Oral history and research part 2: current practice

By Billie Hunter

ABSTRACT

This is the second of two articles investigating the use of oral history research in midwifery. This article explores the relevance of oral history research findings for contemporary and future practice. PreNHS community midwives provided one-to-one, midwifery-led care, which resembles the practice recommended by current government policy. Concerns have been raised as to the sustainability of such practices. This article uses the themes proposed by Sandall (1997) to analyse the practice of preNHS midwives, and suggests that occupational autonomy is of particular significance in maintaining job satisfaction and morale.

In the first article of this series, the method of oral history investigation was discussed, with reference to its uses and implications within midwifery research. This second article considers the relevance of oral history research to current practice.

Contemporary midwifery

The 1990s have seen a sea change in British midwifery. Government policy has challenged professionals to set into motion some fundamental changes in maternity care, which have the potential to radically alter the roles of midwives and women (Department of Health, 1993). As a result, there have been a variety of pilot schemes to explore different methods of providing midwifery-led, woman-centred care. These initiatives take various forms: some midwives carry small personal caseloads within a partnership or group practice setting (Demilew, 1994); others work in larger teams, where responsibility for the caseload is shared (Perkins and Unell, 1997).

The aim is to improve the quality of provision by reducing fragmentation. This is achieved either by providing 'continuity of care' (providing midwifery care from a team of midwives with a shared philosophy), or 'continuity of carer' (one or two midwives provide all antenatal, intrapartum and postnatal care) (Lee, 1997). .

Evaluations of these innovations suggest that they have significant implications for midwives' working lives. Sandall (1997) warns that, unless such schemes are carefully thought through before implementation, they are likely to lead to exhaustion and burnout for the midwives involved. Her study of the impact of continuity of care schemes on midwives' work and personal lives has led her to identify three key themes that need attention if sustainable practices are to be created, and burnout avoided. These are:

- Occupational autonomy
- Social support
- The ability to develop meaningful relationships with childbearing women.

Pre-NHS midwifery

So what relevance do the experiences of pre-NHS midwives have for current practice? Midwives who practised before the introduction of the NHS provided just the kind of continuity of care that has become the current utopia of midwifery practice. Community midwives usually worked single-handed as the lead professional for a caseload. Total care was provided from antenatal booking through to the 28th day following birth. Although antenatal care was limited at this time, postnatal care was time consuming — as women were confined to bed for 10 days after the birth, the midwife's work focused on hands-on care for both the mother and the baby. Given that in 1927, 85% of births took place at home (Walker, 1954), community midwifery was a full-time and demanding occupation. Did these midwives experience stress and burnout, or were they able to achieve more acceptable and fulfilling working lives? If we are planning to return to a form of midwifery that has its roots firmly in past practice, then it is surely important to learn as much as possible about the experiences of these midwives.

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The evidence from oral history may provide us with some clues. My tentative suggestions are based on the research undertaken by myself and Nicky Leap into the working lives of midwives before the advent of the NHS. Findings from this study have been published as *The Midwife's Tale* (Leap and Hunter, 1993). Data were collected from a self-selected sample of 12 retired midwives who had practised in a variety of locations within the British Isles, as well as from women who had given birth during this period. Semistructured interviews were conducted in the participants' own homes, and the transcripts analysed using a simple content analysis to identify various themes. Those relevant to their working lives are described below.

Demanding work

The midwives interviewed provided many examples of the physical and emotional demands of carrying a caseload, and providing one-to-one care. Stories were told of going from one case to the next, and the exhaustion that resulted. For instance:

Mary W: 'You had very little time off. If you'd had a lot of deliveries — lots of nights up, no one made it up for you, you just had to go on and get it over and get your sleep where you could... We were on call 24 hours a day — if you got a call in the night, you still had to do your day's work the next day. In my biggest year, I did 99 cases, but usually about 80.'

Esther S: 'One weekend I had seven babies single-handed and that's when I had that big baby (twelve and a half pounds). That's the only time I've been so desperate... I never understood the term "drunk with tiredness" until then. I was as high as a kite. I never went to my bed for four nights and four days' (Leap and Hunter, 1993: 63–4).

