Negotiating competing discourses in narratives of midwifery leadership in the English NHS

Article *in* Midwifery · November 2015

DOI: 10.1010/j.midw.2015.07.006

1 author:

Bernie Divall
Northumbria University
15 PUBLICATIONS **31** CITATIONS

SEE PROFILE

Midwifery 31 (2015) 1060–1066

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Negotiating competing discourses in narratives of midwifery leadership in the English NHS

Bernie Divall, PhD, MA Research Methods, Enhanced Diploma in Pre-registration Midwifery (Research Fellow in Maternity Care)*

Warwick Business School, Scarman Road, University of Warwick, Coventry CV4 7AL, United Kingdom

ARTICLE INFO

Article history:
Received 26 March 2015
Received in revised form
15 July 2015
Accepted 16 July 2015

Keywords:
Clinical leadership
Midwifery
Narratives
Professional identity

ABSTRACT

Objective: to explore midwifery leaders' narratives of identity, within the context of one region of England.
Design: a qualitative study using narrative identity theory. Data were collected using in-depth, loosely structured narrative interviews.
Setting: the study was undertaken in the Midlands region of England, in the context of a midwifery-specific leadership development programme. Participants were located in local NHS organisations and higher education institutions.
Participants: the interviewees were midwives currently in one of a variety of formal leadership roles, who had recently completed a midwifery leadership development programme. Nine leaders were interviewed for the study.
Findings: two central themes emerged: 'I am still a midwife' showed interviewees' continued self-identification according to their professional identity, despite the majority no longer holding a clinical role; 'Between a rock and a hard place' showed the challenges of maintaining a professionally-based identity narrative in the face of group and organisational discourses.
Key conclusions: among the midwifery leaders interviewed, narratives centred on a continued midwife self-identification. However, participants faced a number of challenges in maintaining this narrative, within the context of wider professional group and organisational discourses.
Implications for practice: midwifery leaders require the support of their professional group and organisational structures if they are to maintain a positive self- and social-identity.

Introduction

In the English National Health Service (NHS), recent policy documents have highlighted the importance of effective leadership in midwifery (DH, 2007, 2010). There has been recognition of the impact of poor or weak leadership within midwifery, highlighted in a number of enquiries into adverse maternal and infant outcomes (Healthcare Commission, 2004, 2006; Fielding et al., 2010). A further concern has been raised in relation to the ageing population in midwifery (Healthcare Commission, 2008; DH, 2010), particularly among senior staff, with 40–45% of the midwifery workforce identified as being within ten years of retirement, and one quarter aged over 50 (DH, 2010).

The English NHS has also focused in recent years on the importance of developing clinical leaders, with clinical leadership defined as leadership *for* clinicians, *by* clinicians. Past models of NHS leadership have been criticised as hierarchical and based on transactional, command-and-control approaches (Firth-Cozens and Mowbray, 2001; Millward and Bryan, 2005); more recently, policy has paid greater attention to the contribution and benefits of clinicians leading (DH, 2008, 2009), and there has been a shift towards distributed and transformational models of leadership (Yukl, 1999; Fletcher, 2004; Turnbull James, 2011).

Although benefits of clinical leadership have been reported in relation to patient experience and clinical outcomes (Murphy et al., 2009; Phillips and Byrne, 2013), workforce engagement and retention (Murphy et al., 2009; Fenton, 2012), and organisational performance (Ham, 2003; Mannion et al., 2005; Oliver, 2006), a number of challenges have also been highlighted. At the individual level, clinical leaders may struggle with a lack of role definition in comparison with their clinical role (Osborne, 2011); the challenge of maintaining a hybrid clinical-managerial role

* Corresponding author. Permanent address: Academic Division of Midwifery, School of Health Sciences, Floor 12, Tower Building, University Park, University of Nottingham, NG7 2RD Nottingham, United Kingdom.
E-mail address: bernadette.divall@nottingham.ac.uk

http://dx.doi.org/10.1016/j.midw.2015.07.006
0266-6138/

(Storey and Holti, 2013) can result in identity conflict, which in turn may lead to decreased job satisfaction and reduced organisational commitment (Kippist and Fitzgerald, 2009); moving away from clinical work altogether, however, may result in a sense of loss of identity for clinical leaders (Ham et al., 2010).

Further problems have been identified at the group level of analysis in clinical leadership. Clinical leaders tend to maintain a professional identification in their new roles (Hoff, 1999; Doolin, 2002; Iedema et al., 2004), viewing their professional identity, based on devotion to service, as superior to a management identity based on politics and 'the bottom line' (Hotho, 2008). However, clinical leaders simultaneously face rejection by their own professional group as they are perceived to have moved to 'the dark side' (Ham et al., 2010). Key to this issue is credibility, with clinicians demonstrating highly negative views of clinical leaders who do not hold a clinical caseload (Osborne, 2011).

