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Abstract

While poor communication between service users and front line staff causes many service user complaints in the British National Health Service (NHS), staff rarely reflect on the causes of these complaints. We discuss findings from an action research project with midwives which suggest that the midwives struggled to fully understand complaints from women, their partners and families particularly about restricted visiting and the locked door to the midwifery unit. They responded to individual requests to visit out of hours while maintaining the general policy of restricted visiting. In this way the door was a gatekeeping device which allowed access to the unit within certain rules. The locked door remained a barrier to women and their families and as a result was a common source of informal complaints. We argue that the locked door and restricted visiting to the midwifery unit were forms of gate-keeping and boundary making by midwives which reveals a tension between their espoused woman-centred care and contemporary midwifery practice which is increasingly constrained by institutional values.

Introduction

Evidence suggests that poor communication is a key factor which contributes to service user dissatisfaction and complaints in the UK (The Information Centre for Health and Social Care, 2011, 2012, 2013), and internationally (Montini et al., 2008). However it is unclear what exactly it is about communication which results in service user complaints or whether effective communication can help reverse a complaints situation so that informal complaints do not lead to formal, written complaints and increased patient/carer dissatisfaction. Unlike formal written complaints which are handled by dedicated senior staff within health organisations in the UK, junior front line staff handle informal complaints in clinical areas (Parliamentary and Health Service Ombudsman 2014). There is some research evidence of how doctors and institutions respond to complaints (Stokes et al., 2006; Allsop & Mulcahy 1998; Nettleton & Harding 1994; Carmel 1988; Fisher 1984) including a paper published by Shojania & Dixon-Woods (2013) in the light of failures in care delivery such as the Francis Report into the Mid Staffordshire Foundation Trust Public Inquiry (Francis 2013; DH 2012). But there is little work on how front line midwifery or nursing staff respond to informal, verbal complaints in clinical areas.

British midwives espouse woman-centred care as an ideal of practice endorsed by government and the profession (Royal College of Midwives 2014). Woman-centred care means that women and their families should be at the heart of everything midwives do in practice. They should be given choice in place of birth, caregiver and care, and be given control over their own care and experience (Page 2003: 33). This philosophical

approach to care has emerged in the context of a broader agenda in health towards power-sharing with patients and families (Hogg 1999).

However, woman-centred care is a contested concept which is enacted in everyday practice in organisations which may constrain such aspirations towards woman-centred practices (Leap 2009). It is also the case that midwives, although experts in normal childbirth, work in contexts that are framed by discourses of risk, with fear of litigation dominating (Mackenzie Bryers & van Teijlingen 2010). This may add to tensions between practice ideals and reality and lead to ambiguity and defensive practice (Scammell 2011). We have written elsewhere about how midwives experience their work as tightly bound by structural constraints such as workload and staffing, NHS Trust policy and health and safety concerns (Author under review). Two of the authors have commented on how routine (Author et al., 2009), geographic spaces in clinics (Author 1999) and boundary work (Authors 2004; Authors forthcoming) shape the delivery of women's reproductive care. In this paper we develop these ideas on boundary work and routines to discuss what *meaning* complaints have for midwives and how they respond to informal complaints in a midwifery unit. We draw on findings from an action research (AR) study[1] into informal complaints management in a midwifery unit in one National Health Service (NHS) hospital trust in the UK. The aim of the project was to work with staff to explore their responses to informal complaints which they had identified as a challenging and stressful part of their work. Using findings from the (AR) project, we suggest that midwives struggled to understand women and their families' complaints

[1] Responding Effectively to Service users' and Practitioners' perspectives ON care concerns: challenging Sustainable responses through collaborative Educational action research (RESPONSE).

about the locked door and restricted visiting and rarely reflected upon the causes of these informal complaints while at the same time espousing woman-centred care.[2] The midwives in this study responded to individual requests to visit out of hours by bending the rules, while maintaining the general policy of restricted visiting. In this way, the door was a gate keeping device which allowed access to the unit within certain rules. However it remained a barrier to women and their families and, as a result, was a common source of informal complaints. We wish neither to blame the system nor the individual but see the individual midwife acting within a system which increasingly and inadvertently constrains woman-centred care. We draw on ideas of gatekeeping (Riley & Manias 2009; McEvoy 2000; Levy 1998) to extend the discourse around boundary making to understand the locked door and restricted visiting to the midwifery unit as forms of gate-keeping which are seen by midwives as holding protective barriers, and by women and their families as boundary markers which had exclusionary functions.

