Healing Rifts: Sociodrama in a Maternity Community

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Abstract
Don Reekie was contracted by a New Zealand District Health Board to facilitate the healing of rifts among practitioners in a hospital maternity community. In this article he describes the efficacy of sociodrama in this work, particularly focusing on his decisions and interventions, and the responses of the participants involved. Reference is made to community members' written attestations regarding the positive ongoing consequences of the sociodramatic interventions. The author particularly acknowledges the community members and key players among them, as co-creators of a new maternity culture.

Key Words
communication, crisis management, hospital, lead maternity carer, midwifery, obstetrics, organisation, psychodramatic methods, role training, sociodrama

Prologue

I present to you a courageous maternity community who set out to heal rifts between their member groups, hoping that sociodrama might provide the elusive answer to their problems. My commission with them lasted eighteen months and well before it was over they had begun to report publicly the difficulties they faced and their remarkable successes following one day of sociodrama. They presented at international conferences and wrote their story in journals, notably the British Medical Association's journal. They aspired to share with the broader community of health professionals the dramatic improvement in delivery of service, quality and safety that can be gained from improvements in relationships and communications.

Settings

Competition and suspicion between midwives and doctors has a long global

history. Medical practitioners gained ascendancy in the Western world, with midwives widely regarded as the handmaidens of obstetrics. A unique twist was given to this situation in New Zealand by the 1990 Nurses Amendment Act, which authorised midwives to provide lead maternity care equal to medical practitioners. Mistrust on the part of many medical practitioners intensified when midwifery education no longer required a nursing qualification as a prerequisite. The 'new breed' of midwives was highly equipped for their task in the eyes of the midwifery profession, but did not conform to traditional hospital or medical culture. In the words of journalist Leah Haines (2009) "Health and Disability Commissioner Ron Paterson described the difference as obstetricians taking a 'risk-averse, interventionist approach' and midwives 'a less-interventionist approach, to allow the normal physiological process of labour to proceed'".

The tensions played out in maternity care contexts, often resulting in poor professional relationships and a search for remedies. A public report by the hospital with which I was involved, presented to delegates of an Australasian women's hospitals' conference, owned that "For a number of reasons . . . it was clear that relations between the various providers of care at their hospital were at an all time low . . . a group of 27 independent midwives wrote to the Managers of the Maternity Hospital expressing concerns and requesting a meeting. This was the first move towards positive communication and reconciliation. The response was, in public hospital terms, unconventional . . ." (Thomas & Stacey, 2002).

Beginnings

It was a Lead Maternity Carer (LMC) midwife who suggested a sociodramatic intervention with the entire maternity community. The community's agreement told me the level of their desperation and courage. The clinical director was passionate about bringing compassion and good relations into hospital practice. He advocated openness, mutual respect and cooperative practice, although some of his colleagues regarded his vision with suspicion. The hospital general manager was collaborative and widely trusted as having her 'feet on the ground'. She and her staff valued the clinical director highly.

As an observer I sat in on a senior staff meeting that included LMC midwives, the District Health Board (DHB) head of obstetrics, DHB members and Maternity Consumers Council (MCC) representatives. All were committed to progressing collaboration although there was no specific mention of the planned sociodramatic intervention, nicknamed by then the Big Day Out. I met with the clinical director and hospital manager on a regular basis thereafter.

Decisions

In order to assess and plan, I met with a number of small groups. The first, a representative microcosm of the organisation, urgently wanted improved services

and collaboration but could not see a common pathway forward. A group of midwives was keen to have a Big Day Out while a group of obstetricians was intent on stopping it, fearful that a facilitator without understanding of "surgical crises at 2am" would make matters worse.

Following are the areas I assess when making decisions about sociodramatic interventions and the conclusions that I came to in this case.

