Intersectionality: The Human Side of Equalities Activism in Midwifery

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**Summary**

Minority stress is a term relating to the experience and internalisation of gender, racial and other forms of discrimination, which can negatively affect health. However, our understanding of minority stress is too dependent on a focus on specific identity characteristics, which does not allow us to understand the impact of multiple intersecting identities and the impact of being minoritised by mainstream cultures for more than one characteristic.

In this article, I would like to discuss the concept of intersectionality, and the very real need for midwives and birthworkers to understand the impact of oppression in medical and social systems on people with intersectional minoritised identities. As a cisgendered, white, lesbian midwife and academic, I feel it is imperative that I provide an example of how someone with my privileged background can start to develop an awareness of the lived experience of others and begin to change the ways in which midwifery is practised through raising our professional consciousness.

**Introduction**

I always sensed that midwifery was heteronormative, largely due to the invisibility of lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, and asexual and/or ally, plus non-cisgender and non-straight identities (LGBTQIA+) people in the books, articles and conversations I experienced during my early years as a student midwife and midwife. The first time I saw unequivocal homophobia within maternity services, I had to advocate for the rights of a lesbian couple, when the co-mother was being excluded from a postnatal ward because visiting time was ‘for fathers’.
The second time I experienced overt homophobia in midwifery was personal, when a student colleague stated loudly in my hearing that lesbians shouldn’t be allowed to be midwives. The third time was a year and a half later, following my own maternity leave, when a senior colleague let it be known that she did not trust me because I was a lesbian. However, throughout my career I have experienced many microaggressions and uncomfortable conversations that provide me with an awareness of a midwifery culture that is not consistently inclusive of LGBTQIA+ people.

**A culture of heteronormativity**

The persistent heteronormativity of midwifery is understandable, yet even after the legal and policy changes that provided recourse for those discriminated against, midwives I knew who were lesbians did not feel safe to ‘come out’. Since then, I have advocated for a better recognition of lesbian parents, and people of diverse gender, sex and sexuality (DGSS) as service users and as colleagues, because I felt this was a site of significant injustice and ongoing harm for expectant and new parents, and for midwives also.

I was warned when I moved into being a midwifery educator and researcher that coming out as a lesbian would be ‘career suicide’. I made it my mission then to make what others saw as my greatest weakness into my greatest strength, and made this part of my professional identity and my role.

The biggest challenge was, paradoxically, to recognise a very simple, and universal truth. We are all complex, multifaceted beings, diverse in our humanity, and being a member of the LGBTQIA+ community is only one aspect of a person’s identity. It is an important aspect for some, not so much for others, and for some, the central focus of their lives because they must constantly and repeatedly advocate for recognition of their identities in a heteronormative, heterosexist world, particularly midwifery and maternity care, which remain entrenched in restrictive cultural tropes.

As an activist now for the decolonisation of midwifery practice, I advocate for a professional world in which the thinking relating to ethnicity and race, linked to patriarchal and capitalist definitions of personhood, value and identity, also addresses gender and identity justice for all.

This requires a knowledge of intersectionality, justice for all people with intersecting ‘characteristics’ (including those defined by the Equality Act 2010). And as useful as the Equality Act is, it does not go far enough to address the challenges
faced by LGBTQIA+ people within midwifery and maternity care, as colleagues or as service users, especially when they have intersecting identities, including ethnic or cultural identities, disability and so on, which can lead to them being marginalised or discriminated against.

To understand intersectionality, we have to draw on those who have already theorised about it.

**An imbalance of power**

Intersectionality ‘concerns primarily how the exercise of power, through intersecting domination and oppression, affects individuals who face multiple social inequities, with consequent multiple marginalizations.’ It requires us, therefore, to understand that inequality is about the power imbalance in our social world. And nowhere is there more of a power imbalance than in the provision of healthcare, and specifically, maternity care, because it is and always has been a gendered field and the site of tension between patriarchal, medicalised concepts of health, illness, the body, and gender, and those of humanistic approaches to people’s wellbeing based on respect and positive regard.

To argue that midwifery and maternity care is both heterosexist and sexist however is contentious, but it has always been my argument that homophobia is rooted in sexism, in a fear of people transgressing the gender roles and power dynamics of heteropatriarchy. To argue that our healthcare systems are racist, colonialist, and discriminatory towards people according to their ability/disability, their health, their body size, their age, social class and other socially constructed labels is also contentious, but we must remember that our very system of medicine is based both within a history of patriarchy and a history of capitalist/colonialist structures.

The hierarchies we still are subjected to as midwives, and the lack of recognition of our specialist expertise, directly derive from this heritage. The ways in which we and our colleagues experience employment are affected by this heritage of medicalisation and the claims for the supremacy of objectivity and so-called scientific rationalism. But as the originator of the term ‘intersectionality’ argues, privilege, discrimination and oppression do not exist in ‘one single categorical axis’. Thus, we cannot see LGBTQIA+ inequality, or equalities activism, as a single approach. We are all much more than the sum of our parts, and to be seen only through one defining characteristic limits our understanding of each other.
People’s unique and individual experiences can be unseen or unrecognised if they are only seen through one single axis of discrimination. People can be rarely defined (or self-defined) by one single aspect of their identity. Therefore, intersectionality, which explores the ways that social categories and processes are dynamically interconnected through enduring inequalities and power relationships can allow us to return to a practice of midwifery that is humanistic and individualistic, seeing people as people, rather than adhering to social labelling that limits our understanding.

Identity politics however is an important part of the lives of many people of DGSS, because all too often they have to repeatedly advocate for their rights and for recognition of their uniqueness and their individual needs. For many, it is important to be seen and known as their true selves, and for their relationships also to be afforded the same respect and value as anyone else, and for their identities to not be stigmatised.

That this stigmatisation occurs in midwifery is evident, both in terms of DGSS and in terms of race and ethnicity. However too often, people of DGSS are in a state of hypervigilance because they must continually advocate for themselves in this way, which can lead to greater stress and poorer health outcomes. This becomes potentially more harmful when there are multiple axes of oppression.

Research shows that people of DGSS share some experiences of healthcare including a lack of trust, affected by negative relationships with care providers – often due to judgemental communication, gender assumptions and lack of inclusive language, vulnerability, particularly due to the need to constantly and repeatedly ‘come out’ to healthcare providers, and racial/ethnic discrimination which increases the stress and stigma of utilising healthcare services.

**Combating discrimination**

To counter this, there must be effective staff training on intersectionality but most importantly, the policies, procedures and practices of institutions must support intersectional awareness and directly counter not only discrimination under the law,
but oppression, inequality and stigmatisation for all service users and staff. Supporting staff with minoritised characteristics to redress inequalities in representation within our services would also be effective, as such staff continue to be under-represented, especially in senior roles in organisational hierarchies.

Regardless of our own identities, however, we should feel comfortable, as midwives, in challenging the status quo, and also challenging our own privilege, unconscious bias and preconceptions, and those of the people we work with. For myself, I feel that I have missed opportunities to do this. I should have asked more frequently why people of minoritised identities remain under-represented in the senior positions of organisations I have worked in. I should have challenged sexist, heterosexist, racist, homophobic, xenophobic and other harmful behaviour, including the asking of irrelevant and intrusive questions of people, and the stereotyping of people according to their ethnicity or culture, which I have observed in my professional life.

**Conclusion**

We, as midwives, are all accountable for providing inclusive, person-centred care, and that includes redressing the balance of power that results in negative health outcomes for women and birth parents. We must, therefore, learn to see people as they would have us see them, providing humanistic care, regardless of and in respect of their identities, taking the forefront in anti-oppressive practice by putting our clients at the centre of all we do. We must view LGBTQIA+ identities as part of the wide spectrum of human life, and recognise that they are one among many parts of the richness and diversity within which midwifery practice, pregnancy, birth and parenthood take place. **TPM**

**References**


Making Waves - Improving Access to Water Immersion in Maternity Units
The evidence

Water immersion for labour and/or birth can be a supportive low-cost, low-tech intervention that enhances women's experiences of their labour and with positive outcome benefits. In a previous article, we highlighted the current evidence in favour of water immersion that demonstrated the positive impact upon women's and birthing people's physical and psychological outcomes, including; reducing pain perception, epidural use, labour duration and hospital transfers; enhancing mobility, freedom of movement, feelings of safety, privacy and positive experiences of labour and birth. Overall, water immersion enhances the neuroendocrinology of a normal physiological labour and is a helpful option for pain relief.

Barriers to access

However, despite these benefits, access to birthing pools can be inconsistent. For example, birthing pools are much less likely to be used in obstetric units than freestanding birth centres or at home, for the same cohort of women. Issues of maternity professionals' lack of exposure, competence and confidence to facilitating intrapartum care in the water are known barriers. These barriers can be reflective of cultural biases, fear, and organisational restrictive policies – however, such concerns do not bear out in the evidence in favour of water immersion. As such, it is incumbent on maternity units to overcome these barriers to offer water immersion as a meaningful choice.

