AIMS For a better birth...

Defining Midwifery Practice

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AIMS has long argued for a midwifery ruling body separate and distinct from nursing. But should the spilt be taken further? Should the midwifery profession, in fact, be split into two distinct groups - "obstetric nurses" and "midwives" to acknowledge the differences in approach between individual members of the profession? Researcher John Mason puts forward one point of view on this controversial subject.

Earlier aspirations of "midwifery-led" maternity services in the UK have been shattered by the increasing incidence of medical interventions as routine procedures in normal birth, and by managerial policies designed to turn midwives into functionally competent "service agents".[1],[2],[3] If identity is reproduced through the practices engaged in, recent reports of a deterioration in midwifery professionalism indicate a crisis for the majority of midwives that could be remedied, by structurally separating skilled obstetric nursing from autonomous midwifery.[4],[5]

In the modern era, the governmental tendency has been to allocate power to doctors, in themanagement of health and reproduction, thus creating a cultural norm of high-tech medical management of pregnancy and birth.

During the latter part of the 20th century, human reproduction was relentlessly appropriated by obstetrics, according to the principle that pregnancy and birth are only normal in retrospect. This belief has been increasingly justified by a North American-style reliance on litigation, rather than investment in public services, to compensate for birth trauma. The American insurance-protective approach is currently being applied in the UK, through the Clinical Negligence Scheme for Trusts which requires effective 24 hour consultant obstetric cover in all delivery suites.[6],[7]

The increasing medical domination of normal birth has generated many accounts by birthing women and others of the de-humanising effects of unnecessary medical interventions which have seriously undermined women[1]s choice and midwifery professionalism.[8],[7]

Even where women are determined to resist medical interventions and prepare themselves for birth, under the guidance of organisations such as the National Childbirth Trust and AIMS, their intentions are rapidly invalidated as soon as they enter the terrain of obstetric power.[9],[10]

From the 1970s, this tendency has been accelerated by advances in fertilisation techniques, embryonic and fetal surveillance and the active control of labour and birth. It has become standard practice in

technically well equipped modern hospitals to "manage labour" according to mathematically calculable models of "normal progress".[11]

In obstetric medicine, the fetus has replaced the mother, as a key focus for medical intervention and ante-natal care has become increasingly directed towards the womb, as a suitable "environment" for fetal growth and development.

A whole new generation of fetal screening and diagnostic tests have became available to identify abnormalities, manipulate assisted conceptions and monitor fetal development. More recently, corporate medical enterprise has developed human reproductive techniques that supply "choices" to its clients, offered as calculated risks, in the selection of "quality" sperms and oocytes[12]

Rational birth

If professional midwifery texts are ignored, changes in cultural patterns of maternity service since the 1970s have been increasingly determined by the concepts of "risk" and "security" informed by a rationality based entirely on statistical data. Within this framework, "choice" has become a medical euphemism for "risk assessment" in relation to the health of the embryo and fetus. This intensity of technological scrutiny has consolidated a wider cultural acceptance of the conventional obstetric opinion that reproduction is "normal" only in retrospect.

Large hospitals now provide a growing multiplicity of medical services and surveillance systems. These commence in early pregnancy and reach a high point during labour and birth. The perpetual uncertainty generated by the rapidly evolving medical technology of screening actively increases women's dependence on the "findings" it detects.

Once a woman enters an at-risk category during pregnancy or labour, she becomes that category as a "thing-in-itself" as she is subjected to the overriding equation "safety requires surveillance". This medically determined definition has led to the widespread institutionalisation of high- tech obstetric-led services for pregnancy, labour and birth.[6],[13]

Despite repeated calls for non-medically managed birth, by a variety of interest groups, many of whom gave evidence to the parliamentary Winterton Committee in the early 1990s, "women's choice" has yet to become a reality for the majority of NHS recipients.[1] Within the norms of hospital managed births, qualified midwives are effectively required to function as obstetric nurses. According to recent parliamentary evidence, only 33,897 out of a total of 92,183 registered midwives are practising within the NHS and evidence suggests that during the past ten years, the unrelenting erosion of midwifery skills and knowledge has fuelled an exodus of highly experienced practitioners[15],[16]

The deterioration of midwifery

Recent observations by AIMS' Jean Robinson on a marked country-wide increase in complaints from women who feel badly treated by midwives indicate a qualitative erosion of midwifery care.[5]

According to these complaints, significant numbers of midwives are causing serious emotional damage through their unsympathetic, dominating and controlling behaviour towards their clients.

In comparison, doctors are seen as "much nicer" than midwives. Consequently, increasing numbers of women are expressing a preference for the "goblin fruit" of high-tech obstetric management.[5] Aligned with other examples of apparent deterioration in midwifery working conditions, such as an increase in "horizontal violence" and personal emotional distress amongst midwives, this phenomenon, indicates a scale of organisational and communicational confusion that could be improved by structural change.[4], [21]

Some midwifery practitioners accept obstetric standards as the "midwifery norm" and prefer the identity of an American style obstetric nurse-midwife who mediates involvement with women through machines and the pharmaceutical agents prescribed by obstetricians and anaesthetists.[18],[19] Others wish to develop autonomous midwifery practice that assists women and their families in unproblematic "bio-social" birth processes through skilful manipulation or "masterful" observant inactivity.[8],[20]

The fact that the New Labour government has recently established eleven "midwifery consultant" posts indicates that there is increasing political will to improve the professional status of midwives[17] Unfortunately, this move appears to be shorted-sighted as it continues to perpetuate the myth of midwifery as a universal entity and denies existing differences in the distribution of resources and power relations, within the NHS. The establishment of a clear, structural distinction between the identities of obstetric-nurse midwives and autonomous practitioners would reflect existing client preferences and encourage specialist development.

According to the probability that significant numbers of women in the UK will continue to choose obstetric management of reproduction, the time has arrived for a consciously evolved, clearly defined, structural distinction between obstetric-led and midwifery-led maternity services, to enable all women to exercise real choices before, during and following childbirth.

This change would compliment the existing abilities of those who are well skilled in the art of assisting birth and establish a distinct difference between these practitioners, as autonomous midwives and those who wish to develop a career as highly skilled, obstetric nurse-midwives[18]

Editor's Note: Readers, please let us know what your views are on this subject.
Contact the AIMS Journal Editor on editor@aims.org.uk

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