Hollins Martin, C. J., Bull, P. (2010). The situational argument: do midwives agree or acquiesce with senior staff? *Journal of Infant and Reproductive Psychology.* 28 (2),180-190.

ABSTRACT

This study concerns midwives' obedience/conformity to direction from a senior person. We sought to identify whether midwives just went along with what a midwife at management level suggested or instead altered their views to match hers. In the first condition, a postal Social Influence Scale-Midwifery (SIS-M) measured and scored 209 midwives' private responses to 10 clinical questions. In a second condition, a senior midwife successfully influenced 60 of these midwives to alter their SIS-M decisions to agree with her suggested correct responses. In a third condition, a postal condition again measured the midwives private SIS-M responses. The aim was to elicit whether the midwives' simply complied with the senior midwife's suggestions during interview or actually changed their opinions to match hers. A 3 (E (lowest grade), F (middle grade) & G (sister grade) × 3 (above conditions) ANOVA found a significant main effect for conditions ($F(2, 94) = 151.87$, $p = 0.001$) with higher scores in the interview condition when the senior midwife passively influenced participant responses. Results inform that the interview manipulation had no lasting social influence effect, consistent with Milgram's (1974) transient situational argument. That is, in the presence of senior staff midwives decisions are profoundly influenced.

Keywords: social influence, conformity, obedience, midwives, opinion

The situational argument: do midwives agree or acquiesce with senior staff?

One aspect of behaviour brought about through social influence is obedience (e.g., Meeus & Raaijamakers, 1995; Milgram, 1974). Milgram (1974) defined obedience to authority as occurring within a hierarchical structure in which the actor feels that the person above has the right to prescribe behaviour.

Milgram (1963, 1965, 1974) designed a bogus experiment on the pretext that the purpose was to study the effect of punishment on memory. In a voice feedback condition, the participant was introduced to a man who was alleged to be another participant, but in fact was a confederate of the experimenter. The experimenter told the two men that they would be assigned a role as either teacher or learner, and the teacher would proceed to teach the learner to remember a list of word pairs. The two men drew lots to decide who was to take each role, but in fact this was rigged so that the genuine participant always became the teacher. The participant witnessed the learner being strapped into a chair and attached to electrical connections linked up to a shock generator. The participant was shown into a separate room where a shock generator was placed on a table. The participant was told that each time the learner made a mistake in recall of the list of word pairs he was to administer a shock by pressing one of 30 switches. The first lever was labelled “15 volts-mild shock”, the next “30 volts” and so on up to “450 volts”. The participant was instructed to press the 15 volt switch first and move one switch up the scale each time the learner made a mistake.

Milgram wanted to know how far up the scale of shocks participants would go when told to continue by the experimenter. That is, regardless of the sound of cries and pounds on the wall from the confederate learner asking the participant to stop.

The results were unexpected and dramatic, with 62.5% of the men in the baseline condition proceeding up to the 450 volt level.

Milgram manipulated a number of variables within the basic experimental procedure and found that situational factors altered levels of obedience from the baseline results of 62.5%. For instance, when the victim was placed in the same room, in close proximity (thus he was visible as well as audible), obedience dropped to 40%. In a further condition, when the experimenter left the laboratory and gave his orders over the telephone, obedience dropped to 20.5%. The results of Milgram's experiments provided overwhelming evidence that the majority of people are unable to defy orders from authority and will proceed to administer unpleasant acts when commanded to do so.

Milgram's research on obedience was followed by a succession of studies by An and Liu (2003), Mantell (1971), Meeus and Raaijamakers (1995), Shanab and Yahya (1977) and Sheriden and King (1972). The general consensus was that modifications in the physical and social arrangements in the setting of the obedience experiment have powerful effects upon levels of social influence exerted by authority figures (Blass, 2002; Meyer, 2003).

