

# Fluid Boundaries and Moving Targets: Midwife Leaders' Perspectives on Continuing Professional Education

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## Abstract

In this study, we aim to understand midwife leaders' perspectives on continuing professional education among midwives in their work unit. We used a phenomenological perspective and method in the process of interviewing the participants and analyzing the data. Five midwife leaders who worked in large maternity wards and had considerable experience as managers were recruited. Results revealed three essential constituents: (a) constraints and the individualization of continuing professional education, (b) normal and at-risk births: fluid boundaries and moving targets, and (c) a personal approach: dimensions of control and trust-driven leadership. We discuss these findings in relation to current research and perspectives on how professional cultures and leadership impact continuing professional education and knowledge management, revealing possible implications to further promote professional development in public health organizations. We conclude that midwife leaders' views on continuing professional education as practical skills training may hinder professional communication and knowledge development in maternity care.

## Keywords

continuing professional education, knowledge management, leadership, midwifery, phenomenology

## Background

One of the professional responsibilities of a health care provider is to continue to develop professionally and acquire the necessary knowledge and skills to provide high-quality health care (Cervero & Daley, 2016; Jooste, 2018). Midwifery is an old profession but is considered to be a relatively new science with a need to develop evidence-based knowledge that can inform professional practice (Hutton, 2017). As a result of the Bologna process and the European strategic directions for strengthening nursing and midwifery toward Health 2020, the World Health Organization (WHO, 2015) describes several priority areas and enabling mechanisms. It underscores the importance of continuing professional education (CPE) and career development, and building midwifery and multidisciplinary research capacity. Midwifery research is needed to develop new scientific knowledge and its application in the practice field. The WHO also stresses the importance of building interdisciplinary and intersectional collaboration and research to develop and provide person-centered care and improved health outcomes.

For midwives holding a midwifery diploma, the possibility to take an academic CPE is important to be up-to-date professionally and to advance their profession (Dahl et al., 2019). Possessing clinical skills is vital to provide high-quality care,

but it is inadequate to develop and strengthen professional autonomy. In this regard, research competence is required (Hutton, 2017). Academic competence combined with clinical skills also facilitates critical reflection, communication, and collaboration with obstetricians, resulting in a joint understanding of professional issues and the possibility to share a common language.

To achieve CPE, postgraduate midwifery programs are instrumental. In Norway, CPE tracks are not predefined and include different professional courses, workshops, and university-based programs. A master's degree in midwifery is among the main programs that can provide the CPE needed; it supports the development of a knowledge base that midwives can apply in their daily practice (Dahl et al., 2019). Research-based knowledge about CPE is also of vital importance for educationalists (in universities and other higher educational institutions) to provide a high-quality curriculum that meets the demands of the workplace (Butler, 2017). In

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Norway, the first formal midwifery education was established in 1818. After several major changes, the first master's degree was developed in 2010 (Dahl et al., 2019). Today, five out of six educational institutions offering midwifery education in Norway have advanced to offer a master's program.

Midwife employers and leaders have an important role to play in encouraging, facilitating and investing in CPE among their employees as they have a responsibility for knowledge management. This is to ensure that professional learning takes place, and that the organization continues to develop (Micić, 2015; Moore, 2007). Although the concept of knowledge management has its origin in private enterprises, the generic idea of management of knowledge in an entity or organization may shed light on management of maternity wards. In this light, knowledge can be defined as "a justified belief that increases an entity's capacity for effective action" (Alavi & Leidner, 2001, p. 109). According to the perspectives of Nonaka (1994) and von Krogh (1998), knowledge is not understood as cognitive representations that are more or less correct according to some external reality. Rather, our consciousness enables the world to come forth, and reality resides in how the world is presented to us. From a phenomenological perspective, our embodied consciousness constitutes the world we live and act in, and through our intersubjectivity, we may co-constitute "objective" knowledge (Merleau-Ponty, 1945/1962). Knowledge in this perspective may be tacit, personal, and nonverbal, or explicit, symbolic, and collective. Knowledge creation in an organization involves and depends on social processes, and management of knowledge means to identify and channel this collective knowledge in an organization to enhance its competitiveness (Omotayo, 2015; von Krogh, 1998). Interpersonal care and trust have been identified as important characteristics of an organization to facilitate knowledge creation and management (Alaarj et al., 2016; Guinot et al., 2014; Niu, 2010; von Krogh, 1998). When trust is lacking, members of an organization will be reluctant to communicate their knowledge, to ask for information from coworkers, and to be open about problems and failures. Trust enables the members of an organization to be curious and seek novel ways of solving problems.