From another perspective, clinical leaders may also have difficult relationships with non-clinical general managers, with conflict based on different leadership styles (Edmonstone, 2008), and perceived language barriers and differences in power structures (Ham et al., 2010; Nicol, 2012). A key challenge for clinical leaders, then, is maintaining and demonstrating commitment to both profession and organisation (Kippist and Fitzgerald, 2009; Ham et al., 2010).

This study examined the challenges described above from the perspective of midwifery leaders. The study objective was to explore the development and enactment of a clinical leader identity among midwives, with a focus on how individual narratives interacted with wider professional group and organisational discourses.

Methods

Design

An exploratory case study, incorporating observation of a midwifery leadership development programme and subsequent narrative interviews. This paper reports on findings from the interviews.

Theoretical framework

Narrative identity theory posits that in the context of role transition, individuals attempt to construct cohesive and coherent self-narratives, in order to establish and maintain a positive self- and social-identity (Ashforth, 2000:8). However, individuals' narratives are necessarily constructed within wider discourses (Gendron and Spira, 2009; Watson, 2009), and validation of individual narratives is required at group and societal levels, if a positive self- and social-identity is to be achieved (Ashforth, 2000:15; Ibarra, 2007).

Principles of narrative identity theory informed the data collection and analysis processes in this study. The research aimed, through the analysis of interviewees' identity narratives, to offer insight into the experiences of and challenges for midwives who have made the journey from clinical to formalised leadership roles in the English NHS.

Setting

In the Midlands region of England, around 2009, senior midwives recognised there was likely to be a crisis of leadership in the coming years, based on the ageing leadership population and difficulties in recruiting to leadership roles. On this basis, a midwifery leadership development programme was established, with the aim of preparing the next cohort of leaders, particularly at the level of Head of Midwifery (HoM). Thirty local midwifery leaders attended the programme, coming from NHS organisations and higher education institutions. All nine of the interviewees for this study attended the leadership course, which ran from June to December 2010. Data from the observation of this programme will be reported elsewhere.

Ethics

Ethical approval was gained from the University of Warwick, and through the Proportionate Review Sub-committee of the NRES Committee East Midlands. Principles of anonymity, confidentiality and the right to withdraw were adhered to throughout the study.

Interview participants

For the interview phase of the study, purposive sampling was employed, in order to elicit a range of narratives based on varied career journeys and experiences. Participants were largely approached face-to-face during the observation phase of the study, with further delegates approached via email once the leadership programme had ended. If potential participants expressed an interest in being interviewed, a participant information sheet was sent via email and questions or concerns invited. Prior to commencement of interviews, understanding of the study's purpose was checked, and participants were asked to read and complete a consent form. Interviewees were made aware that they could withdraw from the study at any point.

Nine midwifery leaders were included in the interview phase, with all those initially approached agreeing to be interviewed. The first six participants were interviewed twice each, and subsequently three further participants were interviewed once each. Interviews were undertaken between March 2011 and May 2012, and were conducted in the participants' workplace according to their preference and convenience.

Data collection

Interviews were in-depth and loosely structured, representing the 'gold standard' of qualitative research (Silverman, 2005:291; Rapley, 2007:15). While an interview guide was used, it was considered important that participants would shape the encounter to a significant degree and that there would be a great deal of flexibility in the interviews (Mason, 2002:231). This was based on the principles of narrative enquiry, whereby through telling their stories, individuals demonstrate their connections with the social, cultural and institutional environment around them, thus enabling a holistic view of the area under exploration (Moen, 2006). A new guide was used at the second round of interviews, based on consideration of themes emerging from data collected so far, and a continuation of narratives several months after completion of the leadership programme.

All interviews were audio tape recorded with consent, and field notes were completed by the researcher following each encounter. Interviews lasted between 45 minutes and two hours, with the majority lasting around one hour. By the final interviews, data saturation was judged to have been achieved, with no new themes emerging.

Data analysis

All interviews were transcribed by the researcher, with identifying information removed and pseudonyms applied. Transcripts were sent to participants for checking and comment, and first interview transcripts were often commented upon as reflective devices by participants during second interviews.

Analysis was undertaken manually, using pen, paper, colour coded markers and page margins (Fielding, 2002:162). Two distinct

Table 1
Participant characteristics.