1. Discomfort, Vision and Hope (See Camson, 1995; Dannemiller, 1997; Dannemiller & Jacobs, 1992)
   The maternity community was in severe discomfort. Each group held to its own visions.
2. Strength of Relationships
   The leaders were creative and courageous with mutually positive relationships with one another and each stakeholder group.
3. Appropriate Authority
   There was no doubt that the DHB had authorised and expected the professionals to produce effective collaborative practices.
4. Proximity, Purpose, Identity and Values
   Proximity between the groups was apparent but they had splintered into distinct identities. Values varied but each was predicated on the good of mother and child. The groups lacked a focus on a common purpose and needed to develop mutual trust.
5. Legitimising by Marking: Outsiders to organisations, including facilitators, are aliens and need to be legitimised by a respected leader to be accepted[1].
   I proposed that the hospital manager open the Big Day Out.
6. Diagonal Slice Representative Microcosm: A diagonal slice group as a microcosm of a community provides a useful representation and can precipitate an expectation that percolates through the community.
   My meeting with such a group revealed that there was a desperate longing for common purpose and identity.
7. A Further Decision Centred on Attire
   I wore suit and tie. I had heard speculation that I would be a 'touchy feely' character wearing crystal beads and kaftan.

There was full acceptance that all groups in the maternity community including mothers, LMCs, pediatricians, DHB members and MCC members would be at the Big Day Out. Ahead of the day, I had invited each professional group to write a collective statement about their particular contribution to successful maternity, and their understanding of other groups' contributions. I believe this assisted the development of appreciation and amenability within and between the groups.

Big Day Out

In this section I will narrate the sociodrama in present dramatic tense as it unfolded, interweaving italicised asides to the reader throughout.

The venue for the Big Day Out is in a conference centre away from the hospital. I set out an elongated oval of a hundred chairs in its large room. Over the next twenty minutes seventy participants arrive. We start promptly. I am acutely aware that everyone sees me as 'on trial' but even with their doubts they want the day to work. I am deeply conscious of this work's importance, the common valuing of mother and baby, and trust myself and the group. In consultative mode, the hospital's general manager sits beside me and introduces me. Her 'marking' me is crucial to my being accepted by some participants.

I have previously applied sociometry, sociodrama and role training in large organisational groups and I am certainly not daunted.

I begin. "Let's put out three chairs. This is a chair for a baby, this a chair for a woman, this a chair for a man. Now let us have a few minutes silence and recognise that what we are about today is the sacred moment of birth that centres on these three people." The silence is palpable. I let it continue. After a little over two minutes I say, "This is what this day is about, the success of this moment, the birth of a baby".

I continue. "Okay, we will clear these chairs to bring other chairs onto the floor. We are going to follow a woman through her pregnancy from the moment of conception to the moment of birth. What is it we know she is likely to ask? Who will she ask and what information will she be given? Let's start when she knows she has conceived." Participants put out chairs to represent the various people responding to the mother-to-be, the midwives, GPs, mothers of mothers, friends and obstetricians. Some participants sit on the chairs and represent the people they have named. Sometimes others volunteer to sit for those named. Others suggest alternative responses. By the close there are about forty-five peopled chairs.

You may notice that I removed the chairs for mother, baby and father. I had considered maintaining an empty chair as a focus for a typical mother, but deemed it unnecessary as this drama is about the carers' responses and their differences. I know my beginning has made 'mother' vitally present. This large group was unfamiliar with role enactment and even a light exploration of typical though diverse responding was likely to evoke powerful experiences.

Halfway through this process an LMC midwife suggests a question that an expectant mother might ask, and then provides a midwife's answer. An obstetrician intervenes to provide what he sees as the 'correct' answer. Their colleagues know these two have had a fierce conflict in the past over a mother's care. The group freezes. Anxious glances flit around the room. All eyes turn towards me. The room is electric.

I kneel beside the man, a little behind his shoulder. I ask, "Are you willing to have me coach you?" He shifts uncomfortably, says "Yes", adding "But what does that mean?"[2] I say, "You've listened to what she said and you've given your opinion. You've given your advice, making a suggestion. You have a different view of things".

He agrees. I go on. "How about you try this way. First you make quite sure you know what she has said. You need her to know that you want to discover whether you heard her correctly. So, tell her what you believe she said". He proceeds to do this. "Now ask her 'Have I heard you correctly?'" He does that. To his surprise she says, "No. That isn't what I said. It's certainly not what I meant".

