**Role Redesign in the National Health Service: The Effects on Midwives' Work and Professional Boundaries**


## ABSTRACT

This article examines the effects of role redesign on the work and professional boundaries of midwives employed in the National Health Service. It outlines midwives' views and experiences of attempts to change their skills and professional boundaries and, using the concept of closure, considers the implications for the midwifery profession. The findings show that role redesign is changing midwives' work and that the traditional emotional, social and caring skills associated with a midwife are being undermined by the growth in technical work. Importantly, midwives attempts to use closure have met with limited success and aspects of their work which they enjoy are being delegated to maternity support workers, while midwives' roles expand to include work traditionally performed by doctors. Midwives' concerns about the implications of work redesign for maternity care and their professional boundaries reflect the uncertainty surrounding the profession about the future role and skills of a midwife.



**KEY WORDS**:
closure/ midwives' work/ National Health Service / professional boundaries / role redesign


## Introduction

Midwives are a relatively small but significant group that have fought to retain a separate professional identity, particularly from nursing, and a distinct role in the provision of maternity services (NMC, 2004; RCM, 2004; Taylor, 2004:41; NMC, 2005). However, midwives' work and professional boundaries are being challenged from within the profession, by the medical profession and by the government's agenda to modernise working practices in the National Health Service (NHS) (Department of Health, 2000a; Department of Health, 2000b).

This article explores these issues and uses the concept of closure to analyse the effects of the current NHS human resource management (HRM) strategies on midwives' work and professional boundaries (Parkin, 1979). The aim is to examine the following questions. First, does role redesign provide midwives with the opportunity to extend their influence? Second, does role redesign lead to midwives being de-skilled and a loss of power? Thirdly, what are the consequences of role redesign for the midwifery profession?

Using a case study approach to address these issues, the researchers examine midwives' views of their key skills and the effects of work redesign on their roles and autonomy. The development and expansion of the role of the maternity support worker is also explored. The findings demonstrate that midwives have tried to use closure to control their role, but have had little success. Role redesign is transforming the professional boundaries of midwifery and their traditional social and emotional skills are being eroded or replaced as they take on more technical roles previously undertaken by doctors. At the same time, the role of the maternity support worker is expanding to incorporate some of the midwives traditional social and caring roles, which midwives are reluctant to relinquish.

**Professional Closure**

In order to understand the effects of work redesign for midwives it is important to consider how different professional groups have responded to attempts to change their boundaries. This analysis will be conducted using the concept of closure and how it has been utilised (Parkin, 1979).

Walby et al., (1994:63) explain closure as, 'a set of practices whereby an occupation creates a monopoly over its skills and prevents others from practising that trade who do not have recognised membership to the profession'. Both established and aspiring professions use closure to protect and preserve their boundaries and to expand their control into other recognized job territories (Abbott, 1988; Macdonald, 1995). The ability of an occupational group to do this depends on their power base and whether they can exercise exclusionary closure, the means by which a powerful group controls a less powerful group (Parkin, 1979; Abbott, 1988; Witz, 1992; Salter, 2004). For example, in the NHS the creation of routine supportive roles, in the form of support workers, has helped health care professions to exercise exclusionary closure.

Both doctors and midwives have used closure to maintain monopoly and power over their professional skills and boundaries. However, the outcomes have been very different and need to be understood in terms of the historical development of these two groups (Freidson, 1970; Donnison, 1977; Larkin, 1983).

The word midwife literally means 'with woman' and traditionally midwives were the main providers of maternity care, exerting considerable control and autonomy over their work and working practices (Donnison, 1977). Midwifery boundaries began to be challenged as the emerging medical profession used closure as a means of controlling maternity care and determining how it should be provided (Donnison, 1977; Arney, 1982). As a result, maternity provision moved out of the home, where midwives managed it, into hospitals where doctors controlled pregnancy, labour and birth. Doctors used a medical model of care based on invasive techniques, involving tests, monitoring and technical interventions (e.g. caesarean sections) (Kirkham, 1996; Bassett. et al., 2000).

The midwifery model of care differs markedly from this approach and advocates holistic, natural care and the development of a 'One to One' relationship between the midwife and woman (RCM, 2001). This requires midwives to utilise social and practical skills such as listening, supporting and observing a woman and striving, where feasible, to use minimal intervention during pregnancy, labour and birth.