Boundary work in maternity care

Discussions of boundary work in maternity care are few and those that do exist have focused mainly on the identity work that is undertaken at the interface of professional boundaries. These include studies of inter-professional boundary work between midwives and doctors (Authors in press) and intra-professional boundary work between midwives of differing status (Author 2005). Underpinning both types of boundary work are competing discourses about childbirth, including who provides care and how. Such

[2] There are of course arguments in favour of restricted visiting and maternity units vary in their restrictions For example, some have open visiting for partners but restricted visiting for others; visiting by partners at night, except on the delivery suite, would be very rare however.

analyses draw on the work of Gieryn (1983), who described how early science sought to identify itself as a separate discipline by drawing discrete boundaries that clarified its uniqueness. Gieryn has argued that contemporary professions may similarly attempt to highlight the superiority of their distinctive approach and philosophy, via discourses that legitimatise their perspective. Such strategies are most commonly used when there is a desire to hold on to professional autonomy or expand into another profession's territory. Gieryn's work has been used to explore the boundary work undertaken between various professional groups, including nurses and doctors (Allen 2001). There is much less evidence that the concept of boundary work has been used to interpret negotiations between service users and midwives in maternity care where there are clearly a number of boundaries between professionals and women and their families that need to be navigated [3]. These include physical boundary markers, such as locked doors, that create firm demarcation lines between the 'public' territory of the hospital corridors, waiting rooms and the 'private' territory of the maternity unit. In our data these physical boundaries are negotiated by bending rules and gatekeeping through the locked door to the maternity unit. Viewing how access to these territories is negotiated through the lens of boundary work and gatekeeping may throw new light on what is happening at this interface.

Gatekeeping and maternity care

We make a distinction between the ways in which the midwives in our study mapped out geographically and physically their spaces of practice (Fry & Stainton 2005) with

[3] There is also of course the need to negotiate access to the woman's body but this is not the focus of this paper.

Levy (1999)'s concept of territory making whereby the midwife maps out her legitimate area of professional expertise and practice. We focus on the physical barrier of the locked door to the maternity unit and the gatekeeping strategies used by the midwives in this study to maintain geographic integrity and hence some form of control over activity in the maternity unit. We argue that the midwives were both constrained to use the door and used access to the unit as a gatekeeping device in compliance with hospital policy while at the same time believing that this gatekeeping function had some legitimacy. We suggest that this behaviour was shaped by notions of professional power as in previous work into gatekeeping yet is also evidence of a professional disempowerment. This work has emphasized the use of gatekeeping to control access to information (Riley & Manias 2009; Street 1992) often in strategies to assert professional control over careers or families (May et al 2001) or other professionals (Manias & Street 2001). Often this body of work has suggested ways in which gatekeeping is a form of interaction. So for example, Riley & Manias (2009) use a network model of gatekeeping (Barzilai-Nahon 2008) to argue that gatekeeping can be understood as a form of power relationship between stakeholders to control information. They illustrate this form of gatekeeping at an interpersonal level of interaction. In midwifery, Levy (1998) describes protective gatekeeping, whereby the midwife suppresses or releases information to protect the woman, and herself. Levy construes protective gatekeeping to involve information flows rather than any sense of physical or geographic use of space. Similarly, Sinivaara et al. (2004) describe how midwives may withhold information about managing labour when communicating with women in delivery rooms as a protective

function rather than a controlling function and argue that judging how much information women needed to make informed decisions was an individualised matter and difficult to determine. Our data do not show evidence of these forms of gatekeeping.

We draw firstly on McEvoy (2000)'s meaning of gatekeeping where he emphasises the protective or safety function of gatekeeping from its historical meaning 'where the role of the gatekeeper in the watch tower was to keep watch at the town entrance and protect the town by sopping unauthorized persons from passing through' (2000:241). Secondly we use Fry & Stainton's (2005) ideas around geographies of care as forms of gatekeeping to explore how geographies of care enforce boundary making. And we develop Riley & Manias' (2009) ideas around gatekeeping as an interaction to explore the relationships between the gated (women in the maternity unit) and the gatekeepers (the midwives) to understand how the women's families might be conceived as either legitimate or illegitimate challengers of gatekeeping.