I coach him further. "Now you say to her 'I mustn't have heard you correctly. Could you please tell me again?'" He does this. As she tells him what she has said the whole group breaths out and then in. I say to him, "See if you have got what she is intending to say. Find out by telling her what you've heard". He retells and she agrees he has "pretty well got it". I say to him, "But you have a different opinion to her. You think you understand what her view is, but yours is different". He agrees, "Yes, that's right". I say, "So now tell her that you have a different opinion to hers". He does. "Now go on from there and tell her how she might view it differently. Give her your reasons for taking a different view". After that I ask the midwife to repeat to him what he is proposing. He agrees she has heard him correctly. She states her position while acknowledging the usefulness of some of the points he brings forward.

The room is crackling with amazed excitement. Eyes acknowledge others across the room. Faces signal something is changing. He is not as far away from her as he had thought. The participants are beginning to believe change can happen.

For weeks afterwards they say to one another, "That was the moment!"

When the group froze, I was alert and free. My mind focused on the relationship between two people and their community. The requirements of my professional association, The Australian and New Zealand Psychodrama Association, are strongly alive in me. "The producer trusts being with themselves moment by moment and has a sense of adequacy through experiencing their spontaneity and creativity. This is in contrast to feeling powerful as a result of the impact of their knowledge of techniques and theory on a . . . group" (ANZPA Board of Examiners, 2011:11).

The group has focused intensely on a typical woman's pregnancy. The session concludes with enthusiasm high. They speak of seeing one another somewhat differently now. There is astonishment that they can discuss this area with strong commitment but without antagonism.

Tea break taken, I invite the participants to form small groups with others they identify with, discuss their communal goals and write them on large sheets of paper. Then in new mixed groupings I ask them to record ideas for achieving those goals. The statements viewed, participants gather to discuss the morning's achievements with a neighbour. I share my intention to explore typical scenarios in the life of their hospital throughout the afternoon. There is a buzz of interest.

In the afternoon I produce rolling sociodramatic enactments with role training elements. We set out typical scenes where tensions occur. Many are in the labour room in the middle of the night. One after another, staff members come forward

to review a scene. Each one receives acknowledgement. None is alone with their experience. Others become actors for the first-actor, often playing a member of their own profession and at times standing in unfamiliar shoes. They role reverse between the characters of the scene. Audience members make recognition and offer commentary. They suggest alternatives and step into scenes. Coaching, with mirroring and brain storming alternatives in action, open up new possibilities.

A midwife describes feeling demeaned when an obstetrician arrived at her request and "He took over". She sets the scene, which others enact with her. Mirrored in a re-enactment she witnesses herself standing aside subserviently when receiving the doctor, which results in an authority vacuum. Through role training she develops her professional autonomy. As an *efficient hostess* she can now summarise the situation, stating the specific assistance she seeks. Obstetricians, anaesthetists and midwives become her obstetrician and all are easily cooperative. Her authority meets his appropriately.

A scene where a doctor feels it necessary to be authoritative in guiding a mother provokes speculative alternatives from several doctors in the audience. Midwives and mothers spontaneously enact radically different approaches. The doctor experiments without shame, finding ways to communicate that are open and satisfying.

At the end of the Big Day Out the sharing and discussion is positive and optimistic. The participants commit to a regular maternity community forum. There are no other promises but many expressions of a willingness to experiment.

In the weeks that follow, the hospital manager and the clinical director hear many reports of success. The maternity community members are cooperating with good humour in challenging situations.

Learning through Crises

As a result of the achievements of the Big Day Out, the maternity community forum was established. Built on goodwill and experimentation, it met monthly. My role was to coach the chairperson and group members, either by their or my initiative. When a community overcomes significant challenges, as this group had done, there is then further development. They learn to trust their efficacy, grow towards openness, realise individual capacities and strengthen interdependence. All these developments were furthered as the forum faced and overcame a series of crises in the following months.

First Crisis: Representation of Mothers

The manager invited two mothers to the first forum meeting, known to her through successful resolution of complaints. After speaking of their birthing experiences, in one case with bitter comment regarding a midwife, they excused themselves and left early. The midwife was present and raised her concern at mothers attending professional consultations. Several agreed that lay people could

gain or contribute little to medical discussions. Others expressed discomfort at such restrictiveness. My view was that mothers should be forum members once they were representative of a wide range of birthing experiences. A mothers' forum was formed with help from the local Parents Centre and Plunket group. A research midwife skilled in liaison worked with them and representatives of the mothers' forum attended the maternity forum from then on.