Improving access

Here are some tips to get you thinking about how to improve water access at your maternity unit:

- Carry out a baseline audit to determine your current rates of water use. You may need to adapt your data collection to ensure you are collecting information for labour, birth and/or placental birth as separate entities.
- Then, consider adopting a ‘water champion’ approach. Identify those experienced and passionate for water facilitation who can be a source of expert knowledge and support for others.
- Raise the profile of water immersion to all staff and service users; consider the use of an information board with vibrant pictures and key facts.
- Ensure the pool room is kept free and available for those wishing to use the pool.
- Offer training and update sessions to all maternity staff, using online videos as resources, our previous articles and the online estiMATE blood loss training tool to support education.
- Ensure water immersion is embedded into antenatal classes and information sheets provided during the antenatal period.
- Consider hiring out birthing pools in the community to reduce the cost for individuals.
- Organise regular MDT meetings to raise awareness, share positive stories, troubleshoot concerns and invite women to speak about their waterbirths.
- Where possible (and appropriate, with consent) invite obstetricians and neonatologists to quietly observe a waterbirth.
- Ensure all staff are competent with intermittent auscultation, usual labour care and how to manage emergencies.
during a water birth.

- Finally, continue to audit regularly to see how your methods are working.

**Conclusion**

Water immersion for labour and birth can be hugely rewarding for women, birthing people and staff alike. However, it is essential that midwives seek out the opportunities to feel confident and competent in offering water intrapartum care. Moreover, hospitals from an organisational level must collectively support this choice so more people have access to this option. It is a vital component of respectful and dignified maternity care. **TPM**

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Summary

This study aimed to explore midwives’ experiences of perineal assessment and repair. In-depth interviews with 18 midwives generated three themes of confirming decision-making, justifying to self and others, and space for birth. We found perineal assessment and repair to be complex and embodied. We have named the learning system
underpinning the journey to competence and confidence and recommend its incorporation into any student or preceptorship training model. This would move away from the dissatisfying task approach to perineal care after birth to a more holistic approach that supports women’s wellbeing and their physical function.

Introduction

Clinical examination of the perineum at birth has been labelled as the cornerstone of trauma diagnosis.¹ Despite considerable work in raising awareness of perineal trauma and the design of training modules in assessment and repair, midwives are still reporting a lack of confidence in this skill.²,³ Pre-registration training has been described as poor preparation for perineal assessment and repair in practice, and there has been inconsistency across the country in availability and content of preceptorship programmes to support skills training post qualification.⁴ New midwives have described how a busy labour ward did not always allow for a positive learning environment.⁵

Method

Respondents were recruited through social media to participate in an interview about their experience of perineal assessment and repair. All 60 interested respondents who left their email were contacted by the corresponding author and invited to participate in a single episode telephone interview. A participant information sheet and consent form was included at this contact. Following a maximum of two email reminders, 18 midwives proceeded to consent and interview. The interview transcripts were analysed using thematic analysis.⁶ This supports a critical realist perspective as it goes beyond the words of the data to explore underlying assumptions and ideologies credited with shaping the words of the data.⁷ Each member of the research team independently read and manually coded the transcripts before coming together in a consultative workshop to refine the coding trees and generate inductive interpretive themes.

Despite considerable work in raising awareness of perineal trauma and the design of training modules in assessment and repair, midwives are still reporting a lack of confidence in this skill
Ethics

Ethical approval for the study was given by the University of Oxford (reference R58988/RE001). Transcripts have been de-identified. All participants reviewed and approved the draft manuscript before submission.

Results

Interviews lasted between 23 and 80 minutes reaching data saturation after 16 interviews, although 18 interviews were fully transcribed, analysed and reported. How midwives gain confidence and confirm competence in assessment and repair exposed a vital modality of learning largely neglected in the literature with regards to this area of practice. The three principle themes generated from the data that appear to constitute this learning system were named as confirming decision making, justifying to self and others, and space for birth.

Confirming decision making

A commonly identified barrier to undertaking confident perineal assessment and repair was the ‘theory-practice gap’. Many of the respondents cited difficulty in reconciling education and skills training undertaken using ‘simulated’ methods, with face-to-face assessment and repair of a woman’s perineum. ‘It’s really difficult because they give you models… it is a practical session, obviously, but it is quite difficult to simulate human flesh and skin… try and do this, you know, when you’re faced with a perineum that’s falling apart.’ (P1) The relative complexity of ‘real-life’ perineal assessment and repair described by participants seemed to be linked to a need to discuss cases with colleagues to ‘confirm’ decision-making. Participants discussed referring to midwifery mentors, peers, seniors and obstetric colleagues for opinions on assessments in particular. This was a dominant theme across almost all the interviews: ‘Most of our births would have a second MW so you always have somebody even to compare, what do you think about this or would you do this here.’ (P3) Although the need to confirm decision-making was identified by several less-experienced participants, it was by no means limited to them, suggesting that confirmation was not just a tool for developing competence. A very experienced midwife, practising for over 20 years remarked: ‘If in doubt you’re always gonna ask a colleague or always gonna ask the coordinator or the registrar or the consultant … you know if you’ve got any doubts at all you’re gonna seek a second opinion.’ (P5)

The need to confirm decision-making with colleagues is an ongoing phenomenon, central to the development of competent and confident practice

The support and dependability of colleagues appears to be an important component in confirming decision-making, of getting decisions right for women. Several discussed this in very empathic terms: ‘It doesn’t matter if you’re a band 5 or top of band 6 or you’re a band 7, if there’s something that you think, I’m not really sure, always, always get somebody to come and have a look or come and support you, come and help you because you’re dealing with people’s lives, you know. It’s not just kind of thinking, you know, shall I put this tyre on the car.’ (P1) Several participants described the systems for assessing competence in their practice areas. There was significant variation in the accounts given. Despite recognition of the critical importance of experiential learning opportunities – ‘Yeah, yeah, that’s like 90% of it I’d say, or 99%, as that’s how we learn.’ (P7) – there was a consistent requirement for some kind of formal confirmation of competence. The judgement that competence is achieved through a formal ‘sign-off’ process, after a certain number of repairs have been completed, was identified as problematic: ‘We had to suture three pairs, no, five pairs before you could be signed off as being competent. It doesn’t necessarily mean you feel confident, and so I’d still get someone to look over my shoulder.’ (P11) This suggests that the need to confirm decision-making with colleagues is an ongoing phenomenon, central to the development of competent
and confident practice. Theoretical knowledge and technical skills developed via simulated teaching reinforce the notion of ‘taskifying’ the perineum – reducing it to a disembodied fragment of a woman’s anatomy. This is problematic for midwives, as a reductionist approach to assessment and repair does not truly reflect what they need in order to develop competence.

The feedback loop of reviewing women postnatally increased confidence in future perineal assessment and decision making – while this was seen as a gap in learning from the institutional setting.

**Justifying to self and others**

Popularity of the OASI Care Bundle was felt by some respondents to have emphasised a culture of culpability in midwifery practice. Across the interviews participants felt they must justify their practice and deviation from guidelines to themselves and colleagues or risk blame. ‘... I do feel like I was trying to explain myself a little bit.’ (P12) While defending the unpredictability of birth, participants expressed guilt, as if betraying their colleagues and the woman by crossing the boundaries of practice out of normal birth to interventional. There was also a sense of solidarity with birthing women originating from an embodied position of understanding: ‘Because the perineum is something important and you only have one for the rest of your life.’ (P13) This awareness conferred a sense of responsibility on the attending midwife and either led to motivation for training and support to do the best job in assessment and repair, or avoidance. Avoidance was framed in a context of fear: ‘I mean everybody has their thing that they are scared about doing, haven’t they’... I’ve heard from colleagues that suturing is their “bête noir”.’ (P8) The cultural split between technocratic labour ward practice and ‘low-tech’ community practice was very apparent in respondents, and raised an interesting challenge to institutional birth practice.

Some experienced community midwives justified their lack of suturing as a conscious decision. ‘The perineum is designed to accommodate a baby’s head... that must mean that some kind of trauma is normal, then the body surely must be equipped to deal with it. People do heal nicely without sutures.’ (P14) A young midwife who had moved into community practice spoke...
of anxiety after her hospital-based training, but after three years of practice feels confident in her decisions not to suture a tear. The feedback loop of reviewing women postnatally increased confidence in future perineal assessment and decision making - while this was seen as a gap in learning from the institutional setting: 'I wouldn’t know how many would come back with problems after that, you don’t find out as a MW.’ (P3) A number of midwives wished to convey the complexity of perineal care, while championing the art of midwifery in optimising a woman’s physiology for birth. Participants tried to justify the importance of relationships, trust and birth support as a significant contributor to perineal care, quoting from the intuitive knowledge base of midwifery. ‘I’ve been a MW for 20 years and I don’t know who will tear until I know.’ (P14) ‘The most important intervention for the woman is the MW herself... the mother-MW relationship.’ (P9) While the theme of justification sits as a defence to perceived challenges to decision making in the unpredictability of birth, it also reinforces decision making to the self and others by verbalising the experiential and intuitive evidence base of clinical judgement in practice. Until the clinical judgement of a midwife is captured in the language of ‘evidence’, midwives will have to justify their perineal care decision making and practice to themselves, their colleagues and birthing women.