In this paper we argue that boundary making is enacted through gatekeeping between professionals and women and their families. It is these negotiations over gatekeeping, including the bending of rules as a form of gatekeeping and how these are experienced by midwives and service users, that form the focus of this paper.

Study design

AR methodology investigates complex, organisational phenomena through the use of mixed methods and stakeholder engagement in iterative cycles over a period of time (Author et al., 2012). The aim of the study was to explore frontline staff experiences in

handling informal complaints and to develop a guide to best practice for staff who manage informal complaints. The project team and the ARG included health professionals, a service user and an NHS senior manager; a combination of their past experiences and their shared reflexivity were integral to analysing the data (Rudge 1996). The project was given a favourable opinion by the NHS Research Ethics Committee, the NHS Trust's Research Governance Committee, and by the University Ethics Committee. The study had two phases and multiple types of participation. In the preparatory phase, collaborators and potential participants were informed about the project. Initial interest in the study was stronger among midwives than nurses and a decision was taken by the research team early on to focus the study's work on midwives (Author et al., 2012). Participants were reassured about anonymity and exceptions to confidentiality were highlighted. Participants signed consent forms before each supervision. An action research group (ARG) was actively involved in all the stages of this project and the NHS Trust Board were informed of findings at key points during the research.

Phase one included a literature review, in-depth interviews with key trust stake holders and scoping of trust complaints data to inform the interventions in phase two which included interventions with midwives, the administration of a staff survey and service user interviews. The interventions with midwives, which inform this paper, were conducted as audio recorded group supervision sessions which met regularly between May 2012 and January 2013. Six midwives met eight times for approximately an hour each time on trust premises; all the meetings were facilitated by the same researcher.

The number of participants attending each session varied between one and six, and the style of the supervisions and role of the facilitator varied according to the number of participants (Selby 2000). Participants were asked to reflect and make notes about significant clinical experiences related to informal complaints to bring to discuss at the group sessions. The intervention therefore consisted of a time to reflect on and change practice (Selby 2000) and the content of each session varied according to experiences brought by the participants.

The audio recorded interventions were transcribed verbatim and analysed using the soft ware NVivo (QSR International, 2013) using a thematic approach (Thomas 2006). The coding scheme was then discussed, revised, and agreed on during a data analysis work shop with the research team and discussed with the action research group (ARG). The subsequent analysis generated sub ordinate themes [organisational issues, domino complaints, patient focus, poor communication], which were then clustered into super ordinate themes: complexities of complaint; communication failures; unclear complaints systems for service users and ward staff. The findings described the complex context of midwifery practice which shapes midwives' responses to complaints. Complaints relating to the locked door of the maternity unit and restricted vising hours made up the bulk of everyday complaints in the maternity unit. They were framed as a misunderstanding of the rules by the women and their families by the midwife participants who viewed the locked door and restricted visiting as both legitimate or illegitimate barriers to the midwifery unit[4]. In this paper we discuss these findings in the

[4] In this paper we discuss the meanings attached to the locked door while acknowledging that a

light of literature on gatekeeping as a physical barrier of boundary making, as a form of protection of watch keeping, and finally explore the relationships between the gated (the women), the gate keepers (the midwives) and the breachers of the gate (families and the partners). When presenting the findings no demographic information is provided. This is to preserve participants' anonymity given the small sample used from one trust[5].

Gatekeeping as a physical barrier

In their notes, the researcher described their experience of accessing the maternity unit:

> "I feel like maternity is like a separate contained world tucked away from the rest of the hospital – a world I have enjoyed visiting but like service users I have also had to grapple with the locked door and the intercom, presenting my case satisfactorily to get access"

In this quote the key themes of maternity – and hence midwifery - being separated physically (by the door, intercom) from the main hospital is evident but also there is a sense of a) the negotiation necessary to be *allowed* to enter this separate world; and b) the rules by which negotiation is either effective or not.

But gatekeeping was not always a physical barrier as rules existed for visiting different areas within the maternity unit e.g. post and ante natal patients; these invisible barriers between different patient groups appeared to be justified by midwifery knowledge. In the following quote Gina, the midwife, applies different rules for visiting based on a

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restricted visiting policy may be a legitimate security policy.