The boundaries of midwifery care are legally and professionally defined by the *Midwives' Rules and Standards* and the *Code of Professional Conduct* (NMC, 2002; NMC, 2004). These require a midwife to be responsible for the safe conduct of 'normal' childbearing and the detection of abnormalities (Kirkham, 1996:166; NMC, 2002). If a complication arises during pregnancy or labour that is deemed to be 'abnormal', responsibility for the care of the woman is transferred to the obstetrician.

In contrast to midwifery, the medical profession has successfully used exclusionary closure to control their work and to determine the boundaries and skills of other occupational groups (Freidson, 1970; Larkin, 1983). This has involved doctors controlling what other occupational groups can do and delegating work that was traditionally part of a doctor's role, whilst retaining control over work processes (Harrison et al., 1992; Cameron and Masterson, 2003). The consequence of this for midwifery is that doctors' technical and repetitive tasks are being delegated to midwives who feel it is at the expense of their own professional expertise (Ball et al.,

2002). Increasingly, traditional midwifery skills are no longer practised and midwives are effectively de-skilled of their caring roles as this work is delegated to maternity support workers(MSW) (Sandall, 1991; Ball et al., 2002).

Midwives' work and boundaries are also being affected by the development and expansion of the maternity support worker role (Sandall et al., 2007). The NHS has regularly substituted 'qualified' staff with 'unqualified' to address labour shortages. The difference now is that the support worker role is being extended in a way that changes skill-mix and occupational boundaries (Wanless, 2002:57). This is exemplified by the social work assistant role which, rather than simply supporting professionals in their work, is now being developed to encompass a wider range of tasks (Kessler et al, 2006). A similar situation exists in midwifery (Prowse, 2005).

Historically, midwifery assistants undertook what was considered to be, 'low skilled', task-orientated work that was mainly clerical or domestic in nature (McKenna et al., 2002). Thornley argues that attempts by midwifery and nursing to achieve social closure, through registration, failed and that many:

'unqualified' people continued to engage in duties that could be defined as 'nursing', while, conversely, many registered nurses engaged in ancillary or auxiliary work. (Thornley, 2000:452)

Thus, the division of labour and skill substitution, between midwives and midwifery assistants, is not straightforward and complicated by the fact that the roles and skills of support staff are not fully understood (Thornley, 2003).

The introduction of the maternity support worker role in the early 1990s was an attempt to address this issue and signalled a direct challenge to midwifery boundaries. Support workers not only undertook National Vocational Qualifications, but were trained to perform some of the traditional midwives' roles. These roles involved providing continuous support to women in labour and having contact with mothers and babies (Lindsay, 2004). Many midwives remain opposed to developing maternity support workers and regarded this as an erosion of their role (Renton, 2004:5).

In terms of closure, both doctors and midwives want to retain control over their work boundaries and the development and delivery of maternity care. This leads to tensions between the two groups. A key factor shaping and affecting professional closure is New Labour's Modernisation Agenda which is directed at using human resource strategies to change working practices, redesign work and reduce professional boundaries (Department of Health, 2000a; Department of Health, 2000b).

**New Ways of Working: Role redesign in the NHS**

The impetus to develop what was termed 'new ways of working' and redesign roles was the White Paper, *The NHS Plan: A Plan for Investment,A Plan for Reform* (Department of Health, 2000a). This proposed a ten-year reform programme for the NHS and identified a number of problems with the structure and delivery of health care (Department of Health, 2000a:10).

The Changing Workforce Programme was established to implement 'new ways of working' and reduce the barriers to working that historically existed between different professionals (Hyde et al,. 2005; Bosanquet et al., 2006). This entailed redesigning workforce roles by developing new ones, reducing occupational demarcations by expanding the scope and breadth of jobs and developing interprofessional working across traditional boundaries (Department of Health, 2000b; Hyde et al., 2005; McBride and Hyde, 2006). Many of the current NHS HRM

policies claim that changing working practices will lead to increased productivity (Department of Health, 2005:26) and that job performance could improve if workers perceive closer links between effort, performance and valued rewards (Kelly, 1992). As a recent HRM policy document stated:

> Ultimately, working differently and productive use of time means local employers making full use of the talent available to them, gaining better service efficiencies and, importantly, boosting job satisfaction and motivation for staff. (Department of Health, 2005:26)

Despite the government rhetoric, debate about the purpose and effects of role redesign reflect the contrasting views surrounding this issue. Critics of the NHS HRM policies suggest that role redesign, rather than improving work satisfaction, is being used to reduce labour costs, de-skill staff and promote greater flexibility of labour (Appelbaum, 2002; Lissauer, 2003:15; Bach, 2004). Consequently, NHS human resource management initiatives are being presented in the guise of reducing interprofessional barriers, improving productivity and enhancing roles (Davies, 2003; Stubbings and Scott, 2004) but, in maternity care, are resulting in doctors' work being delegated to midwives and, in turn midwifery work becoming part of the maternity support workers' role.