Name (pseudonym)	Qualified as nurse	Qualified as midwife	Current role	Working clinically	Other leadership and education roles
Deborah	1985	1988	Senior matron	No	Community team lead HoM* secondment
Lesley	1988	1994	Matron/HoM†	No	Labour suite co-ordinator; lecturer
Natalie	1981	1984	Senior educationalist	No	Labour suite co-ordinator
Pauline	1983	1986	Matron	Occasionally	Community co-ordinator; acting up HoM
Louise	–‡	1998	Matron (acting)	Occasionally	Specialist midwife; Ward manager
Heather	–	2003	Matron	Occasionally	Community co-ordinator; labour suite co-ordinator
Caroline	–	1998	Matron	No	Lecturer practitioner
Karen	1983	1987	Matron	One community clinic per week	Lecturer practitioner; community manager, HoM secondment
Susan	1978	1982	Local Supervisory Authority	No	Community manager; HoM

* Head of midwifery.
† New appointment between interviews.
‡ Direct entry midwife.

approaches were taken: first, a 're-storying' technique was applied to the interviews (Creswell, 2013), which involved analysing individuals' stories for key elements such as time, place, plot and scene, and then re-writing the stories to foreground chronology of the account. Alongside this approach, thematic analysis was also applied, through coding and categorising of themes emerging across the interviews. This dual approach was applied in order to retain the essence of individual leadership journeys, but also to explore themes emerging across narratives (Polkinghorne, 1995:12). While the researcher (a doctoral candidate) was largely responsible for the process of analysis, support was offered by two academic supervisors.

Findings

Characteristics of participants are presented in Table 1. Interviewees' narratives encompassed a range of roles and experiences, and variable timelines to their current leadership roles.

Two central narratives emerged from the analysis of interviews: 'I am still a midwife', and 'Between a rock and a hard place'. Within these narratives, a number of key themes can be identified.

'I am Still a Midwife'

The path to leadership

Various reasons were offered by interviewees for making a transition to leadership. These included a sense of inner drive and motivation, and the need for new challenges:

> I do sometimes think to myself, how did I get to this point and why am I doing this, when I qualified as a midwife and I should be on the floor just – I should be working as a midwife. But it would never have been enough for me, to have just done that, so I needed – I needed to do something on top of my midwifery training (Caroline).

Equally important in the path to leadership was a desire to make a difference on a bigger scale than was possible within a purely clinical role:

> Yes, I love the clinical side, I love going to, you know, to work at – you know, seeing and caring for the women and their babies. But I love effecting change, and … making processes more effective and safer, and especially when you get to the end of an outcome, and you can see, 'Yeah, I've gone through that now, and this is the end result, this is how we're going to be working', and seeing it work effectively (Heather).

Midwifery beyond a hands-on role

Without exception, the interviewees defined themselves as midwives. They were able to offer a clear rationale for this self-definition, and spoke with considerable passion on the subject:

> I absolutely am a midwife through and through. I am a midwife who recognises her scope of practice, and I mean an enhanced scope of practice – my expertise is no longer in the actual delivery of individualised clinical care. My expertise is in the macro-midwifery. And I think that's one of the things we get hung up on, and why people say they don't want to be heads of midwifery, because they're not doing midwifery any more. And actually, they are (Susan).

Interviewees, as Susan shows, spoke of still 'doing' midwifery, but on a larger scale, describing midwifery as more than 'just' hands-on practice:

> I'm still a midwife, you know, I am a midwife. Midwife runs through everything I do. However, I focus on delivering a good service, a safe, quality service, and be that working with the staff or with the users, or the other agencies and the trust, that's where I see my role. But at the end of the day, I am still a midwife (Deborah).

Clinical credibility

At the root of interviewees' self-identification lay their clinician origins, which they believed offered credibility to their current, largely non-clinical position:

> I think the fact that I have worked in many, many areas in midwifery has always underpinned my credibility and underpinned my confidence in my own abilities. So I feel – I might be slightly out of speed on different areas, but I've definitely had an orientation to it. I've been there, I've **been** there, so I can talk hopefully informatively, about most areas of midwifery practice (Lesley).

Furthermore, interviewees identified numerous examples within a midwifery sphere through which they maintained clinical credibility:

> I still have interface with women, in that I'm dealing with complaints and service feedback… And I will go and shadow people… I keep myself up to date, and again I don't feel that I'm – you know, I'm involved in writing guidelines, and we do that through supervision, and you know, reviewing situations and obviously through high risk (Deborah).

Credibility could be maintained further up the organisational hierarchy than the matron role:

> I think within the head of midwifery role, there is that ability to maintain that clinical credibility, even though you're not practising direct, hands-on clinical – you know, I mean we – our head of midwifery, and me, while I was in that role, we go on our mandatory update days with the rest of the midwives, and we do the emergency skills and the same skills drills… And then there's all that input around how you influence the service, and how you develop the practice, and the influence on guideline production, and this sort of thing, that are all ways of influencing the service that maintain your clinical credibility, aren't they? Rather than actually delivering babies or doing a postnatal [examination] on the ward (Karen).