These examples suggest that providing such care could be counterproductive to the midwives' own wellbeing. In fact, there is no evidence from the study that this was so. The midwives interviewed generally described themselves as having had high levels of morale and job satisfaction. They were far from being 'burnt-out' or disillusioned. Most had practised until retirement, often in the same 'patch', and still identified themselves as midwives, keeping up to date with professional issues. It would appear that the demands of the work had been balanced by the rewards. Elizabeth C summarized this feeling of fulfilment:

'It was a vocation for me. I was in my element. People say "oh, you can't have done" when I say I enjoyed every minute of it, even the up-at-nights, but it's true. You were doing something you see. Once the fun began, you didn't feel tired, but you might come in in the morning and just fall into bed. But you'd find energy you didn't know you had' (Leap and Hunter, 1993: 68).

This sense of vocation was reiterated by many of the respondents.

It is worth noting that oral history research is always vulnerable to the distortive effects of selective memory and over-romantic recall; perhaps those times when disillusionment and exhaustion became too much to cope with have been forgotten. However, the frequency of responses such as Elizabeth's suggests that these experiences were authentic.

So how did these midwives manage to provide effective one-to-one midwifery care without experiencing the stress and burnout described by contemporary midwives in Sandall's study? As a framework for analysis, I decided to use the themes identified by Sandall (1997).

Occupational autonomy

First, pre-NHS midwives had considerable occupational autonomy — they practised from home, usually lived in the area in which they practised, and could define the pattern of their working day themselves (births permitting!). This resulted in the type of flexible working pattern identified as significant by Sandall. Given that midwifery is, by its nature, an unpredictable occupation, it would appear that midwives value the ability to control whatever aspects are controllable.

This feeling of personal control is described by this community midwife:

Mary W: 'I never really wanted to go back into hospital once I got used to the district because there's a lot to be said for being an

independent practitioner. Of course, the supervisor used to come round, but not very often, and you were your own boss in a way — got used to your own village, your own practice and doctors' (Leap and Hunter, 1993: 50).

Coupled with this autonomy was a high level of expressed confidence in skills and expertise. There was no question in the minds of the midwives but that they were highly skilled practitioners. In pre-NHS times, midwives were the sole professional at most births, including breeches and twins. Nowadays such 'abnormalities' would be seen as high risk and warranting medical intervention. Pre-NHS midwives, however, appeared to take it all in their stride. Watching the delight on a 91-year-old midwife's face, as she mimed how to deliver a breech baby, was thought provoking and inspiring.

Relationships with doctors were generally good, and most midwives gave the impression that they clearly saw themselves as the doctors' equal. Edie B recalls:

'On the whole we got on well with the doctors. Mind you, we didn't let them get away with things... I once did a forceps delivery because the doctor was on the point of collapse. I said "If you tell me the position and where exactly to put the instruments, where to feel, I'll have a go, but you must take responsibility". However, the baby was all right. I was so relieved. I went about with an imaginary medal on my chest! I enjoyed that, the feeling of power, you know. No, our doctors were very nice. They respected us and treated us like equals' (Leap and Hunter, 1993: 57).

These high levels of autonomy and confidence were evident in the testimonies of all participants in the study, and thus appear to be a significant feature in these midwives' working lives.

Social support

The second of Sandall's themes, social support, appears less applicable. The social support that pre-NHS midwives experienced in their home lives was variable. Several described supportive family or friends as being integral to their ability to cope with the demands of their work, but this was not a universal feature. Indeed the impression received was that many of the unmarried midwives had lived for their work, and even in retirement still identified closely with the profession. Only two of the midwives had been married and had children themselves, and they described themselves as unusual in this. This is in contrast to the profile of contemporary midwives, many of whom have domestic commitments that have to be juggled with work demands (Sandall, 1998).