**Research Methods**

This research took place between 2001 and 2004 and was based on a case study undertaken in a large NHS maternity unit, situated in a major city (XXXX, XXXX). A survey and interviews were used to explore midwives' views of the role and key skills of the midwife, the effects of work redesign and the development of the maternity support workers' role on midwives' skills and professional boundaries.

University midwifery lecturers were also invited to participate in the research (N=25) and the majority agreed (N=20). This group was included as they worked in both midwifery education and the maternity unit where the fieldwork took place (Table 1).

In order to gain a strategic perspective, senior respondents working in the health service, midwifery education and policy were interviewed (N=4). The union perspective was obtained by interviewing three national representatives from the Royal College of Midwives (RCM) and one regional union officer who covered the maternity unit.

INSERT TABLE 1 HERE

Initially, permission was obtained from the Head of Midwifery, to undertake the research and access midwives working in the maternity unit. A formal research proposal was submitted to the Local Research Ethics Review Committee (LREC) and passed with minor amendments to the question and answer sheet that accompanied the survey.

In order to protect the anonymity of survey respondents the questionnaire had to be distributed to midwives at their place of work rather than sent to their home address. The authors recognise that to increase the response rates it is preferable to send a questionnaire to named individuals, accompanied with a personalised letter (Nachmias and Nachmias, 1981).However, this was not possible due to the conditions of access imposed. In an attempt to ameliorate these constraints, midwives were sent an introductory letter explaining the research and inviting them to participate, together

with a questionnaire and a question and answer sheet outlining the research aims and providing some general information. The letter explained what consent and participation involved and stated that respondents could withdraw from the research at any point, with a reassurance that their anonymity would be maintained. Midwives who returned their questionnaire and agreed to be interviewed were deemed to have given their consent to be involved in the research. In order to maintain anonymity, those midwives who were willing to be interviewed returned the form with their personal contact details in a separate envelope from the questionnaire.

The survey consisted of eight pages, divided into five sections that contained a mixture of statements with Likert scales and open-ended questions. In November 2003, the survey pack was sent to all the hospital and community midwives working in the maternity unit (N=277). Respondents were given three weeks to return the questionnaire in a pre-paid envelope (Sarantakos, 1998). A repeat questionnaire pack was sent out in January 2004, together with a letter, thanking those who had responded and urging those who had not completed the survey to do so (Jackson and Furham, 2000; Bowling, 2002). A total of 63 questionnaires were returned, a response rate of 23 per cent. There are mixed views about what constitutes an acceptable response rate and although it was low, the data provided was important and used to produce descriptive data (Rea and Parker, 1992; De Vaus, 1996). Twenty-one midwives sent their personal contact details and agreed to be interviewed and these interviews were conducted over a five month period.

In total 49 respondents from all the groups approached were interviewed. This involved a semi-structured, audio-taped interview lasting a minimum of one hour. An interview guide was used as a prompt to cover issues such as midwives' roles and skills, the role of the maternity support worker and the effect of work redesign on midwives' work. All the respondents agreed to be tape-recorded and a copy of the transcript was sent for their comments (none were returned).

Analysis of the survey and semi-structured interviews initially involved sorting and thematically coding the material and identifying the prevalent themes. Therefore, once the questionnaires had been returned the frequencies were calculated and the data sorted into themes. Content analysis was used to analyse and sort the interview data (Weber, 1990: 9). The major themes were identified using colour coding, then manually sorted and categorised into main headings and sub-categories, with appropriate quotes to support them. These categories were constantly revised to ensure that all the significant issues had been captured. Using these techniques data saturation was achieved (Strauss and Corbin, 1998).The following discussion presents the findings and is organised around four themes: the key skills of a midwife, the effects of work redesign on midwives' roles, midwives' autonomy and the role of maternity support workers.

