see my patients because I'll usually have a patient load [pause] it's busy! I'll quickly do a round of all the other mothers – make sure the staff are happy, and by that time it's morning tea. Obviously I've been back and forth to my ladies if they've been buzzing. Then you have delivery suite on the phone looking for beds and we won't have any beds so then we need to go around and see what discharges are going [laughs], you know its exhausting thinking about it [laughing]. This is what it's like every day!*

Holly provides a litany of work acts. This evokes a sense of continuous, never-ending, ritualistic patterning of care. Postnatal midwifery rituals strongly prioritise mother-and-baby support. Holly demonstrates the link between the cultural demands of the ward to her own individually ritualised work patterning.

Jane:

> *Well the busyness dictates how much time you've got to spend with the patients, what you have to put off until knock-off time, and then do it at knock-off time.*

Jane exhibits frustration working in a culture of busyness while simultaneously trying to organise and prioritise her work. The emerging ritual of each midwife individually

prioritising their work is a consequence of the ward cultural milieu and organisational changes. Jane describes the relationship between her work patterns and the busyness of the ward, depicting a relation and dependence between these two factors.

Holly:

> *It's been more difficult for some of the midwives more than others. Some of them say 'but I can't teach them (patients) everything in two days', and I say 'well you've got to prioritise and you have to teach them the things they basically need to know, to look after that baby, and get them home so they know how to feed it and keep it clean and keep themselves sane'. And really that's all you can do.*

Holly captures the notion of busyness and change in practice (early discharge). The importance of prioritising and empowering mothers at the start of their motherhood career is realistically and practically advocated.

Further interview excerpts explain this link of prioritising the midwifery ward care in a culture of busyness.

Sophie:

> *The busyness does dictate everything: the physical, emotional, and psychological for the staff. It depends very much on the team leader – how she prioritises her work.*

Sophie acknowledges the culture of busyness in the ward and emphasises the importance and value of prioritising work in the ward culture. For many of the midwives working in postnatal services, an individual cultural prioritising of work patterns is a mandatory occurrence throughout their shifts. MacLeod (1994) reminds us that many everyday practices of nursing work are hidden from view and therefore the complexity of nursing practice is difficult to describe. The ward-based midwives have demonstrated through their narratives the necessity to prioritise work in a culture of busyness, hence a ritual of cultural prioritising to cope with ward needs has been illustrated.

The link between the contextual and ritual dimensions has been established through the connection between the ward changes, milieu, and the midwives' own individual and group responses to the changing environment (bicultural tendencies/prioritising/mother–midwife partnering). The ability to understand and operate midwifery work patterns in this dynamically changing culture through bicultural individual and team relationships is the third identified dimension influencing midwifery work patterns.

Personal/interpersonal dimension

A third dimension was identified which expressed midwifery work patterns according to personal and interpersonal factors. These work patterns are influenced through the interpretive strands of biculturalism (personal dimension) and team relationships (interpersonal dimension).

Biculturalism

Biculturalism as described by Kramer & Schmalenberg (1977) encapsulates the individual's ability to cope and respond to a changing environment. Whilst this research is now 20 years old, the concept of biculturalism is still relevant and supported by the findings of this project.

The amalgamation of two former postnatal wards to one large ward and the instigation of several new service delivery changes created a rapidly changing environment for the midwives in the newly formed ward. Those midwives who coped best adapted bicultural strategies. The following narrative from Sophie may help demonstrate the biculturalism:

> *…But I think closing the nursery is not such a bad thing, especially because the enrolled nurses now come on to the floor to work [pause]. Before, the enrolled nurses were locked in the nursery. They are trained to do work on the floors as well. Some of them are very nervous but it is our responsibility as an employer to make sure that our employees are employable. If they chose to leave for any reason, what experience do you have? I was in the nursery for 20 years! Where are her job prospects?*

Sophie demonstrates bicultural tendencies. The painful transition to a new culture can often result in conflict with eventual job-hopping and burnout – generally caused by unresolved conflict or unconstructive conflict resolution. Bicultural adaptation is a useful and healthy form of conflict resolution because the worthwhile values of the previous culture are moulded to fit in with the reality and values of the new setting (Kramer & Schmalenberg 1977). Sophie uses a bicultural framework to see the value in upgrading enrolled nurses despite the upheaval and extra training required to facilitate their transition.

Bicultural tendencies are often manifested through positive verbal expressions of change.

Jane:

> *I'm thinking of better ways in which to do things and I've felt it's made me grow…so I'm really pleased that we did have a big change. I think it's good.*

Holly:

> *I don't really mind change, I think it keeps everybody alive. I think you get a bit stale if you don't have change in your life.*

The link between the contextual dimension (milieu and changes) and the personal dimension (biculturalism) is demonstrated through these excerpts. Each midwife is expressing positive reactions to the overall concept of change in their workplace – bicultural tendencies in the form of lateral thinking and open-mindedness are apparent.

Holly:

> *Let me tell you what happened when they first closed the nurseries. We were coming on and everyone [mothers] had a complaint form on their table. I couldn't believe*

it! And one of the ladies said 'I don't want to put in this complaint; I don't have any complaints. I'm very happy with the staff and having my baby next to me'. I said 'you don't have to if you don't want to'. So I was a bit upset about that. They [staff] were making a problem instead of trying to cope with the change [pause]. They can open the nursery at night if they need to – they've got enough staff to open the nursery. If they've three or four babies that are really upset and the mothers need a break they can take those four babies and sit and feed. But it's funny they had to be told that. They didn't manage to think of it themselves. You know what I mean?

Holly demonstrates a capacity to be flexible and for lateral thinking in this excerpt ('can' open the nursery). She displays a personal and interpersonal awareness of change adaptation and adjustments during organisational redesign and service delivery changes. Keane and Dixon (1995, p 28) state that 'increasing your self-awareness is a major basis for communicating effectively'. Therefore becoming bicultural, when viewed from an interpersonal perspective, may help team relationships during major organisational change. For example, Kramer and Schmalenberg (1977) state that exposure to bicultural behaviour may cause a 'cultural stimulation' or role model ethos to develop. Thus effective personal behaviour and communication techniques (biculturalism) may facilitate improved interpersonal relationships.

In times of great change and cultural adaptation, working biculturally may help ease the burden and pain of culture shock and, additionally, provide and promote a congenial and productive workplace environment for all staff.

Conclusion

Postnatal ward midwives were involved with major ward redesign changes in the middle of 1997. At this time, two postnatal wards merged along with staff, to form a new and larger postnatal ward. Patient throughput and complexity increased, and several ward service delivery changes were instigated almost simultaneously. Two previously defined sub-unit cultures merged, bringing together their own previously held values, customs and beliefs. Postnatal ward midwives were exposed in some way to periods of cultural transition, cultural readjustment and cultural acceptance. The midwives continued to conduct their baby and mother support duties throughout the cultural change. During the study several inspirational culture values (caring, sharing and nurturing) were captured through participant observation, interview transcripts and my own private journal.

Hospital organisational change is generally performed to increase efficiencies and save costs. However, the decision to merge two wards, with a resultant increase in patient throughput and complexity, needs to be examined further, as a culture of busyness exerts, embraces, permeates and dictates many aspects of ward processes. A limitation of this study is its size, however the findings associated with this research have in a small way contributed to the midwifery body of knowledge by capturing the cultural essence and daily world of a hospital-based midwife in contemporary Queensland.

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