The complexity of social practice: understanding inertia and change in maternity care organisations.

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Abstract

Beyond the limited efficiency and economy goals of neoliberal health policy lies the promise of genuine health services reform. In maternity care in particular, recent policy developments have sought to make the management of birth more ‘women-centred and family-friendly’. Interprofessional collaboration and greater consumer participation in policy and decision-making are key means to achieve this goal, but changing the entrenched system of medicalised birth remains difficult. Recent social contestation of maternity care has destabilised but not eradicated pervasive medical hegemony. Further reform requires analysis both of institutionalised patterns of power, and attention to the fluidity and situated knowledge shaping organisational and professional practices. Accordingly, this paper outlines a framework with which to explore the multi-layered social processes involved in implementing organisational and cultural change in maternity care. Analysis of social interventions in health systems, we suggest, can be advanced by drawing on strands from critical organization studies, complexity and critical discourse theories and social practice approaches.

Keywords:
Maternity care, organisational change, professions, health services, social theory
In recent decades increased political demands for accountability and quality improvement have generated considerable interest in innovations and cultural change across the health sector (Dopson and Fitzgerald 2002; Greenhalgh et al 2004; Youngson 2003). In maternity care, emerging policy frameworks have offered opportunities to make the management of birth more ‘women-centred and family-friendly’. Interprofessional collaboration and greater consumer participation in policy and decision-making are key means to achieve this goal. Yet changing the patterns of professional relationships—especially the medical dominance literally built into hospitalised childbirth during the twentieth century—remains difficult. Contestation and conflict remain endemic in many sites as consumers, health service policy-makers and professionals debate the appropriate ‘social design’ of birth (De Vries et al, 2001). The historical rivalry between obstetricians and midwives, and differences within the professions, including over private versus public sector work and in birth philosophies, make change here especially difficult to achieve. The sector faces acute shortages of midwives, nurses and doctors, especially in rural areas (Australian Health Workforce Advisory Committee, 2002). In order to improve the quality of services for women and retain the workforce, many providers are seeking new ways of working and models of care. The challenge though is making it happen: barriers such as fee structures, legal liability, and professional ‘turf struggles’ make it much harder to achieve than might be expected (Reiger and Lane 2008). This paper therefore outlines an emerging conceptual framework for considering questions of change in the contentious field of maternity care. It draws on and extends recent work in Britain which offers enhanced understanding of relationships between innovation processes at the policy level, cultural inertia at the institutional level and professional resistance at the level of practice.

**Innovation at the policy level**

The policy goal of multidisciplinary collaboration in maternity care has emerged in Australia, as in the UK and Canada, in a neoliberal political climate of health reform that demands greater accountability and efficiency, and hence quality and safety, from health services. Yet policy-makers have also sought to respond to midwives’ greater expectation of professional autonomy, consumers’ concerns about lack of continuity of care, and acute workforce shortages (Reiger 2006). Inter- or multidisciplinary collaboration has been represented primarily as a crucial principle in meeting these varied, but not necessarily compatible, objectives—a way of working that utilises the different skills of the maternity care workforce. In 2004 the Victorian policy, *Future Directions* for example marked a significant departure from traditional Australian maternity care by arguing for extending primary care by midwives within a collaborative system (Department of Human Services 2004). It refers to the ‘complementary skills of midwives, general practitioners and obstetricians’ and promotes ‘multidisciplinary learning, respect and trust amongst these different disciplines’. A new statewide-clinical network has been developed to implement these objectives and to encourage greater take-up of evidence–based practices such as in antenatal care. Similarly, a Western Australia policy framework developed in 2006-7 has also established a new Women’s and Newborns’ Clinical network and argued that fundamental change is needed in the ways in which maternity care is organised. Whilst
multidisciplinary collaboration is espoused in terms of recommending a ‘maternity team approach’, in which midwives take a central place, what this would entail is not articulated save for the idealistic comment that women will be able to ‘move seamlessly’ through levels of professional care according to their need (Department of Health Western Australia 2007:15). Queensland’s 2005 Rebirthing inquiry also promotes interdisciplinary work but is more cautious about its implementation in view of the incipient tensions between the cultures of midwifery and obstetrics, noting how widespread they were found to be in consultations (Queensland Health 2005). In 2008 the Premier, Anna Bligh, announced new funding to strengthen midwifery practice in Queensland, especially in rural areas.