Differentiation

Although interviewees commonly described their continued professional identity in relation to characteristics and skills shared with midwifery colleagues, they also spoke of factors differentiating them from non-clinical leaders:

> If a situation arose, I would still go out there as a midwife – you know, because don't forget, you have some managers who have no nursing and no midwife input at all, so therefore, then they are managers and that's all they can do. They couldn't go out there and roll up their sleeves and – whereas we can (Pauline).

Interviewees were careful to note the value of both clinical and non-clinical leadership roles in the context of the NHS:

> Because the general manager, who's my head of midwifery's line manager, if you like – and the one who's above her – they've got no nursing or midwifery, but they're managing the service… I don't know whether having the knowledge that we have makes you a better manager, I can't say, I don't know… It makes you a different manager, because you'll have a different approach (Louise).

However, participants clearly saw roles for clinicians as a central part of NHS leadership:

> I don't have a problem with somebody coming in from Marks and Spencer at chief executive level, because it's a skill that – that's honed, then, to just pure management that you need at that level. Fine. But actually, once you start getting down at – at the further layer, you have to have an understanding, so that you can actually work out how that's going to happen (Susan).

Visibility

Interviewees felt visibility was key to their relationships with clinically-based colleagues, and a means of demonstrating continued professional group membership:

> 'I think you need to be visible, people need to know where you are, get used to seeing you around and about, and – and when you are visible and walking about, that you have got time for everybody, whether it is the housekeeper or whether it's the porter… And then yeah, they know who you are, they're used to seeing you in the – they don't think, 'My God, what's she here for? Why is she walking through the unit?' Or, 'There must be something wrong, because she's here' (Karen).

Visibility also enabled clinicians to communicate concerns effectively and in a timely manner, even though this was sometimes a challenge for interviewees:

> There are days when I know I'm going to walk the floor and I'm going to get an ear bashing. There are days, but I can't put it off, I have to do it, because it's better to try and… defuse. It's better to face it, defuse it, get on with it (Lesley).

Participants identified challenges to their ability to remain visible in clinical areas, and the lack of understanding shown by clinicians in relation to why clinical leaders might be less visible than they might like:

> And you hear it so much – 'Oh, they're not visible'. Well, if you look at diary commitments half the time, for these people, it's – they struggle to be visible… And even if they are visible, you might be in a room caring for a labouring woman and not see them when they have been around (Louise).

Between a rock and a hard place

While interviewees self-identified according to their professional background, a number of issues were raised where it became clear that this self-identification might be problematic, related to the wider professional and organisational context within which interviewees were working.

Leaving the gang

The majority of interviewees had experienced the transition from practitioner to clinical leader role within the unit where they already worked, and they recognised the challenges inherent in leading and managing colleagues and friends:

> It was a bit home from home, really, which in a way is difficult, because you have to really affirm your presence as, you know, 'I'm not your friend, but I am friendly', and actually, earn your stripes and their respect (Lesley).

Some interviewees believed the idea of being a friend to no-one but leader to all meant it might be easier to go to a new unit when taking up a leadership role:

> That's one thing I think is really challenging. If you grow up in a unit, with all your friends, I think it's much more challenging – I'm not saying it's not possible, but I find it easier not to be. So it makes the position more lonely, even though you know you're supported by your staff… But it's a minefield, if you're friends (Susan).

Loss of clinical role

As noted in Table 1, five of the interviewees were no longer practising clinically. Of the remaining four, three managed only sporadic clinical work, and this was generally difficult to achieve:

> Yeah, I do miss that, and I – part of it's in my gift to try and work more, clinically, but when you look at what work you have got to achieve, it feels an impossible task (Louise).

When managing to find time to work clinically, interviewees struggled to be 'just' a midwife:

> Obviously, my phone will ring when I'm at clinic. Yesterday my phone rang from here [the management corridor], and they were like, 'Where are you?' [I said], 'It's Wednesday afternoon – I'm at clinic, I'm being a midwife, a proper midwife [laughing]' (Karen).

In relation to the lack of a clinical role, interviewees often described a sense of loss:

> Going into education, I grieved for practice for a good few years. Occasionally I still do… I do miss some elements of it. Seeing the mother's face when she's birthed her baby, there is something out of this world in that (Natalie).

