



# Professional Learning from Disturbances in Healthcare: Managerialism and Compassion

**Katie Willocks**

*Lancaster University Management School, United Kingdom*

**Jem Bendell**

*University of Cumbria, United Kingdom*

**Richard Little**

*Impact International, United Kingdom*

This study asks what behaviours might convert professional disturbances in maternity wards into opportunities for learning within healthcare and how that process is influenced by models of management and leadership. A framework of Cultural History Activity Theory helped to analyse moments of fractured collaboration in which uncertainty about roles and differences in professional status was a factor. Implications for professional learning are discussed along with the frames that might give coherence and utility to future research. We conclude that any interventions to support professional learning should reflect the broadly compassionate ethos that informs the commitments and activities of healthcare workers.

*Keywords:* leadership, compassion, managerialism, healthcare, maternity, cultural-historical activity theory.

## Introduction

There are few fields of work where professional and organisation performance are as important as front line medical services. Whereas organisations in other sectors can try new ideas from management studies in a spirit of experimentation, situations of life and death place people under an extraordinary obligation to avoid mistakes. The contribution of management as a practice and of management studies to the healthcare sector has been mixed. Since the 1990s, in many countries worldwide, concepts from the private sector have been brought into the public sector. This approach was called New Public Management (NPM) and proponents made the claim it would bring better outcomes for patients and the taxpayer (Schachter, 2014). Aside from introducing a new layer of cost to healthcare organisations, the impact of NPM is hotly debated, even amongst the management consultants and researchers who have made this agenda their professional focus (Schachter, 2014).

NPM can be understood as one branch of ‘managerialism’ – an ideology which ‘justifies the application of managerial techniques to all areas of society on the grounds of superior ideology, expert training, and the exclusive possession of managerial knowledge necessary to efficiently run corporations and societies’ (Klikauer, 2013, p. 1103). Overviews of evidence across sectors, sociologist Thomas Klikauer (2013) summarises the view that for many decades managerialism has been establishing the authority of management as a practice – and managers as practitioners – in ways that, often deliberately, undermine the power of owners, technically-focused employees, social activists and wider citizenry.

Within the healthcare sector, recent ideas on how to address the failings of NPM have echoed the romantic hopes of management theorists more widely. That is a turn towards the mythical role of ‘leadership.’ Perhaps its starkest expression in the British medical sector is this unqualified assertion: ‘Strong leadership is vital to effecting lasting organisational change’ (Amess & Tyndale-Biscoe, 2014, p. 6). Critical scholars of leadership have shown that most uses of the concept are based on untested assumptions about the salience of individuals with authority in a hierarchy and wish lists of personal professional qualities, which serve to distract attention from more meaningful analysis of organisational processes (Bendell et al., 2017). In healthcare that discourse of leadership has been given the name ‘leaderism’ (O’Reilly & Reed, 2010).

Maternity care in the UK is the focus of the research in this paper. Many texts in the literature of maternity care management reproduce uncritically the refrains of the current mainstream discourse of management and leadership (Amess & Tyndale-Biscoe, 2014; King’s Fund, 2014; Kirkup, 2015; Ralston, 2005; Warwick, 2015). One report on leadership in maternity services claims, with an assumption that no evidence is needed, that ‘there is no doubt amongst opinion formers and policy makers that leadership plays a significant part in the delivery of high-quality health care’ (Warwick, 2015, p. 2). The report goes on to describe the necessary leader as (we paraphrase): *adaptive, flexible, responsive, visionary, emotionally intelligent, motivating, inspiring, interactive, non-hierarchical, non-individualistic, listening, courageous, discontented (with the status quo), compelling, tenacious, patient, collaborative, innovative, enabling, open, honest and effective*. That is an unfeasible list of requirements and implies a form of leadership that miraculously cuts across prevailing institutional and professional forms of authority. If this is the form of leadership that impacts fundamentally on the provision of high-quality health services then we must seek it elsewhere than in a narrow range of professionally defined positions.

Contemporary discourses of management associated with NPM have disrupted older notions of professional authority, such as the role of Matron

in hospitals (Reed et al., 2004; Smith, 2008). The professional status of midwives (in relation to doctors, for instance) has developed slowly and the process is not complete; similarly, the status and function of Maternity Support Workers (MSWs) or maternity ‘assistants,’ a more recent role developed to support qualified professional midwives is contested and evolving and differs between countries. For example, the role of *kraamverzorgende* in the Netherlands, who assist midwives during the birth and support mothers afterwards, is more explicitly written into an ideology of childbirth than is that of MSWs in some other countries (Benoit et al., 2005). In the UK, where the research for this paper took place, The Royal College of Midwives (RCM) handbook for Maternity Support Workers states that ‘There is currently no single definition of the MSW role and a wide range of titles are used for particularly higher-level roles’ (2016). Elsewhere, the RCM admits that ‘[Studies, including King’s Fund, 2011] have noted the development of support workers in maternity services [. . .] can be ad hoc and inconsistent’ (2017). MSWs themselves have complained that they are disempowered in a maternity context by having had a generalist training (Sanders et al., 2015).