To date there has been a dearth of obedience studies conducted within the arena of midwifery practice. One relevant study was conducted by Hofling et al. (1966) who carried out a field experiment in which a doctor ordered a nurse to give an overdose of injectable medication to a patient. The drug order was issued by telephone and violated hospital policy. Out of 22 nurses, 21 would have injected the prescription had the researcher not interrupted them. The significance lies in the tendency of people to be obedient to those they perceive to be both trustworthy and expert.

Hollins Martin and Bull (2005) showed that a senior midwife was profoundly capable of promoting obedient behaviour from midwives. In the Hollins Martin and Bull experiment (2005), the very ease by which the senior midwife successfully influenced change to midwives' decisions arouses suspicion. Did the midwives actually change their opinions (compliance with opinion change) or were the experimental victories only scored on paper? (compliance without opinion change). If situational factors are temporary forces holding the midwife to her obedient role, it seems reasonable to predict a sharp drop in obedience when the preconditions of the experiment are eliminated. That is, when the senior midwife is absented from the midwives' decision-making process.

The results of obedience experiments are persuasive in supporting the position that situational factors affect the amount of obedience a participant will yield to a senior person. Therefore it seems reasonable to predict that removing a senior person from a midwife's decision-making process will eliminate normative pressures of the group. Milgram called this an "experimenter absent condition". Hence, in this study, questions asked by a senior midwife during an interview were reissued in a private condition. The following research question was addressed:

> Do subordinate midwives simply comply with recommendations of a senior midwife or does something more complex occur that effects a permanent change to their judgements?

METHOD

PARTICIPANTS

The study assessed a representative sample of midwives recruited from 7 maternity units in North Yorkshire (UK). Participants were assigned to three groups (E, F or G grade).

ETHICS

At commencement of the research, ethical approval was sought from the appropriate authority structures. Authorisation to conduct the study and full cooperation was attained from seven clinical managers. After agreement to participate, the midwife was asked to sign a written consent form. What follows is a study in which the experimenter contact time was placid, gentle and friendly, with participants permitted to withdraw at any point.

DEPENDANT VARIABLE

A valid and reliable scale was constructed - Social Influence Scale-Midwifery (SIS-M) (see TABLE 1). The SIS-M is scored using a 5-point Likert scale based on level of

TABLE 1 NEAR HERE

agreement with each statement. Five of the items on the SIS-M are reverse scored. The respondent selects a response that scores between 1 - 5, with 5 representing the most conformist response and 1 the least. Since there are 10 items, the achievable range of total scores lies between 10 - 50, e.g.,

> (5) I believe that it is acceptable for a women to have more than one "birth partner" present during labour when the unit policy states only one person at a time.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Scores[1]	1	2	3	4	5

DEVELOPMENT OF THE DEPENDANT VARIABLE

The SIS-M was developed using discriminatory item analysis and exploratory factor analysis approaches to the data. Principle Components Analysis (PCA) resulted in

[1] The scores are just for illustration and are not shown on the questionnaire.

emergence of four factors with eigen values greater than one. The direct oblimin oblique rotation with loading criterion of 0.3 produced a four-factor terminal solution and a pattern matrix with all items loading onto four factors. These were labelled: *Conformity* (F1), *Client Control* (F2), *Personal Control* (F3) and *Non-conformity* (F4). The subscale domain of *Conformity* (items 3, 4 and 6) pertains to compliance or obedience with prescribed orders; *Client Control* (items 5 and 9) with desire to influence the choices of childbearing women; *Personal Control* (items 1, 7 and 10) with rejection of external influence; and *Non-conformity* (items 2 and 8) with arguing with authority figures over care decisions. Confirmatory Factor Analysis (CFA) was performed on the 10-item scale to test the a priori specified hypothesis that a four-factor correlated model would offer a significantly better fit to the data compared to a uni-dimensional single-factor model (comprising a global dimension of conformity). The CFA findings suggest that the SIS-M comprises four sub-scales that measure distinct but correlated domains of *Conformity, Client Control, Personal Control and Non-conformity* (see Hollins Martin, Bull & Martin, 2004). An internal consistency analysis of the SIS-M was also conducted to ensure that the measures satisfied the criteria for clinical and research purposes using the Cronbach coefficient alpha statistical procedure (Cronbach, 1951).