Clinical concerns

Although interviewees were generally confident that they could return to clinical practice if called upon, they acknowledged the possibility that they might need support in doing so:

> If I went on and I was asked to help a woman birth her baby, I could get on with it, but if she started haemorrhaging, where's the catheter? I know there's a full bladder… That's what makes me unsafe… Because you actually lose those skills very, very quickly (Natalie).

This issue was also recognised by Caroline, who described her plan to return to some degree of clinical life alongside her leadership role:

> It worries me, not having done it for so long… I'm going to have a preceptor when I go back to – you know, to start working again on the floor… And it's funny, it's the ones that I've – I've preceptored over the – years ago, and the role's reversed, and I've said, 'You'll have to, you know, get me – support me back in practice', and they were laughing.

Being 'one of them'

Interviewees discussed their interactions with clinical staff on the subject of 'the management':

> So, quite often, you know, where I'm having a conversation with the [senior clinical] midwives, and they'll say, you know, 'And management says' – and I'll say to them, 'Well, who do you think management is, then?' You know, 'It's me, it's you, you **are** the management' (Karen).

Similarly, others commented on a questionable dichotomy between 'us' (clinicians) and 'them' (managers), which they met in their leadership role:

> Some will see me as a midwife, because when – they often refer to sort of the senior management team, and often really, we're kind of classed in that senior management team, when they're sort of criticising. But, 'I'm part of that team. Is that what you think I'm like?' And they're like, 'No, no, you're here all the time, you're kind of one of us' (Louise).

Interviewees described the challenge of the hybrid clinical leader role in relation to their attempts to spend time in the clinical area, with challenges coming from both clinical and managerial colleagues:

> I'll often be looking after somebody, and I'll get a phone call from the head of midwifery, or one of the consultants from clinic, and I'll have to come out of caring for somebody to answer the phone to deal with, you know – it could sometimes be just a five minute phone call, and then I'm back, or – or members of staff will stop me in the corridor and say, 'Can I come in and see you? Can I make an appointment to see you?' (Heather).

Interviewees were concerned that this inability to be 'just' a clinical midwife impacted on the care they were able to offer women:

> People see you there, and they'll collar you for – 'I need to discuss this with you', 'I need to discuss that with you', or you get a phone call, you get – and you're pulled out all the time. So you find you spend your whole time apologising to the woman you're caring for, because you're going backwards and forwards and someone's after you and interrupting all the time. And to me, that makes it more uncomfortable, because I'd much rather be able to spend the time with the women I'm caring for, to be able to go through that uninterrupted, so that they get my time and appropriate care (Louise).

Influencing above and below

The question of where interviewees' offices were situated offers an insight into the challenges of acting as a clinical leader. Some interviewees believed there were benefits to having an office situated close to the clinical area; for example, the ability to see problems that might be looming:

> Because I can go out there, and they'll say, 'Oh, look, we've got an hour's waiting time', you know, 'so and so's running late'. And I'll say, 'Well, why's that, then?' You know – Now, if I wasn't here, I wouldn't know – all I would hear is that that clinic's always an hour late (Pauline).

A further advantage perceived by clinical leaders was their availability at times of clinical need:

> And you know, the emergency bell goes off, I just can't sit at my desk. I can't sit at my desk typing, when it goes off! So I go in, and I just, 'Anybody need any help? Are you okay?' And sometimes they do need my help, and sometimes they don't (Lesley).

However, being situated close to the clinical area also created problems. One concern described by interviewees related to being *too* available:

> You kind of just wanted to lock the door and say, 'I'm not really here', and not answer it. But then, personally I find that very hard to do as well, because if someone says they need my help, they need my help and I'll go, even where the pressures are elsewhere (Louise).

A further issue was raised in relation to not being part of the senior management team if clinical leaders were situated in or near the clinical area. Heather, for example, had recently moved from an office on labour suite to one in the senior management corridor, away from clinical areas:

> I could see the benefits of me moving up here. I think as a matron, you know, as a manager of the maternity unit, I felt that yes, I had to have that strategic input, and I wanted that, and I did feel left out of the loop at times, when I knew that, you know, the other community matron was up here, the head of midwifery and the consultants, and things were being decided. And sometimes, I wasn't being involved. And that's completely changed. I'm now making – you know, helping make those decisions.

Discussion

In this study, narratives of identity offered a clear example of the interplay between individuals and wider professional group and organisational discourses in the construction of the clinical leader self-identification. Several key points can be identified as particularly important to the development of clinical leaders, in the NHS context and beyond.

A coherent and cohesive narrative

At the root of the interviewees' assertion, 'I am still a midwife', lay a continued commitment to their professional identification as individual and group member. Interviewees were able to offer reasons to justify this identification, related to the idea that 'midwife' remained the most salient individual (role) and group (social) identity (Stryker, 1968), and they incorporated leadership and management roles into an expanded midwife identity.