Employers and leaders can facilitate knowledge management and employee growth but may also inhibit it through a lack of support for CPE (Orzano et al., 2008). This is of relevance in studying midwife leaders' thoughts and reflections when introduced to a different level of competence for midwives. However, leaders' perspectives on CPE for midwives have received little attention in scientific research. This study explores midwife leaders' experiences and perspectives on support for CPE among midwives in their work unit.

## Data and Method

### Method

Our research is anchored in the phenomenological perspectives of Edmund Husserl (1913/1962) and Merleau-Ponty

(1945/1962), which prioritize study of the lifeworld. We have opted for this method, because it allows for in-depth description of the lifeworld without invoking preconceived theoretical constructs or commonsense understanding. The analysis thus urges the researcher to consider all interview data as relevant to provide a coherent description of different facets of the world in which the person lives and works. A person's lifeworld becomes apparent through consciousness. Husserl states that consciousness is always directed toward something other than itself; it is intentional. Furthermore, "consciousness makes objects come present"; it actualizes and constitutes the world we live and work in (Giorgi, 2009, p. 105).

A vital aspect of the phenomenological method as applied in social science is so-called phenomenological psychological reduction (Giorgi, 2009). Within phenomenological reduction, one seeks to bracket, or suspend, knowledge that comes from hearsay, convention, and abstract concepts, and adhere to what is given to our consciousness. It is a reduction to what presents itself to consciousness, namely, phenomena. Theoretical and professional knowledge on midwifery leadership and professional development is thereby bracketed. This results in a description of the leaders' experiences without a researcher's preconceived ideas about what these experiences reflect or should reflect.

### Recruitment and Participants

An information letter that described the project was sent to the management of midwifery units at five large hospitals representing the four public health regions in Norway. These wards represent about 40% of annual births in Norway. Criteria for the selection of participants were that they worked in large maternity wards and had at least 10 years' experience as managers. Five leaders who met the criteria came forward to participate in the interviews. Two of the leaders had a master's degree but not in management or midwifery.

### Research Ethics

This project was originally a quality assurance/evaluation project and was approved by the Norwegian Centre for Research Data (NSD No. 918247) on January 31, 2019. The research was therefore carried out in compliance with the ethical standards of the 1964 Declaration of Helsinki and its subsequent amendments. The participants were recruited by email, with written information about the relevance, content, and use of the interviews. The participants gave their consent by email to the project leader. At the start of all interviews, this information was repeated orally, including a question about consent. All participants gave their consent. The interviewer did not have any work-related or social connection to the interviewees. There are 17 maternity wards in Norway and, to ensure anonymity after analysis, the quotes used to illustrate the findings were carefully selected to assure that the participants could not be identified.

## Data Collection and Analysis

The participants were interviewed once by a researcher with management experience and no professional connection with the Norwegian midwifery praxis field. The interviews were conducted as semi-structured research interviews (Kvale & Brinkman, 1996). The interview guide had three open themes: the maternity ward policy on knowledge development, experiences and examples of working in an evidence-based manner, and experiences with midwives with a master's degree in midwifery. Each interview was conducted in the office of the manager in the hospital and lasted from 20 to 45 min. The interview language was Norwegian and the interviews were transcribed verbatim. Although we conducted a small number of interviews, during the later interviews few new phenomena were brought up, which indicated that the data had reached the point of saturation.