**Attempting change in practice**

In New Zealand primary midwifery care has been mainstreamed and in Canada midwifery has been legitimised as an autonomous profession. In Australia, however, while many new initiatives, such as team and caseload midwifery, are under way, implementing state policies to promote change from the traditional medically dominated framework remains difficult, and has had little effect at all on the private obstetric sector in which some 25% of Australian births take place. The policy ideals of collaborative maternity care frequently run into trouble on the ground (Reiger and Lane 2008). So, in view of significant policy commitment to change, what is going on? A Victorian midwifery forum in October 2007 brought together bureaucrats, midwifery leaders and some 40, primarily public, maternity unit managers to consider just why the ‘future directions’ of collaborative primary maternity care were proving elusive. Those present pointed to structural problems faced in hospital workplaces and by community-based midwifery, especially differential funding of medical and midwifery services and cost-shifting between State and Commonwealth authorities that mitigated against efficiency and continuity of antenatal, intrapartum and postnatal care for women. Other entrenched problems were industrial and political constraints, such as reluctance of the Australian Nurses’ Federation—the union to which most Australian midwives still belong—to move from an award wage and roster-based model to annualised salaries and flexible work hours for midwives in new models of care.

Underlying the discussions at that forum and others was the metaphorical ‘elephant in the room’—the continuing problem that many health professionals avoid confronting directly, but which social scientists have no trouble naming as a deeply gendered pattern of medical dominance or hegemony (Willis 1983; Murphy Lawless 1999; Reiger 2001). Cultural assumptions arising from hierarchically organised, medicalised maternity care remain entrenched, not only in many service settings but in the policy-formulation processes as well. Recognising that Western maternity care is a system in which medical hegemony has been entrenched since the nineteenth century requires attending to not just overt or ‘top-down’ forms of power, but to how power operates in subtle ways. While medical knowledge and authority still shape many hospital protocols, such as use of continuous electronic foetal monitoring or induction for ‘post-dates’ for example, what Jordan (1997) calls ‘authoritative knowledge’ is also contested especially by midwives and consumers. Dynamics of the field are complex, played out face-to-face in local sites as well as in policy-making settings, professional forums and ‘virtual’ discussions. Some
doctors resist the change in their privileged position that would be required by genuine collaboration, but some promote it. And while many hospital-employed midwives still want to work as what others disparagingly call ‘medwives’ or ‘obstetric nurses’, others are keen to work in new midwifery-led systems of care (Children, Youth & Women’s Health Service 2005). As argued elsewhere, in many units then, professional boundaries are being renegotiated and becoming more fluid (Lane 2006; Reiger and Lane 2008), with midwifery managers moving into positions of significant power and influence. Furthermore women as maternity care consumers are now commonly involved in policy and decision-making processes, albeit often as individuals without effective education or group support, rendering their ‘participation’ limited at best, tokenistic at worst. Nonetheless, by aligning with midwives, maternity advocacy groups have succeeded in placing pressure on health policy-makers to reform childbirth services (Reiger 2001, 2006). Although in this short paper, it is not possible to provide detail of these developments, they are considered in some of our recent work just cited. To address the complexities of reform and resistance inherent in this changing field of practice, we focus here on developing a new conceptual framework for thinking about how to put collaborative, ‘women-centred’ policy into practice.