[5] All names have been changed to protect anonymity

woman's natal status and is surprised by this geography of care not being understood by the visitor.

> Gina: A senior colleague approached them and said 'I'm ever so sorry that it's not visiting hours'. Not realizing that the lady was an antenatal patient not a post natal patient and there are different visiting hours for the two (SG 06/09/12)

This example had given rise to an angry informal complaint by the mother of the postnatal woman who, on overhearing that the antenatal woman's visitor was allowed to stay, did not understand why she was unable to stay as well. What is interesting here is how the differing needs of post natal and antenatal women, i.e. different visiting hours, were seen as justifiable to the midwife but less obvious or indeed unknown to the service user. Furthermore, Gina did not perceive this lack of user knowledge as a deficit to be remedied in some form of explanation. While the rules may have a (good) rationale, there appeared to be little recognition by the midwives in the SGs that the rules around such geographies of care (Fry & Stainton 2005) are difficult to understand for the women.

<u>The protective function of gatekeeping: keeping watch</u>

Complaints about controlled access to the unit through the locked door and the restricted visiting hours were familiar to the midwives. When reflecting on their responses to these complaints in the supervisory groups (SGs), the midwives explained the rationale for the locked door and restricted visiting was to protect the women and babies. They justified the controlled access as primarily for the babies' safety.

> Julie: Absolutely, because we've got new-born babies…you have to have an element of security and protection for them and their families…anywhere with children (SG 03/08/12)
>
> Liz: Very new grandparents…had raced across the country really to see their brand new grandson on the post natal ward…it was mid-morning and of course they weren't let in because it wasn't visiting time (SG 25/06/12)

Midwives described being alert at all times for outsiders to the unit and challenging outsiders (in the following case a man) to provide a legitimate reason for being on the unit.

> Bella: I'd come on a morning shift and there's a gentleman in the corridor so quite rightly you sort of 'hello, who are you with?'…I think 'oh that's interesting, she [the mother] hadn't just come back from the delivery suite so she'd been here for 12 hours so I asked 'have you just come in or have you been in a while?'…would you mind going out and coming in at 9 o'clock because visiting doesn't start until 9'. He was incredibly angry because he'd been told to come in …it was most likely to have been the mum [that is, who told him this] but he was indicating it was a staff midwife (SG 03/08/12)

This extract is important for several reasons. Firstly, it indicates that the midwife felt she had a right to challenge a man she did not recognise '*so quite rightly you sort of 'hello, who are you with*' even when new on duty and she could not have known all visitors' faces for that shift. Secondly, the midwife did not trust what the father was saying to

her '*he was indicating'* which implies she questions the truth of his statement. The sense of suspicion and professional boundary making in this quote is striking.

Another rationale given by the midwives for gatekeeping the door and keeping watch over access to the maternity unit were midwives' descriptions of feeling under threat from families' aggression. Discussion of the potential for aggression featured heavily in the supervision groups although in the following quote Julie was reticent in saying exactly what she means by 'powerful reactions'.

> Julie: Things [in midwifery unit] do elicit quite powerful reactions in patients and visitors having to wait a long time ….occasionally in maternity you get physical aggression but it's very unusual (SG 17/01/13)

Midwives referred to calling the security team to support them in dealing with aggressive behaviour.

> Bella: If you decide this is a potentially really aggressive person who could cause harm to staff or whatever then it's, then you just get the security in (SG 25/06/12)

In this quote, Bella implies that at this stage in an interaction with a family member, the midwife's watch keeping became insufficient and security had to be called.

But midwives also described quite subtle experiences of aggression where aggression was implied and covert.

> Liz: the husband was very controlling…it wasn't a case of 'oh don't do that' but it was a real tone to the voice and it was really very unpleasant to the point which I

felt slightly vulnerable, very, very uncomfortable being in that situation…I didn't want to be on my own with the husband in the room (SG 25/01/13)

Clearly some forms of aggression were a) startling and b) unacceptable.

Mia: the worst one was a man who came up to me, who grabbed me by the throat and my name badge and basically held me up…. (SG 16/10/12)

However Mia, later in the SG, reflected on how this particular incident would not happen to her now as she had learnt how to manage similar situations and keep herself out of harm's way.