The descriptive phenomenological method (Giorgi, 1970, 2009) was used to analyze the transcribed interviews. This systematic method consists of four steps: (a) reading the entire interviews to get a sense of the whole, (b) dividing the transcribed interviews into meaning units, (c) transforming these units into a psychologically sensitive language, and (d) synthesizing these transformed meaning units into a general meaning structure. During Step (c), we transitioned from Norwegian to English. All authors completed Step (a). Steps (b) and (c) were performed by the first author. Step (d) was carried out by the first author in collaboration with coauthor Rob Bongaardt. These researchers have extensive experience of the use of the descriptive phenomenological method.

When reading to get a sense of the whole, we read the interview transcriptions several times. The meaning units were identified by being sensitive to and marking a change in meanings in the text. The transformation of the meaning units into a more psychological language is the heart of the method. With the aid of imaginative variation during Steps 3 and 4, more general meanings were identified. To use imaginative variation means to examine the descriptions and to try out different levels of categorical abstraction to identify invariant meanings encompassing concrete experiences from several persons. These invariant meanings of all the descriptions of the phenomenon are then synthesized into an essential meaning structure. Note that the analysis was not conducted in a strictly linear fashion; it was a dynamic process where we moved freely between the different steps until the final general meaning structure was described.

## Findings

The general meaning structure of the phenomenon, "midwife leaders' experiences and perspectives on continuing professional education," is presented first. This structure is then separated into three essential constituents that are described and enriched with specific examples and quotes.

## Essential Meaning Structure

The essential meaning structure reads as follows: Among the midwife leaders in public maternity units who participated in this study, an image of professional development emerges that interweaves financial and time restrictions, formal requirements for competency improvement plans, personal engagement, professional boundaries, and women's health in general. Despite certain restrictions, the leaders all express having the freedom and agency to endorse professional development.

In the broadest sense, the main focus is to support women's health. A woman giving birth is to be regarded as a natural event that deserves the least possible invasion by technical or medical means; assisting birth is emphasized as a manual, hands-on skill. Professional development, then, is to contribute to ensuring that midwifery is a profession that supports women's health.

An important factor is the acknowledgment of boundaries between midwives and obstetricians. The latter group is described as having expanded its terrain with an eagerness to intervene earlier and with more technical means than midwives traditionally have. The leaders in this study all mention this trend but their preferred responses differ. For some, professional development is about increasing manual skills. For others, it is more about increasing academic insight, for example, in the form of research-oriented studies at master's or PhD level. That is because academic insight carries much weight when midwives seek collaboration with obstetricians.

Professional development in the form of academic education is supported by the leaders who have personally experienced or witnessed its value. These leaders say they trust engaged personnel to define their own developmental path in the form of continued education. In stark contrast to this stands leadership that focuses on practical skills training, which comes with a more instrumental use of competency development plans and of the available financial means. The expressed aim is to increase the overall quality of manual skill in the unit. Most deserving of support to continue training are full-time employees because they display greater engagement in their profession. A final point in this meaning structure is that, whether the education pertained to skills enhancement or academic training, leaders expected midwives to invest private money and time in continued education.

For the sake of analysis, we have separated this meaning structure into three constituents: constraints and the individualization of CPE, normal and at-risk births: fluid boundaries and moving targets, and a personal approach: dimensions of control or trust-driven leadership.

### *Constraints and the Individualization of CPE*

Financial restrictions, shift work, formal requirements for competency improvement plans, and the midwifery profession as a culture are perceived by the leaders as important constraints on CPE.

*Being Restricted in Practical and Financial Terms.* The leaders specified that midwives could expect to obtain funding for a couple of days for professional courses in addition to skills training at the hospital. The hospitals also organized their own obligatory professional 1-day courses on different topics. However, all five leaders described the financial means for CPE as a significant constraint.

