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# A Difficult Choice

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*Caroline Hollins Martin, Lecturer in Midwifery University of Manchester, explores the difficulties that midwives face with providing choice and control to childbearing women*

Much of my working life has been spent as a midwife where I gradually became aware of authority/subordinate relationships within the workplace. As a practitioner these were part of everyday working life. It became clear to me that authority structures impose restrictions within the working environment that inevitably on occasion inhibit midwives from providing the woman-centred care that is directed by social policy documents.[1, 2, 3] The rhetoric of 'woman-centred care' is difficult to achieve in a hierarchy that appoints people to positions of authority. Once in position, authority has the power to redefine norms and objectives[4], which may conflict with what a woman wants from her personal birth experience.

Research has shown that high status midwives (for instance ward sisters and managers) have more power to socially influence decisions within the workplace[5, 6, 7, 8] which will inevitably have profound effects upon whether a childbearing woman is 'permitted' a water birth, to have a par ticular style of pain relief, to adopt alternative positions in labour or have several bir th par tners present at her birth. What is clear, is that none of these activities present a threat to maternal or fetal outcomes and therefore ought to be client led. The inevitable consequence of conflicting direction, is that midwives are sometimes presented with moral conflict between a drive for obedience and their role as advocates for women.

Obedience literature clearly informs that insubordination is difficult when a person is placed in a hierarchy that appoints people to positions of authority.[9, 10, 11, 12] In a recent study,[6] I showed that a person senior in the hierarchy was significantly successful at socially influencing midwives' decisions. A situation was created in which a senior midwife socially influenced junior midwives to perform an observable action (to change their viewpoints to match the ones she proposed). This concurs with the observation that nurses will agree with an irregular order from an authority figure[13] and feel pressurised to conform.[14, 15, 16] The level of obedience shown by the par ticipating midwives was consistent with amounts found in other groups of people who have participated in experiments.[9, 10, 11, 12]

Obedience experiments highlight superordinatesubordinate relationships in which people become agents of a legitimate authority to whom they relinquish responsibility for their actions[17, 18] Once they have done so, their actions are no longer guided by their conscience but by the adequacy with which they have fulfiled authority's wishes. Studying obedience to authority is a complex issue, since legitimacy, as

defined by rules, may come into conflict with a practitioner's view of what is or is not appropriate.

The clear fact that hospital authority reinforces acquiescence of midwives whilst simultaneously advocating woman-centred care, causes conflict for midwives. The situation creates contradiction between the midwife's demands to follow Rule 6 of the Midwives Rules and Standards[19] which prescribes woman-centred care or to follow the direction from a senior midwife, unless per chance they both happen to be in agreement. In essence, the midwife is a link in the hierarchical chain of command that the organisation reinforces, with both senior and junior midwife encountering constraints presented by those in authority.

I also found that the vast majority of midwives (95%) held positive attitudes towards providing woman-centred care. However, many gave details of factors that controlled the agenda of options that were actually available. Three main categories were apparent: (1) the imposition of hospital policies, (2) hierarchical control, and (3) fear of consequences of challenging a senior person.

The following excerpt illustrates one par ticular midwife's perception that she was obligated to follow guidelines and policies:

*'If the policy says one birth partner, I must go along with that'.*

One midwife expressed feelings of subordination. Clearly, she perceived that she had no choice but to follow 'guidelines' and 'policies'.

*'It is one of those sets of circumstances where I would feel unhappy about rupturing the membranes, but it's there and that's it (policy).You must work within the guidelines.'*

Many of the midwives remarked that they perceived their role as subordinate within the hierarchy. In essence, the midwives' own limited choices regulate what they can provide to childbearing women:

*'I would not say that I wouldn't do it, because someone senior has asked me to (cardiotocography).'*

Some of the midwives claimed that they conformed, not because they agreed with what was suggested, but instead to avoid the retribution that might result from their disobedience. Such acquiescence could be interpreted as perceived necessary agreement:

*'I am not sure, it depends who it is. Some of them (senior staff) get difficult with you if you don't do as they say.'*

Consequently, when trying to facilitate childbearing women with making an informed choice, midwives try to balance the expressed needs of the woman, the procedures and policies of the organisation they (the midwives) work for, and their own personal and professional needs.

The paradox is that obedience and conformity are essential for effective functioning of maternity hospitals. When in doubt, it is crucial that the midwife obtains suitable advice and follows guidance that is typically well informed and of sound intention. If they do not do this, childbearing women may not receive appropriate care. Regrettably, there are occasions when the person in charge expresses a

preference that should in fact be the choice of the childbearing woman, quite simply because there are minimal risks that can result from her preferred option. For example, a woman who wants a natural physiological labour or more than one birth partner present at her bir th. In such situations, acquiescence with the senior person's point of view may breach the woman's preferred option.

Unfortunately, many of the obstructions to choice provision are embedded in hospital culture, with explanation rooted within ethos and hierarchy. What is apparent is that the midwife's role blends rules with disciplinary sanctions and autonomy. Midwives are bound by regulations and at the same time they are required to respond to women's requests.

As practising midwives know, supporting choices can be very difficult when faced with protocols and objections from senior staff. One response to this verdict would be to make senior hospital staff aware of characteristics that affect a subordinate's perception of their direction. Second, that managers provide clear definition of roles and responsibilities for members of staff, which would reduce confusion over the limits of practitioner's responsibilities. Since midwives are placed within a hierarchy, they are likely to feel duty-bound to acquiesce to directions from senior staff. This perceived obligation often supersedes playing advocate for women's choice.

For sure, management could also dismantle the hierarchy. Of course, many would consider this unworkable. If this is the case, those who are higher up the chain of command must do for the subordinate what she/he cannot do for herself in terms of interpreting direction from authority. Senior staff could incorporate the women-centred element into their direction. The midwife who acts as authority directs, and in doing so denies a childbearing woman a safe option in care, breaches Rule 6 of the Midwives Rules and Standards.[19] Rule 6 states that the midwife should *'enable the woman to make decisions about her care based on individual needs, by discussing matters fully with her'.*

Senior hospital staff could be made unambiguously accountable for direction that they give, which should include the preference of the childbearing woman to whom it relates. Clearly the question arises as to how this may be done. If the senior member of staff wants a task under taken that ignores input from the childbearing woman, that individual must have the integrity to tell the junior midwife during the decision-making process that this is the case. If the decision excludes the childbearing woman from having a choice about the care she is to receive, the commissioning senior person should admit that this is so. This would allow the junior midwife to know the truth before electing to acquiesce. If the junior midwife then proceeds to submit to the senior person's point of view, they would also quite clearly be responsible for the decision to exclude the woman from the decisionmaking process. Some form of documentation could be designed to accommodate this process.

Essentially midwives want to support women's choices but are being asked to do two things: (1) know their place within the hierarchy, which involves following the prescribed rules, protocols and directives from senior staff. At the same time they are asked to (2) provide choice and control to childbearing women. On occasion these two obligations clash.

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