Significantly, although interviewees described a clear transition from a purely clinical role to one involving leadership and management, their commitment to the midwife identity remained constant. Within clinical leadership literature, problems of role identity have been described in terms of dichotomies: either a professional or an organisational identification, with role conflict associated with attempts to manage the hybrid role interface (Edmonstone, 2008). However, the interviewees' descriptions of managing this interface were more closely aligned with suggestions that it is possible to operate in a more fluid, less fixed model of hybrid professional-organisational identification (Iedema et al., 2004; Kippist and Fitzgerald, 2009; Ham et al., 2010), and a process of role incorporation and expansion appeared to be the mechanism through which identity conflict was avoided.

Individuation and de-individuation

Individuation is described as part of the compromise involved in dealing with tensions between individuals' need for uniqueness and distinction, and the need for validation and similarity to others (Brewer, 1991). Interviewees used individuation in their descriptions of what they were not, with general managers used as a comparison in relation to interviewees' self-identification as midwives. This comparison was not made in a derogatory sense; the general managerial group was used as a comparison point to accentuate what midwifery leaders considered themselves not to be, but there was a sense that general managers had a valuable role to play alongside clinical leaders. This understanding of the value of other groups in the enactment of leadership supports other studies (Hoff, 1999; Ham et al., 2010), in which a strong professional identification led to little sense of division from general managers, as they were perceived as valuable in their own right.

Non-clinical managers also provided a reference group in the process of de-individuation, through which interviewees justified their continued group membership (Brewer, 1991). The other group used in this process was of course the interviewees' professional group, to which they showed a strong commitment. This process of 'othering' an out-group (general managers cannot work clinically) and in-group emphasis (we are midwives because we can still take on a clinical role) was highly significant to the interviewees' continued self-identification at both individual and group level.

Comparison and categorisation are seen as central to identity (Tajfel and Turner, 1979; Burke and Reitzes, 1981; Stets and Burke, 2003). One identity is always constructed in relation to another, whether this is at individual or group level. The interviewees' comparisons demonstrated this aspect of identity construction very clearly, with comparisons to both in-group and out-group emphasising their continued identity at the group level, and interaction with clinicians based on what they believed to be an undisputed shared history and language at the individual level.

The challenge for clinical leadership

Although interviewees believed they continued to 'do' midwifery, simply on a broader scale, they did show awareness of wider discourses which might challenge this belief. Concerns about clinical credibility, visibility, and perceptions of both clinical and managerial colleagues, demonstrated the challenge of maintaining a professional self-identification in the context of competing discourses. These findings echo other studies within clinical leadership, where clinical credibility has been seen as a key element in peer acceptance of clinical leaders (Osborne, 2011; BMA, 2012).

Although interviewees were able to describe their management of a hybrid clinical-leader role identity, the real challenge lay in validation at the professional group and organisational level. If identity is constructed and enacted through the use of narratives at individual, cultural and societal levels (Watson, 2009), then individuals necessarily develop their identity narratives within the discourses surrounding them, and these surrounding discourses specify what constitutes 'truth' (Gendron and Spira, 2009). In the context of NHS leadership, studies suggest that clinical leaders tend to be construed as 'managers', and that the term 'management' has strongly negative connotations (The King's Fund, 2011). For clinical leaders, challenging this derogatory view relies on validation by professional group members, which in turn requires organisational support in the form of some element of clinically-based role.

Limitations

The local focus of this study might be considered a limitation, in terms of the generalisability of findings. However, there were many similarities with findings from studies into leadership within other NHS clinical professions, and in wider organisations, as described in the discussion section.

Conclusions and implications

Midwifery leaders offered narratives of their journeys to leadership in which they continued to self-identify according to their professional role, giving rise to the theme, 'I am still a midwife'. This was achieved via their belief in a commitment to midwifery beyond hands-on practice, a continued sense of credibility based on their years of clinical experience, and a process of differentiation from non-clinical, managerial leaders in the organisation.

However, maintaining a professional self-identification was not without its challenges, described in leaders' narratives as being 'between a rock and a hard place'. Challenges arose from the threat to their clinical credibility from midwives, associated with a loss of the clinical element of their role, and a lack of organisational commitment to the maintenance of some degree of clinical practice, something desired by the majority of interviewees.

Support from the organisational level is essential if clinical leaders are to maintain credibility with their clinically-based colleagues, and thus enact a cohesive and coherent career narrative at individual and professional group levels of analysis. Given health-care organisations' commitment to the development of clinical leadership careers and a distributed model of leadership, it is essential that clinical leaders are supported in their desire to maintain credibility and a continued professional self-narrative.