So you get a lump sum and that's it, and then you try to work out what you can spend on professional development in particular, and it really doesn't come to very much. (Leader 1)

It's stipulated that everyone should have a competence development plan, and everyone should be able to develop professionally, and then we have very limited finances to realize that. (Leader 3)

The midwife leaders found that the financial constraints forced them to limit strictly what type of professional development was seen as vital for the unit and therefore supported: "I'm very particular about who I send to what—it must be relevant to the action plan we write once a year" (Leader 5). They felt committed to the rule that the unit should have a professional development plan that specified the type of additional training needed, with funding available for midwives. Some acknowledged the freedom and associated responsibility to determine what was considered important professional development.

But we have—I have quite a lot of responsibility myself—we don't need to ask the head of the clinic or the director what I can spend the money on or what type of professional development we should do in midwifery. (Leader 3)

The leaders found that professional development in the unit was hindered by shift work and even more so by part-time employment: "It's quite challenging to arrange professional development in an organization with three shifts. There's always someone it doesn't suit" (Leader 3).

Part-time employees were described as not very engaged in their job. Because they often worked weekends or afternoons, the leaders found it challenging to pass on information to them about new developments at the workplace: "If they have a 50 percent job, they're here every third weekend, and they come in now and then and they don't read emails—so they don't keep updated" (Leader 1).

Full-time employees are the ones who normally take on extra workloads or assignments. For this reason, the leaders expressed the need for more full-time positions to enhance professional development at the workplace.

*Individualizing Responsibility for Professional Development.* The leaders all emphasized that midwife employees could not expect full funding for their CPE. Rather, the leaders viewed professional development as dependent on the individual midwife's motivation to invest her leisure time and

own money. The leaders stated that employees aspiring to take a master's degree have a strong personal motivation to join in professional discussions with doctors and to be part of professional development in the field. This is underscored by the fact that they pay for much of their education themselves due to limited funding, or lack of support, for professional education at their workplace.

The leaders stated, however, that midwives in general are not strongly engaged in their professional development. They were all concerned about this lack of interest among the majority of midwives.

I sometimes think that midwives could be more interested in professional development, and not just their shifts. (Leader 5)

The thing that can be a problem with midwives is that they base their work on their own experience a lot. (Leader 4)

These leaders perceived midwives as generally not interested in investing in professional or research projects that demanded time beyond ordinary working hours.

There are relatively few who are interested. For midwives, it's important that what they do takes place during working hours, which means that many of them aren't interested. (Leader 4)

Some of them just want to go to work and go home and not have any plans—maybe more than half of them, I reckon . . . (Leader 1)

They emphasized their point by comparing midwives with doctors with respect to engagement in professional development. They speculated that doctors display more engagement due to differences in basic education: "Maybe it's something to do with their basic education? It probably is" (Leader 1). They also suggested that different types of people aspire to be midwives and doctors: "It's kind of different people who want to be doctors and nurses" (Leader 1). Another leader said,

and then we midwives have a tradition, it's maybe not such a nice thing to say, but we don't have the tradition that doctors have, where you develop your own knowledge. You have ownership of it, and increasing your knowledge and keeping it updated, that's a way of increasing your own value. (Leader 3)

Thus, the leaders underscored that the lack of engagement in the midwife profession was not just a matter of the personal interest of (part-time) midwives, but also the tradition in the field. Furthermore, as several leaders surmised, these differences were accentuated by the fact that many midwives seek voluntary part-time positions: "Lots of them want part-time jobs—voluntary part-time jobs . . ." (Leader 1).

One leader, despite this impression of midwives' professional culture, described a clear increase in midwives taking continued higher education:

You know, thinking back ten years, we really made an effort to get people to go to Gothenburg to take the master's program there, but now that's completely unnecessary. We're overwhelmed by people who want leave and financial support to take these master's programs, and they want to go on to do PhDs . . . (Leader 4)

### ***Normal and At-Risk Births: Fluid Boundaries and Moving Targets***

The leaders all described a dilemma between what should be considered normal and at-risk births. Striving to normalize birth was parallel to fighting for women's health.