Space for birth

The birthing space was felt to define action of the attending midwife in relation to the use of her skills toolbox and the influence of time. Within a community setting, if the woman sustained a tear, many community midwives felt deskilled in suturing and would not hesitate to transfer into the labour ward for repair. Some cited a lack of suitable lighting or supportive surface, others were open about their strengths being in different areas of practice. ‘If we only have 35 deliveries a year and then you are suturing five of them, is that good enough to maintain a competency? I don’t know that it is.’ (P14) Time was felt to be a significant factor affecting the space of birth in community or hospital, especially in relation to perineal assessment and repair. Time was considered an important component of the learning journey, being given freely as a pre-registration midwife or preceptee. ‘First of all, it’s about having the time, to supervise someone, to talk through with somebody, to go through step by step when you’ve got a busy unit, you know, raging around you.’ (P2)

However, time became a precious commodity once the midwife was deemed competent in assessment and repair. The focus moved from skill acquisition and support to keeping the process of the busy labour ward moving. The complexity of perineal repair was felt to be devalued and taskified by the time pressure of the unit with an expectation that the midwife would ‘just do it’. ‘They think, “oh come on, you are signed off on your competencies, you should be able to do this by now”... It’s almost like a taboo that you should be able to do.’ (P12) ‘I’ve seen my colleagues... come in and say things like “Well, that’s only a small little tear, come on, you can do that, get on with it.”’ (P7) Unless the midwife actively asked for help, she was absorbed into the workflow of the unit, impacting confidence and continued competence. ‘...It’s not something we necessarily have to do every single day, erm, your lack of confidence because of that maybe, the lack of practice.’ (P13) ‘If a woman has just been admitted who is 8cm dilated, I’m going to move that midwife and get someone else later to sort the suturing. I have to meet the constantly moving priorities of the workflow on labour wards.’ (P6) The pressure of keeping the system moving, alongside midwives’ sense of responsibility to the women they support, invaded the space of birth. This impacted participants’ confidence and maintenance of competence in perineal assessment and repair through restrictions on time, continuity and the availability of support.

Discussion

In contrast to the competence ‘sign-off’ that taskified the perineum - reducing it to a disembodied fragment of a woman’s anatomy - was the value put on experiential learning of an intuitive knowledge base built up through talking with and learning from each other about the whole birth journey. This approach is central to midwifery practice (see box). The
feedback loop from colleagues also reflects an accepted style of practice-based clinical learning, allowing discussion, explanation and rationalisation based on the individual context presented by the perineal damage. Unfortunately, the context of the birth process does not always support this learning style because of time pressures and skill mix. Since accountability inevitably lies with the individual midwife if hospital-level training is not felt to be adequate, this can lead to avoidance of suturing. The issue of keeping the process moving underlay participants’ need to justify the time spent on perineal care, suggesting its low-priority status in the workload of the birthing unit. Midwives also felt the need to justify their practice and care decisions in the increasingly culpable practice context felt to accompany the OASI care bundle, even if colleagues are supportive. Justification of practice and solidarity felt with women facing perineal trauma emphasises the midwives’ focus on long-term perineal health of the woman, illustrating an embodied and holistic approach to care.

Limitations

The participants of our interview study were self-selecting but reflected a national picture of practice variation across birth contexts independent of years of qualification.

An experiential and supportive learning system underpins the journey to competence and confidence in perineal assessment and repair

Conclusion

The findings of this study recommend an expansion of the practice-based competency models of the preceptorship year to all maternity units to consolidate and build upon the foundation of learning achieved as an undergraduate. An experiential and supportive learning system underpins the journey to competence and confidence in perineal assessment and repair and would do well to be formally recognised and incorporated into any training model. This would move away from the dissatisfying task approach to perineal care after birth to a more embodied, holistic approach that supports women’s wellbeing as well as their physical function. TPM

Practice recommendations

- Valuing the role of a trusting relationship and development of an intuitive knowledge base through talking with colleagues about the whole birth journey can support detaskifying the perineum.
- Offering the designated support of a colleague on shift to discuss and support assessment and repair could build the confidence midwives need to maintain their competence.
- Working with system constraints to value the perineum and appreciate its long-term role in the life of the woman to allow space for embodied and holistic care.
- Incorporate a feedback system of perineal healing through the community midwife team to confirm good practice and build confidence among midwives in their skills.

References


Cultural Safety in Midwifery Practice – Protecting the Cultural Identity of the Woman

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Summary

This paper discusses the importance of cultural safety in midwifery practice. Recently the NMC (Nursing and Midwifery Council) produced standards on proficiencies for midwives stating the importance of combining clinical knowledge with cultural competence during midwifery practice. However, it is suggested that midwives should be engaged in working towards ‘cultural safety’ and be prepared to challenge their own culture and cultural systems rather than prioritise becoming ‘competent’ in the cultures of the women they care for. We must acknowledge the impact of midwives’ professional and workplace culture on providing culturally safe care during pregnancy. In particular, the importance of midwives acquiring cultural safety during practice is key and the strategies that can be used to achieve this.

The concept of cultural safety

The concept of cultural safety has been around since the 1980s and was developed in New Zealand to cater for the needs of the indigenous Maori population. Williams states the concept of cultural safety as an ‘environment that is spiritually, socially and emotionally safe, as well as physically safe for people; there is no assault, challenge or denial of their identity, of who they are and what they need’. In contrast to cultural competency, the focus of cultural safety moves to the culture of the clinician or the clinical environment rather than the culture of the woman. Women should be valued as cultural beings
who have a personal view of how they wished to be cared for during pregnancy. Cultural safety stipulates that midwives should not focus on learning cultural customs of different ethnic groups but focus on being aware of differences, consider power relationships, implement reflective practice, and allow the woman to determine whether a clinical encounter is safe. Unsafe cultural practice comprises any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual or does not recognise the cultural identities of individuals. Cultural safety is needed in midwifery practice and should be a basic human right for all pregnant women.

**Midwives’ professional culture**

The midwifery profession has developed a culture with norms and beliefs guided by the statutory framework of the NMC that may impact on the achievement of cultural safety. Midwifery culture may also be internalised by individuals entering the profession created by training and teaching methods, which individuals adopt in order to become part of the profession. The professional code of conduct specifies how a midwife should behave in order to maintain the integrity of the profession. The midwifery professional culture may be conformed to despite the individual midwife’s own cultural beliefs. It is alleged that healthcare professionals tend to lean towards ethnocentrism, whereby a person judges the culture of other people from the point of view of their own culture. Any ethnocentrism in midwifery practice may result in a disregard of other cultures and lead to dominance of one’s cultural beliefs over others, which conflicts with the concept of cultural safety. Unfortunately, midwives have been socialised into assuming control as part of their autonomous role, resulting in failure to identify and legitimise the cultural identity of the women they care for.

**Workplace culture**

The workplace environment also has influence on the individual midwife’s behaviour and views. A workplace environment can influence how things are done, who does what, and defines the hierarchical structure of an organisation. Workplace culture is comprised of behavioural norms and practices that are expected and ‘allowed’ within a workplace. If there are particular ways of performing or behaving in a workplace, this may become an integral part of a midwife’s beliefs and attitudes. There may also be conflict between the midwife’s beliefs and workplace practices that impacts on the quality of care that is provided to women. Some maternity units may have adapted practices that embrace women’s cultural needs or this could be the opposite. The woman’s cultural needs may fall to the bottom of the agenda when there is overwhelming
pressure on maternity services such as during the COVID-19 pandemic. Cultural safety acts as a buffer against factors that impact on service provision which in turn may affect the quality of care.

**Integrating cultural safety into midwifery practice**

**Using critical consciousness**

It is essential for midwives to recognise the assumptions and beliefs behind their thoughts and actions; they should recognise that the way they practice midwifery is influenced by their beliefs. There is a call for midwives to understand the bicultural nature of the patient-practitioner relationship, beginning with themselves, their own race, culture and imprinted stereotypes.

Midwives need to be engaged in working towards cultural safety during midwifery practice by using critical consciousness.

To do this, midwives must be prepared to critique the ‘taken for granted’ power structures and be prepared to challenge their own culture and the cultural systems in which they provide midwifery care. This challenge of the midwife’s own culture should be a subconsciousness process on a daily basis when caring for any woman, something that is always ‘at the back’ of the midwife’s mind.