This situation of unclear and evolving professional roles and the challenge of NPM to prior bases for professional authority provides a context within which inter-personal disturbances could occur. Another context for our study is that of a UK National Health Service (NHS) subject to funding constraints as patient demand grows faster than budgets, leading to cuts in the number of frontline medical staff in many hospitals across the UK. Organisations facing such pressures are likely to experience more workplace disturbances (Borges et al., 2017).

The changing nature of roles and the pressure on resources means that professional learning by staff in the healthcare sector is important. The likelihood of disturbances at work means that how they are handled and learned from to improve both patient care and staff wellbeing is also a key issue. The mixed history of NPM provides an important context for management researchers interested in how healthcare could be improved. In our case, it led us to research how staff on maternity wards can learn from disturbances in the pursuit of good patient care and staff wellbeing. We consciously sought to avoid NPM-related tropes about leadership, management or training interventions, and instead to take our cues from those providing crucial care on a daily basis. The research examines disturbances in three maternity wards in the UK and draws out implications for professional learning (Boyd et al., 2014). We hope that this line of inquiry will lead to a better understanding of what behaviour will help turn such disturbances into actionable learning outcomes.

In the next section, we outline our methodology, before presenting vi-

gnettes of three workplace disturbances and our analysis of what they show in the context of how professional learning was occurring in the maternity wards. We explore ideas for how professional learning could be better supported. We conclude that a post-NPM and non-managerial approach to improving practices could be founded on solidarity with the innate compassion of healthcare workers, and support for them to develop their own competencies for compassionate communication with each other and their patients.

### **Methodology**

Our research and analysis is founded on theories of professional learning (Boyd et al., 2014) as well as Cultural Historical Activity Theory (CHAT). Central to Cultural Historical Activity Theory is the acceptance that the process of organising is 'ongoing, culturally and historically situated, materially and socially mediated' (Roth and Lee, 2007). An activity system has a subject and object, both mediated by material and social contexts, a system of functions and roles and a set of rules, norms and procedures (Engeström, 2001). One of the distinctive features of CHAT for our purposes is that it recognises that work practices are both developmental and inherent with inconsistency, paradox and tension (Engestrom & Lemos, 2016). In this way, it supports research that explores the complex, tentative developments taking place in professional health care work. Within this framework, a range of methods was employed, including ethnographic observations, interviews with a range of maternity staff and document analysis.

In our analysis, we have considered several other approaches including Practice Theory (Schatzki, 2001, 2006; Nicolini, 2012) and Discourse Analysis (Fairclough, 2001) each of which offers a way into the very broad questions: how do work practices evolve positively towards greater organisational efficacy and member satisfaction? What makes a disturbance disturbing to participants and how might disturbance affect that positive evolution?

The NHS Trust where the research was carried has been named 'Trust X' for the research purposes. The data was collected over 2 years from three maternity wards that collectively deliver over 2000 births a year. The subjects of the research were midwives and Maternity Support Workers (MSWs). In total 47 practitioners were interviewed (9 from 'Red Ward,' 22 from 'Blue Ward' and 16 from 'Green Ward'). Pseudonyms have been used throughout this paper for both the hospital wards and practitioner/patient names. The data generated from this research was coded with the use of constructs and principles from the Cultural Historical Activity Theory (CHAT). Firstly, the various aspects of CHAT such as the 'tools' 'rules' and 'object of activity' were identified in the data, and labelled. Any perceptible tensions

and disturbances in the data were also labelled and coded. Once an initial coding had been completed using the various CHAT constructs, a second and third round of data analysis was conducted, which involved further coding and grouping of the data using the CHAT terminology.

In this paper, we focus on an exploration of some of the disturbances that were observed in the data. These were identified as such either by the practitioners themselves or due to there being a problem either in the provision of medical care or in the emotional response of one of the medical staff. We examined why these disturbances manifested, and the impact on practitioners, before considering the implications of such disturbances for professional learning. We chose to frame these disturbances not as personal pathologies, but as expected dynamics in organisations that are undergoing some turbulence.

For this paper we have selected three particular disturbances from the range of data as they are illustrative of the emergent themes on professional learning. We then look more closely at these three disturbances and the professional learning they reflect, with a view to developing recommendations for interventions that could support such professional learning and enhanced practice in future.

## Findings

In the following sections, we present descriptive summaries of three disturbances that occurred during the research. Each is presented in relation to a form of learning that we chose to ascribe to it during analysis. The primary research was undertaken by the lead author of this paper, which is the reference to 'I' in the descriptions. Each disturbance involves Midwives and Maternity Support Workers (MSW) in the flow of maternity practice. Midwives are trained health-care professionals specialising in pregnancy, childbirth, postpartum and newborn care, they are members of the Nursing and Midwifery Council (NMC). Maternity Support Workers work under the supervision of a registered midwife providing care for women, their partners and babies. The ostensible intention of the NHS in recruiting increasing numbers of MSWs was to boost public health messaging, especially in promoting breastfeeding. MSWs themselves have been recorded expressing frustration that the training they had received was focused on the requirements of generic health care rather than the specifics of maternity care (Sanders et al., 2016). Informal observation during the fieldwork for this paper suggested that uncertainty on the part of midwives and MSWs about the nature and status of MSW competence may be a contributing factor to the disturbances described below. For easy reference in the subsequent discussion, the three disturbances have been given concise labels of 'collective learning'; 'reflective learning'; and 'emergency learning.'

