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Part 2 of 2

The midwife professional: Can a midwife achieve professional autonomy in the contemporary United Kingdom (UK) maternity system? A Sociological perspective.

Key words: Risk, professionalisation, managerialisation, sociological imagination, new professional,

Key points:

- The NMC code (2018) advocates the need for midwives to be autonomous

- Autonomous midwifery practice is difficult to achieve in the face of litigation, medicalisation of childbirth, managerialisation and consumerism

- Guidelines are founded on the best outcome for the most people

- Working in the public sector is pressurised

- Midwifery autonomy varies depending on clinical or home environment

- Reflection in action can help professionals instigate change

- Sociological imagination and combined with being 'with woman' can facilitate choice and autonomy. The midwife's autonomy is therefore a conduit to woman's autonomy.

Abstract

Professionalisation, the midwifery profession and professional autonomy are explored from a sociological perspective to answer the title question. Within part-one the obstetric influences and frictions, government policy and guidelines, risk, litigation and increasing managerialisation were considered, highlighting the complexities of professional midwifery and the challenges it faces. In part-two choice, service pressures, evidence-based care, consumerism, leadership and reflexive practice are considered in an attempt to navigate professional autonomy with the intention of retaining women's choice as the core belief of the profession. A conceptual framework has been devised to enable this utilising the concept New Professional Midwifery. The object of this work is to keep women's choice as the central aim.

Introduction

The national ambition to provide women with the power and autonomy of choice in addition to the development of New Professional Management (NPM) problematising this ideal are considered. Understanding how a midwife's professional status contributes to women's care is important for high quality care provision. By considering contemporary practice and reviewing midwifery professional history sufficiently enough to ask 'why have patterns persisted?' enables the understanding of the wider professional structures and reduces the focus on individual milieu (Wright Mills 2000). Sociological imagination and knowing oneself in the context of history and politics enables the individual to recognise what is happening and to

contribute to society (Wright Mills 2000). Through exploration of the organisational, national, and professional factors that affect midwifery, in addition to what women and their family's needs are, the question; Can a midwife achieve professional autonomy in the contemporary UK maternity system? is answered. This attempts to prepare midwives for future practice (Wright Mills, 2000, p153) with a conceptual framework to support new professional midwifery and professional imagination (Power 2008).

Autonomy, choice and managerialisation

The role of the professional is given value for the ability to walk the tightrope between the managerial processes and the needs of the individual but ultimately there is reward for the reduction of risks. Managerialism presents a major challenge to the midwifery profession (Carvalho 2014). Standards and outcomes are measured by policy and audit (Carvalho 2014). A hybridized professionalism was identified through qualitative interviews demonstrating the legitimisation of managerialism within traditional professional values (Carvalho 2014). Moreover, an ability to control the bureaucracy furthers individual status (Faulconbridge and Muzio 2008). This 'organisational professionalism' supports the notion of hybridisation. The support of organisational systems contributes to the success of individual professions. The advancement of one's personal midwifery success by aligning to the medical imperialized profession (Mander and Murphy-Lawless 2013) could be attributed to this hybridisation. In addition, a review of literature on professionalism identified that management in the medical profession has eroded professional control (Numerato, Salvatore, and Fattore 2012). The rationalisation and standardisation of healthcare

can affect clinical practice, dictating the need for negation, this hybridisation and strategies to support care provision. A response to this is reverse managerialisation, where managerial discourse is provided but organisational process and utilisation of guidelines are avoided in practice (Numerato, Salvatore, and Fattore 2012). The hybridization of new professional management could be argued to align with evolution of a semi-professional role (O'Connell and Downe, 2009) and lean toward a technocratic model where intervention in birth is seen as normative (O'Connell and Downe, 2009). This does not fit within the aims of the National Maternity Review (2016) and the direction of UK maternity care.

The pressures of working in public services with scrutiny from service users, organisations and quality assurance methods are well known and it is viewed that the paid professional cannot be free to utilise their autonomous powers due to the capitalist employment system (Power 2008). The rise of a trust conflict due, in part, to public demand for accountability of professionals has been exacerbated by health scandals (Shore 2008) and from the inception of general management in healthcare originating from the Thatcher administration (Kirkpatrick, Ackroyd, and Walker 2005). From this the importance is on economics rather than professionalism (Sardar 2000). The Morecombe Bay report (Kirkup 2014) and Investigations of the Midwifery Supervision Extraordinary Review (Porch et al 2014) provided the midwifery profession with significant challenges to its reputation and integrity. The recommendations for increased governance further contributes to 'audit culture' and disempowers professionals to fulfil the ideals of autonomy (Power 2008) whilst increasing the 'coercive accountability' of both the individual and the organisation (Shore 2008). Additionally, the Care Quality Commission (2017) compounds the

proliferation of audit and risk through healthcare inspection and this governance procedure as a central constituent of safety are scrutinised and ethical principles examined.

