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The Death of Midwifery? - It May Be Closer Than You Think

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I am a non-practising midwife and, for the moment, the lay chair of an inner city MSLC. I have a passion for the politics of childbirth. I believe that woman-centred practices based on truly informed choice would be liberating for women on a number of levels from the social to the physiological. I remain a member, not only of AIMS but also of the Association of Radical Midwives, and what follows is motivated by a sense of despair about maternity services in general and the state of midwifery in particular.

I have been involved one way or another in this field since 1978, and my despair became crystallised around the hugeness of the gulf between the rhetoric of excellent practice which ARM stands for and the reality of what happens as I perceive it locally. I believe that midwifery as ARM would like to see it practised is more vulnerable now than it has been in my experience since 1978.

There are many reasons why I believe this, and I have no systematic analysis to offer, just some observations.

Midwives with a radical perspective largely either cease to practise, as I did, or they go into education. The idea there is that they impart woman-centred teaching to students, but the reality is that the students learn good theory in the classroom and bad practice on the wards. This puts the students into a double bind. As students they cannot be expected to challenge the status quo as practised by people superior to them in the hierarchy. This is a mirror of the double bind which midwives as a whole were put into when they were asked to implement *Changing Childbirth*, which implicitly, by even raising the idea of midwife-led, woman-centred care, challenges those superior in the hierarchy. (And they were asked to do this without an increase in resources, and with no structural support.)

Motives for change, *Changing Childbirth* for example, are laudable, but I think fundamentally things have got worse. The institution is like an organic entity which compensates for change almost homeostatically in order to protect itself and its defensive structures.

Isobel Menzies-Lyth outlined in 1959 how the structures of nursing (and this is just as relevant for midwifery) served to protect the individual defences which nurses developed to allay the huge levels of legitimate anxiety which are intrinsic to nursing. And the levels of anxiety exist also in midwifery and medicine, although aspects of the anxiety may be different for each profession.

If midwives from a radical perspective leave or go into teaching it is partly because to practise holistically is impossibly uncomfortable in a context where the institutional structures encourage fragmentation. It is my belief that a fundamental change in attitude would occur if health professionals could allow

themselves to accept and feel this anxiety, to recognise that it is based on dealing with taboos, and most notably the possibility of illness and death. This is terrifying, and it's OK to be terrified.

In midwifery and obstetrics one aspect of the anxiety is uncertainty. Uncertainty is excruciatingly uncomfortable, and whenever people meet it they sometimes try to reduce it by making sense where no sense exists, by seeking certainty where there can be none. It seems to me, for example, that the bulk of ante-natal interventions serve to reduce the intrinsic uncertainty of childbirth primarily for the professional.

One defence mechanism which Isobel Menzies-Lyth described which is particularly relevant for midwifery is unnecessary referral upwards in the hierarchy, such that practitioners are not allowed by the institution (by protocols or guidelines) to carry out and be responsible for procedures which are well within their capability. Add to this a culture of fear, of the process, of litigation - a fear which is fuelled by the medical culture of childbirth - and it is little wonder that some midwives seem not to want autonomy.

If this sounds adversarial, it is. And it is because the culture as I perceive it is adversarial: midwife versus obstetrician, professional versus client, mother versus fetus. There is talk about teams, but I see little mutual respect in practice. And when people perceive themselves under threat they feel inadequately resourced and they fall back into splitting and projection, scape- goating and blaming. I think all parties feel under threat, including the doctors who saw *Changing Childbirth* as very threatening: how could they trust midwives, less well educated, lower in the hierarchy, to keep their women and babies safe in the perilous waters of childbirth? In addition to this feeling of threat there is the real lack of adequate funding for the maternity services. And when this culture occurs in the type of social and ethnic complexity which is found in the inner city there is occasion for racial, class- based and inter-professional abuse.

What follows are some examples of the way in which the institution changes to protect itself.

I believe that there is a move, at a high level, quite simply to subsume midwifery within nursing. For example, since Jane Salvage (whose commitment to the political development of nursing is unquestionable) took over the editorship of the *Nursing Times* it has seemed to me that articles concerning midwifery matters seldom use the word *midwife*, and there is no longer a supplement explicitly devoted to midwifery. The Royal College of Nursing has a midwifery section and is represented at the International Congress of Midwives.

Structurally this reproduces the larger situation where midwives are numerically smaller than nurses and are frequently con fused with them (some women emerge from their childbearing experience with no idea that they have seen any one other than a nurse, and are also frequently represented by them. And this disguises the fact that the needs and professional orientation of nurses and midwives are quite different.

