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WARNING

Midwifery: a case of misleading packaging?

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To determine their perceptions of the unique characteristics the midwife contributes to the health team, 405 practising Australian midwives were surveyed and results showed marked agreement between midwives in different States. Profiles established that they worked in controlling and active roles rather than passive and counselling roles as may have been expected.

Despite professional and possibly community perceptions to the contrary, midwives see themselves as highly analytical, accepting considerable responsibility for the conduct of birth. This paradox is explained using a feminist analysis and it is postulated that role conflict and professional dissatisfaction which results contributes significantly to the loss of midwives from the profession.

This paper presents midwives' own description of their role and function in the health team. The impetus for the survey came from concerns expressed by the National Midwives Association about the lack of knowledge of how midwifery is practised in Australia, and their support in establishing content and collecting data was an essential contribution to the project. It is estimated that nearly nine per cent of practising midwives cooperated to provide information that can be used to identify the unique contribution of midwifery and assist in policy development and education.

Rationale

There are at least two ways in which the role and function of the midwife may be determined: by task analyses or by asking midwives what they believe they contribute. Specific task analyses of midwifery have been undertaken in the United Kingdom[1] and the United States,[2,3] and a similar but more limited study was done by Kiiver in New South Wales.[4] Kiiver's task was to gather information about the contribution of various occupational categories within the sphere of obstetric service, to provide a baseline for evaluation, coordination and planning, and the substance of her findings in regard to midwives and midwifery functions replicated the conclusions of English and American researchers.

The outstanding feature of these task analysis studies is that they demonstrated under-use of midwifery skills and the dissatisfaction this causes midwives. Results from my own earlier studies[5] though formulated differently, tended to support these two important findings, leading to the conclusion that it is more important to examine what midwives regard as ideal characteristics for practice than document their dissatisfaction further. Therefore, rather than repeat previous task analyses, I chose to examine the characteristics midwives consider necessary to fulfil their role.

In the United Kingdom the midwife is the senior responsible person at 76% of all deliveries[6] but her role in normal antenatal and postnatal supervision is decreasing.[7] The opposite situation exists in the United States

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where the midwife is less likely to be permitted to deliver the infant than to perform antenatal and postnatal care.[5,9] In Australia the practice varies widely, with the midwife in isolated areas doing both and where medical services are amply provided, neither. Invariably, whether working in a rural or urban setting, the midwife manages labour and postnatal care.

Thus, the division of labour between medical practitioners and midwives is inconsistent across countries and reflects social, political and economic systems rather than any scientific validation of practitioner suitability for the task. This inquiry sought to identify and rank in order characteristics which Australian midwives believed were central to their practice and followed comparable work which led to innovation in medical school curricula, designed to develop qualities seen as essential by medical graduates.[10] Identifying the characteristics essential to midwifery could assist educationalists and others to focus on the outcomes of training and key elements of practice.

Method

The Executive of the National Midwives Association allocated time on the agenda at a regular meeting to discuss the project and identify unique midwifery characteristics. This activity had been foreshadowed for some months and individual representatives encouraged to think about and discuss the issues in their own State.

Using the methods of deliberation, debate and recourse to a thesaurus, the National Executive developed a list of fifteen desirable characteristics, which on analysis were of two distinct types: Type A implied characteristics that I have described as *Controlling/Active*; Type B implied *Counselling/Passive* characteristics, and contained words and phrases essentially describing interpersonal and communication skills. (See Table 1)

The study was designed to obtain midwives' subjective individual perceptions of the qualities and characteristics they believed were essential for the practice of midwifery. Lists A and B were combined to prevent one or other category predominating or leading a respondent (see Table 2) and the Role Analysis Form thus formulated, together with an explanatory letter was circulated to 550 Australian midwives, who were required to nominate five of the fifteen characteristics they perceived to most accurately define their role.