Facilitating evidence-based practice is central to the creation of guideline culture. Whilst guidelines provide care recommendations, their use is not essential. Guidelines align themselves with the utilitarian foundations of the best outcome for the most people (Symon 2006). The expectation of use is assumed (Berg et al. 2000). The intention to provide equal and objective care to all ensures transparency and parity, however, evidence-based practice illuminates the importance of individual choice (Sackett et al. 1996) as opposed to guideline adherence. As a result, Berg et al. (2000) describe guidelines as a double edge sword. Compliance with guidelines support and legitimise a clinician's actions and aid the decision making process, however, this can reduce the influence of the individual circumstance. Notwithstanding, keeping a focus on the care recipient ensuring a shared sense of responsibility is acknowledged as good practice and correct utilisation of the guidelines. This enables the retention of clinical autonomy (Berg et al. 2000), juxtaposed to a de-professionalisation view of guidelines (Numerato, Salvatore, and Fattore 2012).

Furthermore, it is proposed that street level bureaucrats can have autonomy over how they adhere to policy but are they are criticised for this as being non-compliant with guidance (Lipsky 1980 cited by Evans 2010). Conversely this is proposed as being a 'professional' and having agency over ones decision making by Evans

(2010). ==Arguably,== street level bureaucracy is necessitated by a shortage of time and resources leading to those on the 'front line' (midwives) not being able to provide autonomy to the women they serve. However, Finlay and Sandall (2009, p1233) oppose this view by presenting the argument that a continuity of care model may provide the street level bureaucrats that are 'stuck in the middle' a way to reassert and align the autonomous underpinnings of midwifery to serve both the individual women and the organisation.

The 'Dominant social values of individualism and consumerism' (Symon, 2006, p37) in the postmodern period have provided benefits of technology in addition to hazards. 'Risk society' (Beck, Giddens and Lash, 1994 cited in Shore, 2008) reduces confidence in natural processes of pregnancy and childbirth, and reduces midwives autonomy and the ability to provide women with real choice (Edwards and Murphy-Lawless 2006). Women are expected to choose the least 'risky' course possible and adhere to medical recommendations (Symon 2006). The individual women is at the end of world risk society consequence (Beck 2009). The avoidance of being labelled immoral by not acquiescing to scientific recommendations can change a woman's mind from what she wishes to the standard care option (Edwards and Murphy-Lawless 2006). Furthermore, social and cultural values of convenience and control increase doubt in women's belief in their own bodies to birth. Moreover, Thompson's (2013) qualitative study of ten midwives' views of caring for women who have requests that sit outside of clinical guidelines and recommendations found that midwives can be uncomfortable in caring for these women. In this ==study,== midwives expressed fear of litigation, an addition of time and resources needed to care for these women, and threats to their own autonomy and professionalism. The midwives

did highlight the importance of support from coordinating midwives and medics (whilst being anxious of the response they may get initially if this was medicalised and unsupportive of women's choice) (Thompson 2013). The role of the professional is to hand hold the individual through their choice (Leicht 2016) and uphold the belief of individualised informed choices not confront individuals. However, incremental changes to the environment and professional expectations as well as institutional pressure can lead to ethical drift (Kleinman 2006). This drift is a gradual deterioration of ethical principles once upheld and is detrimental to the profession, the professionals and the organisation.

The liberal professional and the bureaucratic professional are bound by ethical principles Leicht (2016), as in the case of midwifery. However, the corporate employer of the professionals is not bound by ethical codes (Leicht, 2016). The publication and visibility of the NHS Constitution (NHS 2015) allows staff, consumers and the general public to understand the values and social purpose of the NHS. However, the upholding of these values is difficult to police, particularly in the case of privatised organisations contracted to the NHS (Frith 2013). The Care Quality Commision (2017) is tasked with this responsibility. Through healthcare inspection, incorporating ethical principles the Care Quality Commission (2017) does hold employers to account periodically.