**Collective Learning**

The first key finding to emerge from the research was the frequency of collective learning. In several scenarios, staff were observed developing collective insight and understanding through their interactions. The collective learning was often not explicit. Participants rather navigated their way through situations and learned together as events unfolded. The knowledge they acquired through such processes might not be developed through classroom-based learning methods.

The disturbance below covers a period of fieldwork from the early hours of a Thursday morning, around 3 am. The delivery suite was extremely busy and the midwives were under discernible pressure. Several women were reaching the culmination of labour at the same time and midwives were occupied in every delivery room. Only one maternity support worker was on duty and on this occasion, she was covering both the delivery suite and postnatal ward:

*Disturbance 1: 'Acting up'*

The doorbell rings and Debbie the maternity support worker rushes to answer it. A woman in a wheelchair is wheeled in by her partner, she's puffing and panting and she's telling Debbie she thinks she might need to push.

Debbie attempts a joke with her and tells her 'she's come to the right place then'!

Debbie takes hold of the wheelchair and quickly pushes the woman down the corridor onto the delivery ward.

A midwife who's scribbling some notes looks up, greets the woman and rushes to her side, tells her everything is going to be ok. Midwife 'nods' to Debbie and they push her promptly into one of the delivery rooms. In about twenty minutes or so the midwife emerges and tells me the woman had given birth to a boy.

Debbie had acted as the 'second person' in the delivery. Around an hour later Debbie is called from the office area into another delivery room to assist another midwife with the delivery. When the ward seems to settle down it's around 7 am. Debbie and I engage in some conversation about the shift as she makes toast for one of the women.

I ask how Debbie thinks the night has gone. Debbie tells me that she had really liked being so involved in the deliveries tonight, it's not often 'I get to catch the baby' she says let alone 'two in one night.' She tells me that when it is 'crazy like tonight they'll often need us (MSW's) in

with them.’ ‘You see’ she says, ‘When it’s going like a fairground they will let you do a lot more.’

I ask why that is and Debbie replies saying that whilst midwives always prefer another midwife to be in the room with them in case anything goes wrong, they (MSW’s) are officially allowed to act up as the second at birth if the situation requires it.

In the scenario above, the arrival of a woman (whose birth is impending) to an already busy ward creates an ‘urgent situation.’ Given the imminence of the birth and the lack of midwives available to help the midwife, Debbie’s involvement in the birth first seems to go unquestioned. Through prior experiential practice on the ward, Debbie has learnt what kinds of situations may require her involvement and that when the practice becomes extremely pressurised, her help is promptly required.

In this situation, Debbie learns the precise point in practice in which she could be called upon to assist the midwife, and the importance of her being on hand promptly to help with this pressurised situation. Through her experiencing the scenario, Debbie learns how the midwife will seek her help, either through ‘nodding’ as the woman enters the ward signalling Debbie’s assistance, or verbally asking for her help. Debbie’s involvement appears quite customary. However, after both deliveries, Debbie informs us that it only tends to be when the ward is exceptionally busy that midwives involve support workers in deliveries. On these situations, it is assumed acceptable for them to be involved with the labour, a task referred to as ‘acting up as the second midwife:’

It was a rough delivery so usually she would always prefer to have a midwife in with her rather than one of us acting up so we would tend to only be asked to help on those occasions when we are really short-staffed [. . .] In the last room, there was a shoulder distortion which I used to find terrifying but I have had to stay, cos there was no-one else. I knew exactly what she [the midwife] was asking me to do, and I could do it so it was fine; all was OK. I do feel much more confident about helping midwives with births the more I do. [Debbie, MSW]

Arguably, it is only because the situation is so pressurised that Debbie has the opportunity to ‘access’ the learning (Lave & Wenger, 1991). Had another midwife been available, Debbie would not have ‘had to stay’ and her learning about this challenging and complex birth would have been circumvented. However, as Debbie indicates, there was simply nobody else to support the midwife. By being given the opportunity to assist the midwife, Debbie’s confidence increases. There are two key points we wish to raise here. Firstly, it is because the situation is so tense that the midwife and

the MSW learn to work together in the moment to moment flow of practice. Disturbances and tensions are key sources of learning and transformation (Engeström, 2001). Secondly, only by jointly experiencing the same disturbance can collective learning ensue.

Collective learning is that which occurs between more than one practitioner in the maternity environment while addressing a problem (Laberge, 2006). When faced with a shoulder distortion, the midwife and the MSW develop collective insight and understanding. The midwife has learnt exactly what the MSW needs to do and can articulate this clearly to her. Likewise, the MSW also learnt how she can best support the midwife for the successful delivery of a child. That learning is not explicit, with participants navigating their way through situations and learn together as events unfold. With time MSW's learn to anticipate what the midwives need and can position themselves accordingly to support them. Gemma, an MSW from 'Red Ward,' explained that 'You get to learn who will need you next.' As is typical with collective learning, it evolved, as they had experienced the situation together several times before (Bunnis et al., 2012).