As a midwife, I'm trained to care for normal, healthy labor and birth, and I try to keep it that way, but if there's anything abnormal, I have to contact a doctor. So we obviously have a slightly different approach to maternity care. (Leader 5)

Hands-on skills, without technical instruments, were emphasized by leaders as vital in the professional development of midwives. This focus on hands-on skills was supported by a large number of procedures that the employees have to master. Higher academic education, such as a master's or PhD degree, was not viewed as instrumental toward this goal, and therefore rarely promoted by leaders.

I think midwifery is in itself a very practical kind of work. To be able to prevent tearing properly, you have to have delivered a lot of babies. To prevent the baby's shoulders getting stuck, you have to have delivered a good number of babies. To deal with bleeding, it's not enough to know the theory, but also the practice. (Leader 5)

The midwife leaders described the technological developments endorsed by doctors as increasing the tendency to treat normal births as at-risk births. Doctors had been found to invade and minimize what was considered normal, threatening the midwife profession. This professional tension and rivalry are pivotal motivators of CPE. This is interwoven with the motivation to provide better service to patients, where service is often used as a key factor in the argument to fight for professional boundaries. The emphasis on skills training was an important means to protect professional boundaries that midwives felt were threatened by doctors.

. . . when young doctors are ready to do midwives' stuff, it's really important to us to protect our field of work and make sure they don't come in and take what belongs to us. (Leader 2)

But we have our own particular tasks, and it's quite important to me that midwives keep their autonomy and don't ask doctors too much. (Leader 5)

They believed that insecure midwives easily lose professional territory to more eager and confident doctors.

I think physicians do more today than they did 10 years ago. More of the things midwives knew how to do. And the youngest midwives are maybe more likely to give way . . . It's more important for them to ask for confirmation that they've made the right choices. (Leader 2)

These leaders stressed that midwives should protect their autonomy and professional boundaries through *limiting* their communication and interaction with doctors. Unwittingly, at the same time they acknowledged that mistakes and deviations were often caused by miscommunication between midwives and doctors or patients:

and with a number of things that don't work out the way you wanted, it maybe turns out that people talked past each other or didn't understand each other . . . Most of the deviations we've had, roughly speaking, are about poor communication and bad behavior, I mean the inability to ask the person "Have I understood you correctly? Did you understand what I said? Are you happy about this?" That's the kind of communication people in our unit have missed . . . (Leader 2)

Other leaders viewed professional development as embracing a perspective beyond technical procedures, skills training, and the practical management of work duties. However, they differed in how engaged they were. One midwife leader who was personally involved in academic work stated that she put considerable time and effort into engaging her employees in activities that supported professional development, but expressed disappointment in the apparent lack of professional engagement among her employees.

I'm working to get more academia into our midwifery . . . that we seek out new knowledge and are willing to change with new knowledge that comes . . . often when I bring up new things and say this has been researched and we must do evidence-based work, they (the midwives) won't accept it. (Leader 1)

Another leader, who was not personally engaged in academic work, stressed the need for an official program to determine the professional development of midwives. Both these leaders also stressed the necessity and value of collaboration with doctors, and not to engage in, nor encourage, professional protection of boundaries or rivalry. Both leaders valued higher academic education as a means to enable participation in professional discussions with doctors and in the development of projects and the production of new knowledge. Acknowledging the inherent tension and rivalry, one leader expressed some insecurity in presenting her wish for a common professional agenda that would help to break down professional boundaries.

I don't know if I dare say this, but I find that we work very differently from our closest colleagues, i.e. the doctors . . . but what I miss particularly here in our clinic is cooperation with doctors on key areas, because they're even more autonomous than us . . . what I miss is a joint professional approach . . . a joint agenda and joint involvement. (Leader 3)

### *A Personal Approach: Dimensions of Control or Trust-Driven Leadership*

Some midwife leaders emphasized the need to lead and control the professional development of their employees. One leader stressed the importance of staff seeking approval before enrolling in continuing higher education. She expressed the importance of the opportunity to evaluate not only the utility of the education for the workplace, but also the employee's personal aptitude.