Midwifery roles and professional issues

Place of work can impact on midwifery autonomous practice due to the domination of the medical model persisting. As demonstrated in Nilsson et al's. (2019) ethnographic study, midwives had doubts about their own knowledge and reduced freedom to work autonomously when on delivery suites. The midwives in Nilsson el al's (2019) study were expected to be busy rather than focusing on the woman's needs alone. Whilst this study was completed in Sweden some similarities can be seen; the access to free maternity care, the dominance of the medical model, a women-centred care ethos and a long history of midwifery. However, there are restrictions on the home birth provision in comparison to the UK (Lundgren et al. 2020) which may affect the results in Nilsson et al. (2019) results.

The art of seeming to do nothing is a much valued professional attribute of the midwife (Powell Kennedy 2000). This art can be described as having the ability to be vigilant, unrushed but timely. Demonstrating a belief in the natural process of pregnancy, birth, and the postpartum period without be casual whilst providing learned judgement. It is additionally important to ensure necessary referral to obstetric expertise, however, only when needed. This art is part of being an exemplary midwife and is important to the professionalism of midwives (Powell Kennedy 2000). On delivery suite, the ability to provide this advocated art is challenged by the productivity insisted upon by healthcare organisations (Powell Kennedy 2000). Workplace culture challenges this further as midwives are expected to appear busy, which reduces midwives time with the women.

Being 'with woman' is known to increase a woman's calmness and the contraction hormone 'Oxytocin' which in-turn promotes successful normal birth (Davis and Homer 2016). Additionally, whilst the principles of care were provided equally in all birth settings, the way in which this care was achieved varied. The delivery suite was felt not to be the woman's space but the organisation's, whereas; home birth was the woman's space. The feeling of being watched and conforming to the busy work of the delivery suite drew concentration away from the women. Moreover, practice that is deemed acceptable at home was considered 'unprofessional' on delivery suite for example 'enjoying a cup of tea with the family' (Davis and Homer 2016, p411). Furthermore, on delivery suite the scrutiny of care provision and the time constraints provided midwives with a sense of being rushed and a need to conform to the guidelines instead of listening and being guided by the woman. This was described as more unsafe by the research participants (Davis and Homer 2016). These findings have been acknowledged previously by other researchers (Curtis, Ball and Kirkham, 2006). Moreover, the skills of time efficiency and technological equipment use are greatly valued in the delivery suite (O'Connell and Downe, 2009) demonstrating further the value of the medical model. This contrasts with community midwives who feel more autonomous (Sargent, 2002). Midwives within the study identified that their behaviour and care approach adapt depending on birth environment (Davis and Homer 2016).

Midwifery leadership, senior midwifery expectations and women's expectations can lead to an acquiescence to managerialisation and medicalised care (O'Connell and Downe, 2009). Porter et al. (2007) supports this bureaucratic acceptance. Interestingly, midwives place blame for this acceptance on other midwives, doctors

and even women but refrain from taking individual responsibility (O'Connell and Downe, 2009). This opposes ethical professional expectations of accountability (Nursing and Midwifery Council 2018). Some international maternity systems facilitate the autonomy of both women and midwifery. 80% of women in New Zealand opt for Midwifery Lead Carers (LMC) in pregnancy and childbirth, LMC's work in a collaboration with obstetricians (Skinner and Maude 2015) and are not constrained by institutional demands with the ability to assess risk in a social and cultural context related to the individual. Although the system can be manipulated (Skinner and Maude 2015) a conclusion was made that uncertainty should be embraced and more work into how this might be dealt with is needed.

A crisis?

The midwifery profession is at a possible point of crisis, with 67% of midwives reporting moderate work-related burnout, exacerbated by reduced NHS staffing, a lack of autonomy and organisational pressures (Hunter, Fenwick, and Sidebotham 2019). Woman's choices are affected by pre-existing values, experiences and beliefs (Coxon et al. 2017). Choices within the guidance are given by use of persuasive or permissive language (Nolan 2010) and risk society has permeated and increased medical influence (Symon 2006). Beck (2009, p192) warns us of an 'apocalypse-blindness' and society's inability to identify societal change highlighting the possibility of self-destruction without this recognition. Yet the audit and risk culture perpetuate due to what Beck (2009) describes as a blindness of sociology to learn and use the sociological imagination and within that, our history. This is due to ever increasing amounts of data and a wish to perfect science. Our modernisation has rendered us incapable of transforming within a social-historical context.