### **Reflective Learning**

The previous discussion provides insight into how maternity practitioners learn in unstructured ways during the working day. Learning also occurred naturally when practitioners were given the opportunity for collective reflection and discussion. That way practitioners became more attuned to the ideas, beliefs and diverse perspectives of their colleagues. The research also identified that staff valued connecting and sharing knowledge with others, and that dialogue with more experienced colleagues and peers was an optimal learning practice. Maternity practitioners valued being able to connect and share stories and knowledge. Practitioners also explained that conversations with their peers were valuable in helping them to understand the paradigms from which their colleagues worked. They also saw these opportunities as a way of dealing with some of the ambiguities and tensions that arose in practice.

Reflection enabled midwives in Trust X to learn about the sources of role-related issues. Specifically, both midwives and MSWs use reflection as a way of unpacking the sources of role ambiguity or tension. Professional reflection is an active process whereby practitioners gain understanding about how historical, social and cultural preferences contribute to practice (Schön, 1983; Jasper, 2003).

The second 'disturbance' we have selected from the research reflects ongoing tensions in the maternity units that were heard on numerous occasions. It takes place on a quiet afternoon in the large open plan office area on the delivery ward at 'Blue Ward.' Midwife Doreen is reading one

of the participant information sheets that I, your lead author, had left on top of one of the desk areas. MSW Theresa is drinking coffee and texting on her mobile. Brenda, another midwife, enquires as to the topic of mine and Doreen's discussion. I explain that Doreen and I are talking about my research project. Given your lead author's participation in the following conversation, the attempt to accurately record its content was made immediately after it occurred:

*Disturbance 2: Role Erosion Concerns*

Brenda: 'Ah, this study [our research] it's all about getting more health-care assistants [support workers] on here right . . . ? Well, it's not more healthcare assistants we need: it is more midwives.'

Lead Author: 'No, no I'm not here to try to increase numbers, I'm looking at the role of the MSW and what kind of things they do in different areas of the Trust.'

Brenda: 'Well they want rid of midwives, and I can tell you, they [presume she means MSW] shouldn't be doing certain things, they miss things, don't know how to interpret them properly.'

Doreen: 'No they help complement the midwife, what's the point of the midwife doing the BP [blood pressure] and dipping the urine then seeing the doctor, it's a waste them seeing two professionals. We don't need more midwives we need more MSW's, there is no point midwives spending time on stuff like infant feeding, it's not rocket science if they are trained properly. You can't have them just cleaning, it's a waste of their skills.'

Theresa: 'Yeah exactly, there are times, like yesterday afternoon when you [to Doreen and Brenda] have not got the time to give the full support to women afterwards [after birth] cos it's just so busy. That's something that we could take more responsibility for, we could go in, do the basic things that need doing and [. . .] if we are in there bathing the baby, having a chat, you know 'have you got any kids at home . . . ' you know just general chit chat . . . and you do find if they have a problem or anything they will tell us, they won't always tell a midwife you know.'

Doreen: 'Well yeah there are some midwives who are reluctant to allow maternity support workers to do that sort of thing, but I think nowadays we need to look at what midwives can provide and we can't provide it all, we need to recognise the bits that we can pass over.'

The discussion relates to the MSW role and midwives role erosion concerns. The scenario is an example of what Engeström's (2008, p. 554)

terms 'troubles of talk' caused by the 'multi-voicedness' of participants. This notion is that, within work teams, members have diverse views about themselves and their work. In the 'disturbance' above, the different perspectives of the practitioners are a source of contestation. Despite the different priorities, the discussion favours learning for all the practitioners.

Firstly, the two midwives Doreen and Brenda learn that they have markedly different views about the way in which support workers can be used in practice. These views are also brought to the attention of Theresa, who is given the opportunity to learn some of the reasons why different midwives have varying delegation practices. We have already identified that a source of distress for some MSWs is that they sometimes do not understand why some midwives permit involvement in some duties whereas others do not. All of the practitioners involved in the situation are learning about the values and risks of employing the support worker in practice. Finally, the MSW learns to vocally clarify her role to her midwifery colleagues. That is important given that practitioners in assistant positions often lack confidence defending their role parameters to those in more senior positions (Keeney et al., 2005).

Learning through collective discussion has been identified as a valuable form of learning at work, with such dialogue helping staff to function more effectively within their daily work practice. Research has also identified that dialogue with more experienced colleagues and peers is an optimal learning practice (LittleJohn & Margarayn, 2011). Informal interviews were also carried out with staff in each of the wards. They revealed similar findings. Maternity practitioners explained that conversations with their peers were valuable in helping them to understand the way their colleagues worked and their views on role delineation.

In these interviews, staff were able to reflect upon and discuss very recent practice. The lead author interviewed MSW Julianna one afternoon as she took a ten-minute break from working alongside a midwife. Julianna had been precluded from performing certain tasks such as blood pressure monitoring, conducting urinalysis and providing postnatal support to women. Instead, the midwife had opted for carrying out these tasks herself. The lead author encouraged Julianna to reflect upon the morning and consider what knowledge she may have acquired about practice:

It's a lot of old school, you know. I just think for some it's 'I am the midwife' and they are quite protective of their role, and they say well you can't do that because that's the midwife's role, so yes I guess this is probably why there are issues. [Julianna, MSW, 'Blue Ward']