Midwifery traditionally has incorporated structures such as supervision and refresher courses which could be seen, and have been seen, as desirable by nurses. (It is debatable that both of these structures have been used oppressively in the past.) Midwives also in the past have had an autonomy of practice

which I believe some nurses now want to adopt. Midwives, for example, have long been theoretically allowed to prescribe certain drugs - although in effect, certainly in hospital practice, this has not been the case. In theory a midwife can take on the total care of a woman, who could emerge from the other end with her baby, never having seen a doctor. I believe that there are those who are interested in raising the professional profile of nursing who believe that absorbing midwives would facilitate this end. But from my perspective it contributes to the reduction in autonomy of the midwife to the detriment of childbearing women.

The development of the UKCC brought together the governing bodies of nursing, health visiting and midwifery, to the numerical disadvantage of midwifery, and further structural changes in education, in clinical grading have meant the needs of the numerically vulnerable midwifery profession are lost. University administrators do not necessarily under stand that in order to teach midwifery, a midwife has to be a practitioner. They do not necessarily understand that supporting a woman in childbirth is different from caring for the sick.

Further recommenced structural changes to the governing body of these professions have not redressed this situation, and may have exacerbated it. These changes have been tagged on to the end of the Health Bill, and are likely to be passed by the huge parliamentary majority without adequate debate of the issues. One worrying proposal is that further changes could be made to the statutory bodies governing nursing and midwifery without the need for changes in legislation.

Within maternity care, medicalisation of normal labour continues. The pages of the*AIMS Journal* are filled with examples and I do not need to elaborate, except to say that the confidence of midwives in facilitating normal labour in my area is so low that the designated low-tech labour ward is underused because the midwives apparently feel nervous being down a corridor from the main labour ward and therefore not in the immediate vicinity of an obstetrician. I do not have to point out that this bodes ill for their confidence in facilitating labour at home.

This over-medicalisation perpetuates the unequal power relationship between obstetricians and midwives; an unequal relationship which is mirrored in that of professionals and women. Local labour ward protocols also perpetuate this by, for example, advocating routine electronic fetal monitoring, artificial rupture of membranes at three centimetres dilatation. A midwife sits on the working party which produces these guidelines, but the hierarchy is such that she does not dare to remonstrate that this type of protocol is not backed up by evidence, that it serves to increase the likelihood of pathology.

Or it may be that she does not know that remonstration is in order. It is my experience that "guidelines" come to be interpreted as "rules", and any non- compliance has to be defended. The institutional structures do not allow midwives to use a sound theoretical basis on which flexibly to use their clinical judgement in response to each woman's unique circumstances. But if midwives don't practise like this, they don't - they cannot - implement *Changing Childbirth*, they cannot offer choice.

Continuing over-medicalisation must be serving purposes other than benefiting mothers and babies,

because almost all the evidence supports the low tech. This was stated clearly in the article "Mater Over Matter" in the recent *AIMS Journal* (Winter 1998/99: 8-10). Over-medicalisation serves to create an atmosphere where the role of the obstetrician is overvalued compared with that of the midwife; it keeps women in a state of fear of the process, lest they try to take some of the control for themselves.

There is a hierarchy of power, now as ever, in which the obstetricians come top and the women come bottom. Midwives exist painfully in between. Some are woman-centred. Some are obstetrician centred. Some are burnt out. It is difficult to state this, precisely because *Changing Childbirth* has happened. According to the authorities the structures for the implementation of woman-centred care should be in place, and if they are not it is because the idea must be unworkable. *Changing Childbirth* was set up to fail, and it did. It is my theory that the Tory government wanted midwives to undermine the medical profession, as part of their ideology of undermining all professions where the prime motive was care of people rather than the marketplace. It didn't work like that.

Midwifery has been undermined and obstetricians have co-opted the language of choice. We have seen this in the caesarean-sections-on-demand movement. Obstetricians sometimes save lives, this is undoubted. But their scope of practice has become too wide, they have medicalised normal childbirth to the point that it scarcely exists, certainly in hospital. Locally, when discussions were occurring about the implementation of *Changing Childbirth*, it was decided that midwife led care was only appropriate for 15% of women. In other words the bodies of only 15% of women in our area are considered capable of giving birth without medical intervention.