DESIGN

The study used a longitudinal within participants design with observations taken at three points.

CONDITION ONE (C1) - THE PRE-INTERVIEW QUESTIONNAIRE

At the first observation point, the SIS-M was issued to measure 60 midwives' responses to the 10 SIS-M questions. In private the midwife provided her own opinions in the absence of social influence from a senior midwife.

CONDITION TWO (C2) - THE INTERVIEW

At the second observation point and after a 12-month time gap, an interview was conducted to measure the same 60 participants' responses to the 10 SIS-M questions in a situation where social influence was brought to bear by a senior midwife. The senior midwife, by making her preferred responses explicit, endeavoured to socially influence participants SIS-M responses in a conformist direction and accordingly increase SIS-M scores. The senior midwife who interviewed the participants was a lecturer in midwifery. In this capacity she worked at the local maternity hospital as link midwife to the university. This role equates to a management position and is perceived within the hierarchy as senior to all of the participants.

FORMAT OF INTERVIEWS

A case study was presented to the participant before each SIS-M question, e.g., in Question 4:

> Karen McDonald is a 26 year old para 1+0 at 39 weeks gestation with a straightforward pregnancy and normal labour. Karen arrived in the delivery room 5 hours ago with a cervix 3 centimetres dilated, partially effaced and a uterus contracting 3 moderate in 10 minutes. On routine repeat vaginal examination Karen's cervix is found to be 6 centimetres dilated, fully effaced and uterine contractions 2 strong in 10 minutes. Progress is slow. Membranes spontaneously ruptured half an hour ago and at present there are no signs of fetal distress. The guidelines for management of labour state an expectation that the cervix of a parous woman usually dilates 2 centimetres an hour and that 3-4 good contractions are expected every 10 minutes with slow progress indicating commencement of syntocinon to increase uterine activity and accelerate proceedings.

The senior midwife made her preferred response to the SIS-M question explicit. In Question 4, the interviewer *Strongly Agreed* with the question asked.

Question 4 - I would administer oxytocin to a woman desiring a normal labour if it was a requisite of the guidelines for routine labour.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

With each of the 10 SIS-M questions, the participant read a different case study, intended to improve ecological validity. That is, simulate a situation that reflected a real obstetric context. The midwife made her preferred question response clear.

CONDITION THREE (C3) - THE POST-INTERVIEW QUESTIONNAIRE

At the third observation point, post-interview the SIS-M was used to measure 50 participants' responses to the 10 SIS-M questions again in private. The intention was to test whether the physical presence of the senior midwife during the interview was the key factor in promoting participants' acquiescent responses, in keeping with Milgram's (1974) finding of reduced obedience in his experimenter absent condition. After a 6-month time gap, a second postal questionnaire was sent to the participants' workplace. Completion of this further SIS-M identified whether the midwife had merely agreed with the senior midwife during the interview (C2) whilst harbouring unchanged personal viewpoints. It was predicted that many of the midwives' public responses to the SIS-M questions would revert to those given in the private pre-interview questionnaire (C1).

All three measures were scored and compared, with changed SIS-M responses between postal and interview conditions informing as to whether situational aspects of the interview had simply effected a transient change to participants' opinions.

RESULTS

The Cronbach's alpha of the SIS-M was found to be 0.61 for time 1 (Pre-Interview Questionnaire), 0.68 for time 2 (Interview) and 0.65 for time 3 (Post-Interview Questionnaire), with all three exceeding Nunally's (1978) criterion for acceptable instrument internal reliability.