By being given the opportunity to discuss a specific and very recent aspect of the practice, Julianna spontaneously offered thoughts on what she

felt may underlie the midwives behaviour; ‘old school’ attitudes and role protection. Our research found many other MSWs felt that midwives were hostile towards their role expansion. Arguably, however, if MSWs develop a greater understanding of why midwives hold such attitudes and, therefore, sometimes do not delegate, working relations may improve. Professional reflection is a fundamental aspect in this process. Reflection also enabled midwives in Trust X to learn about the sources of role-related issues:

Well, I guess it’s probably because some [midwives . . .] feel that they need to do absolutely everything for their woman and it’s probably the way we work in the unit. I trained in a unit a lot bigger than here and we had a lot more health care assistants and the midwives just did midwifery, we didn’t do housekeeping, we didn’t do bed bathing [. . .] the health assistants did all of that [. . .] So, yes, when I think about it, there are a few of them who think they should do everything for their woman and they want to do everything for them but obviously it does create tension. [Linda, midwife, ‘Blue Ward’]

Both midwives and MSWs used reflection as a way of unpacking the sources of the tensions and identified the way in which differing ideologies of midwifery shape delegation decisions.

Some authors have argued that reflecting on professional experiences rather than learning from formal teaching is the most important source of professional development and improvement (Jasper, 2003; Schon 1983). The quotes above highlight the value of reflection as a crucial element in improving practice in maternity care. Unfortunately, a key finding in the research was that reflection was a skill that was not easily developed or practised due to time constraints in increasingly busy clinical environments – something we will return to in our recommendations.

### **Emergency Learning**

The third disturbance we have chosen to highlight from our data involves practitioners working around problems in practice:

#### *Disturbance 3: Being Faced with an Emergency*

It’s around 3 pm and the ward seems quite busy. Around 20 minutes earlier Jayne had responded to the buzzer coming from one of the delivery rooms. She had been asked to help with the final stages of a woman who was having a very fast delivery.

The labouring woman is alternating between loud screams and whimpers. The midwife is knelt in front of her monitoring the heartbeat, with one hand on the woman’s stomach and the other on the emerging baby’s head.

The midwife had rung the buzzer about five minutes earlier, to try and attract another midwife but no-one had come.

Midwife says to Jayne: 'I need you to draw up and administer an injection, quickly; do you know how to do that?'

Jayne says: 'Erm, well yeah, but, are you asking me to give it . . . ?' (Hesitates, remains on the spot)

Midwife: 'Yes' (firm tone)

Jayne: 'Pauses, Sytometrine'

Midwife: 'Yeah yeah . . .' (eyes on the woman)

Jayne clearly deliberates (few seconds). Moves over to the bottom of the delivery trolley, goes in a box, pulls out a syringe, and an amp of a drug. Says '1 ml' yeah?

Midwife: 'Yeah the whole lot, the whole amp.'

Jayne draws injection, passes over to midwife who glances to the injection, midwife says 'yep, fine' and points to the woman's left thigh area. Julie injects the woman as midwife watches. At this point, the head and shoulder are out.

After administration, Julie disposes of the needle and walks round to the other side of the patient. Starts stroking her hair and comforting her, 'you are doing great pet, not long now.'

Only a few minutes later the baby is born.

When the lead author talked with Jayne shortly after her involvement in the delivery, she commented that:

I wasn't comfortable doing that you know. When I worked down south we did administer the odd one but I'm talking a long time ago but now, well I don't know. What should I have done, I mean if you are not sure if you should be doing something but the midwife seems to expect you to, can you refuse? I just didn't know how to approach it, I felt awful in there with the poor woman on the bed, she must have wondered why I . . . . [Conversation tails off as support worker bows head] Ohhh . . . afterwards, I worried a lot about it, would I be pulled up for it? I didn't mention it because I came to think well at end of the day she was the one carrying the can.

The situation above arises because staff are faced with an emergency. In medical work, emergencies are acute situations that pose an immediate risk to a person's health. Emergencies often require assistance from other practitioners; usually, there is adequate midwifery staffing to deal with such events. The patient above requires an injection of a drug immediately. The

midwife seeks assistance from another midwife but there is no response to her calls. In interviews, several midwives at the site provided examples of emergency situations where due to a lack of midwifery support they had to ask an MSW to undertake tasks that are not explicitly written in their job descriptions. The above situation is a case in point.

Because an MSW is called to undertake a task she does not know if she is qualified to undertake and is left feeling anxious and distressed about her actions, this disturbance could be termed a 'failure' (Edmonson, 2004). Some of Jayne's uncertainty comes from not knowing if giving the injection is outside her role boundaries. Her hesitation also relates to a lack of knowledge about the consequences. In a later interview, she explains that she wasn't sure it was something 'she should be doing' and was worried she might be later reprimanded for undertaking the action.

The episode was successfully navigated by the two practitioners who collectively learnt to handle a pressurised event so care could continue. Edmonson (2002) terms such practice a 'quick fix,' 'work-around' or first order problem solving and explains that it is particularly common in medical work. First order problem solving removes the immediate obstacle to patient care (the MSW drew up the injection and administered it) but does nothing to change the chances of the situation reoccurring (Edmonson, 2002). In this disturbance, like the previous one we presented, there was no evidence of any collective discussion after the incident. The MSW, whilst notably distressed by the episode, does not share her experience of the event due to fear of being reprimanded. Unfortunately, this fear means that the parties do not learn as much as they might. Other practitioners similarly miss out on the learning opportunities this disturbance might afford. The underlying factors which contributed to the issue are not addressed, thus, the likelihood of a similar situation arising is high.