**Involving women in decision making**

Midwives should regard cultural competence as representation of good clinical practice and should regard each woman in the context of her own culture, as well as from the perspective of their own cultural values and prejudices. Taking this approach inadvertently sets a basis for a culturally safe interaction where the woman is able to verbalise her views and foster a trusting relationship. Culturally safe midwifery practice can be achieved when there is no unintentional disempowering of women: indeed, where women are involved in the decision making and become part of a team effort to maximise the effectiveness of their care. This should be a requisite for all midwife-client interactions; asking the woman to discuss her care needs at every stage during pregnancy opens up the opportunity for such interactions to occur.
Conclusion

Midwives need to be made aware and educated on the tools that can be used to develop cultural safety. Developing critical subconsciousness of cultural views is required by a midwife when caring for women and understanding that involving women in decisions made about their care is crucial for cultural safety. In particular, acknowledging that it is the woman who states that she has received culturally safe care is relevant. Organisations should be aware of any workplace cultures that can impact on the midwife placing the woman’s culture at the centre of her care and allowing her to be involved in decisions about her care. Adopting these approaches can achieve cultural safety and effective midwifery practice that places the woman in a culturally safe environment and protects her cultural identity. TPM

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Midwifery Units in England: Time for Urgent Change

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Professor Helen Spiby
Summary

In the fourth and final instalment of this series, this article focuses on our research exploring the barriers and facilitators affecting midwifery units (MUs) in England. We conclude that they are still not available in about 25% of hospitals, and where they are available, they are underused. After 10 years of good-quality evidence supporting them as the preferred option for low-risk women, MUs are still not viewed as an equal and complementary provision alongside the traditional labour ward. Based on findings from our research, this article discusses why and what can be done about it.

The original paper can be found here:
https://bmjopen.bmj.com/content/10/2/e033895.full?ijkey=87FIooytMBH5eug&keytype=ref.

Introduction

Despite NHS maternity care policy and NICE guidance in England recommending midwifery units (MUs) for women at low obstetric risk,\(^1,2\) they remain a marginal choice for most women. Since the publication of the results of the Birthplace in England study in 2011,\(^3\) both the availability and use of MUs have risen, and usage now stands at around 15% of all births.\(^4\) However, this is much lower than a potential 35% based on Sandall et al’s population-based cross-sectional study of women who gave birth in England 2010-11.\(^5\) Specifically, the caesarean section rate fell from 11% to 4%, the assisted vaginal birth rate (forceps and vacuum assisted) from 15% to 7% and normal birth rate rose from 74% to 86% in alongside midwife units (AMUs) and 91% in freestanding units (FMUs). In addition, augmentation of labour with intravenous oxytocin fell from from
23% to 8.5% and the episiotomy rate from 19% to 10%, with no increase in serious tears. Outcomes for babies for women birthing in MUs were no different from OUs. FMUs had particular safety benefits for mothers, with lower rates of postpartum blood transfusion (0.48) or admission to high dependency care (0.32). The Birthplace study also found that having a baby in a MU was more cost effective – taking into account both costs, which were lower, and outcomes. On the basis of these results, maternity care policy was strengthened and NICE clinical guidelines were updated to encourage women to choose MUs. Since this time, international systematic reviews have backed up these findings.

Our research mapped the availability and uptake of MUs in England since the Birthplace study, finding that the number of births in MUs had almost tripled from 5% in 2010 to 14% in 2015, although there were still 32 NHS Trusts without any MUs. The growth in the availability of MUs was confined to AMUs, which increased from 53 to 97. The increase in the numbers of FMUs was marginal, from 58 to 61. A more recent survey confirmed this trend, with the numbers of AMUs now 112 and FMUs still 61. In addition, our study found that the percentage of all births occurring in MUs varied enormously across the country, but the majority were birthing between 10% and 20%. Only one hospital achieved more than 30%. As already mentioned, this is well short of a potential 35%.

Operational factors

Two findings from our mapping of organisational processes shed light on why MUs are struggling to increase capacity and utilisation.

Ninety seven percent of AMU midwives and 50% of FMU midwives were moved regularly during shifts, usually to the obstetric unit (OU).

This had serious implications for the functioning of MUs. Twenty eight percent of AMUs and 39% of all FMUs were closed regularly. AMUs that were birthing 10% or less of all hospital births were closed three times as frequently as those that birthed 20% or more. This situation resulted in MU midwives providing care for low-risk women in OUs while AMUs and FMUs stood empty.

We also found that the use of AMUs was increased by maternity services operating an opt-out policy, so women who met eligibility criteria were defaulted to them unless they opted otherwise, rather than a more traditional OU opt-out policy. In addition, it appeared that services with a consultant midwife specialising in MUs improved MU use.

The main focus of our research was to examine in-depth barriers and facilitators to the uptake of MUs in order to illuminate underlying processes that influence this. We did this by undertaking individual interviews with key stakeholders and by conducting focus groups with midwives and service users in six NHS hospitals across England. The remainder of this paper summarises our findings.

Medicalisation and risk

Five decades of OU birth, for the vast majority of women in England, has contributed to an institutional and wider societal view of birth as risky, requiring obstetric oversight and a low threshold for medical intervention. We found that a number of managers, clinicians and service users were concerned about risks associated with birth and assumed OUs were inherently
safe and the best place to birth. Some managers and clinicians mentioned the spectre of litigation as a rationale for obstetric surveillance and obstetric intervention. Coxon et al suggest that the construction of birth as risky in policy initiatives and by service providers has shaped women’s preference for birth in OUs.12

Our research demonstrated that birth in OUs is the embedded and ‘taken for granted’ model, and MUs are positioned as an optional extra, struggling for legitimacy as an equal partner.

The managers and practitioners who support MUs often faced obstruction when they tried to open or improve use of a MU in their hospital. Despite this tendency, we also found that women reported lack of information and advice from professionals about MUs services and the evidence in relation to where to plan to give birth. Many women explained that they had not known about the existence of the MU or that this was available to them.

Beliefs v evidence

Despite the clear evidence of the benefit of MUs and maternity policy recommending their use, we found that some managers, midwives and clinicians in provider settings harboured considerable ambivalence about the safety of MUs and tended to view them as an unaffordable luxury. It is known that personal belief can moderate evidence13 and is a key variable to address in systematic reviews of what facilitates the translation of evidence into practice.14 FMUs were especially vulnerable to negative beliefs about their efficacy. Unfavourable media coverage of FMUs contribute to this perception as demonstrated in a recent paper.15 We suggest that the increased numbers of AMUs compared with FMUs since the Birthplace study reflect these beliefs.

Financial constraints

Financial constraints within hospitals were often seen as limiting the development of MUs even though economic evaluations suggest the overall economic outcomes of increasing births in MUs are positive.7 Most managers we interviewed alluded to the start-up costs of MUs, but the longer-term savings from lower morbidity in the target population that accrue across the health system were not recognised. We gained the strong impression from managers that, in a climate of scarcity related to economic austerity in government policy, new ways of organising healthcare must demonstrably save money, or at least be
perceived to in the short term. FMUs were more vulnerable to this and were performance managed closely on achieving maximum capacity. This mitigated against their sustainability, resulting in them undergoing a recurrent cycle of threat of closure and sometimes reprieve.

‘Us and them’ culture

Although we found examples of constructive relationships between MUs and OUs, we also found an ‘us and them’ culture in several case study sites. OUs tended to dominate this relationship with MUs having to fit around their demands and workload. FMU staff occasionally experienced institutional bullying from host OU staff, which manifested in a hostile interface during intrapartum transfer. FMU staff, including managers, often felt marginalised in decision-making about FMUs’ future. Hospitals with positive relationships between OUs and MUs promoted their MUs to service users, often having a target for the number of births they wanted to achieve.

Loss of skills and confidence in normal birth

A defining characteristic of MUs is that their functioning is entirely dependent on midwives, because they are midwife led and managed. Skills in managing normal labour and birth and decision-making autonomy are prerequisites for practice in this setting.

> Our findings highlighted a lack of midwifery confidence and skill, which can be traced back to the training and practice of UK midwives within predominantly obstetric-led services.

Numerous surveys and papers have demonstrated this over the last 30 years, since Robinson’s pioneering research on the loss of traditional midwifery skills in the 1980s.\(^\text{16}\) Midwives, in particular, spoke about this, and focus groups and some services have introduced mandatory normal birth skills training to address it.

Clinical pathway issues

Focus groups with service users revealed an unclear and confusing pathway for accessing MUs in many case study sites. Information about the choice of an MU, the eligibility criteria, how and when women can plan to give birth in one, and then access it at the start of labour, were not standardised between sites and even within sites. Some women did not even know they had given birth in an AMU, as previously demonstrated by McCourt et al in the context of AMUs.\(^\text{17,18}\)

Importance of leadership

Overall, our findings highlight the significance of leadership to installing MUs as an equal partner with OUs. This leadership needs to be exercised vertically, via the layers of organisational hierarchy, and horizontally across different professional groups, so there is ownership and commitment to embedding the MU model. We found, from the more successful case study sites, that an important component of leadership was the identification and subsequent impact of having MU ‘champions’. Champions were clinicians, managers or service users who were highly influential in promoting the service and recruiting support for it. Service user partnership was also a key factor in the success of MU establishment and utilisation.
Conclusion

English maternity services are struggling to establish MUs as a parallel service to their OU provision, despite 10 years of evidence and policy endorsing them. Our study revealed a complex interplay of factors influencing the existence and utilisation of MUs. We identified multiple contributory factors, including: broader societal perceptions around risk, medicalisation and cost, the beliefs of service providers (that are at variance with evidence), suboptimal organisational processes, a loss of midwifery confidence and skills in normal birth, and a negative organisational culture between MUs and OUs. Among a range of strategies, pro-active enabling leadership is crucial at both a strategic and clinical level, within local maternity services, to address these factors. Good practice in the above is being demonstrated in some services in different geographical areas of England and it is essential for the expansion and sustainability of MU provision that this is widely disseminated. TPM

Acknowledgments

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References


Summary

In the UK, Black, Asian and minority ethnic (BAME) women are more likely to die during pregnancy and after childbirth compared with white women. A recent spotlight on ethnic disparities in maternal deaths has rendered a much-needed discussion on maternal health outcomes and experiences of maternity care for BAME women. The increased risk of death is unexplained by researchers, healthcare professionals and public health officials. This article, the first in the new series ‘Racism matters’ seeks to unpack these issues to challenge, educate, and to drive improvements in maternity care. Here, Anna Horn, a Black American woman, UK maternity service user and equity advocate offers insight into a deeper, systematic and historical precedent of racism and injustice as underlying contributor to health inequalities.