Mia: It came as a bolt out of the blue to me, I was too naïve to pick it up, pick up any warning signals. Whereas nowadays I would be aware, much more aware of you know backing away, I wouldn't be standing that close to him to allow him to do that…because I've learnt and I suppose the conflict training has helped with that.

But Mia feels that the aggression is often caused by long waiting times:

I think a lot of the problems happen when we don't keep people informed, but that was about delays getting to labour ward and to be honest I don't find here that's as bad as in London (SG 16/10/12)

Given these examples of physical aggression, while physical aggression may be rare it is clearly frightening for the midwives and explained their keeping watch and gatekeeping over the door to the maternity unit as Julie suggests below:

Julie: there are some situations where the [intercom] actually it helps…when you're faced with someone who's incredibly aggressive in front of you and

you've got to deal with their aggression that's in front of you and that is incredibly frightening (SG 03/08/12)

So the door to the midwifery unit was a way to control and in some cases restrict access. But midwives were willing to bend the rules when they felt less keeping watch was required. These negotiations around gatekeeping between midwives and the women and their families and partners are now discussed.

Negotiating gatekeeping

Relationships between midwives, the women they cared for and their partners and families were shaped by differing professional and lay expectations. These differences can be seen as a form of boundary making where midwives used gatekeeping over midwifery tasks as a form of control over what was and what was not midwifery. These differences gave rise to gatekeeping by midwives and consequently complaints around access to the maternity unit through the locked door.

Gatekeeping as a geography of care defining midwifery work

Midwives described their own frustrations with the perceived demands of women and their families while at the same time recognising the probable causes of the women's frustrations as Gina and Liz acknowledge:

Gina: it's really difficult, I'm spared the antenatal ward complaints but occasionally we'll have women who wait 5, 6, 7 hours

Liz: or longer

Gina: it's no wonder they absolutely furious (SG 17/05/12)

Admission to hospital from the ante natal clinic to the ante natal ward during pregnancy is relatively unusual and indicates that there may be potentially serious concerns about the wellbeing of the mother and/or her baby. So a woman waiting in antenatal clinic for admission may feel anxious above and beyond feeling frustrated with the long wait. Although Gina does acknowledge the women's frustration '*It's no wonder they're absolutely furious'*, she does not comment on the potential anxiety. In fact Gina appears to frame the women's wait as having nothing to do with them, '*I'm spared*' perhaps as a way of coping with the anxiety. This quote *'I'm spared*' suggests clear geographies of care between different areas in the maternity unit (in this case, the ante natal clinic and ante natal ward). It also suggests that these geographies of care are forms of boundary making between the midwife and the woman as in the following quote:

> Bella: yeah we like look at priorities really, our priorities are different to women's (SG 17/01/13)

These quotes suggest that gatekeeping as a geography of care might have been a way to survive in a busy NHS unit, literally to *spare* themselves the discomfort of witnessing women's emotions (Author 2009) by boundary making '*our priorities are different to women's*.

Another way of boundary making through creating geographies of care was by defining certain requests for help by women as *'silly'.* In the following quote, it is clear that the midwives had a hierarchy of legitimate tasks which they would either see as justified or unjustified requests. So changing a nappy may or may not be legitimate whereas picking up a piece of paper definitely is *silly*:

Bella: when patients say 'are you busy?', I always struggle to know how to answer that, because I never wanted to say 'yes we're busy' because that seems wrong…I don't want them to trouble me to pick up a piece of paper…do something silly but where a baby's nappy needs changing [after a C section]? (SG 17/01/13)

In some instances, midwives believed that service users would complain about expectations of achieving a birth which were not possible for clinical reasons.

Bella: They had a complete and utter ideal about how their baby was going to be born which is fine until reality means it needs to be different…I think it threw them off and everything wasn't good enough from then on (SG 03/08/12)

Everything in this case included the complaint that the midwife was too young and therefore perceived to be presumed to be inexperienced. This latter complaint was described in the SG as unreasonable.

Midwives were aware that women expected care for a wide range of seemingly (to the midwives) non-clinical tasks. For example, in the following exchange, Bella and Julie are talking about women asking them to change a nappy which they resent as it is not (in their eyes) a clinical task:

Bella: you wouldn't have complained about the fact that you didn't have all your observations done correctly…but you would have complained about the fact that you

Julie: nappy

Bella: yeah the nappy and that's the difference, we look at it as two different points of view

Julie: to women?