State representatives of the Executive of the National Midwives Association took responsibility for the distribution and collection of forms. This enabled an Australia-wide survey to be undertaken and the people who distributed the forms were instructed to apportion them across institutions and types of practice wherever possible. Additional distributors were nominated by their local midwives group

TABLE 1
Fifteen Characteristics of the Midwife

List A: Controlling/ Active	List B: Counselling/ Passive
confident	listener
resourceful	non-judgmental
analytical	empathetic
key-worker	observer
teacher	patient
skilful	ethical
accountable	thinker
capable	

TABLE 2
List A and List B Combined*

( ) Confident and self-assured practitioner
( ) Resourceful
( ) Attentive and responsive listener
( ) Non-judgmental
( ) Can analyse situations and implement appropriate action
( ) High ethical sense
( ) Key worker in maternal child health team
( ) Teacher and guide
( ) Skilful in the organization and delivery of care
( ) Flexible thinker
( ) Empathetic and sensitive
( ) Accountable
( ) Capable and efficient
( ) Insightful and intuitive observer
( ) Patient

** to prevent one or other category predominating or leading the respondent.*

TABLE 3

Table of Distribution and Return

	Distributed	Returned	Invalid	Total Sample
N.S.W.	110	95	8	87
N.T.	10	10	2	8
S.A.	60	46	1	45
Vic.	210	171	5	166
W.A.	50	45	4	41
Qld.	60	26	1	25
A.C.T.	15	13	-	13
Tas.	35	20	-	20
Total	550	426	21	405

TABLE 4

State and Total Australian Responses to the Role Analysis Form

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Aust Total
Confident	4	22	0	8	19	8	49	17	127
Resourceful	3	16	2	1	4	4	30	5	65
Listener	8	39	4	4	13	5	7	3	113
Non-judgmental	5	8	2	0	9	5	39	3	71
Analytical	8	67	7	18	36	12	131	32	311
Ethical	1	15	2	8	7	3	31	9	76
Key Worker	2	24	4	3	10	4	47	11	105
Teacher	3	50	3	16	30	12	90	17	221
Skilful	6	54	6	19	28	8	97	24	242
Thinker	7	14	3	6	11	7	42	12	102
Empathetic	6	39	3	9	14	8	65	28	172
Accountable	2	29	1	8	8	11	29	8	96
Capable	2	26	1	14	17	3	62	11	136
Observer	6	24	2	4	10	7	40	19	112
Patient	2	18	0	7	9	3	41	6	86

and their assistance ensured an excellent response rate of 76%. It is acknowledged that this type of sampling is likely to result in some bias since the majority of respondents were probably members of their local midwives association.

Forms were distributed in approximate proportions to the numbers of midwives working in each State or Territory, calculated from figures provided in Volume 2 of Nursing Personnel: A National Survey (1979).[11] Distribution and return data are recorded in Table 3.

Findings

Responses from each State were collated independently and as part of an Australian profile, and results between States proved to be remarkably consistent (see Table 4). No patterns of stereotyped responses, such as alternate 'yes' and 'no', or marking the first five items on the list occurred, and from this and accompanying comments it could be concluded that respondents gave thoughtful consideration before choosing their priorities.

The method involved summing the responses made by midwives in each State to establish a State profile, then summing these to form an Australian profile. The remarkable consistency of agreement between midwives is illustrated by the fact that 311 of the 405 respondents ranked 'can analyse situations and institute appropriate action' (Analytical) in their top five priorities, and more than a quarter (130) ranked it first.

The profile compiled from the responses shows midwives chose four characteristics from List A and only one from List B. It seems reasonable to infer from this that the midwives *actual though not acknowledged* role remains much the same as it has been historically, despite economic, political and social systems that are diminishing her public sphere of responsibility. The midwife in fact still requires and uses the characteristics of an independent practitioner, yet at the same time experience indicates that this is unlikely to be openly manifested and acknowledged.

Discussion

When planning the study it seemed reasonable to hypothesize that increasing medical control of normal childbirth would significantly alter the midwife's role, that some authority must be relinquished as she appeared to move from a position of independence and responsibility, to one of social and emotional support. If this authority or control was only required in an emergency and not as part of her everyday activity, one might expect *resourcefulness* to score higher than it did (fifteenth ranking on the Australian profile). Despite the high incidence of medical management of pregnancy, labour and the puerperium and the costs inherent in this system, the midwife clearly accepts responsibility for a physiologically safe as well as an emotionally rewarding experience in childbirth. The apparent movement of midwives into a social and emotional support role appears to be a social perception held by the community and other professional groups, but not by the midwife herself.

This simple study indicates that midwives have high expectations of their level of performance, yet paradoxically it exposes the considerable self-effacement they must experience as their role becomes less obvious and more apparently *feminine* in character. At the same time midwives do perceive themselves as less responsible than they may have been historically, and the paradox of this is that our health care systems neither recognize nor remunerate them accordingly. Control of the service is being assigned to others and ritualized, for example, by the doctor delivering the baby without observing or managing labour.