The dream

This moment in time didn’t arrive without careful thought, consideration, grit and a call to greet the unknown and what-ifs with open arms. You’ve dreamt about this moment for years and finally you’re pregnant. You and your partner are on your way to building the life you imagined for yourselves over many nights of pillow talk. Immediately your mind goes to tiny booties, baby names and how you plan to share the news with family and friends. Now imagine you’re a Black woman.

The nightmare

Only a quick Google search highlights British media coverage of high-profile Black women, such as singer Beyoncé and tennis star Serena Williams, famously opening up about the difficulties that Black women face around pregnancy and soon after childbirth. As a Black woman in the UK, you may be falsely assured that the increased risk of death that Black women face in pregnancy and around childbirth are unique to our sisters across the pond. However, latest national reports show that Black women in the UK are the most likely to die from pregnancy and childbirth-related complications compared with white women. The guards go up, the fear creeps in and you’re suddenly in survival mode, desperate to protect yourself, your unborn baby and the family you’ve worked hard to create.

The fear and mistrust
To understand why Black women mistrust maternity services, we must also consider the wider context of the institutional racism which infiltrates our education, justice, housing and employment systems. Why should we, as Black women, believe the healthcare system has been excluded from systematic strategies crafted to innately benefit the middle class and very wealthy white people?

Fear and mistrust of maternity services doesn't start at conception and amplify in our expanding wombs. We carry the fear and mistrust of our mothers, our grandmothers, the wider African diaspora and our shared ancestors. In western society, people have shown us who they are for generations and thus, we believe them. Our concerns about our lives, the lives of our children and our communities are steeped in the direct consequences of the lack of equity, diversity and inclusion.

From slave breeding farms, to forced wet nursing and the inhumane treatment of enslaved Black women to perfect the surgical techniques of J Marion Sims, known as the father of gynaecology, there’s a longstanding history of the dehumanisation of Black women’s bodies that still rings in the ears of Black women today. Not only are our bodies still under attack, but also like many mothers, we fear for the health and safety of our children. Of the neonatal deaths that occur in England and Wales, white babies continue to have the lowest occurrences. Those of us who are lucky enough to take our babies home from the hospital then have the added responsibility of teaching our young people about how to get safely back home to us.

Unfortunately, the fear of violence, injustice and discrimination against our children is as a part of Black motherhood as daily school runs.

Take, for example, mothers Doreen Lawrence and Sybrina Fulton, who both lost their sons to racist attacks. On 22 April 1993, Doreen’s 18-year-old son, Stephen Lawrence, was stabbed to death by a racist group while simply waiting at a London bus stop. Nineteen years later, on 26 February 2012, Sybrina’s 17-year-old child, Trayvon Martin, was shot to death in Florida by a self-appointed neighbourhood watchman. Both mothers continue to fight a system and a culture that did not
see their children as victims, or even as human beings.\textsuperscript{10,11,12}

The silencing

Therefore, many Black women are not surprised by the ethnic disparity in maternal deaths. There is a shared historical, political and social lived experience that Black people have endured for generations, which makes this horrific disparity a reality. We are also not shocked by the discomfort race brings when the topic is raised in the birth world. Very publicly, there have been attempts to silence Black women who bravely share their experiences as mothers. Social media influencer Candice Brathwaite (@candicebrathwaite on Instagram), was accused of ‘playing the race card’ when raising the lack of diversity in the white majority online world of ‘mum influencers’.\textsuperscript{13}

On the ground, organisations that are built to provide support to mothers and ensure that their voices are included in the implementation of maternity services are often absent of women of colour. I’ve also experienced, first hand, healthcare workers questioning the validity of ethnic disparities and reports of bias treatment by Black women.

In turn, as a Black woman, I was expected to provide evidence, education and an explanation for the race disparities within maternity services.

I’ve also witnessed on two occasions Black women being scrutinised for requesting pain medication. Is it because healthcare professionals didn’t believe their pain? Given the stressors and racial discrimination that many people of colour often face, one experiencing this situation can’t help but wonder. Most midwives may protest in disbelief that such an event ever occurred. After all, the heart of midwifery philosophy is to put the woman at the centre of care. Many midwives would even say that it would never happen in their practice or the practice of their colleagues. If we can’t listen to each other, then how can we make a positive change?

The truth is there are complexities to improving maternity services, including inequalities. Like many other minority voices, Black women need to be believed. We need to be included, and not superficially, to give an illusion that an organisation is diverse. We need to be on the frontlines of maternity care, on boards and committees at the local and national levels.

The call to action

Very famously, American poet and civil rights activist Maya Angelou said:

‘When people show you who they are, believe them.’

Many Black women feel as though we are set up to fail and our experiences in maternity services are no exception. After all, a white patriarchal society has shown us who they are – and we believe them. There is an on-going effort to make maternity services better for women, babies and their families. Many people of all races, ethnic backgrounds, national origins, genders and social backgrounds are working hard to ensure that every voice is heard and policies, practices and work culture in maternity services enable people to have the best experiences and health outcomes. I challenge those who are working in the birth world to show us who you are by addressing inequalities, discussing race and being open to the experiences of people who are different to you – no matter how difficult or unpleasant. Show us who you are and we will believe you. TPM


Compassion as a Powerful Intervention: How the interactions between women, midwives and maternity services influence women’s childbirth experiences and subsequent trauma

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Summary

This article combines work from two separate PhD research studies by Dr Jenny Patterson and Dr Diane Ménage. These studies explored, from different perspectives, how the nature of interactions between midwives and women may contribute to, or prevent, trauma. The findings are presented and discussed. Jenny and Diane argue that their joint findings add new insights and show that the compassion shown during interactions between midwives and women may be key to preventing experiences becoming traumatic for women and midwives. They uphold compassion as a vital human connection in midwifery care and the workplace culture as key to sustaining it.

Introduction

The whole is more than the sum of its parts.¹
Two midwives independently carried out PhD research projects on different aspects of the experiences of midwifery care. Jenny Patterson researched women's and midwives' experiences related to traumatic births. Diane Ménage researched women's experiences related to compassionate care. Both used a qualitative methodology called Interpretive Phenomenological Analysis (IPA) to elicit rich, meaningful data on participants’ unique experiences. IPA, now a well-established methodology for studying lived experience, draws on the philosophical principles of interpretive (or hermeneutic) phenomenology. Jenny and Diane did not know each other or about each other's studies until they met at a conference near the end of their research. Later, when both had completed their research, they discussed their findings and realised that somehow, surprisingly and quite independently, their separate findings appeared to depict the same things. They had, in fact, been studying opposite sides of the story. This paper outlines both studies and argues that, together, their evidence provides important insights into the nature and impact of different interactions between women and midwives.

Summary of Jenny's findings

Birth trauma and related Post-Traumatic Stress Disorder (PTSD) symptoms are distressing complications of the childbirth experience. For up to 45% of new mothers, their childbirth experience fulfils the clinical definition of trauma: ‘To have experienced or witnessed, actual or threatened, death or harm’. Furthermore, some women go on to develop full (4%) or partial (9-27%) Post-Traumatic Stress Disorder-Post Childbirth (PTSD-PC) with negative impacts on women, children, families and wider society. A woman's perception of her interaction with her care providers is a significant factor in the development of Birth Trauma and PTSD-PC. Therefore, Jenny chose to hear both sides of the story of the lived experience of interacting during maternity care, from the perspective of women with full PTSD-PC and midwives.

Jenny’s findings found that the women and midwives all expressed the importance of and strong desire to ‘be with’ the other. This ‘being with’ encompassed relationship, communication and understanding individual needs, alongside a level of connection that enabled the provision and receipt of respectful care. Traumatic memories for the women frequently related to times when this ‘being with’ was non-existent, dysfunctional or became lost. Similarly, for the midwives, great distress arose when they were unable to ‘be with’ women in the way they desired, leaving them feeling that they were not fulfilling their role. When women and midwives did not experience ‘being with’ they described feeling abandoned or abandoning. This was most profoundly felt in the time directly after the birth of the placenta, when midwives were instructed to go to care for another woman. The midwives described this as the worst thing.