Bella: yeah. (SG 17/01/13)

What is interesting is that these midwives did not describe that they explained these geographies of care, i.e. why a nappy change might be 'less' of a priority in a busy post natal ward than observing for say, post operative bleeding. In this instance, they did nothing to break down the boundaries through sharing knowledge (Levy 1999; Riley & Manias 2005). In other cases, they did shared their knowledge for example about delays in antenatal clinic. So midwives described advising women to take certain actions in order to prevent complaints somewhere else in the system.

Bella: a woman comes in with a bleed, it's likely she'll stay for 24 hours, so saying to that woman on the phone 'bring a bag with you, you're likely to stay for…' she's kind of set up and that's in her head already whereas if someone isn't informed and …worse they wait around for three hours thinking they're going to be seen and then they're told 'oh no you're going to have to stay overnight'….(SG 17/01/13)

Bending the rules as a form of gatekeeping

While midwives used gatekeeping as a form of boundary making, they also used it flexibly in individual instances; in this situations rules were bent to allow access into the unit outside visiting hours.

Bella: And sometimes you end up sort of negotiating with them and I might say 'oh come on for five minutes but that's it, you can have five minutes and then you're off'

Liz: Yeah

Bella: Which I know is breaking the rules

Julie: It's really difficult

Bella: Left, right and centre (SG 25/0612)

In these conversations the midwives appear to empathise with the service users *1st grandchild, 'flying off to Texas'* and experience the imposition of the policy of restricted visiting as '*hard*' or hopeless.

Liz: find it very frustrating the whole visitor thing because we do, the information is given out isn't it, all over the woman's notes, it's there…there's notices all over the place but people still try it on…'we were never told and it's my first grandchild' and all this sort of stuff…Yeah or I'm going off to Texas tomorrow so I really need to get in now to see this child and it's hard.

Bella: And it's also hard, you picked up on it, to have a conversation that's of any meaningfulness to either party through an intercom.

Liz: It's hopeless isn't it, hopeless (SG 25/06/12)

And in a later conversation in the same SG:

Liz: It's very frustrating

Gina: It's really hard to deal with because you are limited to what you can do about it

Mia: and it's tiring and stressful because you want to give care to patients and sometimes all you're doing is fighting fires and apologising. (SG 17/05/12)

The door and visiting hours were rules within the system yet midwives were aware that these rules were not always self-evident to women or their families. However they accepted these rules and bent them rather than challenged them.

Julie: it's not totally understanding the system and trouble is we know the system so well…it's really hard to remember what it's like not to know it…being a patient yourself …it really, really makes you realize how difficult it is to be a patient and very disempowering, it's scary but for us it's our second home….(SG 17/01/13)

What is interesting in this quote is how Julie acknowledges women's difficult position as patients. In many instances in the SGs midwives described an ambiguous positioning vis a vis the rules and the system. On the one hand they explained that the rules about restricted visiting hours and controlled access through the door were to provide rest and security for women and babies, i.e. they were based on clinical considerations. Yet they gave examples of not always enforcing visiting rules as well as other rules.

Liz: I was doing a drug round and wearing a yellow tabard and it says on it 'please do not disturb. She says 'I know, I know it says on your tabard that I can't interrupt you but…' and she wasn't very happy because she'd had contrasting advice…I wouldn't say 'I can't talk to you now', that's not going to help the situation. I think you have to judge the situation (SG 25/01/13)

In this quote it is clear that although Liz understood the rule, she did not see it as constraining her actions; she was prepared to break the rule of not talking while doing the drug round. In certain circumstances, midwives appeared to understand service users' frustrations with how the maternity unit was organised yet felt powerless to remedy this situation. As Julie explains in relation to complaints generally:

> Julie: It's really hard to deal with [complaints about delays] because you're limited to what you can do about it.
>
> Iona: And it's tiring and stressful because you want to be giving care to patients and sometimes all you're doing is fighting fires and apologising.
>
> All: hmmm
>
> Iona: ad you feel like you've gone around all day apologizing all day rather than...and your time is wasted.
>
> All: hmmm (SG 10/05/12)

They appeared to experience their work as tightly bound by structural constraints such as NHS trust policy and health and safety concerns which they had no control over (Author under review).