A 3 (E, F & G grade midwives) × 3 (Conditions) analysis of variance (ANOVA) found significant differences in SIS-M scores between the grades and conditions. A significant main effect for conditions was found, ($F(2, 94) = 151.87$, $p = 0.001$), with higher scores on the interview measure (for means and standard deviations see TABLE 2).

TABLE 2 NEAR HERE

A posteriori analysis using the Bonferroni procedure, corrected for multiple comparisons, found the public condition to have significantly higher scores compared to the two private measures (both comparisons $p < 0.001$). Post-Interview Questionnaire (C3) scores were significantly higher than the Pre-Interview Questionnaire (C1) ($p = 0.05$). No significant interaction between grades and conditions was found, ($F(4, 94) = 1.65$, $p = 0.17$). No effect of midwife grade was observed ($F(2, 17) = 0.25$, $p = 0.78$).

Visual examination of the scatter plots and correlations of the pre-interview questionnaire (Cl), interview (C2) and post-interview questionnaire (C3) scores revealed that SIS-M scores increase significantly (see TABLE 3), and that they did this in a linear fashion.

TABLE 3 NEAR HERE

TABLE 4 presents an overall picture of the participating midwives' responses to the SIS-M questions in the three conditions of the study.

TABLE 4 NEAR HERE

DISCUSSION

Similar mean SIS-M scores are evident in the two private measures, with both differing significantly to that of the interview. This indicates that the social influence manipulation during the interview had no major lasting effect, consistent with

Milgram's (1974) transient situational argument. Although mean SIS-M scores in both postal measures are similar (23.32 for C1 & 24.58 for C2, see TABLE 2), the modest difference is also statistically significant. One feasible explanation for this is the issue of policy changes that have effected the clinical environment. For instance, consultant midwives have been appointed. Also new policies have directed implementation of midwifery led care (RCM, 2006).

What remains important within the context of this study is the relative return to the similar mean baseline score following the very large increase in SIS-M scores in the interview condition (C2). The global picture confirms that many participants simply went along with direction given by the senior midwife during the interview. The vastly reduced mean scores in the post-interview condition supports that generally participants did not internalise the authority figure's views and merely acquiesced with what was proposed. The social influence effect was typically fleeting and in response to forces that relate to the immediate interview situation. A similar result was shown in Milgram's Experiment 7; when the authority figure departed from the laboratory levels of obedience dropped remarkably. The number of obedient participants in the first condition (26) was almost three times as great as in the second (9), when the experimenter gave orders over the telephone. Such obedience is rooted in the physical presence of the authority figure, with participants able to resist direction far better when they did not have to confront the experimenter face-to-face.

Surprisingly, results of the analysis of variance showed no significant effect for midwife grade. Whether the midwife was employed at E, F or G grade made no difference to the success of the social influence in changing participants' viewpoints. The failure to find any effect due to relative position within the hierarchy may have been because the interviewer's status was higher than all three groups of E, F and G

grade midwives. Had the interviewer been an F grade results may have differed. If one considers that a senior midwife was able to obtain acquiescence from junior midwives, it is reasonable to assume that a midwife of lesser rank could also obtain cooperation as long as the participant was "a grade or more below" in the hierarchy. Equally, just as Milgram did not elicit the same amounts of obedience from all participants, the senior midwife was unable to obtain matching levels of acquiescence from all of the midwives.

Results support that immediate situational factors affect the amount of acquiescence that a midwife will yield. Yet, at the same time as acquiescing, some participants stated that their submission was reluctant and used strategies to circumvent what they saw as needless direction from the senior person, in keeping with Levy (1999a, 1999b, 1999c). The perception that circumvention would avoid "a big scene" serves to underline the relative powerlessness of the midwife. Such use of covert tactics to subvert the power of more influential others reinforces hierarchical structures between the senior person and the midwife (Hollins Martin & Bull, in press). Kitzinger et al. (1990) calls this behaviour "hierarchical maintenance work". What follows is an example of a circumvention strategy reported by one participant:

> *I used to know this consultant who went bezerk when they had more than one (birth partner). You only had to have one in delivery. But I used to hide them in the toilet and there was always the toilet. He'd be doing the ward round, so you would say, "go in the toilet", 'cos they wouldn't stay long.*

During interviews, two main categories were provided to explain the midwives' obedient behaviour: (1) imposition of hospital policies, and (2) fear of consequences from challenging senior staff (Hollins Martin & Bull, 2006). Hospital

policy was perceived by some to obstruct midwives' better judgment. For example, the following participant stated:

> *I would feel a "bit narked" that I would be having to rupture this woman's membranes, but it's there and it is in black and white. That is the issue, you have to work within these guidelines*.

Three consequences were identified. Fear of: (a) an abnormal obstetric outcome, (b) litigation, and (c) conflict and intimidation (Hollins Martin & Bull, 2006):

> *I would be thinking if I don't do it and as you said if anything goes wrong.*

> *You don't practice just how you would like because of the fear of litigation.*

> *The costs of being direct with some of these individuals is……and you know that they are going to make your life a misery for the next goodness knows how long*.

THE EFFECT ON DELIVERY OF WOMAN-CENTRED CARE

Situational restrictions within the working environment will inevitably prevent midwives from providing the woman-centred care directed by social policy documents (DoH, 1993; DoH, 2003; DoH, 2004). It is probable that situational constraints will include close proximity of the authority figure and the face-to face nature of such social interaction.

It is of considerable interest that so many midwives devalued the childbearing woman by choosing to prioritise their own concerns. For example, in SIS-M question two, the midwife was asked if she would argue with a senior person who opposed a

healthy woman's request for a home confinement[2]. It was found that 33 (66%) of midwives in the private pre-interview measure (C1) declared that they would confront the authority figure to act as an advocate for the childbearing woman. Yet, when exposed to social influence from the senior midwife during the interview (C2), only 12 (24%) participants sustained this point of view. In the interview measure, the remaining 38 (76%) midwives did not give their support. Instead, many prioritised their own concerns and elected not to disrupt the social etiquette of the situation. These results are similar to Milgram's 62.5% of obedient participants in baseline Experiment 2. Again in the private post-interview measure, when the social pressure was removed, 37 (74%) participants reverted to their initial opinion and again agreed they would confront the senior person.

These results highlight considerable differences between what midwives say they will do in private and what actually happens when they are placed within a hierarchy and exposed to social influence from a senior person. The results emphasise that temporary situational factors effect change to midwives' opinions. When face-to-face with a senior person, the majority of junior midwives simply comply with recommendations that are made.

Results of the post-interview questionnaire (C3) show that many participants were in some sense opposed to the action they agreed to take during the interview (C2). Between thoughts, words, and the critical step of arguing against the senior midwife lies another ingredient, the capacity for transforming beliefs and values into

[2] Olsen (1997) carried out a meta-analysis of the relative safety of homebirth compared to hospital birth. A total of 25,000 births from five different countries were studied. The results found no difference in survival rates between babies born at home and those born in hospital. However there were several significant differences between the groups. Fewer medical interventions occurred in the homebirth group. Fewer home babies were born in poor condition. The homebirth mothers were less likely to have suffered lacerations during birth. They were less likely to have had their labours induced or augmented by medications or to have had caesarian sections, forceps or vacuum extractor deliveries. As for maternal deaths, there were none in either group.

action. What these midwives failed to realise is that subjective feelings are largely irrelevant to the moral issue at hand. The abandoned principles of providing woman-centred care and evidenced-based practice has shown to be determined significantly by authority figures. There appears to be a clash between values which relate to the expected activities of a midwife and values that pertain to the maintenance of social norms within the organisation. Time and again, during the interview (C2), midwives devalued what they were doing but could not muster the inner resources to translate their values into action. The problem of acquiescence therefore is not wholly psychological. The form and shape of the organisation has much to do with it.