What are the alternatives? Productivity could be measured by outcomes in optimal health and the experience, empowerment and respect of the woman and her family (Powell Kennedy, 2000). Professionals can have influence on the risk management agenda to maintain values and ideologies insuring cultural fragmentation does not occur (Leicht 2016). Midwives engaging in risk discourse, attending meetings, ensuring the underpinning professional values and pillars of the Code (NMC, 2018) underpin the guidance, engaging the Professional Midwifery Advocates to advocate the midwifery agenda, strengthen the maternity workforce, support fellow midwives in their own advocacy of women and their family's needs and leading by demonstration and commitment of values (NHS England 2017). Research evidence (Brocklehurst et al. 2011) and current maternity policy (National Maternity Review 2016) provide society with an opportunity to regain individualisation and autonomy. Yet, Beck (2009) argues that society is incapable of fixing the problems itself has created in an age of advanced modernity and rationalisation. A view that the service user's need should be prioritised over the economic one is important (Eliot Freidson 2001). Through reflective practice and sociological imagination, a solution may be found.

Reflective practice

Reflection is used widely in healthcare to enable practitioners to make sense of what they do, to change practice and to promote professional development (Taylor 2010). Whilst Schon (1983) may appear a dated source the fundamental principles he presented are still applicable today. He identified the theory-practice gap and advocated for a transition from technical-rationality to professional practice based on

reflection-in-action. Rather than using specialist knowledge to confer power over individuals and retain professional autonomy, the profession uses knowledge to empower the individual to acquire that same knowledge through communication and conversation. The demystification of knowledge allows individualistic and tailored reflective conversations and contracts to occur. Reflecting on limits and understanding that actions are interpreted differently by different people enables the professional to engage individuals and offer greater accountability (Schön 1983). With ongoing reflective practice and the transformations in care provision (continuity of care) as advocated by National Maternity Review (2016) it may be possible to engage in sociological imagination, learning from history and research, to make change happen. The National Maternity Review (2016) has provided contemporary maternity care and the professionals within this care an opportunity to utilise both the science (the research at hand) and the art or midwifery to affect this change. As identified by Power (2015, p656) 'one single approach is too inflexible'. Combined, perhaps autonomy and authority over the women in midwifery care would then be relinquished allowing for exceptions such as in crisis and emergency situations (Schön 1983). Professionals can promote institutional change by understanding, interpreting and planning action in the interest of and on behalf of the clients they serve (Leicht 2016).

Conceptual framework for New Professional Midwifery

To ensure that a profession survives it should acknowledge and understand the needs of society (Elliot Freidson 1988). The variability incurred by a professional working with others outside of their profession (midwives working with women) presents difficulties due to the changeable needs of society. However, the profession and the professional have the power to control its own functioning (Freidson, 1988).

Power (2008) identifies different perspectives of professionalism. 'The distressed professional' identified in midwifery through the lack of decision-making and bullying to conform to the medical model and the 'oppressed professional' due to managerialisation, in addition to the wide availability of information creating consumers rather than care recipients (Power 2008). Both of which Power (2008) critiques as not acknowledging the wider perspectives influencing professionals. Wright Mills (2000) 'sociological imagination' is supported by Power (2008). Asking relational (structure of the profession and the differences in comparison to other professions), temporal (social historical position of the profession, included and excluded parties, how is it changing?) and dispositional (who is in the profession? How are they selected? What type of people are they? What affects them?) questions can afford us the ability to consider both personal and societal views to enable change (Power, 2008, p157). Reflected below, in the top half of the conceptual model.

In addition to professional sociological imagination the component of 'woman' has been considered to highlight the central aim of the midwife, to be 'with woman' facilitating and advocating choice and autonomy. The midwife's autonomy is therefore a conduit to woman's autonomy. 'The Code' (Nursing and Midwifery Council 2018) is upheld and individualised choice and care is provided and advocated through evidence-based practice, in the context of the woman's own life ensuring the principles of 'Reflection in action' are utilised (Schön 1983).