If I'd been asked beforehand . . . I think I would have said, "Maybe you should find a different area to specialize in. Because that would just be a big disappointment for you." (Leader 2)

When employees failed to seek approval in advance, or the education was not considered relevant to the ward, she did not make any effort to support them in their professional development, financially or otherwise. Another leader reported that in staff appraisal interviews she checked her employees' knowledge of how their ward scored on certain statistical measures, such as the frequency of perineal tear. She interpreted her employees' ability to remember the details and answer such questions correctly as a sign of professional engagement.

and I've said there are some figures I expect you to know all the time if you're at a seminar and someone asks. They're supposed to know that. But if I check it in a staff interview, maybe only a third of them know. (Leader 3)

As a leader, she is expected to know these statistics when attending meetings and conferences. She therefore considers the figures as basic knowledge without which one would seem ignorant to other professionals.

Those are figures I'm always asked about when I'm at a seminar: What's the cesarean frequency? What's the frequency of perineal tear? A bit kind of basic, you know, to show that you're on the ball. (Leader 3)

Leaders who expressed the need to control the professional development of their employees also stressed practical skills training as the main goal of professional development. A higher academic education was not instrumental toward this goal, and therefore seldom supported by these leaders. One of the leaders who underscored the importance of skills training described formative experiences from her own past as a novice midwife without extensive skills training in basic procedures as extremely hard and painful.

Other leaders described a more trust-driven leadership style. They worked to facilitate, rather than control, professional development and to support and value individual professional engagement. They acknowledged that personal engagement was important not only for the professional development of the individual, but also for that of the ward. Thus, they were inclined to support the educational pursuits

of midwives with a strong professional engagement: "It's mainly good for the individual, but the whole ward benefits from it as well" (Leader 1). More trust-driven and facilitating leaders often had a broader view of CPE beyond technical procedures and skills training, clearly stating the value of more academic knowledge and the development of research skills. A personal history of investment in academic activities and research, which was evident in one of the leaders, seemed important for providing practical support for academic CPE.

### **Discussion**

The results of our study indicate that midwife leaders' experiences and perspectives on CPE are to a large extent informed by the midwifery professional culture and boundary work at the workplace, which means a variety of leadership styles. We found that midwife leaders primarily viewed midwifery as a practical, hands-on professional field, and thus prioritized practical skills training as the preferred form of CPE. Leaders expressed that midwifery had a strong tradition and identity as a practical craft. Moreover, expertise in midwifery skills was viewed as important to protect professional boundaries from the medical profession. This traditional view was accentuated by economical and practical constraints, limiting the possibility to fund CPE beyond practical skills, such as a master's degree. Furthermore, CPE beyond minimum requirements was largely dependent on the employees' goodwill and ability to invest their own resources, notably time and money.

### *CPE, Women's Health, and Professional Boundary Work*

The midwife leaders in this study explained how the dispute over professional boundaries was a notable feature of the present Norwegian maternity care system, and a major motivator for CPE among midwives. In health care organizations, members of different professions must work together to enable their primary mission to provide quality patient care (Powell & Davies, 2012). Professional groups have different habits, values, and interpretations in their everyday work. The leaders communicated a strong professional identity that was defined in contrast to "the others," that is, the medical profession. They explicitly drew boundaries between midwives and doctors while referring to "normal" births (the domain of midwives) and "at-risk" births (the domain of obstetricians). Doctors were perceived as employing a biomedical perspective in which they anticipated danger and emphasized risk, whereas midwives were perceived as fighting for a natural birth and the health of women and their babies. By underlining and further enhancing their treatment philosophy and the uniqueness of midwifery through promoting CPE as practical skills training, the leaders sought to endorse their professional identity and protect their professional autonomy (Behruzi et al., 2017; Sanders & Harrison, 2008).