Key themes related to meeting basic human needs, especially to feel safe. The women described sometimes feeling directly threatened by midwives, either verbally or physically, leaving them fearful for themselves and their babies. They could not believe this was happening. Their (realistic?) expectations of being in a place of safety (hospital), in the hands of those who should be trustworthy, were shattered.

Women’s shattered expectations related not to the process of birth, but how they felt treated by those they expected to trust. For midwives, they described unrelenting workplace pressures, coupled often with undermining and unsupportive behaviour by colleagues. This left them feeling ‘torn in two’ between ‘being with’ women, meeting women’s needs and meeting the demands and expectations of the workplace and colleagues. Midwives also experienced a lack of personal or professional support in response to clinically challenging or traumatic events. These experiences can contribute to trauma and the development of PTSD for midwives, which is a significant concern affecting up to 33% of them. The term Sanctuary Trauma is equally applicable for both the women and the midwives:

In balance, most women find their interactions with midwives to be positive and affirming, and many do not develop birth trauma, and even less develop PTSD-PC. This is likely due to the amazing dedication of many midwives, who even in the face
of clinical and organisational challenges remain ‘with woman’.

**Summary of Diane’s findings**

In contrast, Diane’s PhD examined women’s lived experience of receiving compassion from midwives. Women who self-identified as having had compassionate care from a midwife or midwives were interviewed about this experience. Arguably, the most striking theme
was Women’s Need for Compassion, which supported the concept of compassion being a response to suffering.\textsuperscript{14,15} Women spontaneously described their experience of compassionate midwifery care in the context of emotional and physical vulnerabilities and difficulties around pregnancy and birth. This suffering most often related to fear and anxiety, but physical and emotional pain also featured widely. Importantly, the women told of how compassion from a midwife helped them to feel less fearful and more able to cope.

Three themes represented the ways in which women experienced compassion from midwives. ‘Being with’ reflected the feeling that there was something about the way that the midwife was with the woman that was at the heart of compassion. Being with was about being present, attentive and tuned in to the woman. Relationship encompassed the ways that midwives showed compassion within a relationship with the woman. This moved beyond the midwife’s attentive presence and involved the midwife and woman having an authentic interest in each other as people. The theme of Empowerment highlighted the ways in which women felt compassion from midwives through interactions that helped them to feel more empowered. These included giving information, teaching and coaching women in a non-authoritarian way. Women talked of midwives who empowered them by providing them with knowledge and skills while simultaneously being ‘on their side’ or ‘on the same level’. Furthermore, the theme of Balance came out of women’s ability to see very clearly how midwives have to balance different aspects of their work in order to interact in compassionate ways. Women not only identified midwives who managed to do this but also spoke of situations when midwives were unable to balance conflicting demands and therefore unable to show compassion.

The findings suggest that midwives are constantly trying to balance the organisational demands on them with quality, compassionate care for women. While the balance is successfully maintained, so is compassionate midwifery. However, it is a precarious balancing act at times. Once the balance is lost, then so is compassion.\textsuperscript{13}

**Parallels**

Both studies point to the same thing from different angles.

Jenny’s study uncovered the reality of Sanctuary Trauma when a less than optimal interpersonal response is made towards women by those who are considered responsible for their wellbeing. Meanwhile, in Diane’s study, sanctuary in the face of suffering was experienced by women through compassionate care.

Both studies highlight the underlying essential human need for connection, respect, and to feel safe and supported.

A human experience, childbirth intensifies these needs. Childbirth creates particular vulnerability: psychologically; physically; and hormonally,\textsuperscript{13} alongside the potential for suffering, all compounded within the complex, risk-focused culture of modern maternity systems, which feed fear for both the woman seeking safety and the midwife responsible for maintaining safety.\textsuperscript{17}

Essentially, high-quality compassionate interactions happen when midwives show a very human response in conjunction with their professional role. This very human response may be demonstrated in many different ways but was clearly epitomised in Diane’s study by the symbolism of tea. Offering, making and sharing tea for women and their partners highlighted how midwives used this ordinary, non-clinical action to show caring, as a friend or family member might do. This small act of ‘looking after’ appeared to echo a form of kinship that increased women’s feelings of connection, safety and normality, and had a calming and grounding effect. While tea has had some recognition within healthcare more widely,\textsuperscript{18} until recently there has been little empirical evidence of its place in midwifery care. Calls for a more humanised approach to childbirth\textsuperscript{19,20,21} support the idea that women using maternity services must be seen as unique human beings first and
foremost. Therefore, culturally embedded rituals and symbols of human connection (like making tea) are important aspects of humanised care.

**A deeper understanding of the role of interaction**

These convergent findings are consistent with wider research highlighting the central role of the woman/midwife interaction. Whether this interaction constitutes a short-term connection or some level of relationship, the perceived experience of this interaction clearly influences a woman’s perception of her childbirth event.

**Are midwives to blame?**

On the face of it, a poor interaction in which women feel dismissed, chastised or ‘like a bother’ to the midwives, and do not find their midwives to be compassionate could be seen as poor behaviour by midwives. On the other hand, interactions that women experience as compassionate or where they develop a strong bond or relationship, even for a short time with their midwives, could be seen as a job well done by midwives. Either interpretation potentially places responsibility or even blame on the midwives. However, the reality is much more complex.

So, what contributes to the difference between compassionate and traumatic interactions?

**Workplace context**

The midwives Jenny interviewed were strongly motivated to create very positive experiences for women, within the context of keeping women and babies safe. This impassioned starting point is often expressed by midwives and student midwives. Yet, midwifery is a physically and emotionally demanding profession and midwives are at risk of work-related psychological distress, and the workplace environment and culture that midwives work within can have a big impact on midwives’ emotional wellbeing. A recent study from Cardiff University reported worrying levels of stress, burnout and depression amongst UK midwives. Moreover, NHS-employed clinical midwives were at much greater risk of emotional distress than midwives in other countries. When midwives are themselves suffering they have very limited ability to recognise and respond to the emotional needs of others. Therefore, this has very serious implications for the delivery of high-quality, safe maternity care. As a woman in Jenny’s study put it: ‘I dunno, there’s something wrong with a system that doesn’t allow you to be human.’

**Workplace ideology: ‘Vigil of Care’ vs ‘Care as Gift’**

Another angle to explore is the workplace culture and underlying ideologies of care that midwives work within. Much midwifery literature explores the tensions between the social and medical models of midwifery, both of which exist within the highly technocratic business model of NHS care. Reflecting on the concept of Sanctuary Trauma discussed above, it is suggested another layer of care ideology exists, referred to as ‘Vigil of Care’ (characterised by surveillance, authority, knowledge and power) and ‘Care as Gift’ (characterised by engagement, individualised response, generosity, and trust). Whether a woman is accessing a social or medical model of midwifery care, the provision of this care as ‘Vigil’ or ‘Gift’ concerns the interpersonal approach by the care provider. In a workplace context where ‘Vigil of Care’ is the cultural norm, this may contribute to midwives detaching themselves emotionally in order to administer the appropriate levels of monitoring and/or intervention deemed necessary. Jenny’s theme of being ‘torn in two’ (between the needs of women and demands of the system) often left midwives withdrawing from women just to cope. In contrast, ‘Care as Gift’ encompasses
the compassionate interactions experienced by women in Diane’s study, where midwives found a way of maintaining affirming positive interactions. This may be because of a more conducive workplace culture, or due to more confidence and experience in working within less conducive environments, as a result of greater experience in the midwifery role or from life.

**Positive interpersonal interactions are not extra**

These studies highlight that positive interpersonal interactions between women and midwives during maternity care are not ‘optional extras’. The quality of these interactions is critical to the psychological wellbeing of both women and midwives. The highly prioritised physical outcomes are potentially being impacted too, since psychological wellbeing has a direct impact on physical birth processes and outcomes. Therefore, the status of psychological wellbeing should be placed equal to physical wellbeing. This would require maternity services to urgently address workplace cultures and conditions that negatively impact on midwives’ behaviours, leaving them unable to ‘be with’ women as they need and desire to. To ignore this, is to break the tenet of ‘first do no harm’.

**Compassion is a powerful intervention**

Compassionate midwifery is a powerful intervention that reduces women’s fears and anxieties and helps them feel more able to cope. The value of this for women at risk of birth trauma is evident. Recognition of compassion as a key midwifery tool should be demonstrated in all areas of midwifery practice, policy and education. Compassion, essentially, is about being human and professional at the same time.