Second Crisis: Cultural Accessibility

The maternity day clinic, which had worked hard to become culturally accessible, proudly reported their improvements to the forum. However, at the following meeting the Pacific Island Midwife Advisor reported that Pacific Island mothers experienced the clinic as alienating. I coached an uncomfortable forum group to choose a small group to meet with the clinic director. They would also open discussions with the midwife advisor and a group of Pacific Island mothers to find ways of extending the gains already made. The forum accomplished this successfully.

Third Crisis: Recognition of the Midwifery Profession's Training

A midwife, reporting a new edict requiring validation of competence from the DHB's anaesthetics department for midwives to administer epidurals, urged the forum to gain acceptance for midwifery's own professional training and validation practices. The forum agreed and the hospital general manager raised the matter with the CEO of the DHB, its departments of midwifery and anaesthetics and its solicitor. Through December and January efforts to gain approval from all parties dragged on. I coached the manager and clinical director regularly, urging them to push the system. I asserted that the fledgling forum's trust levels would fracture if it did not receive a response within two months. Eventually the DHB accepted the proposal and the forum members discovered that their consultations and actions could make a difference.

Fourth Crisis: Working with Power Differentials

In response to a health professional's proposal, a senior DHB leader explained in a kindly and conciliatory way what he considered were the real needs of a situation. I intervened instantly, inviting the senior person to explore available options. I suggested he begin by taking the view that the other person might be differently informed, rather than inadequately informed. I coached him to appreciate her view as having intent and purpose. I pointed out that a communication offered in an explanatory form cannot avoid being dismissive. In this instance the group saw that there was substance and usefulness in the proposal, in spite of the senior man being closer to the centre of power, policy and history. At the next meeting, the chairperson caught himself offering an explanation before checking out intent and purpose. He was quick to use the learning from the previous forum, recognising the dynamic and retracing his

steps. The readiness of those with greater power to bend their habits to an openness that values contributions from everyone led to robust participation.

Forum members themselves were more conscious of their success in forming action groups with report times that reviewed, developed and reformed their collective practice. Notable among them was an autonomous quality improvement team. These small groups not only accomplished their tasks, they built close, strong relationships between the professional groups.

Reflections

This is the only time an organisation has engaged me specifically for sociodrama. I approached the work expecting that the maternity community members were intelligent, compassionate, sensitive to the human spirit and committed to mothers and babies. I appreciated that birthing affirms life and accepts the reality of death. I took a whole group focus with values central to working with relationships. In becoming an audience to a staged drama of their community's life and then actors in that story, the community members oscillated between participator and spectator. They were courageously experimental, opening up to consultation and care with one another.

Psychodramatic wisdom indicates that when a community intent on building cooperative practices becomes an audience to itself, it inevitably lays bare its shared life and variety of values, re-experiences its tensions and takes hold of hot coals of conflict. In my work with this community, I set out to promote respect for others' priorities, consideration for their disparate motivations, and the discovery of shared values. I did not invite a sociodramatic question, but one was implicit. How can mothers, LMC midwives, hospital midwives and hospital medical staff work together effectively? The answer has been lived now for a full decade. I am confident that this community, reviewing and visioning together will potentiate its identity, its belief in a future and its realisation 'We are in this together'.

Epilogue

The hospital's first public report to delegates of an Australasian women's hospitals conference affirmed the efficacy of sociodrama in bringing about dramatic improvement on every measure.

> *A facilitator was employed who by training and experience with sociodrama, using psychodramatic methods, was able to guide a conversation including everyone's personal experiences, values, and attitudes. Replay of actual or typical incidents were set out and preferred practice explored. The focus was on the rights of the mother and baby and the role of the professionals to see this as a priority. It was seen by all as a success in opening the channels for communication.*
>
> Thomas & Stacey (2002:5)

It is not very often that a client group attests to the efficacy of sociodrama in an international journal. In their writing, these authors noted that many were fearful in the lead up to the Big Day Out. However:

> *Participants role-played labour room crises, slowing down time to allow exploration of interactions, behaviours, beliefs and difficulties in communication. At times, the tension was electrifying . . . A midwife, role-playing an obstetrician, declared . . . Now that I know we share values, it will be much easier for us to work together in the future' . . . a monthly, multidisciplinary Maternity Forum — helped by the same facilitator — was agreed. Forum members continued to confront and modify beliefs about others' behaviour and received and acted on feedback about their own. The first Forum was characterized by more conflict and heightened emotions. Feedback from the facilitator allowed us to recognise our behaviour and explore the often-false beliefs underlying our reaction.*
>
> Youngson, Stacey & Wimbrow (2003:398-399)