Given the belief that the strength of clinical leadership lies precisely in these leaders' clinical background, there needs to be greater emphasis within health-care organisations in supporting this strength. In the context of this study, interviewees expressed both a desire for time spent in clinical practice, and serious challenges to achieving this aim. If clinical leadership is to be a reality in the English NHS, these challenges need to be addressed – for the sake of individual identity narratives, and their validation within professional group and organisational discourses. Future research should address ways in which clinical leaders might be supported to maintain an element of clinical practice, and explore whether there is an ideal hybrid identity that could be better supported by clinicians and organisational structures alike.

Conflict of interest

No conflict of interest.

Acknowledgements

This study was funded by a CASE award from the Economic and Social Research Council, UK. My thanks to Professor Graeme Currie and Professor Mark Avis for their doctoral supervision.

Appendix A. Supplementary material

Supplementary data associated with this article can be found in the online version at http://dx.doi.org/10.1016/j.midw.2015.07.006.

References

Ashforth, B.E., 2000. Role Transitions in Organisational Life: An Identity-Based Perspective. Lawrence Erbaum, Mahwah, New Jersey.
BMA, 2012. Doctors' Perspectives on Clinical Leadership. Available at: < www.bma.org.uk > .
Brewer, M.B., 1991. The social self: on being the same and different at the same time. Personal. Soc. Psychol. Bull. 17, 475–482.
Burke, P.J., Reitzes, D.C., 1981. The link between identity and role performance. Soc. Psychol. Q. 44, 83–92.
Creswell, J.W., 2013. Qualitative Inquiry and Research Design: Choosing Among Five Approaches, 3rd edn. Sage Publications, Thousand Oaks.
Department of Health, 2009. Inspiring Leaders: leadership for quality. Available at: ⟨www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093407.pdf⟩.
Department of Health, 2010. Midwifery 2020: delivering expectations. Available at: ⟨www.gov.uk/government/publications/midwifery-2020-delivering-expectations⟩.
Department of Health, 2008. High quality care for all. NHS next stage review final report. Available at: ⟨www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf⟩.
Department of Health, 2007. Maternity matters: choice, access and continuity of care in a safe service. Available at: ⟨www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@endocuments/digitalasset/dh_074199.pdf⟩.
Doolin, B., 2002. Enterprise discourse, professional identity and the organisational control of hospital clinicians. Organ. Stud. 23, 369–390.
Edmonstone, J., 2008. Clinical leadership: the elephant in the room. Int. J. Health Plan. Manag. 24, 290–305.
Fenton, K., 2012. What is clinical leadership? Nursing Times. Available at: ⟨http://www.nursingtimes.net/nursing-practice/leadership/what-is-clinical-leadership/5045399.article⟩.
Fielding, P., Richens, Y., Calder, A., 2010. Review of Maternity Services in University Hospitals of Morecombe Bay NHS Trust. Available at: ⟨http://www.morecambebayinquiry.co.uk/images/pdfs/fieldingreport.pdf⟩.
Fielding, N.G., 2002. Automating the ineffable: qualitative software and the meaning of qualitative research. In: May, T. (Ed.), 2002. Sage Publications, London, pp. 161–178.
Firth-Cozens, J., Mowbray, D., 2001. Leadership and the quality of care. Qual. Health Care 10, 3–7.
Fletcher, J.K., 2004. The paradox of postheroic leadership: an essay on gender, power, and transformational change. Leadersh. Q. 15, 647–661.
Gendron, Y., Spira, L.F., 2009. What Went Wrong? The downfall of Arthur Andersen and the construction of controllability boundaries surrounding financial auditing. Contemp. Account. Res. 26, 987–1027.
Ham, C., Clark, J., Spurgeon, P., Dickinson, H., Armit, K., 2010. Medical Chief Executives in the NHS: Facilitators and Barriers to their Career Progress. NHS Institute for Innovation and Improvement. Available at: ⟨http://www.institute.nhs.uk/images/documents/Medical%20Chief%20Executives%20in%20the%20NHS%20-%20Facilitators%20and%20Barriers%20to%20Their%20Career%20Progress.pdf⟩.
Ham, C., 2003. Improving the performance of health services: the role of clinical leadership. Lancet 361, 1978–1980.
Healthcare Commission, 2008. Towards Better Births: a review of maternity services in England. Available at: ⟨http://image.guardian.co.uk/sys-files/Society/documents/2008/07/10/Towards_better_births.pdf⟩.