**Conclusion and implications for practice**

Increased emphasis needs to be placed on how human connection can run alongside professional practice in midwifery education. This must be done through acknowledgement of midwives’ needs. Wagner, on writing about the humanisation of childbirth, emphasised the importance of seeing the woman as a human being. This is essential, but it cannot work without understanding that midwives are human too. The relationship between the expression of compassion from midwives and the balancing act that midwives must maintain in order to provide this sort of care needs to be understood and requires further study. The workplace culture and conditions that midwives work within are pivotal to the provision of compassionate care. Therefore, all those practising, managing and commissioning maternity care need to consider how they can take action to support midwives to provide compassionate midwifery care. TPM

**Key statements from these joint findings:**

1. Compassionate midwifery has the potential to reduce birth trauma and associated PTSD-PC.
2. The ‘Gift’ or ‘Compassionate’ components of midwifery care are fundamental to safe care.
3. The status of psychological wellbeing needs must be placed as at least equal to physical wellbeing in order to drive forward essential change.
4. Interpersonal skills must be acknowledged to be as important as clinical skills and taught and assessed accordingly.
5. Toxic and damaging maternity workplace environments and cultures must be urgently addressed.
6. Poor interpersonal behaviour by maternity staff at all levels must not be condoned and needs to be called out compassionately in recognition of the humanity of staff.
7. There is no compassion in midwifery without you!
References


Humanisation of Childbirth 1. The Humanisation of Childbirth

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This is the 19th series of Midwifery basics. In it, a collection of authors, curated by Elizabeth Newnham, will be examining the concept of the ‘humanisation of childbirth’. They identify the need to prioritise humanisation, and explore some of the ideas around humanised birth and how this might effect practice change. Some of the papers draw on the findings of an ethnography of birth in a hospital setting, which was published last year as the book Towards the humanisation of birth: a study of epidural analgesia and hospital birth culture (Newnham et al 2018).

In this first article of the series, Elizabeth Newnham and Lesley Page consider the importance of humanisation of birth in all contexts, and set the scene for the following articles in the series, by outlining its history and defining features.
A word on language from the authors: we acknowledge that there are people having babies who do not identify as female and support the idea that midwives use language and terminology that is decided by individuals as appropriate for them. However, we are also committed to recognising the historic and ongoing gender and power issues that accompany childbirth. We therefore consciously use the terms ‘woman’ and ‘mother’ (and ‘father’) in this series, while remaining respectful to all of the wonderfully different and various individual and family characteristics that exist.

**Humanisation of childbirth defined**

Humanisation of childbirth as a term was first coined in Brazil in the late 1990s. Beginning as a positive-language movement to address obstetric violence, humanisation of childbirth has now been enshrined into legislation in several South American countries. The humanisation of birth movement, situated within an agenda of human rights and ethics, is a resistance to dehumanising, disrespectful, medicalised and industrialised birth practices (International Confederation of Midwives [ICM] 2017; Newnham et al 2018).

An ICM discussion paper defines humanised childbirth as: “care that recognizes the significance of birth for individuals, family and society, and that respects the human rights of the woman to access high quality, evidence based care. Humanized care puts the woman at the centre of care, recognizes that the mother and baby are inseparable. The woman her baby and family are treated with dignity and respect, and the woman has the right to make decisions about her care. This decision making process will be enhanced by a relationship of reciprocity with her midwife or midwives, and supported through the appropriate provision of high quality information” (ICM 2017: 1-2).
Why we need to ‘humanise’ birth

In the recent Lancet series on maternal health, Miller et al (2016) identified two co-existing problems in maternity care: care that is too little, too late (TLTL) (lack of resources and access to quality care) and care that is too much, too soon (TMTS) (medicalisation, over-intervention and iatrogenic harm). To avoid TLTL and TMTS, care needs to be tailored to each woman in order to achieve the optimal birth experience for her.

**Table 1 Characteristics of humanised childbirth** (adapted from Page 2019)

<table>
<thead>
<tr>
<th>Medicalised/industrialised</th>
<th>Humanised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depersonalised/fragmented</td>
<td>Respectful, relationship-based care</td>
</tr>
<tr>
<td>Mother and baby separate</td>
<td>Mother/baby dyad inseparable</td>
</tr>
<tr>
<td>Mistrust of normal physiology/focus on pathology and risk</td>
<td>Physiology of birth trusted and supported/focus on salutogenesis/promoting wellbeing</td>
</tr>
<tr>
<td>Cultural belief in ‘safety’ of technology/medical intervention/unnecessary intervention</td>
<td>Evidence-based, appropriate care/intervention when indicated</td>
</tr>
<tr>
<td>Environment designed for clinicians, intervention and risk assessment</td>
<td>Environment (including choice of place of birth) seen as important influence on birth</td>
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<td>Focus technology/institution</td>
<td>Woman at centre of care</td>
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<tr>
<td>Eradication/limitation or mistrust of midwifery</td>
<td>Scaling up midwifery</td>
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unique needs. It is common to believe dehumanised childbirth practices occur only in low-resource countries, but TLTL and TMTS are parallel problems seen around the world. TMTS can be particularly problematic in low-resource settings where funding is limited. This is why we need to get birth right in all settings and to mitigate against factors such as poverty, racism, war, fragile states and geographical disasters as well as geographical location and context. Scaling up midwifery is a vital part of the solution to this complex problem.

Despite overwhelming evidence, progress to implement midwifery has been slow. Renfrew et al (2019: 1) propose that this is due to “the intersectionality of gender, social, professional and economic disempowerment, fuelled by powerful precedents and perverse incentives’. Other solutions to dehumanising care (such as showing compassion and respect) seem obvious; however evidence that the problem is ongoing is reflected in the continued findings of disrespect and abuse of women during childbirth in all settings (World Health Organization [WHO] 2014; Bohren et al 2015; Reed et al 2017; Vedam et al 2019). Questions we need to be asking ourselves as midwives are: Why is dehumanised care still happening? and What are we going to do about it?

Series focus

In this series of papers, we will be exploring more deeply what is humanisation of childbirth, how to progress humanisation, and how we might address the significant challenges to its implementation. Coming back to the research on which this series of papers is based, some of the issues that arise in the project of humanising childbirth are: to question whether large institutions are actually appropriate as birth settings for most women – if we continue to use them, we must pay attention to ‘deep humanism’ (Davis-Floyd 2018), attending first and foremost to the needs of the woman and her birth physiology (including time and environment); a change in approach to pain in labour, and the way that childbirth is understood culturally; a sustained critique and evaluation of technology and how its use is situated within medical belief systems; an emphasis on the importance of relationships, including specific elements of relational care, such as love, compassion and respect.

Looking towards the future
Humanisation is about whole-system and whole-world transformation in attitudes and care around birth. Although it is not solely about scaling up midwifery, educated, skilled and compassionate midwives in high-performing systems of care are critical to this transformation. However, humanisation is, at root, a political issue. It is about contributing to equity and respect for all human beings, no matter who they are, their circumstances and where they live.

Humanising childbirth is fundamental to the future not only of childbirth practices but to the future of humanity (Page 2017). Overmedicalised and industrialised approaches to childbirth are harmful to individuals, populations and health services, and disregard the essence of birth: the profound human, physiological, psycho-social and also sacred and sexual nature of the childbirth experience. Humanised childbirth is not just about human rights and respectful care in childbirth; it is about reclaiming these aspects of birth, recognising what birth means to each woman, and situating her at the centre of care. It is about understanding the impact of new and emerging science, such as epigenetics and study of the microbiome, on birth and on long-term health and wellbeing. It is about a cultural shift to new ground, avoiding the polarisation of single issues and, instead, transforming to a new reality. Humanised childbirth goes beyond crude outcome measures and recognises the impact of birth on the infant, on the emerging/new mother, on the family into which the baby is being born, on the life-enhancing importance of secure attachments. This is an issue that affects society at its deepest level. We are talking about the creation of mothers, of fathers, of families – and if we get this right, we can make a substantial impact on the health and wellbeing of society. TPM

References


The Professional Midwifery Advocate and Restorative Clinical Supervision

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Summary

As a band 6 integrated midwife, anecdotally I often encountered and witnessed work-based stress. Increasing pressure on midwives and little time for support could result in low levels of job satisfaction, and emotional and physical fatigue. These are challenging times and I wanted to help facilitate change, make a difference, remind us all that midwifery can bring joy. With the support of my employer, I decided to undertake the Professional Midwifery Advocate (PMA) training. The most pertinent function, for me, was the ability to offer midwives restorative clinical supervision: time to stop, think and talk about how they feel.

The role of the PMA is exciting and growing in strength, endorsed and promoted by the head of maternity care for NHS England, Professor Jacqueline Dunkley-Bent who aroused both inspiration and hope at the recent PMA conference: #PMACONF2018. This provides us with hope for a future where we once again care about and value midwives.
It is widely acknowledged that midwifery has increasingly become a stressful and emotionally challenging occupation (Wallbank 2013; Golden 2018). With greater expectations and demands from local and national policy to provide woman-centred care (Department of Health [DH] 2017), staff shortages being commonplace, emotional support often absent, working conditions difficult, together with ever-changing patient demographics, care packages are becoming more complex. As a result, time to care to one’s full potential has become more challenging (Royal College of Midwives [RCM] 2016; 2018). Coupled with the ongoing pay restraint failing to acknowledge the commitment, skill and generosity of midwives, this has resulted in more midwives putting down their pinard stethoscopes, hanging up their uniforms and leaving the profession (RCM 2016; 2018).