New Professional Midwifery- a conceptual model
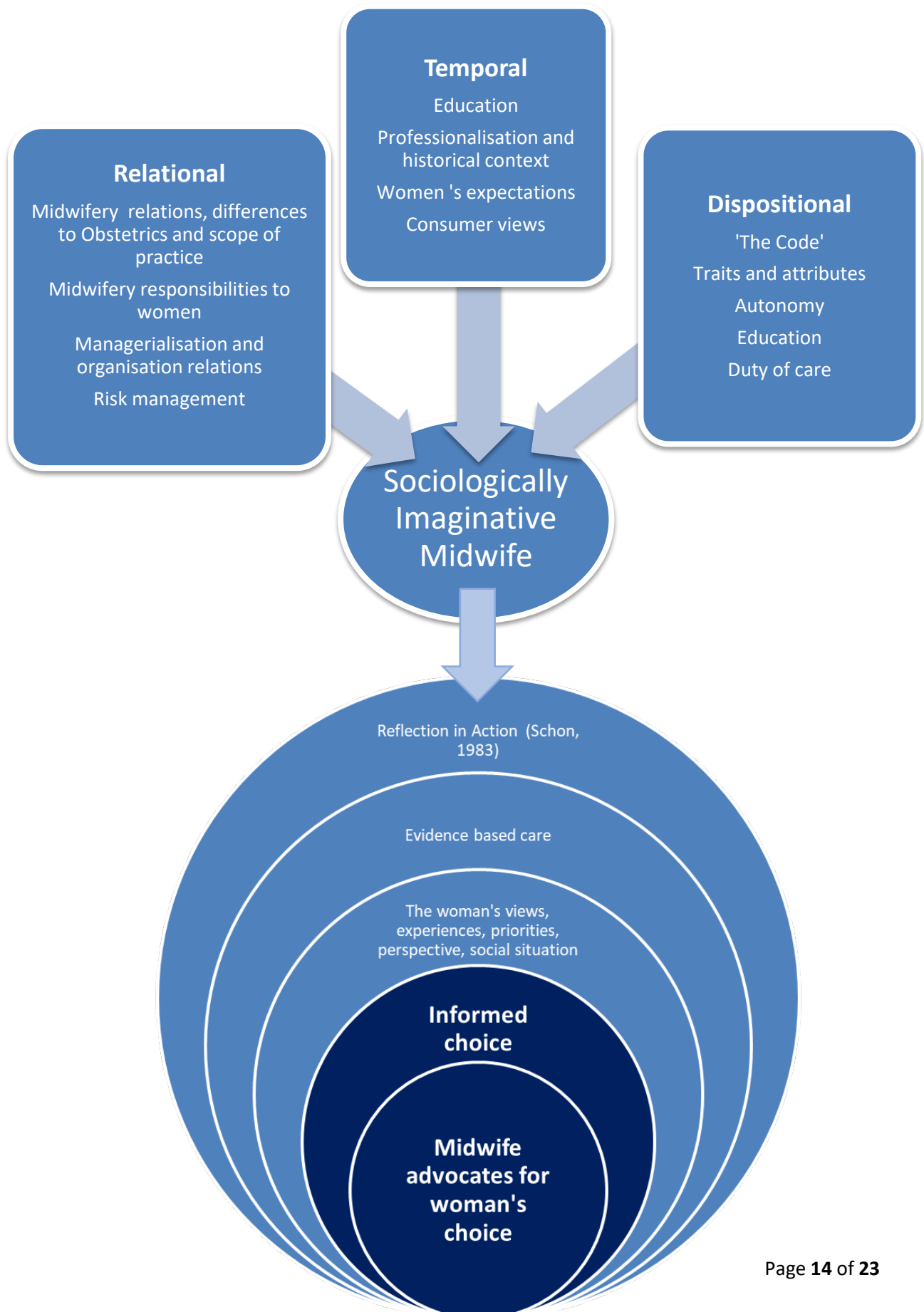
Conclusion

Can a midwife achieve professional autonomy in the contemporary UK maternity system?

The answer is complex. Whilst autonomy is advocated and expected by the professional regulator (NMC) it can be difficult to achieve. The evolvement and permeation of risk management and managerialisation throughout maternity services has removed, in part, the autonomous practice of many midwives due to the fear of non-conformity and litigation. It could be argued that midwifery is in fact a 'semi-profession' because of this. It is a professional duty to focus on how professional practice affects women in maternity care as midwifery exists to serve the needs of society. If evidence-based practice, government policy, women's voices, maternity support groups and data demonstrate that midwifery practice serves society well then, the professionals of the occupation have an ethical duty to ensure that the profession survives. If women want choices, and research supports that they do, then midwives must retain autonomy to support and protect individual choice despite managerialisation. Having midwifery representation in the political and policy making landscape, free from obstetric influence, will potentially influence risk society to ensure women's choice remains a central aspect of the quality improvement agenda. Whilst autonomy is a challenge to midwifery, working in partnership with women it can be achieved. However, risk is currently shouldered by the individual professional in their day to day practice. Through New Professional Midwifery and sociological imagination, relationships and partnerships with other professions and contemporary practice could shape the future for women's care and the midwifery profession.

Reflective questions

- How can you ensure women in your care are provided with choices?

- Do you know who is responsible for guideline management in your organisation?

- Do you feel that the 'Conceptual framework for New Professional Midwifery' is of use to your practice?

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