> Julie: The resource issue has got worse over time….more high risk women
>
> Bella: Lots more bits of paper (SG 17/01/13)

Hence they bent the rules in individual cases by allowing unrestricted visiting and in some instances uncontrolled access within certain conditions, but did not feel they could change the general policy on restricted visiting or controlled access. The door therefore appeared as a self-evident necessity to midwives but they understood it

appeared as a gate keeping device to women, their partners and families. This theme emerged as a key point in the data analysis as we struggled to explain the reflections in the SGs which showed individual acts of empathy and bending the rules while at the same time upholding the general policy if restricted access to the unit. However sometimes individuals' actions might have consequences as their autonomous actions may not be communicated to others in the midwifery team. In the following extract a midwife reflects that such bending of the rules in one area of the unit can have negative consequences for a colleague at a later date:

> Julie: [A young mum] was told in ante natal [that] it would be okay if her mum stayed with her. Absolutely fine if granny stayed with her overnight because she was young….when told on labour ward that the [granny] couldn't stay, she got aggressive after being talking to and explained (about visiting). (SG 25/06/12)

Bella: And that's the problem with as we were saying before about visiting is that sometimes you let, you let *[all agreeing]* a partner stay and other women will know that that partner stayed so then they come in and labour and they want to know what that same rule isn't being bent for them *[all agreeing]* and you so, but when you're faced with someone who is in early labour, is sobbing because she's in pain and you're saying her partner's got to go and leave her on her own, it's really difficult and we're frustrated because we don't, it would be much easier for us if their partner stayed. (SG 25/06/12)

Bella's remark about the presence of men during early labour on the antenatal ward was frequently discussed by the midwives and was a common cause of informal complaints. She suggests that her focus was on the needs of the workforce '*would be much easier for us*' if the partner stayed, rather than empathizing with the '*sobbing*' woman and her desire to have the support of her partner. This lack of criticality regarding the organisational procedures, which appear in this quote to have negative consequences for this woman, has been noted before (Kirkham 2000; Levy 2006). Bella does not appear to consider the disputed nature of early labour and how early labour is experienced by women as opposed to how it is constructed by professionals (Janssen et al 2009). This may be because Bella feels she cannot change organisational rules and policies as illustrated in the following quote:

> Bella: You've got to have time and we just sometimes, if you have to weigh up between doing that and giving care to a woman, it's clearly quite right you go with the giving clinical care, that's a constant balance that you've always got, how much time do I give to both? (SG 25/06/12)

Bella appears to believe that there are risks in breaking the rules. But these data also suggest a professional disempowerment which is unacknowledged. This sense of disempowerment could explain defensive forms of practice suggested both in Bella's quotes and in Julie and Trudie's discussion below. In the following quote, the midwives suggest that changing one rule would risk all rules being threatened, which in turn would threaten their professional practice and put them at professional risk; that is,

'*you're not covered'*. What is striking about this quote is their use of boundary metaphors such as pushing, territory:

> Julie: If you start to bend the rules that's when you're getting into dodgy territory because as soon as you start then the lady and partner are aware that you can, and they know they'll push everything (all laughing)
>
> Trudie: then you're not covered as well, so even if there's a complaint later in future, you're not covered. (SG 25/06/12)

For Ruth, the solution is to manage expectations rather than change the system to avoid complaints:

> Ruth: It's managing their expectations isn't it…hopefully it stops them from making those informal complaints…we know it's a problem all the time (SG 17/05/12)

The extent to which the AR approach used in this project facilitated a change in rules and policies is addressed elsewhere (Odelius et al forthcoming).

Discussion

This action research project exploring frontline midwives' experiences of handling informal complaints has provided unexpected insights into the ways in which midwives manage service user and professional boundaries through gatekeeping, and how the potential flexibility of physical boundaries is interpreted and acted upon by bending the rules. It should be noted that the data we present are derived from eight consecutive groups held with a sample of six midwives working within one NHS Trust setting, and their experiences may not represent those of midwives working in other settings.