Collective reflection after the event could have brought several issues to the fore. Firstly, practitioners might learn that when it comes to certain areas of practice, the role boundary of the MSW is fluid. Secondly, practitioners might learn that when faced with extreme uncertainty there are situated practices which can help to ease the discomfort Jayne felt. These might include gentle, yet clear clarification and reassurance by the midwife that she was personally sanctioning the action and therefore responsible. Collective reflection would also ease worries relating to accountability and litigation.

In the above discussion, the activity, theoretical construct of 'disturbances' has been drawn upon in order to capture various tensions and turbulences as they situationally unfold in the delivery of maternity work. This particular construct from CHAT encourages researchers to explore empirical data for noticeable breakdowns in practice. In maternity care, the

notion of disturbances proved especially helpful in making visible the tensions that typically arose at the role boundary between the midwife and the maternity support worker. The three different disturbances explored above whilst taken from different aspects of maternity work, each illustrates the way in which tensions can manifest as a consequence of workload pressures, staffing challenges and role boundary related ambiguities. Using activity theory terminology, the 'division of labour' between midwives and support workers was a significant factor in creating disturbances in daily practice. What was of particular interest to the authors, however, was how navigating the disturbances afforded different types of professional learning for the practitioners involved.

### **Forms and Limits of Professional Learning**

Much of the learning that took place in the maternity wards that we studied was 'local,' closely tied to the situation practitioners were engaged in. Local learning took place through 'observation' of peers in the flow of practice (Myers et al., 2015). In this case, support workers were not learning about best or worst practice, but about the current division of labour and where they could contribute to practice. They also gained valuable knowledge about how they could handle situations in the future. Given the ambiguity and uncertainty about the role of MSWs that we mentioned in opening this paper (Sanders et al., 2016), rules for practice may be presumed to arise locally, situationally and through practice. Therefore, the disturbances were not just disturbances of a presumed order but also the mechanism by means of which order is achieved.

Midwives and support workers were learning in a social context, through their interactions and communications with each other (Vygotsky, 1962). In many of the workplace disturbances identified, it was the social environment, the pressured working conditions and the interactions between different professionals that facilitated the learning. Furthermore, the learning that took place occurred in the flow of the practitioner experience; practitioners were often not consciously aware of what knowledge they were acquiring. Thus, the findings illustrate that learning in maternity practice is not simply a cognitive process but is frequently social and participatory in nature. We may say that support workers and the midwives must in some sense share an experience before new knowledge can emerge. Such experiential learning quickly developed staff confidence and ability to work with colleagues under stressful conditions.

Based on these findings, we argue that if managers in the healthcare sector are to facilitate professional learning, then they must first be willing to actively recognise such valuable learning that takes place in situated and often turbulent practice, and inquire with staff about how to support that.

At the time fieldwork was carried out, practitioners and managers did not acknowledge the learning that took place through the disturbances of which they were part. Increasing awareness of practice-based learning will be important before exploring how to share that learning on a wider organisational level.

A further key finding from the research was the frequency of collective learning. In numerous scenarios, staff were observed developing collective insight and understanding through their interactions. Often the collective learning was not explicit and so not easy to achieve through classroom-based learning methods. Through discussion, practitioners began to learn about the reality of their work and became more attuned to the ideas, beliefs and diverse perspectives of their colleagues. Practitioners also explained that conversations with their peers were valuable in helping them to understand the paradigms based on which their colleagues worked. Interestingly, they also saw these opportunities as a way of dealing with some of the disturbances that arose, including those concerning respective responsibilities. Despite that, there were few opportunities for such joint reflection to take place nor support provided for the practitioners to learn how to better engage with each other in reflective conversation.

Another finding related to 'failures' in practice and learning. In maternity care, when there were breakdowns in performance, staff carried on with daily duties regardless. On one level, whilst this allowed the practice to continue relatively uninterrupted, opportunities for learning via collective discussion were limited. That meant the problems may recur and more significant failures could occur in time (Edmonson, 2002). An implication here is that managers in healthcare could encourage staff to see their workplace as a learning environment where they could openly discuss errors, mistakes and issues of concern, rather than one in which people are blamed for such admissions.

The cross-cutting finding, at this point, is that conversations at work are key to shaping the practice. Therefore, before making recommendations, we can draw on a scholarship to provide additional perspectives on the disturbances we have described in this paper. An ethnographic consideration of the exchanges between midwives and MSWs brings into relief processes of class, gender and professional status. For example, in the third disturbance concerning the administering of injection, we might see a potential discontinuity between a masculinised, directive professional communicative style and a more tentative, subjective and hesitant style. Tannen (1994) shows that social class and professional status may trump gender in shaping workplace conversations. In that exchange, the phatic content of the MSW's speech, which is typically done to establish a connection with someone, finds no echo in the responses of the midwife. The difference between

the participants' styles both reveals and is sharpened by the anxiety, apparently felt by the MSW about whether her action, previously legitimised elsewhere, remained legitimate in this particular context. This highlights how some codes of behaviour are elaborated, while others, including styles of communication, are implicit (Bernstein, 1971). This reminds us that people respond to communication, based on their expectations, which can differ widely, and so reflection on emotions can be useful to overcome misunderstandings. Also, people can change when attention is brought to their patterns of communication and the expectations and feelings of colleagues.