**The Key Skills of a Midwife**

In order to protect midwives' skills and work, the Royal College of Midwives stipulates that a midwife's role is to provide continuity of care for women and develop a relationship and rapport with a woman (RCM, 2001; RCM, 2002). Therefore, one of the first issues the researchers wanted to establish was what midwives felt were the key skills and roles of their profession.

All the respondents considered social and emotional skills as imperative and described these as: 'being with woman', 'supporting women in pregnancy and labour', and, 'providing care and reassurance'. Midwives explained that in normal childbirth they use a non-interventory approach. As one midwife explained:

> ‘A lot of what a midwife does is actually not do anything. So a key skill that she has is not to do anything at all. She is there to monitor and support women’.

Although respondents acknowledged the need for midwives to have ‘good practical skills’, these were not considered as important as the key midwifery skills. This conflicts with the NHS HRM agenda, which is creating new roles that are medical/technical in nature and do not allow midwives to practise the social and emotional skills they identified as a crucial part of their job (Department of Health, 2000b; Department of Health, 2002). This HRM Agenda not only challenges midwives professional boundaries, but undermines their attempts at closure as maternity provision shifts from a ‘normal’ social to an ‘abnormal’ medical model of care.

**The Effects of Work Redesign on Midwives’ Roles**

A central premise of the NHS HRM strategies is the need to redesign workforce roles and develop new ones, whilst at the same time expanding the scope of jobs so that staff can take on new responsibilities and skills (Department of Health, 2000a; Department of Health, 2000b). The effect of this for midwives was discussed in terms of the increase in “extended roles” and the development of new specialist midwifery roles. Both illustrate the changes occurring to midwives’ work, but have different implications for midwifery closure.

The concept of extended practice (UKCC, 1992) is based on the premise that midwifery training provides students with basic midwifery skills (Dunn and Newton, 2000:112). Qualified midwives who want to perform extended roles are required to undertake additional training and be ‘signed off’ as competent to practice. Generally, extended practice covers roles that doctors formerly undertook and are often repetitive, requiring technical rather than midwifery skills (Dunn and Newton, 2000:112).

In contrast, the development of new specialist midwifery roles (e.g. health promotion, smoking cessation, teenage pregnancy, substance misuse) signalled an attempt by midwifery to promote professional closure by creating new roles that used the midwifery model of care and expertise (Department of Health, 1999).

Within midwifery tensions existed about the effects of extending practice or developing new specialist midwifery roles and interviewees did not exhibit a collective approach. Some were prepared to undertake these roles, in the belief that it would enhance their status (Lessing-Turner, 2004), whilst others declined. Similar, differences were voiced about the effects of role redesign on midwifery boundaries, with a number believing it enhanced the profession, whilst others felt it undermined it

Respondents were not opposed to changing working practices and agreed that midwives needed to learn new skills, arguing this would give midwifery more autonomy (Table 2). However, there was concern about the impact of these changes on midwives’ skills and workload. Interviewees frequently mentioned that one of the reasons why midwives’ roles were being redesigned was to reduce junior doctors’ hours to comply with the European Working Time Directive (WTD). Yet midwives did not want to be used as substitutes for doctors or give their roles to maternity support workers.

INSERT TABLE 2 HERE

A problem identified with extended roles was that they often prevented midwives from providing individualised woman-centred care as midwives spent time

going from one woman to another performing repetitive technical tasks. Midwives have little choice over whether to extend their roles and many now feel pressurised or are compelled to do so. Work was often described as a 'production line' and a case of 'get them in, get them delivered, and ship them out'. The difficulty with a 'production line' approach is that midwives regard themselves as responsible for providing care, as distinct from treatment (Walby et al., 1994). Therefore, developing extended roles eroded midwifery skills and expertise and midwives described feeling like a 'Jack of all trades and master of none'. There was a consensus that it was important for midwives to be empowered, but to resist being pressurised by managers or doctors into undertaking technical work or developing skills they did not necessarily consider to be part of their job or confident to do. As one hospital midwife stated:

> 'Why should I hurt a lady by sticking a needle in her? Somebody else can do it. Sometimes it's worth de-skilling yourself, but certain jobs like suturing (sowing a tear), we do a really good job we should keep it. We were there when the damage was done so we should be capable of repairing it. I'm quite happy to do that because it's a skill I have and it saves me waiting for a doctor'.