Developing meaningful relationships with women

This theme, however, appears to have been highly significant for at least some of the participants. Many of the midwives we interviewed described these relationships warmly, and often the midwives were still in touch with their 'babies', 50 years on! For instance:

Elizabeth C: 'I don't think they thought of me as just a midwife, more as a friend. Most of the kids and all, they used to call me "Auntie Betty", even the adults... they still write to me now as Auntie Betty... I think there's a lot in being a personal friend to the person having the baby. You want a bit of sympathy and someone you can talk to just then. Not someone telling you "Now shut up. Stop making a noise." I used to say... "Shout if you want to dear, I won't take any notice!"" (Leap and Hunter, 1993: 66).

Elizabeth also identified the importance of 'knowing the midwife' for effective midwifery care:

'I'm sure it's really important to know the person who's going to look after you in labour. I'm sure it's very comforting to have someone you know and that knows you, and sort of knows your temperament, knows what you can take and what you can't. Knowing the midwife, it's better than dope or something because it's a normal thing you see.'

However, not all the midwives expressed such warmth and empathy. There was an apparent link between these attitudes and

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KEY POINTS

- There is evidence that current continuity of care schemes may lead to stress and burnout.
- Pre-NHS midwives appear to have been able to provide midwife-led, one-to-one care while maintaining high morale and experiencing job satisfaction.
- Significant factors in the maintenance of sustainable pre-NHS practice appear to have been the ability to develop meaningful relationships with women, high levels of occupational autonomy, expressed confidence in skills and status within the community.
- These findings are worthy of application to contemporary practice, as they may offer insights pertinent to current innovations.

social class: midwives from middle class backgrounds appeared more likely to express critical attitudes about the women they cared for. This observation is worthy of further investigation and will be developed in a later paper.

The role of the midwife within the community

Finally, in addition to the themes identified by Sandall, data analysis suggests that the role of the midwife within the community was also a contributory factor in enabling the midwife to sustain her practice. Many of the midwives described the high status that they held, on a par with the doctor, but also, perhaps more significantly, the warmth and affection that they were accorded. This was partly attributed to the visibility of the midwife within a small community. Mary W recalls that:

'All the shopkeepers knew you — "there's the nurse going along". On your old bike, trundling along. Patients would be outside houses sometimes and shout "How are you? Got time to come in for a cup of tea on your way back?"' (Leap and Hunter, 1993: 59).

This mixture of public respect and concern for the midwife's wellbeing would appear to be a key feature, and perhaps one that is no longer as apparent. This is likely to have provided another form of social support, in addition to the collegial and home support identified by Sandall. It may be that visibility is a significant factor in establishing public respect — people were aware of the midwife's role and the demands it entailed.

My findings suggest that the midwife was accepted as the expert in normal pregnancy and childbirth, and that there was respect for the commitment that midwives gave to their work. However, with the transfer of childbirth from the community to the hospital, and the increasing medicalization of childbirth, the role of the midwife has become obscured, and hence status has fallen.

Conclusion

Evidence from this study suggests that, although midwifery practice before the NHS was highly demanding, and there were obviously times when midwives experienced their work as stressful, in the main the midwives interviewed described high morale and high levels of job satisfaction.

The themes of occupational autonomy and meaningful relationships with clients are identified as being as relevant to sustaining midwife-led practice in pre-NHS Britain as in contemporary practice. In addition, two further themes appear to have been significant for pre-NHS midwives. These were 'expressed confidence in skills' and 'status within the community'. Both of these are linked to the concept of occupational autonomy.

It is also likely that the lack of domestic commitments experienced by the majority of respondents, together with the strong sense of personal vocation described, would have further reduced the stress experienced.

The experiences of pre-NHS midwives, as identified by oral history research, offer some useful insights for contemporary midwifery practice. Current innovations have blazed ahead, and it is only now that their implications are being critically evaluated. The findings of this study suggest that the issues identified by Sandall (1997), in particular that of occupational autonomy, will need to be addressed if new initiatives in midwifery practice are to be effective and sustainable. This has implications for both practice and education. BJM

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