It is useful to consider the implications of this study. It appears likely that the role strain involved in covertly maintaining a highly responsible practice without overt acknowledgement of this by institutionalized systems of care is considerable. It may well contribute to the problems of retention of graduates in the profession discussed by the author elsewhere[12] and demonstrated in overseas studies.[13] Further, the devaluing by society of the midwife's public role has a number of consequences:

- midwives have lost their traditional authority and expertness as supervisors of normal midwifery
- any authority or status that remains is either covert and hidden from the general population, or vicarious because midwives work so closely with the prestigious medical profession.

Midwives have difficulty in developing and retaining a social rather than therapeutic view of childbirth as their training, control, orientation and work environment all lie within a system designed to deal with and remunerate pathology.

Conclusion

That midwives have become experts at taking a secondary or subservient role is consistent with women's experience generally in both professional practice and social experience, and is a well recognized *problem*. That this is only a superficial view of the midwife's function and not her actual role, emerges from this work, but as the situation is unlikely to remain static it is possible to hypothesize and project further. The danger of accepting implicit rather than explicit

power lies in the concessions one makes to develop and use it. Midwives have the option of gracefully accepting the decline into impotence that has already begun or they may become more vocal and independent and throw off the social camouflage that hides their worth and importance. They could reassert and make explicit their expertise in normal midwifery. As Kloosterman (a Dutch professor of obstetrics) has stated, obstetricians by orientation and training are less fitted to manage normal labour than midwives.[14]

Midwives must define their status and derive satisfaction from their own skill and no longer seek vicarious prestige from the science of obstetrics. In Australia today they are being used as obstetric nurses to support medical practitioners, an historical and regional anomaly wasteful of training and resources. Only midwives know this domination is in the perception of the observer and not actual experience and this enquiry demonstrates that, though the community's perception of her role may have changed over the last thirty to forty years, it remains *controlling and active*. Midwives do not simply carry out absent doctors' orders.

It can also be postulated that mothers' needs and preferences will remain unmet and their rights ignored, unless midwives move, metaphorically speaking, outside the medical institution and become a bridge between the social and therapeutic worlds.[15] The difference between these worlds can be summarized in the phrase inherent in institutionalized care: 'Childbirth is potentially hazardous and a life crisis'. The midwife's traditional philosophy is rather: 'Childbirth is inherently normal and a peak experience'.

Midwives themselves have contributed towards answering the question: 'What is the midwife's role in Australia today?' by stating clearly that it is active and analytical before anything else. Though they may appear to act in a *feminine* supportive role in fact they do not. The system does not permit the manifestation or acknowledgement of their true worth, and this contradiction has been well explained by feminist theory.

Spender describes how women's insights, knowledge and experiences have been lost to successive generations over centuries. The dominant male culture has ensured that women's contributions have been distorted, devalued or simply forgotten, so new generations of women have had to rediscover them.[16] Gender is one mechanism that allows male doctors to dominate female health professionals; it also flavours the relationship between the woman giving birth and the person delivering her. The difference between professional and non-professional is intensified when maleness/femaleness is overlaid and it increases the control of the accoucheur over the event.[17] One is struck by the inadequacy of attempts by conventional discipline to explain this phenomenon fully in theoretical terms, although theorists such as Willis[18] get us closer than we were before. No attempt satisfactorily addresses features of the relationship between medicine and midwife that maintain domination on such poorly justified or justifiable grounds, and they do not explain women's compliance with this dominance. A feminist argument better explains what happens to women as midwives or as women giving birth:

> Having been initiated into a male dominated society they (women) have been well instructed in the art of woman devaluation, and if they have learned their lessons well women will have emerged with their confidence undermined, their assurance dissolved and their sense of self debased.[19]

Ardner[20] used the terms 'dominant' and 'muted' to describe how women were excluded from the formulation of meaning within cultures. He initially suspected this originated as a 'flaw' in anthropological methodology, yet other theorists note a similar flaw in their own disciplines, for example O'Brien in political theory[21] and Oakley in sociology.[22] It seems that the 'dominant' and 'muted' concept transcends interdisciplinary enquiry and is rather a description of an ordering of society manifested in our intellectual traditions and even the structure of our language. Male meanings are the encoded and validated ones:

> When the meanings of women are consigned to non-existence, when the registers for discourse are male decreed and controlled, women who wish to express themselves must translate their experience into the male code.[23]

The knowledge which becomes public and is legitimated in a male dominated society is the knowledge of men; it is based on their own experience and reflects their own perspectives and priorities. Hence: ". . . the absence of a body of accepted knowledge in relation to a problem experienced by women."[24] This enquiry has identified the substance of another *women's problem.* It is the paradox of being seen as nurturing and supporting while performing a highly responsible, active and analytical function. It appears reasonable to link this women's problem with professional dissatisfaction and the loss of midwives to the profession.

REFERENCES

1. Robinson, S., Golden, J., Bradley, S., 'Research Project on the Role and Responsibilities of the Midwife', *Midwives Chronicle*, Parts 1, 2 and 3, 1981 January, pp.11-15, February, pp.49-53, March, pp.74-76.
2. Dempkowski, A., 'Future Prospects of Nurse Midwifery in the United States', *Journal of Nurse Midwifery*, 27:2, 1982, pp.9-12.
3. Rooks, J.B., Fischman, S.H., 'American Nurse Midwifery Practice in 1976-1977. Reflections on 50 years of growth in and development', *American Journal of Public Health*, 70, September 1980, pp.990-996.
4. Kiiver, T., New South Wales, Hospitals and Health Services Commission, *Task Analysis of Obstetric Care: An Investigation of the Health Services Mobility Study (Gilpatrick) Method*, 1976.
5. Barclay, L.M., 'How is the Midwife's Training and Practice defined in Policies and Regulations in Australia Today?', *Health Policy*, 5, 1985, pp.111-132.
6. Fenney, R.J., 'Recognition and Regulation of Midwives', *International Journal of Obstetrics and Gynaecology*, 17, 1979, pp.105-107.
7. Robinson, S., Golden, J., Bradley, S. *op.cit.*
8. Rooks, J.B., Fischman, S.H. *op.cit.*
9. Dempkowski, A., 'Future Prospects of Nurse Midwifery in the United States', *Journal of Nurse Midwifery*, 27:2, 1982, pp.9-12.
10. Colditz, G.A., Sheehan, M.G., 'First Year Medical Students' Autonomy – Its Impact on Response to Courses', in Miller, A., (ed), *Research and Development in Higher Education*, 3, 1980, Higher Education Research and Development Society of Australasia, Sydney.
11. Nursing Personnel: A National Survey, Volume 2. The Report of the Committee on Nursing Personnel Survey, Commonwealth Department of Health, Australian Government Printing Service, Canberra, 1979.
12. Barclay, L.M. *op.cit.*
13. Walker, J.F., 'Midwife or obstetric nurse?' Some perceptions of midwives and obstetricians on the role of the midwife', *Journal of Advanced Nursing*, 1, March 1976, pp.129-138.
14. Kloosterman, G.J., 'The Midwife: Her Task and her Responsibility in a Technical World', (in) *New Horizons in Midwifery*, (ed) Forman, A., Woodville, L., London, International Confederation of Midwives, 1973, pp.48-53.
15. Cartwright, A., *The Dignity of Labour? A Study of Childbearing and Induction*, London, Tavistock Press, 1979, pp.164-166.
16. Spender, D., *Women of Ideas and what Men have done to them*, London, Ark Paperbacks, 1983, pp.1-7.
17. Oakley, A., *Women Confined: Towards a Sociology*, Oxford, Martin Robertson, 1980, pp.44-45.
18. Willis, E., *Medical Dominance*, Australia, George Allen and Unwin, 1983, pp.92-124.
19. Spender, D. *op.cit.* p.4.
20. Ardner, E., 'Belief and Problem of Women', *Perceiving Women*, (ed) Ardner, S., Malaby, 1975, pp.1-28.
21. O'Brien, M., *The Politics of Reproduction*, London, Routledge & Kegan Paul Ltd., 1983, pp.93-115.
22. Oakley, A., *The Sociology of Housework*, Oxford, Martin Robertson, 1974, pp.3-4.
23. Spender, D. *Man Made Language*, London, Routledge & Kegan Paul Ltd., 1982, p.81.
24. *ibid.*, p.368. ■