In order to retain the distinction between doctors' and midwives' work, interviewees stated they should not be undertaking extended roles, particularly those that were predominately technical/medical in nature and had formerly been doctors' work (Table 2). For example, midwives regarded extended roles such as assisting at caesarean sections or ventouse deliveries (assisting the delivery of the baby by the use of vacuum extraction) as medical, rather than midwifery work. The problem is that in some parts of the country midwives are already participating in these procedures and this demonstrates the inconsistent approach taken by the profession to boundary changes.

When asked why midwives had taken on some of the extended roles, midwives explained that it allowed them to offer continuity of care and otherwise women or babies could wait hours to be seen by a doctor. As a midwife noted, 'It's quicker to do the job and better to do it yourself'.

The national RCM representatives suggested that extended roles could be incorporated into student midwifery training, to ensure the work remained within midwifery, rather than being undertaken by other health care workers. Although this may protect midwifery boundaries it does not equate with what midwives want to do, as 95 per cent of survey respondents agreed that midwives felt frustrated because they cannot practise 'woman centred' care and cited this as a reason why midwives became dissatisfied and left midwifery (Table 2).

There was evidence that closure was maintained in some areas of midwifery and not all midwives agreed to perform extended roles and either resisted or avoided undertaking them. As one midwife stated, 'I'm a bog standard midwife really, I'm happy that way'. Some midwives had decided to stop using their extended skills and in effect, deskilled themselves. The reasons given for this included not getting sufficient experience, being unfamiliar with the equipment or techniques, a lack of support in clinical situations, and a lack of confidence to practice. This illustrates an interesting pressure between the current NHS HRM agenda (Department of Health, 2005) that espouses staff should be able to utilise their skills, and the problems midwives encounter with practising holistic/caring skills. Arguably, there is a tension between midwives developing new technical roles and the erosion of traditional midwifery skills, particularly if an essential skill of a midwife is that of looking after

and listening to women. The consequences of this were outlined by a midwife who expressed concern that midwives had lost one of their key skills:

> 'They (midwives) have lost the skill of watching and observing and keeping their mouth shut. The old fashioned midwife would sit in the corner knitting at the woman's home and watching the labour. A midwife means 'with woman' but unfortunately we aren't and that's half the problem. Midwives are looking after two women, how can you support two women? I couldn't do the job, tick in the box, be back in five minutes it's not caring as a midwife'

The development of the specialist midwife role also illustrated some of the tensions within the midwifery profession about what the roles and boundaries of a midwife should be. The specialist midwife role was introduced in the late 1990s and these midwives were expected to develop subject expertise in midwifery (e.g. smoking cessation in pregnancy) and maintain their general midwifery skills. However, many specialist midwives found it difficult to maintain their competence in all areas of practice, with some losing confidence in performing key roles such as assisting a woman during childbirth.

Criticism of the specialist midwife role centred on interviewees' beliefs that it was important for midwives to retain their general skills (i.e. the ability to assist a woman in labour using a normal midwifery model) and many questioned whether a specialist midwife should be called a 'midwife' if they were unable to do this. This raises the issue of whether midwives need to be skilled to work in every area of midwifery (e.g. antenatal and postnatal wards, labour ward, high dependency and consultant-led care, clinics and community settings) or should be able to work as a specialist. Equally, it highlights the complexity of defining a new skill, or arriving at an accepted definition particularly if there is disagreement amongst midwives about the skills required or whether they should be developing them (Noon and Blyton, 2002:115; Grugulis et al., 2004:1).

One of the results of work redesign is that the boundaries between midwifery and medicine were more obscure and there was greater role ambiguity, due to the extended roles and specialist midwifery roles. As a midwife explained, 'I can't decide whether I am an obstetric nurse, a cleaner, a servant or a midwife'. Increasingly midwives have to work within two competing models of maternity care provision, namely the natural/holistic (midwifery model) and the biomedical/technocratic (medical model) (Henley-Einion, 2003:179).

**Midwives' Autonomy**

The implications of role redesign for midwives' autonomy were also outlined. These were discussed in terms of the fact that traditionally there was a clear distinction between 'normal' and 'abnormal' pregnancy that defined the work boundaries and autonomy of doctors and midwives. However, with the government HRM policies directed at reducing professional demarcation and delegating medical work this demarcation is becoming less clear-cut and challenges midwives' autonomy (Department of Health, 1998; Department of Health, 2000b; Department of Health, 2002) Interviewees were concerned that extended roles reduced the number of midwives practising 'normal', rather than 'abnormal', midwifery and compromised midwifery closure. As the national RCM representative commented, 'Some midwives will want to undertake technological roles. That's fine, as long as they're not reducing the numbers, because you still need the same number of midwives'.