A critical approach to discourse in organisations and healthcare can also bring additional insights to those generated from a more simplistic application of CHAT. It reminds us that MSWs are members of a community, so their actions are mediated by rules and norms, by role-definitions (Benoit et al., 2005) and boundaries, by material instruments and by the evolving object of their activity (helping women to give birth). With an awareness of this discursive aspect to CHAT, we can see how the practitioners in our study were not simply giving voice to some truth of their inner-state, but drawing upon readily available tropes from the prevailing discourse of organisation and professional interaction. That discourse comprises approximate formulations appropriate to each professionally or organisationally situated role. If their talk tends not to produce new configurations, or ways out, it would not be because they lack the necessary ingenuity, but because that discourse constrains and limits their options: it includes what 'goes without saying' (Bourdieu, 1972). Beyond such assumptions lie everything that is unthinkable and unsayable (and all the practices that might have arisen, but did not).

If each practitioner in our study was more of a 'participant observer,' aware of the socially constructed nature of moment-to-moment exchanges and able to act in such a way as to introduce critical reflexivity into the dialogue, sensible of its capacity to produce meaning and transform relations, every such disturbance could become a 'pro-turbance' (our neologism). A proturbance has, enfolded within it, multiple potential future practices and relations amongst which is a best-way-forward. If enough disturbances are recognised as proturbances, they may change every modality described within CHAT: cultural, historical, material, social and discursive. This possibility is the basis of dialogical approaches to organisational learning and change, where shifts in the format and content of conversations then lead to self-organised changes in practices over time (Shaw, 2002; Stacey, 2015; Bush & Marshak, 2016).

The main discursive shift that we recommend, the better to enable professional learning, is to move away from describing 'errors' and 'failures' and to deliberately use words such as 'disturbances,' 'breakdowns' and

'learning opportunities' instead. Such a shift might encourage staff to bring forward episodes of disturbed practice in a spirit of inquiry rather than blame. It would encourage staff to look for the underlying causes of disturbances – rather than personalise an issue – and to discuss ways to prevent the problem recurring. Such activities have been termed 'second-order problem solving' and have been shown to achieve significant benefits for healthcare teams (Tucker, 2004). We recognise that these shifts in framings, and then procedures, are easier said than done.

We recognise that the maternity units we studied are full of people doing their best to bridge the gap between an imaginary organisation of clear roles and calculated procedures and the real organisation of imperfect knowledge and fuzzy role boundaries. That 'real' organisation, experienced every day, is one in which procedures and best practices never catch up with contingencies. As the practitioners we studied continually bridge that gap, they learn and they change. For their individual learning to become collective and institutional learning, there must be a more radical reconfiguration than is implied in the rhetoric of both managerialism and mainstream leadership. Typically, when things go badly wrong, senior managers proclaim 'we take these things very seriously,' and 'we will learn the necessary lessons' – slogans of proceduralism uttered in the voice of an imaginary institution. While that is an understandable response to public criticism, transcending managerialism will be key to better support for professional learning.

The conditions for collective learning include, we believe, orientations towards open, non-hierarchical participation in dialogue; towards an ecological view of the organisation as a living collaboration between interdependent individuals each self-authorised to act in support of dialogue and collaboration (Habermas, 1985). Those conditions also include respect for competence and professional authority tempered by a critically-reflexive habit of questioning, towards a responsive, dynamic view of the aim of institutional action (Engeström, 2008). These conditions are not achieved accidentally, but can be translated into training and can come to permeate policy. How should such professional support be designed and delivered? Our view is that a starting point for any intervention should be solidarity with the staff in maternity wards, underpinned by recognition of and support for their practical daily compassion. We will explore that further now, as it forms the basis for a post-managerialist approach to developing recommendations for interventions.

### **Compassion-Based Approaches to Organisational Development**

One important limitation of management researchers and trainers in examining the healthcare sector might arise from how we typically do not profess the same daily commitment to active compassion as healthcare workers

do. Indeed, many of us exist in institutional cultures that require a dispassionate approach to our subject.

The interpretation of any disturbance should focus on the acceptance of shared humanity and respect for participants – and so should the practice of organisational learning from disturbances. If there is a senior management capability conspicuous by its absence from most lists and operating manuals, it is *humanity*; as, for example, in the kindness of a senior professional acknowledging the desire of an MSW to be useful and joining them to resolve their uncertainties about responsibility and role definition, or the generosity of a more experienced member supporting a less experienced one. Where, in the list of leader virtues reproduced earlier, are humanity or kindness? Managerialism has distracted many of us from the simplest and deepest conditions of collaboration – active practical compassion.

In our study, we have identified compassion as a motivator for people being in a workplace, aspiring to learn and work well, to overcome conflict, and as a necessary dimension of their everyday practice. A review of existing studies in the *Journal of Human Relations* that mention compassion reveals that it has not been considered in this way – as a key focus (Kanov et al. 2016; Lilius et al., 2011). Therefore, we hope our study will encourage more research on the significance of compassion, and its cultivation, at work.