Nevertheless what is striking about these findings is the way in which individual midwives describe using gatekeeping flexibly to bend the institutional rules. At other times feel they have to 'hold the rules together' and reinforce gatekeeping practices. Our data show evidence of compromised care practices, suggesting that the system for some midwives is a constraining one, where they maintain the policy despite feeling frustrated and hopeless. However as illustrated in this paper, they did not move beyond recognising the constraining system which shaped the care they felt able to deliver; in other words, they did not challenge the system. In the light of reports of a lack of caring in the NHS (Francis 2013) these midwives' actions seem to show varying levels of empathy towards women's needs. Despite descriptions of numerous user complaints about the system of restricted visiting, there were no data on any challenges to this policy which suggests at a system level even when using control through gatekeeping, they do not feel empowered to act and change practice within the NHS. We suggest that the midwives respond to challenges to controlled access and restricted visiting from their positional power as midwives and use the locked door and restricted visiting as ways of reinforcing their authority through boundary making.

As discussed earlier, boundary work is undertaken to delineate territory between groups or individuals. The term is generally used to describe demarcation lines between different professional groups in relation to their conflicting claims for occupational jurisdiction, rather than between service users and health professionals. In many health care settings, there is simply no need to clarify the boundaries between users and professionals – these are made explicit by the patients' condition and their need for

professional expert assistance. But current day maternity care is different; the emphasis is on birth as a normal life event, most women and their babies are well and, in the ward settings described by the participants, they are often either waiting to give birth or to go home. This may make it more likely for boundary struggles to ensue. Women and their families may challenge the formal physical boundaries of the unit in order to ensure their needs as a family are attended to and they receive the woman centred care they have been expecting. The midwives respond to these challenges by acting as gatekeepers, exercising a degree of flexibility, but gatekeepers all the same. Understood in this way, bending the rules at times and not others is a powerful gatekeeping tool to maintain authority in the face of challenges from women and their families. We suggest that the rules are more likely to be bent when the request does not seriously challenge the midwives' authority or upset the institutional routine, *you can have five minutes and then you're off*. In situations where the individual midwife has much less discretion or authority for example, *fathers staying overnight is as a general rule, no, absolutely not*, then midwives appear to respond by enforcing the rules rather than bending them.

We argue that our findings suggest that complaints about controlled access and the locked door suggest that there is boundary work going on between women, their families and midwives underpinned by attempts to exercise control and power. The access issues are actually underpinned by struggles related to control over birth and woman centred midwifery. Midwives experience dissonance between their espoused ideals of woman centred care and the need to attend to the needs of the institution

(Author 2004) . Bending the rules enables them to provide woman centred care to individual women, albeit rationed, but when they feel their authority is challenged or workplace demands are too great, they revert to institutional care mode.

Conclusions

We have illustrated two strategies used by midwives in our small study, bending the rules and holding the rules together, which are evidence of attempts to challenge organisational power (bending the rules) while at the same time exerting professional power (holding the rules together). Holding the rules together is effected through boundary making which we have argued is enacted through gatekeeping between professionals and women and their families in one maternity unit. We have focused on the watchkeeping function as a protective device and the control of the geography of care as ways in which midwives enact their use of gatekeeping access to the maternity unit. We have also presented the negotiations which midwives use with women and their families, including the bending of rules as a form of gatekeeping and how these are experienced by midwives and service users. Our findings are not conclusive to allow us to argue that midwives unequivocally maintained their professional power and authority in the light of challenges by women and their families. They used gatekeeping to maintain their professional power in some instances but not others. This may be because they themselves felt disempowered within the organisation and attempted to assert control over women and families; this stance then allowed them to empathise with the women while not requiring them to challenge the organisation.

Our findings throw up some interesting insights into potential causes of failures to challenge poor practice. While the Francis report (Francis, 2013) argues that staff have to be enabled to raise such issues of poor care and that clinician leadership should be able to drive service improvement (such as the long waiting times described in our data), we suggest that this is an over simplistic explanation of failure to change systems in the NHS. There is evidence in our data that staff can identify improvements that could be made but not challenge the system. We argue that the lack of challenge may not be caused by disempowerment but because established boundary making practices (Author in press) may enable midwives to exercise agency in a working environment that provides limited opportunities to exercise autonomy. This is an important finding which provides evidence of the tensions midwives experience of holding an ideal of being 'with woman' but within a context where meeting institutional needs (processing women efficiently through the system, 'getting through the work' etc) is what is valued by managers and colleagues. The tensions are exacerbated by complaints from women and their families who are expecting woman centred care and are frustrated when this is not forthcoming.

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