This has important consequences for the functioning of maternity hospitals and the quality of care childbearing women receive. The midwife who acts by the proposal that authority directs and where this denies a childbearing woman a safe option in care, breaches Rule 6 of the Midwives Rules and Standards (NMC, 2004, p. 17). Rule 6 states that the midwife:

- Must make sure the needs of the woman or baby are the primary focus of her practice.
- Should work in partnership with the woman and her family.
- Should enable the woman to make decisions about her care, based on individual needs, by discussing matters fully with her.

CONCLUSION

The clear fact that hospital authority reinforces acquiescence of midwives whilst simultaneously advocating woman-centred care, causes conflict for midwives. The situation creates a contradiction between the midwife's demands to follow Rule 6 of the Midwives Rules and Standards (NMC, 2004) or to follow the direction from a senior midwife, unless they both happen to be in agreement. In essence, the midwife is a link in the hierarchical chain of command which the organisation reinforces, with

both senior and junior midwife encountering constraints presented by those in authority. This matter requires address by midwifery officialdom and the Department of Health.

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Table 1. Questions Asked in the Social Influence Scale for Midwifery (SIS-M)

(1) I believe that guidelines are unnecessary when labour is progressing normally.
(2) I would argue with the consultant if he refused to support a home confinement when a mother with a healthy pregnancy is keen to have one.
(3) I would follow a senior member of staff's request to rupture a woman's membranes if this was the decided course of action.
(4) I would administer oxytocin to a woman desiring a normal labour if it was a requisite of the guidelines for routine labour.
(5) I believe that it is acceptable for a women to have more than one 'birth partner' present during labour when the unit policy states only one person at a time.
(6) I would automatically commence cardiotocography if it was requested by a senior member of staff.
(7) In general I would challenge a senior member of staff if they decided to override a decision I made regarding normal labour.
(8) I would conceal my opinion from a consultant obstetrician when my stance about carrying out elective section for social reasons differs.
(9) I would allow a women to have her two friends and husband present during labour and delivery if this is what she wanted.
(10) Informed choice for women is an idealised dream when the reality is that we know what is best for women in labour.

Table 2. Means and standard deviations of scores on the SIS-M as a function of condition type and midwife grade

Grade	Condition		
	Private (C1)	Public (C2)	Private (C3)
G	23.84 (3.91)	34.95 (6.35)	24.05 (4.67)
F	23.44 (4.59)	37.22 (5.39)	24.33 (4.31)
E	22.38 (3.15)	34.31 (6.46)	25.69 (4.11)
Total	23.32 (3.96)	35.60 (6.05)	24.58 (4.37)

Table 3. Correlation between Pre-Interview Questionnaire (Cl), Interview (C2) and Post-Interview Questionnaire SIS-M scores

	C1 Total	C2 Total	C3 Total
C1 Total Pearson Correlation	1.000	0.319*	0.483**
Sig. (2-tailed)		0.013	0.000
N	60	60	50
C2 Total Pearson Correlation	0.319*	1.000	0.413**
Sig. (2-tailed)	0.013		0.003
N	60	60	50
C3 Total Pearson Correlation	0.483**	0.413**	1.000
Sig. (2-tailed)	0.000	0.003	
N	50	50	50

*Correlation is significant at the 0.05 level (2 - tailed)
**Correlation is significant at the 0.01 level (2 - tailed)

Table 4. Numbers of Midwives Who Acquiesced in the Pre Interview Questionnaire (Cl), the Interview (C2) and the Post Interview Questionnaire (C3)

SIS-M Question	n = Acquiesced in Private Cl n = 50	n = Acquiesced in Public C2 n = 50	n = Acquiesced in Private C3 n = 50
1	14	47	24
2	9	31	8
3	13	39	14
4	10	39	14
5	2	11	5
6	9	48	12
7	0	31	1
8	14	36	16
9	3	14	1
10	2	39	8
Mean	7.6	33.5	10.3