Towards a new approach
Strategies to reform health care in both the UK and the US have identified change in the social relations of care, not merely modification of clinical practices, as central to reform of health services (Greenhalgh et al 2004). In the work of the NHS modernization agency in the UK in particular, there has been growing recognition that organisational cultures, power dynamics, and management and leadership issues lie at the heart of such a project (Fitzgerald et al 2002; Greenhalgh et al 2004; Kernick 2004). Distinct, but we believe, compatible theoretical frameworks can be brought into dialogue, not just as an intellectual way forward, but to facilitate politically progressive accounts of change such as in health care organisations. In particular, we can build further on critical realist organisational approaches by turning to complexity theory which suggests a fluid and dynamic yet systemic perspective. In addition, from critical postmodernism, critical discourse analysis offers analysis of the mechanisms that produce and destabilise embedded power structures. Finally, social practice ideas go further in analysis of agency by locating agents as practitioners in a specific context. In this brief overview, we argue that a multi-layered approach that can capture both structure and agency is essential.

Critical organisation studies
Several critical thinkers have made a major contribution to analysing both inertia and change in organisations, stressing the operation of patterns of power, knowledge and communication processes which are entrenched and enduring but also inherently unstable. Theorists taking a critical realist position, especially those influenced by Roy Bhaskar (1991) in Britain, have focused primarily on underlying causative mechanisms as shaping outcomes. Judging the postmodernist emphasis on epistemology to be excessively relativist (e.g. Archer et al 1998), they have reasserted the importance of a ‘deep’ and layered ontology, one that stressed not merely empirical evidence and events but underlying social structures that are ‘intransitive’ or independent of our particular forms of ‘transitive’ knowing. They are nonetheless knowable as causal entities due to
their real effects or emergent properties (Lopez 2001). Critical realists (following precursors like Durkheim and Marx) seek to understand, indeed explain, the world in terms of discovering how structures ‘limit our range of possible choices of action and thought. We do not ‘create’ social structure. We reproduce and transform it. But it too causally effects us’ (Lopez 2001:15). Structure thus precedes agency, and while neither can be reduced to the other, critical realists argue against postmodernism for assuming that ‘…social reality can be entirely reduced to the accounts that are given of it through the socio-linguistic practices and textual forms by means of which it is determined’ (Reed 2005:1626) or that there is no extra-discursive realm that is not expressed in discourse (Ackroyd and Fleetwood 2000:8).

This structural emphasis, while it explains the stability and resilience of medical power for example, needs however to be extended to deal with the complexity of change processes. Indeed there are suggestive strands in the critical realist tradition which point in such directions, including Pearce and Woodiwiss’ (2001) exploration of realism in Foucault, Archer’s (2003) analysis of the ‘layering’ of individuals, and Lopez’s (2001) and Scott’s (2001) conceptualization of social structure as both institutional patterns and social relations together forming ‘complexly organised entities’. This argument has then been further extended to embodied social action as a third dimension of structuring processes (Scott 2001; Manicas 2006). Conceptualising both structure and agency in terms of processes is also central to complexity approaches to organizations.