I wonder whether the continuing medicalisation of the normal has a punitive element: if midwife-led, woman-centred care ceases to be an aberration provided by independent midwives for a mad, middle-class minority, but becomes incorporated in the structures of the NHS, it is dangerous because it implies a fundamental change in the power balance between professionals and all clients. But maybe also these midwives are just getting too uppity and need to learn their place. Maybe the continuation of over-medicalisation in contradiction of all evidence is a response to the threat *Changing Childbirth*, if implemented fully, posed realistically to doctors' power in childbirth.

It is my perception that *Changing Childbirth* itself led to midwives' demoralisation. There are midwives who, for their own defensive reasons, do not want to work in a woman-centred way. And there are midwives who are desperate to do so and who found themselves working in a piecemeal situation where projects started without any strategic plan and with very little resourcing, and none to support their continuation if they were found to be effective. Caring midwives were frustrated that they could not take advantage of this opportunity for the benefit of women.

As a member of ARM and a direct-entry midwife I can argue that nursing and midwifery are separate and distinct disciplines in my sleep. But I now find myself longing for midwifery to incorporate a bit of basic nursing care. It is as though qualified midwives are too professionally distant to be kind. This may be unkind of me, but little routine gestures, the bed bath immediately after delivery, the tea and toast, the arm round a shoulder of a mother in tears, seem inconceivable. And it may he due to staff shortages,

although that does not explain basic rudeness, but I do not believe that this is sufficient explanation.

It may also he overcompensation: the professionals with the highest status, the doctors, perform the least basic physical care, the least in the way of interactive care - they get nurses and. midwives to do their explaining for them. There are individuals who find this distancing congenial, but the institution also finds what used to be called "total patient care" uncomfortable: every time there has been a move in that direction it is decided that care needs to be fragmented because otherwise it is not cost effective, there needs to be "skill-mix", which is another way of saying there have to be low paid menials to perform the human tasks. I am shocked at the way in which midwives have allowed their care of a woman in labour to be fragmented so that it seems all their efforts go into making formal observations and writing notes (in case the woman sues) and there is no time for back massage, for encouraging words, for breathing with her. These are not luxuries to a woman in labour.

I mourn what has happened to independent midwives with the refusal by the RCM to insure them. Whatever political objections there may be to private practice, the*quality* of their practice alone, and provided an aim for all midwifery practice. This has largely been lost, with independent midwives either ceasing to practise or, in some cases, doing it without insurance and therefore keeping their heads down.

Independent midwives demonstrated a style of practice in which the principles of*Changing Childbirth* were manifest, and they also demonstrated a practice which was based on midwifery principles, rather than obstetric. Midwives' history in relationship to obstetricians mirrors closely that between women and men in society at large. Midwifery knowledge is not systematised, is intuitive and cannot be made to fit easily the paradigms of male institutions. I do believe that the rendering invisible of independent midwifery is one factor in the lack of confidence I perceive in practising NHS midwives and their often reluctant acquiescence in unnecessary medical interventions. And it is one for which the RCM must take responsibility.

I am despondent about the larger political context of the maternity services. Medicine is an industry, serving the self-interest of the practitioners and the profits of investors in pharmaceuticals and electronics. And there is a link between the electronics industry, which has had such a detrimental influence on the care of women in labour, and "defence": is it that purchase of fetal monitoring equipment provides profits which fund research into weapons?

If I see midwifery under threat, it is maybe because I see midwifery as embodying the woman-centred values and it is those which are under threat. Maybe obstetric nursing is alive and well, thriving. Certain people would have us believe that the aims of*Changing Childbirth*, of woman-centred care, informed choice and control have already been met. Opposition to this point of view is regarded as defeatism. But I think it is important to be clear about what seems to me to be a parlous state of affairs if there is to be change which is truly radical and which can there fore be sustained. I am suggesting that unless the broader structures change, there will be no fundamental change, and what changes there have been are cosmetic in effect because the underlying structures have been untouched.

And I believe that *radical* change is as necessary now as when I started, and by radical change I mean change which affects the power relationships between women, midwives and obstetricians. I am afraid that gains have been lost, and will never be recaptured. When ARM started in the mid seventies there was a language of liberation which has been expunged from the common vocabulary, and it seems hard even to find the words to express my concerns.

Is what I have written mad?

Editor's Note: for more information on Changing Childbirth, the British Government's mandate for making a mother-friendly maternity service, see AIMS Journal 1993, 5(2): 10-11; 1993, 5(3): 1-4 ; 1993, 5(3): 4-5. Related articles on the state of midwifery can be found in AIMS Journal 1994, 6(3): 1-5 and 6-9."