A narrow focus on CPE as skills training, promoted by some leaders in this study, may create confident midwives acting on the basis of established knowledge. The promotion of “normal and natural” childbirth in midwives’ professional culture is supported by research indicating that routine medical interventions such as electronic fetal monitoring, frequent vaginal examinations, and induction may have a wide range of unintended negative consequences for the mother and child (Aanensen et al., 2018; Jansen et al., 2013; Røseth et al., 2018; Zwelling, 2010). However, what constitutes a normal versus an abnormal or at-risk birth is culturally determined and shifting, with fluid boundaries around large gray areas (Gieryn, 1983; Sanders & Harrison, 2008). A polarized and overly simplistic view of the medical profession may hinder open communication and lead to unsafe practices and adverse events (Lewis, 2005). Professional narratives and paradigms may also represent barriers to knowledge creation because different perspectives, or new knowledge that does not harmonize with the established view, tend to be devalued or disregarded (von Krogh, 1998). Thus, midwifery professional culture with its stories and habits may hinder knowledge creation and management because it prevents a trusting and open relationship with doctors. New knowledge may emerge in the intersection between different professional fields by embracing the ambiguity present in the differences of perceived meanings as an invitation for further exploration (Orzano et al., 2008). CPE that promotes openness through dialogue and communication across professions enables interdisciplinary cooperation and mutual understanding; ultimately, effective knowledge management is needed to find the right balance between considering a birth as normal or at-risk.

The search for security in CPE as practical skills training and the means by which midwives protect their profession may work against the objective of the WHO (2015) to enhance midwifery and multidisciplinary research capacity to meet the new demands of health care. Midwives have been portrayed as a subordinate profession in maternity care, working in the background rather than openly confronting the medical tradition (Hunter, 2005). This use of covert strategies may give an illusion of compliance and uphold the professional hierarchy and dominance of the medical profession in maternity wards. Moreover, midwives’ immersion in practical tasks and limiting communication with doctors, as a covert style or strategy to protect their professional autonomy, is ineffective in influencing policy making, developing treatment procedures, and producing new knowledge. To be communicated, tacit wisdom needs to be verbalized and made explicit, which is a process that depends on the level of care in an organization (von Krogh, 1998). A low degree of care and trust in the organization between individuals or professions promotes an individualistic and competitive context where sharing knowledge may lead to reduced power and influence (von Krogh, 1998). Within an organization, trust or confidence that other employees, such as doctors, will not exploit one’s vulnerabilities is essential for effective knowledge management and organizational learning (Alarj et al., 2016; Niu, 2010; Orzano et al.,

2008). Some leaders expressed a lack of trust, especially toward the medical profession, which led to covert strategies to protect their professional territory. Such covert strategies inhibit reflective practices and a more open challenge to the medical profession, and hinder effective intra- and interprofessional communication and knowledge management. In addition, knowledge management is severely constrained by limited financing and formal and practical factors due to shift work. Thus, if midwives identify themselves solely as practitioners, other professions such as the medical profession will dominate future knowledge production and its application in the field. Our data indicate that midwife leaders had a view of knowledge that focused on practical skills, which will diminish the possibility for midwives to participate on equal terms with doctors on maternity care issues.

### *CPE and Leadership Styles Surfacing in the Face of Work Complexity*

When leaders navigate a complex landscape, as described above, they make choices about which information to emphasize and which not. Wittingly and unwittingly, the leaders highlight some aspects that matter to their leadership and professional development in their unit, while ignoring others. What showed in our analysis were two clusters of information, or rather views on CPE, that this information supported. In the first cluster, CPE takes shape through perfecting manual skills and learning procedures. In the second cluster, CPE is formed by increasing research-based knowledge about new procedures. Inherent in the two different clusters are divergent strategies of protecting the midwife profession from doctors. These clusters are not necessarily mutually exclusive. However, the leaders in this study showed a preference for one approach to CPE or the other. How can this be understood, and what are the possible consequences of the different leadership strategies?