Interpreting complexity
Social and historical explanations need to be cognisant of structuring processes but also sensitive to contingency, mired neither in determinism nor voluntarism. Complexity theory makes an important contribution to this objective. In recent years, diverse social scientists, some with a more structuralist, others a more constructionist orientation (Cilliers 1998, 2005; Byrne 2005; Urry 2003, 2005; Walby 2007), have turned to complexity theory’s emphasis on fluid intersections between non-linear, open systems to facilitate explanation of social phenomena. Complexity ideas offer an analytical framework with which to understand, and hence to explain, social dynamics operating at several levels. The attention to recurrent patterns (‘attractors’) would seem to offer a path that retains critical realism’s structural emphasis, yet also a way beyond its limitations. Complexity theory is a broad church though and includes different readings. Sylvia Walby (2007) leans rather to a more structuralist framing of complex, non-nested but mutually constitutive systems of social inequality associated with class, gender and race/ethnicity, all played out in institutions and practices. Yet she too stresses the contingency of specific outcomes and the possibilities of change which can arise from unexpected and contradictory intersections as well as from political interventions. Urry, like Cilliers (2005), leans to a more postmodernist interpretation in which ‘local causes may produce unpredictable, chaotic and unintended macro effects not in the sense of considered agency but through continuous flow and fluidity’ (Urry 2005). Although complexity theory still allows us to reiterate the importance of the ‘real’ in social life, it offers, we argue, a dynamic account of structures allowing a multiple articulation of institutions, social relations and embodied action.
Some critical organisation theorists, notably Ralph Stacey (2006), who have turned to complexity approaches, have influenced the application of a ‘complex adaptive systems’ approach to health systems (Kernick 2006; Youngson 2003). This sees health services as intrinsically dynamic, in motion, and thus as unstable rather than fixed (Kernick 2004). It is thus difficult to determine cause and effect due to their constantly changing character and because each component, whether a network, a hospital or a labour ward, is ‘nested’ within larger also-changing social systems. Such approaches, whilst keeping a systemic focus, are consistent with a more poststructuralist strand of critical organization studies which stresses how the complexity of meanings, or ‘sense-making’, and fluidity, contingency and paradox, makes organisational systems unpredictable (Davide, Gherardi and Yanow 2003; Stacey 2007). Organisations, and the people within them, thus need to be understood holistically as ‘complex responsive processes’ (Stacey 2007). Others in organisational studies have turned to critical analysis of discourse as a related way of using poststructuralist insights to extend the structural analysis offered by critical realism in ways that can account better for change (e.g. Chia 2000; Willmott 2005).

**Critical discourse analysis**

Through the work of Norman Fairclough in particular, critical discourse theorists offer a middle ground between realist and postmodern frames and thus make a crucial contribution to articulating how social structures are iterated and reiterated in social life generally and in organizations in particular (e.g. Fairclough 2005). As Fairclough describes the application of critical discourse analysis to organisational studies and especially to organisational change, his ‘analytical dualism’ includes in the concept of discourse not only textual/linguistic patterns of meaning but the linguistic/semiotic dimensions of structures and social practices (Fairclough 2005: 916). In directly engaging with critical realism, Fairclough argues for a ‘realist discourse analysis’, accepting the stratified ontology of critical realism and acknowledging that discourses bear a complex relationship to other, non-discoursal social elements. For our purposes here, Fairclough’s articulation of core issues and contestation in organisational change is especially important; he identifies ‘emergence, hegemony, recontextualisation and operationalisation’ as matters requiring investigation in order to grasp the relationship between changes in social processes, practices and structures (Fairclough 2005:931). Fairclough also attends to the ways in which resistant and alternative discourses can undermine the status quo and set up a new hegemonic ‘fix’. Successful strategies for overturning entrenched power blocs thus include the emergence of new discourses and their dissemination across different contexts and infusion into new identities and institutions. How do discursive patterns actually take effect in complex social systems then? Yet another ‘turn’ in social theory, this time the ‘practice’ one, provides possible answers here.

**Theorising social practice**

Although already well established in fields such as gender analysis (Connell 1987), in recent years analysis of social practices has entered organisational studies (Schatski 2001), including through feminist research (e.g. Bruni, Gherardi and Poggio 2004). Many practice approaches build explicitly upon Bourdieu’s (1990) influential notions of field and of habitus. For Bourdieu, the embodied, automatically conducted activities that occur
in everyday life, the implicit understandings which reiterate social norms, occur in specific local contexts (Bourdieu 1977; 1990). Practices are not merely idiosyncratic but signify regularised iterations of cultural mores, institutionalised constraints and embodied mannerisms. Chia and MacKay (2007) argue that practice concepts explain the durability of actions, mental states, actions and preferences, or what Bourdieu calls ‘a sociality of inertia’. Resurgence of interest in ‘doing’, as against that in language and meaning, has emerged partly in reaction against poststructuralism but also as an extension of Foucault’s emphasis on discourses as embedded in practices (Foucault 1984). Giddens’ (1984) structuration theory, Actor-network theory and other social theory strands have also contributed to the emergence of practice approaches as a distinct perspective, including in studies of the dissemination of technologies (e.g. Orlikowski 2000). The philosopher, Ted Schatzki has sought both to develop the theory and to apply practice concepts to organizations, interpreting a social formation as a web of meaningful activities located in its context: ‘the site of the social is comprised of nexuses of practices and material arrangements’ which are ‘bundled together’ (Schatzki 2005:474). The development of ‘practice-based approaches’ has proved especially fruitful for grasping the operation of power at the everyday and locally specific level of what people ‘do’—their routinised actions and embodied interactions as well as the meaning-making in which they are wrapped.