Healthcare Commission, 2006. Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, The North West London Hospitals NHS Trust, between April 2002 and April 2005. Available at: ⟨http://webarchive.nationalarchives.gov.uk/20060502043818/http://healthcarecommission.org.uk/_db/_documents/Northwick_tagged.pdf⟩.
Healthcare Commission, 2004. Investigation of the maternity service provided by the Royal Wolverhampton Hospitals NHS Trust at New Cross Hospital. Available at: ⟨http://webarchive.nationalarchives.gov.uk/20060502043818/http://healthcarecommission.org.uk/_db/_documents/04011738.pdf⟩.
Hoff, T.J., 1999. The social organisation of physician-managers in a changing HMO. Work. Occup. 26, 324–351.
Hotho, S., 2008. Professional identity – product of structure, project of choice: linking changing professional identity and changing professions. J. Organ. Change Manag. 21, 721–742.
Ibarra, H., 2007. Identity transitions: possible selves, liminality and the dynamics of voluntary career change. INSEAD Working Paper. Fontainebleau. Available at: ⟨http://www.insead.edu/facultyresearch/research/doc.cfm?did=2720⟩.
Iedema, R., Degeling, P., Braithwaite, J., White, L., 2004. 'It's an Interesting Conversation I'm Hearing': the doctor as manager. Organ. Stud. 25, 15–33.
The King's Fund, 2011. The future of leadership and management in the NHS: no more heroes. Available at: ⟨http://www.kingsfund.org.uk/sites/files/kf/future-of-leadership-and-management-nhs-may-2011-kings-fund.pdf⟩.
Kippist, L., Fitzgerald, A., 2009. Organisational professional conflict and hybrid clinician managers: the effects of dual roles in Australian health care organisations. J. Health Organ. Manag. 23, 642–655.
Mannion, R., Davies, H., Marshall, M., 2005. Cultures for Performance in Health Care: Evidence on the Relationship Between Organisational Culture and Performance in the NHS. Open University Press, Maidenhead.
Mason, J., 2002. Qualitative Researching, 2nd edn. Sage Publications, London.
Millward, L.J., Bryan, K., 2005. Clinical leadership in healthcare: a position statement. Leadersh. Heal. Serv. 18, 13–25.
Moen, T., 2006. Reflections on the narrative research approach. Int. J. Qual. Methods 5, 1–11.
Murphy, J., Quillinan, B., Carolan, M., 2009. Role of clinical nurse leadership in improving patient care. Nurs. Manag. 16, 26–28.
Nicol, E.D., 2012. Improving clinical leadership and management in the NHS. J. Healthc. Leadersh. 2, 59–69.
Oliver, S., 2006. Leadership in health care. Musculoskelet. Care 4 (1), 38–47.
Osborne, J.A., 2011. How do they manage? A study of the realities of middle and front line management work in healthcare. Challenges facing healthcare managers: what past research reveals. Cranfield Healthcare Management Group Research Briefing 6. Available at: ⟨www.som.cranfield.ac.uk/som/dinamic-content/media⟩.
Phillips, N., Byrne, G., 2013. Enhancing frontline clinical leadership in an acute hospital setting. J. Clin. Nurs. 22, 2625–2635.
Polkinghorne, D.E., 1995. Narrative configuration in qualitative analysis. Int. J. Qual. Stud. Educ. 8, 5–23.
Rapley, T., 2007. Doing Conversation, Discourse and Document Analysis. Sage Publications, London.
Silverman, D., 2005. Doing Qualitative Research, 2nd edn. Sage Publications, London.
Stets, J.E., Burke, P.J., 2003. A sociological approach to self and identity. In: Leary, M., Tangney, J. (Eds.), Guildford Press, New York, pp. 128–152.
Storey, J., Holti, R., 2013. Possibilities and pitfalls for clinical leadership in improving service quality, innovation and productivity. Final Report. NIHR Service Delivery and Organisation programme. Available at: ⟨www.netscc.ac.uk/hsdr/files/project/SDO_FR_09-1001-22-V05.pdf⟩.
Stryker, S., 1968. Identity salience and role performance: the relevance of symbolic interaction theory for family research. J. Marriage Fam. 30, 558–564.
Tajfel, H., Turner, J., 1979. An integrative theory of intergroup conflict. In: Austin, W. G., Worchel, S. (Eds.), Brooks-Cole, Monterey, CA, pp. 33–47.
Turnbull James, K., 2011. Leadership in Context: Lessons from New Leadership Theory and Current Leadership Development Practice. The King's Fund, London. Available at: ⟨www.kingsfund.org⟩.
Watson, T.J., 2009. Narrative life story and the management of identity: a case study in autobiographical identity work. Hum. Relat. 62, 1–28.
Yukl, G., 1999. An evaluation of conceptual weaknesses in transformational and charismatic leadership theories. Leadersh. Q. 10, 285–306.