Leadership theory underscores that, over the past few decades, work settings have become more complex—the information flow is richer and changes quickly; interdisciplinary and intersectional collaboration is needed, while greater specialization of the individual worker is also required; demands may come from different angles, such as end users, reports, colleagues, leaders, as well as the formal and informal rules and regulations of the workplace. The necessity to handle such complexity and venture into unfamiliar territory was previously less urgent, or even ill-advised, when adaptation to existing mores (established procedures and practical skills) was sufficient for high professional accomplishments. To keep up with present-day developments in many workplaces, however, such a well-established adaptation has made way for an urgency for rapid adjustment to new information flows (Elkington et al., 2017; Horney et al., 2010; Kegan et al., 2016).

In our study, the leaders who promote traditional midwifery culture represent a more traditional leadership that emphasizes the importance and possibility of control (Bourgeois & Eisenhardt, 1988). Leaders who endorse the

primacy of CPE in the form of manual skills and steady adaptation to existing mores may feel challenged by the pressure that comes with having to channel complex information flows at the workplace. This pressure is unfortunately often handled by effectuating more of the same: in this case, increasing the effort to perfect skills.

An alternative leadership style was also described in our data, more open and trust-driven, which can represent a process view of leadership (Chia & Holt, 2009). A process view proposes that to truly manage transformation, we have to relinquish the idea of control and predetermined outcomes (Chia, 2014; Tomkins & Simpson, 2015). Instead of immersing themselves in and restricting themselves to what is familiar and habitual, transformational leaders reach beyond the immediate tasks and emphasize flexibility, trust, employee empowerment, and more creative and visionary goals. They value and see the necessity of manual skills but prefer to delegate the responsibility for skills development to the workers themselves and rather focus on seeking out and integrating new knowledge. Transformational leadership requires leaders who dare to reach beyond the territory of the known and open up to the possibilities of a choice of ways forward (Tomkins & Simpson, 2015).

Leaders are important enablers of knowledge management (Orzano et al., 2008). Enablers provide the foundation of knowledge management, but their success depends on the characteristics of their relationships with others, such as a leader's openness to new knowledge and perspectives, and ability to promote a caring culture of trust, sharing, collaboration, and reflective practice within the organization (Horak, 2001; von Krogh, 1998). The midwifery leadership seen in our data indicates that the leaders' view of knowledge that focuses on practical skills and organizational and financial frameworks is too narrow to enable midwives to constructively develop maternity ward practices.

### Recommendations for CPE for Midwives

We recommend hospital managers and midwife leaders to pay more attention to and recognize the need for academic competence among midwives. Midwives are called upon not only to provide excellent clinical care to women, but also to develop skills to analyze critically and synthesize research to implement evidence-based practice.

To lead the new generation of midwives with master's degrees, future leaders should have a degree in the same discipline at least at the same level to assure their familiarity with the art as well as the science of midwifery practice. Rewarding academic competence in midwifery and leadership might be helpful to overcome professional boundaries and contribute to the development of maternity ward practices.

### Conclusion

Our study explored midwife leaders' experiences and perspectives on supporting CPE. Although midwife leaders in public maternity wards generally found their ability to encourage

professional development at their workplace to be significantly limited by financial and practical constraints, they reported having the freedom to choose the direction of professional development within these limits. However, the responsibility for professional development was to a large extent placed on the shoulders of the individual employee. The need for professional development was connoted with multidisciplinary teamwork and an ongoing professional tension over role boundaries and power, especially between midwives and doctors. How the leaders navigated professional development in the midst of this tension varied and was related to their ability to handle the increasing level of information complexity. Leaders who put high value on practical skills tended to control professional development and limit it to skills training, and to discourage open communication with doctors as a strategy to protect professional boundaries. Unfortunately, such covert strategies hinder effective communication, knowledge management and creation, and are ineffective in influencing policy making. Leaders who recognized the value of more general academic knowledge often promoted professional engagement and academic thinking. They also encouraged interprofessional trust and communication with doctors and discouraged boundary work and professional rivalry. This study underlines the value of academic competence in leaders when faced with increasing information complexity.

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