While attention to recurrent social practices can seem to explain social ordering, practice approaches can also be change-oriented—demonstrating how reciprocal positioning in power relations occurs can itself destabilise them (Bruni, Gherardi and Poggio 2004). For many years, Raewyn Connell’s gender theory has provided just such an account of how gender relations operate through practices. Connell’s approach (1987, 2003, 2006) suggests that agency and structure are better seen not just as ‘dual’ processes, as in structuration theory, but as involving everyday practices which involve the simultaneous enactment of pre-existing power relations and which modify, change and construct social life and individual subjectivity anew. Through distinguishing between structural processes associated with the division of labour, power and authority, sexuality and emotion and with cultural symbolism, and by exploring their multiple and criss-crossing enactments of embodied humans, Connell has demonstrated the complexity of the organisational processes associated with implementing gender equity measures in Australian public institutions (Connell 2006).

In maternity services, recent Victorian research into changes in midwifery and obstetric professional roles, as reported elsewhere (Lane 2006; Reiger and Lane 2008; Reiger 2008) indicates significant shifts in gender dynamics, personal and professional identities and everyday work practices. In accordance with the framework advanced above, it is these dynamics which put the larger social processes of complex health organisations into effect. Changes in medical work include reorganising clinic systems, introducing more specialist units and lessening the cultural authority of medicine. Some hard-won and stand-alone midwifery-led units, as well as team midwifery and birth centres in mainstream hospitals, are beginning to promote new autonomy and status for midwives without regular medical surveillance. Neither masculine medical dominance nor feminine midwifery subservience can any longer be taken for granted. Entrenched
medical power continues however to influence organizational and clinical decisions. Whilst the presence of more female doctors, the creation of midwifery consultant positions and greater ethnic diversity among obstetricians contributes to changed hospital dynamics, several senior ‘white men’, especially professors of obstetrics, still exert overt authority. Yet while this traditional class-based and patriarchal legacy is now challenged on a daily basis, none of the new arrangements either are stable, settled organizational forms. Gains in midwifery professional recognition are often undone and even reversed as a result of local factors. The outcome of such struggles is far from clear but it is evident that these health practitioners ‘do’ their daily work and hence ‘organization’ differently now. They strategise across institutions, read and share research evidence, construct new clinical guidelines and regularly reinvent their organizations, their professions and themselves.

**Conclusion**

This paper has argued for a more complex analysis than is evident in most policy pronouncements on change directions in maternity care. The first section of the paper examined the ways in which multidisciplinary collaboration and women-centred care have been constructed as a policy objective in several states in Australia. While the rhetoric is well-intentioned, we contend that it is quite inadequate in the face of a medically-dominated past which still weighs heavily on the present. Although change is certainly underway across the sector, it remains difficult to achieve in institutional sites, and an effective conceptual framework is critical to thinking through further reform strategies. To this end we have argued that the most fruitful theoretical direction is not to polarise realism and constructionism but to attend to the multiple levels at which ongoing structural constraints and local action intersect. We suggest bringing together insights from critical realist organisational studies and complexity theory in order to interpret macro structures as enduring yet fluid, and those from critical discourse and social practice theories to assist in understanding how social systems are effected in everyday life by embodied agents. Social systems such as those shaping the medical hegemony of modern maternity care are reproduced through multiple discourses and their related practices. They are also rightly contested.

**REFERENCES**


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