It is recognised that investing in the mental health and wellbeing of both nurses and midwives reduces their individual stress and anxiety levels, and improves their ability to provide better patient care (Pezaro et al 2016).

Midwives often rely on reflection to help them process events and associated feelings. Regular reflection on practice and learning is, in fact, statutory to meet the requirements necessary to remain registered as a professional practitioner (Nursing and Midwifery Council [NMC] 2015), and it does prove very successful with regards to clinical skill, but not so much in alleviating work-based stress and anxiety (Deery 2015). Reflective accounts are often unsupported, and reliant on the individual midwife processing his or her own thoughts and feelings; it is rare for them to admit that they are struggling (Pezaro et al 2016).

**Why we should have Professional midwifery advocates**

Historically midwives had access to a supervisor of midwives (SoM) if they required support. They also had a statutory obligation to meet, annually, with their named SoM, at which point they would be offered support, as well as discussing and confirming their fitness to practise (NMC 2012). However statutory supervision ceased in March 2017, due to cases of local supervision and regulation failing to identify poor midwifery care (NHS England 2017). Coupled with increasing demand from policy and society alike, this leaves midwives in a very vulnerable and insecure state.
Thankfully, the value of the non-regulatory elements of supervision were acknowledged, and a new model of supervision was introduced (NHS England 2017). A-EQUIP (Advocating and education for quality improvement) is a model underpinned by the work of Proctor (1986) and Hawkins and Shohet (2012). Central to this is the care provided to the women and babies, believed to be enhanced by addressing the needs of the midwives, using the following four components of the model: • restorative clinical supervision (RCS)

• personal action for quality improvement

• education and development

• monitoring, evaluation and quality control (NHS England 2017).

Along with the new model of supervision, a new role evolved – that of the Professional Midwifery Advocate (PMA): an experienced midwife who would receive additional training to deliver the A-EQUIP model. The role is in its infancy and, as the service is employer-led, these midwives will be responsible for providing leadership within their locality to develop the role and advocate for their colleagues, enhancing their personal and professional resilience – thus improving the quality of maternity care (NHS England 2017).
Restorative clinical supervision

It is suggested that the challenges and stressors of maternity care (and consequently support for midwives) is often overlooked because midwifery is perceived (idealised, even) as a joyful occupation (Wallbank 2013), concerned only with normality. It has also been noted that practitioners who were persistently exposed to emotive and stressful situations
remained in an almost constant state of anxiety, resulting in an inability to think clearly and practise effectively, even in ‘normal’ situations (Hawkins and Shohet 2012; Wallbank 2013).

A model was developed and piloted with midwives, doctors and obstetric nurses (Wallbank 2010). Underpinned by the Solihull Approach, the model enabled practitioners to have the space and time to process anxiety or negative feelings with regard to their work (Pettit and Stephen 2015). The belief was that doing so would promote resilience, the ability to learn from experience and form coping mechanisms, thus improving the professional’s health and wellbeing, as well as their capacity to provide good care (Wallbank 2012; Hawkins and Shohet 2012). The results of this pilot and subsequent work with health visitors demonstrated a significant improvement in job satisfaction, a reduction in stress and burnout and improved patient care (Petitt and Stephen 2015); so much so that NHS England (2017) has incorporated and promoted regular sessions of RCS in the A-EQUIP model.

Empathy

To facilitate effective RCS requires discussion, reflective conversation, supportive challenge and open and honest feedback (NHS England 2017). The supervisor-supervisee relationship is often more valuable when this is a peer (Clarke et al 2018), most probably underpinned by the sense of equality, and the belief that a peer has the ability to empathise. Empathy is crucial within RCS, as midwives are individuals with different personalities and needs, who will experience and feel things differently. Rather than ‘feeling sorry for someone’ (Burnard 1988), empathy is the ability to relate; to draw on one’s personal experiences which have incurred similar feelings and emotions – not to resurrect one’s own turmoil, but to trigger the ability to feel as others feel; to suspend judgement; to recognise others as individual people and imagine how their emotions can feel and affect them; to truly listen; to note hidden meaning; and to understand from the other’s perspective (Wiseman 1996).

Holding and containing

To be effectively ‘restored’, the practitioner must be supported psychologically. They must feel safe to be open and honest and to explore their thoughts and emotions. The theories supporting this are of ‘holding’ and ‘containing’. ‘Holding’ relates to the mother-infant relationship, the baby having confidence in the mother’s love and, in moments of distress, having the embrace of the mother’s arms and the sense of her care to soothe them. This cultivates feelings of security, enabling the infant to develop a sense of safety, even when the mother is not there (Winnicott 1965; Ogden 2004). The parallels for supervision are the supervisee having confidence in their peer – in their trust and understanding – this then soothing their
initial fear and anxiety and enabling them to acknowledge and subsequently discuss the emotional implications of their work.

This proceeds to ‘containment’: a reciprocal relationship with the ‘container’ that enables the ‘contained’ to fully experience (and therefore work through) painful and unwelcome feelings (Bion 1961; Ogden 2004). Being allowed and encouraged to feel as such, while receiving positive regard and support, enables them to process and utilise their emotions productively, to formulate coping mechanisms and plans of action, and restore their capacity to think (Bion 1961; Ogden 2004).

Motivational interviewing

Consider a work-based conversation that you were involved in or privy to that may not have gone as well as everyone hoped: it wasn’t a positive experience for the parties involved. Using the concepts of motivational interviewing and appreciative enquiry, explore how those might have facilitated a much more positive exchange and outcome.

The use of motivational interviewing is recommended to navigate through these processes (Wallbank 2013). The premise of motivational interviewing is to work in partnership with the supervisee, to enable them to elicit, clarify and negotiate any personal changes they need to make. It is important to remain empathetic, promote self-efficacy and self-worth – and not to challenge resistance. Reviewing the pros and cons of situations and the practitioner’s goals and values, and simply allowing them to explore their own thoughts and feelings, will eventually enable them to develop their own resolution. Some situations may be more challenging than others for the supervisor to manage. In consideration of this, the pneumonic OARS is suggested as a tool:

• Open ended questions – which elicit a more thoughtful response
• Affirmation – acknowledging the practitioner’s strengths, enabling them to view themselves more positively
• Reflective listening – confirmation that the supervisor has understood the issue
• Summaries – strategically recapitulating the session’s content, highlighting the positive elements and simplifying the need for change with very basic action plans, to enable the practitioner to progress (Miller and Rollnick 2013)
Appreciative inquiry

Appreciative Inquiry is another medium that encourages progress and change and lends itself well to motivational interviewing. It supports midwives on an individual basis, but also for collecting and collating information to promote leadership and management of organisational change. It is underpinned by five generic processes:

1. Choose the positive as the focus of the inquiry
2. Inquire into exceptionally positive moments
3. Share the stories and identify life-giving forces
4. Create shared images of a preferred future, and innovate
5. Improvise ways to create that future (Mohr and Watkins 2002).

Within the domain of RCS, this involves focusing on the positive elements of the discussion and/or practice to neutralise negative feelings. The supervisor may lead the session by encouraging the midwife to explore what elements of the presenting situation and/or their role in general they enjoy; what they believe they do well; what protective factors exist within their organisation to facilitate that good practice/feeling; and what changes the midwife might like to see within their own practice and that of the organisation in which they work. The goal is to learn from very positive moments rather than focusing on breakdown, thus releasing positive rather than negative energy (Mohr and Watkins 2002), creating a replenished vigour when tackling work-based issues. At an organisational level, if practitioners are encouraged to focus on the safety that is already there, built in to their organisation (in other words the opportunity to make comments without fear of recriminations), then all types of feedback are likely to be forthcoming. Encouraging them to identify changes they deem beneficial, in a safe and secure way, may engender more creative input. Staff with more positive attitudes are more likely to offer constructive criticism and more clarity with regard to the perceived needs of the organisation, as opposed to ongoing dissatisfaction and disappointment, predisposing all parties involved to be resistant to change (Dale and James 2013). The supervisor/PMA is fundamental in identifying trends, advocating and leading change management, which will benefit midwives and enhance the care provided to women and their babies (NHS England 2017).
The future

It is recommended that midwives have access to a PMA at least once a year and, additionally, as the need arises (DH 2016). As an evolving service, this may provoke resistance, because midwives have been exposed to significant change and may be sceptical. The midwifery profession has been subjected to a series of major changes: the Midwives rules and standards was revoked and the role of the supervisor of midwives, abolished. Furthermore the NMC has actively dissolved its midwifery committee, once regarded as a specialism and its members recognised as autonomous practitioners. Midwives are gradually being stripped of their identity and, as a consequence, they have been left feeling emotionally raw and fearful for the future of their profession. However, the introduction of the A-EQUIP model of supervision and the role of the PMA must be viewed as a great opportunity, championed and represented by like-minded peers, the true advocacy of midwives’ needs, both as a profession and on an individual basis. From an organisational and individual perspective, this is something to be very much welcomed. To all midwives out there: We are coming back. TPM
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