The closest mainstream management studies come to discussing compassion is the field of ‘emotional intelligence’ – a formulaic approach to feelings and empathy. The value of the concept of emotional intelligence is, in our view, diminished by its wide instrumentalisation, as in the *Harvard Business Review* where editors reported on the strong link between empathetic leaders and financial performance (Ovans, 2013), or, worse, turned into an instruction manual for sociopaths: ‘emotions are important because of the open loop nature of the limbic system’ (Boyatzis, et al., 2002). Enabling people to learn from disturbances may need skills of ‘emotional intelligence’ less than acceptance of mutual goodwill and collaborative intent – both abundantly demonstrated by the MSWs in the vignettes above. Therefore, we will base our recommendations on a valuing of compassion.

Healthcare practice is synonymous with compassion (Mills et al., 2015). We may go further and say that health professionals systematise compassion in their practice and that compassion is too easily sentimentalised. Increasingly however, there are concerns that contemporary health care systems are failing to provide safe, compassionate care for their patients. In the UK, there have been a number of high-profile cases detailing inadequate and at times unsafe health care provision. This raises implications for the development of practice standards, or a revision of existing standards that lack notions of compassion in their content. It has been noted that health care providers are under pressure to tighten regulations with some NHS

Trusts going as far as to implement ‘compassion initiatives’ to improve patient outcomes (De Zulueta, 2016). Compassionate healthcare focuses on demonstrations of altruism, kindness, genuine sympathy and empathetic concern for the suffering of patients experiencing health challenges that are often distressing. Evidence suggests that both empathy and kindness as aspects of compassion have a beneficial impact on health outcomes (Frost, 1999). Compassionate health care environments are those where both health care practitioners and patients feel understood, supported, nurtured and cared for emotionally, physically and spiritually (De Zuleta, 2016; Kyle, 2017).

We feel it is timely to discuss a more comprehensive perspective on the relationship between compassion and organisational performance, and one less liable to proceduralism and list-making. How can an institution itself, in its procedural and material affordances, match and support the compassion towards mothers and babies that is the fundamental commitment of midwifery professionals? How can the rhetorical and institutional formulae for management and leadership, like the one quoted in our introduction (Warwick, 2015) and the current NHS model (which includes, without irony, the question ‘Do I carry out genuine acts of kindness for my team?’ (National Health Service, 2013, p. 6), be rewritten so that, rather than anatomising, institutionalising or quantifying complex relations they reflect the complex interplay between compassion and professional competence? We note the contemporary salience of the term ‘emotional wellbeing,’ as in ‘Do I take positive action to make sure other leaders are taking responsibility for the emotional wellbeing of their teams?’ (p. 6). Despite the efforts of its well-intentioned authors, such phrases suggest a drift towards instrumentalism and a tendency to misdirect attention, away from broader social and economic forces, away from local institutional conditions, towards, instead, an omniscient fantasy leader whose ‘self-awareness, self-confidence, self-control, self-knowledge, personal reflection, resilience and determination’ (p. 6) hold everything together. That may be what happens, but the documentary recommendation of it may be seen as an unwarranted incursion by managerialism into the life-world of healthcare workers.

It is questionable to what degree maternity practitioners such as those discussed in this paper can provide compassionate care to their patients if their places of work do not exemplify these same virtues. We imagine that, in a compassionate working environment, both staff and patients would feel understood, supported and nurtured. Furthermore, openness, learning and reflection would arise more naturally in the organisation (to be enhanced, rather than induced, by teachable skills). As discussed earlier in the paper, in such contexts, mistakes, errors and ‘failures’ could be openly and fearlessly discussed.

## Conclusion

Our research found that practitioners in maternal health have abundant resources for moderating workplace conflicts and that moments of disturbance often prompted them to consider roles, boundaries and collaborative practices. Our research shows how learning was occurring through experiential, implicit and evolving processes. Such learning may not be easily parsed and therefore not easily taught. The implication is that any proposed interventions to support workplace performance in maternity should be designed to equip practitioners with the tools for enhanced communication so they better learn together in those experiential, tacit and evolving ways. This means seeing the workplace as a place that can and should be a site of learning that offers opportunities to practice reflective and compassionate conversation. Ultimately, good maternity care needs health institutions and educators to work in solidarity with and to learn from those who express active compassion in their work every day.

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**Dr Katie Willocks** works on Post-experience Programmes, with the Executive Education Development Team at Lancaster University Management School. Previously Dr Willocks worked with Liverpool University and Cumbria University, specialising in organisational behaviour. [k.e.willocks1@lancaster.ac.uk](mailto:k.e.willocks1@lancaster.ac.uk)

**Dr Jem Bendell** is a Professor of Sustainability Leadership at the University of Cumbria, an Adjunct Professor with Griffith University, and the founder of the Deep Adaptation Forum. [iflas@cumbria.ac.uk](mailto:iflas@cumbria.ac.uk)

**Dr Richard Little** is a senior consultant with the leadership development organisation Impact International and a Visiting Professor with the University of Cumbria. [richard.little@impactinternational.com](mailto:richard.little@impactinternational.com)