> *Our experience suggests that understanding your own and others views and beliefs; valuing others' contributions and being open to challenge are as important to quality improvement as the possession of robust data if the aim is to make changes to working practices that lead to significant improvements for patients . . . Effective leaders focus efforts on creating new experiences that challenge personal beliefs and lead to new behaviours and new results. In adulthood, personal beliefs are relatively fixed and require a significant emotional event to change. In the role-play workshop and subsequent forums, we intervened in a dramatic way to expose conflicting beliefs and create new, shared experience that reinforced common goals and collaborative behaviours. None of this is for the faint-hearted! Courage was required to manage high levels of interpersonal conflict, anger and blame but the expression of strong emotion was a necessary part of the process in changing beliefs.*
>
> Youngson, Stacey & Wimbrow (2003:400)

The positive outcomes of the Big Day Out were even reported in the *New Zealand Listener* eight years after the event.

> *. . . something extraordinary happened. Relationships healed, caesarean rates fell to 15%, and babies . . . went from having some of the worst health outcomes immediately after birth to having the best in Australasia.*
>
> Leah Haines (2009:14-15)

I have been in somewhat of an ethical conundrum regarding my wish to name this maternity community. On the one hand I have had to consider the confidentiality requirements of the *ANZPA Journal* while on the other my ethical duty to reference writers. The community deserves to be heralded strongly. A Crisis in Maternity Services: The Courage to be Wrong was their article leading into the 2004 Quality and Safety in Health Care Conference. The courage to be wrong is a proud and honourable watchcry for this healthcare community. They

determined to be open with clients and wider communities regarding their failures and successes. This ethic led them to banish blame with naming and shaming, and to create a community that takes responsibility for each failure through thorough, open enquiry and shared learning.

The community is richly entitled to be proud of the achievements of the Big Day Out and the developments that followed it. Everyone contributed with vigour and unrelenting determination. Hospital and community midwifery leaders made wise and powerful contributions. The hospital's general manager and her clinical director deserve particular mention. The mothers' forum was a great strength. The maternity forum worked diligently to create a positive culture. More recently the forum itself has been retired, and management structures and personnel have changed. The community's goodwill and mutual trust though have stood the test of time. New challenges and initiatives will no doubt continue to occur.

Postscript to the Epilogue

I was delighted to receive acknowledgement of article drafts and a personal endorsement from a key participant in these events. Speaking of the results of the sociodramatic interventions, he writes:

> *The goodwill and collaborative relationships in maternity persist strongly to this day, as do the excellent clinical outcomes. Almost all of the same players are still there. I have resigned from the DHB and had a touching farewell from people connected with the maternity service. About 25 met for dinner, including many of the participants in the original big day out. The self-employed LMC, who initiated the joint letter to management, and was so courageous in the big day out, became my daughter's midwife. The things I learned from you have been widely applied and taught to others.*
>
> R. Youngson (Personal Communication, 2011)

End Notes

1. In ethology I learned that troop and pack animals will accept aliens only when marked by their leaders, who physically put their scent on them. I have noticed that people are only likely to accept and receive from an outside facilitator or trainer if their organisation's leader has properly introduced and taken responsibility for them being there.

2 . When working sociodramatically, we have the resource of Jacob Moreno's (1977) spontaneity development theory to assist us. He provides clues to making incisive assessments of the underlying motivations of role interactions. Sociodramatic attention is primarily focused on the whole group, its interactive networks, cultural patterns and common and disparate values. A specific interaction may invite a zoom in on an individual for open investigation. The approach taken by the director will determine the likelihood of an open response. The director's ability to recognise the level of spontaneity and the phase of spontaneity development to which the person

has returned in response to their social context, will assist in the engagement of that group member. In this instance I approach a competent senior health professional and also view him as functioning at a role taking level and in the developmental phase of the matrix of all identity, where he echoes a preverbal world of experience. I move gently alongside to enter his universe, recognising his vulnerability. For further elucidation, see Reekie (2007, 2009 & <donreekie.com>) and Turner (2008).

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