Notwithstanding the rhetoric contained in the NHS HRM policies about increasing inter-professional working, in reality some aspects of midwives' work have become more restricted and midwives have less discretion or have lost control to obstetricians (Department of Health, 2000b; Department of Health, 2002). As one midwife stated, 'A lot of what we've done in the past has been taken away from us, so that we don't have the responsibility for that'. On the whole, midwives felt unable to challenge what was happening due to what some described as, 'the disparity of power' between doctors and midwives. This is despite the fact that over half of survey respondents agreed that, 'The development of new roles will give midwives more autonomy'. The evidence shows that developing new roles had not resulted in increased recognition for midwives or the profession (Oakley and Hound, 1990; Kitzinger, 1991; Lessing-Turner, 2004).

**The Role of Maternity Support Workers**

The growth in MSWs arguably offered midwives an opportunity to exercise exclusionary closure (Parkin, 1979). However, this did not prove to be the case for a number of reasons that midwives discussed in relation to the role of the MSW.

Overall, experienced MSWs were greatly valued, as they freed up midwives, reduced their work pressure, and were seen as a valuable contribution to the team. Midwives acknowledged the need to develop the MSW role, but felt they were being used as a cheaper option to midwives and were taking midwives' work. Rather than promoting exclusionary closure, concern was expressed that both expanding the MSW role and the development of generalist skills by midwives compromised midwives' skills, knowledge and status (Sausman, 2003:227). There was general agreement that the MSW role would have to be expanded, but that any delegated work would need to remain within the control of the midwife (RCM, 1999). As a hospital midwife commented, 'If the maternity support worker could do what we're doing then they'd be midwives, wouldn't they?'

For midwives there was a tension between wanting to develop new roles and being able to cope with increased work demands and midwifery shortages. Midwives struggled to accommodate these pressures, but were unwilling to delegate their work to MSWs as they did not want to relinquish their traditional roles and disagreed or were undecided whether MSWs should take on more of their social and emotional roles. The problem is that the areas of work that can be delegated to MSWs are often 'the caring bits', or 'being with woman' and are the roles which midwives are reluctant to give up. More importantly these were cited as the main reason why midwives chose to be a midwife. As a midwifery lecturer/practitioner observed:

> 'Midwives don't want to be pulled out of (delivery) rooms, they're desperate to be with that woman and stay with that woman but they can't. So somebody's got to take that midwife's place and it does feel a little bit as if we're losing the nice bits of midwifery to other people. And we're going to have to take on all the bits of midwifery that are all very organisational, technical, legal and all the really nice bits we're going to have to give up and I'm not sure I really like that'.

There was a consensus that the roles of midwives and MSWs need to complement, rather than clash, and there should be greater clarity about work responsibilities. The fact that MSWs already have formal training and want to develop their roles and were being encouraged by the NHS Trust to do so, has caused some conflict between midwives and MSWs, regarding the nature of their respective work and what both groups should be doing. A community midwife predicted that:

> ‘We are breeding something there that will bite us in the face in a few years time – because support workers are either trained or qualified for longer than they think they should be, and at the same time they think it’s alright for a midwife to come in and clean a bed; that’s not their job any more’.

## Discussion and Conclusion

This study demonstrates how the NHS HRM agenda and work redesign are challenging professional boundaries, changing midwives’ skills and subjecting them to a number of pressures. Attempts by midwives to use closure to tackle these issues have had a limited effect for a number of reasons that will now be discussed with reference to the questions posed earlier in the article.

The first question asked whether role redesign provides midwives with the opportunity to extend their influence. The evidence suggests that role redesign has not increased midwives’ influence and they are being pressurised to extend their roles in the guise of providing continuity of care for women and losing aspects of their work that they enjoy. In terms of closure this has two main consequences. First, the boundaries between midwives’ and doctors’ work is shifting towards a medical model, driven by the government HRM policies, as the distinction between ‘normal’ and ‘abnormal’ birth, which historically demarcated their work is increasingly blurred.

Secondly, despite, the Nursing and Midwifery Council (2004) defining the activities of a midwife, the skills required for providing ‘normal’ and ‘abnormal’ maternity care are polarising midwives’ work. As a result, there is a potential for the midwifery profession to further divide into two distinct roles; one solely organised around midwifery-led care and the other focused on high-risk, medically-led care. This trend is likely to continue with the present NHS HRM agenda, and could potentially fracture the midwifery profession. Although this argument is not new, the difference is that work redesign and the modernisation agenda are driving these changes and reducing the influence of midwives (Department of Health, 2000b; Department of Health, 2002).Arguably role redesign offers the potential for midwives to develop their role and influence. However, this has not been the case to date and raises the question of whether they are being marginalized by government and the medical profession.

The second question asked if role redesign leads to midwives being de-skilled and results in a loss of power. There is undoubtedly pressure from both within and outside midwifery to change working practices resulting in an extension of technical roles and the development of new specialist roles, but these undermine key traditional midwifery skills and challenge professional boundaries (Abbott, 1988). Many midwives feel they are being deskilled and losing power, as these changes not only eroded their social and emotional skills, but made them increasingly reliant on technology, rather than midwifery expertise. Midwives feel less able to practice the social and emotional skills requited to ‘be with woman’. Ironically, it is this aspect of their work which is being delegated to MSWs, where midwives obtain the greatest job satisfaction and their highest intrinsic motivation. This raises questions about government assumptions that NHS role redesign will improve midwives’ productivity (Department of Health, 2005). The problem is that if the aspects of work midwives enjoy the most are changed or they are no longer able to do this type of work, this has consequences for midwives’ intrinsic motivation and job satisfaction (Hackman et al., 1975). At the same time, some parts of midwives’ work have become more restricted

and they have less autonomy or have lost control to the medical profession. Arguably, given the historical development of midwifery this is not new. However the climate in which this is occurring is significantly different. The government imperative to modernise working practices is driving these changes, mainly predicated on the need to increase productivity in the health service (Department of Health, 2005). A question this raises, which requires further consideration, is whether the modernisation agenda and NHS role redesign constitute an attempt by government to influence and effect professional closure directly.

The third question asked what the consequences of role redesign are for the midwifery profession. From the evidence presented a number of conclusions can be drawn. Without a doubt, midwives' work is changing and the NHS HRM agenda is affecting midwives' work and their professional boundaries. Overall, midwives acknowledged the need to develop new roles and change working practices and are not resistant to these developments *per se*. However, the problems associated with professional boundary changes and the historical tensions between midwives, doctors and the government undermine these developments and prevent midwifery closure. The evidence from this research demonstrates that closure remains the privilege of other professional groups, and the preserve of the medical profession in particular. The midwifery profession continues to be manipulated by government, doctors and by midwives themselves and closure remains illusory. Despite work redesign, midwives' professional boundaries with doctors and maternity support workers remain unclear, both in terms of their current and future form. This creates uncertainty and unease, across all healthcare groups, but in particular, exacerbates midwives' concerns about the implications of role redesign for their profession and for their work.

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**Table 1 Interview Respondents**

| Respondents | Numbers |
|---|---|
| Practicing Midwives | 21 |
| Midwifery Lecturers | 20 |
| Royal College of Midwives | 4 |
| Strategic Midwives | 4 |

**Table 2- Respondents' Views of Midwives' Skills and Roles (rounded percentages)**

| N=63 | Strongly Agree | Agree | Undecided | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| Midwives need to learn new skills. | 14.0 | 61.0 | 16.0 | 6.0 | 2.0 |
| The development of new roles will give midwives more autonomy. | 6.0 | 57.0 | 30.0 | 8.0 | |
| Changes to the way midwives work in the future will give them more autonomy. | 18.0 | 33.0 | 41.0 | 6.0 | 2.0 |
| Most midwives feel that developing new skills increases their workload. | 29.0 | 57.0 | 8.0 | 6.0 | |
| Midwives should take on some of the doctors' roles. | 2.0 | 27.0 | 29.0 | 30.0 | 13.0 |
| Current midwifery roles should not be changed because of staff shortages. | 18.0 | 31.0 | 21.0 | 29.0 | 2.0 |
| Support workers should take on more of the midwives' roles. | 2.0 | 21.0 | 34.0 | 37.0 | 7.0 |
| Midwives need to give up some of their traditional roles. | 5.0 | 19.0 | 30.0 | 40.0 | 6.0 |
| Midwives feel frustrated because they cannot practice the type of care they want to. | 61.0 | 34.0 | | 5.0 | |