Midwives’ support needs as childbirth changes

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INTRODUCTION

The study on which this paper is based forms part of a research project which examined the supervision of midwives in England. The main report of that study is published (Stapleton et al. 1998) as is an analysis of the culture of midwifery in the National Health Service (NHS) derived from that data (Kirkham 1999).

The supervision of midwives, enshrined in statute in the United Kingdom (UK), is designed to provide support and guidance for midwives as well as to ensure the quality of their practice (ENB 1999). The research findings showed support to be of great importance to the midwives studied, an importance which stretched beyond the support which could be expected of a supervisor. Support needs were felt particularly acutely because of surrounding changes in organization and practice. This article therefore revisits this research, focusing upon the support needs described by the midwives studied, and discusses these needs in their organizational context.

BACKGROUND

Midwives’ support needs reflect their history and the culture in which they work. In less than a century, English midwives became regulated, professionalized and medically controlled (Heagarty 1996, Kirkham 1996). The
values reflected in the organization of midwives were those of an organizational vision culturally coded as masculine (Witz 1992, Davies 1995). The domestic, caring, female values (Bologh 1990) became increasingly invisible, although remained essential, in the support of individual childbearing women. Adjusting to profound changes, midwives manifest the classic responses of an oppressed group (Freire 1972, Roberts 1983), internalizing the powerful values of medicine and exercising ‘horizontal violence’ towards colleagues seen as deviant (Fanon 1963, Leap 1997). With the centralization of birth into hierarchically organized and increasingly large hospitals, midwifery increasingly adopted the responses and values of those institutions. All these responses served to protect the status quo, which reinforced the values of obstetrics, not midwifery.

Looking at the hierarchical organization of hospitals as a psychologist, Raphael-Leff (1991 p. 225) describes similar ‘horizontal antagonism’. She sees the fragmented care given in maternity hospitals as part of a ‘social defence system... constructed to help individual professionals avoid experiencing anxiety, guilt, doubt and uncertainty’. Rather than giving and receiving emotional support ‘both caring and gratitude are diminished in a system where people behave and are treated in a depersonalized way’. Here again ‘any activities which threaten the status quo are intensely resisted’ (Raphael-Leff 1991 p. 226).

Recent changes

There have been profound recent changes in UK maternity services.

The climate of competition, as well as the introduction of business management in health care, has affected organizational structures. Midwives have reclaimed some areas of traditional expertise and become more able to challenge medical power-holders (ENB 1995). The emphasis upon a flexible workforce and the flattening of management hierarchies has the potential to resolve many tensions between medicine and midwifery, but has also resulted in the loss of midwifery management posts. Thus, many midwives reported that they felt insecure, because they lacked the support of experienced seniors. Recent studies link occupational stress (Mackin & Sinclair 1998) and burnout (Sandall 1995, Bakker et al. 1996) with service changes beyond the control of midwives but which nonetheless affect their practice.

Women have reacted and organized against the conveyor belt processing of maternity care. Changing Childbirth was a challenging and symbolic title for the Report of the Expert Maternity Group (Department of Health 1993). The aim of woman-centred care became NHS policy and this was heralded in some quarters as a great opportunity for midwifery. Nevertheless, these changes had to be achieved within structures built for very different purposes and within existing budgets. At the time of the research reported here (1997–1998) the initial impetus to achieve the aims of Changing Childbirth was beginning to be tempered by economic pressures and disillusionment.

THE STUDY

Research method

Six sites in England were studied: five very different NHS sites (selected for the diversity of their maternity care in its organization and client groups) and one consisting of non-NHS midwives working in independent practice or privately employed.

This paper is based upon data from the qualitative part of the study. An ethnographic approach was adopted and in-depth interviews were conducted with midwives and supervisors: 168 interviews were conducted with midwives drawn from all grades and practice settings on these six sites, approximately 10% of staff on each site, and included supervisors. Midwives were asked to reflect upon their practice and, when assured of the confidentiality of the interview and the anonymity of the data, they did so with considerable insight. The majority spoke spontaneously of their support needs and, when asked to elaborate, they did so with feeling. Ethics committee approval was gained in all areas of midwifery practice.

The style of the study appeared best suited to a grounded theory approach in its analysis (Glaser & Strauss 1967). Such an approach allows for the emergence and continual evolution of theoretical frameworks in synchrony with the actual research. Using such an approach changes the interview format as the analysis develops. Since respondents were not all asked the same questions and chose to address aspects of the issues studied which were important to them, quantitative data are not used in this analysis.

The interview transcripts were coded selectively and categorized in accordance with the principles of grounded theory. The categories were constantly explored in the ongoing interviews and analysis and, whilst some categories collapsed or merged, others appeared. This process went on until no further ‘movement’ of categories was detected and the researchers felt confident that the categories had reached the point of ‘saturation’ (Straus & Corbin 1990).

FINDINGS

The culture of the NHS and the need for support

A clear picture of the culture of midwifery in the NHS emerged from the detailed descriptions given by respondents of the context of their practice. The analysis of this
culture has been published (Stapleton et al. 1998, Kirkham 1999). Respondents described the culture of midwifery in the NHS as a female culture of caring expressed through service and sacrifice, operating within institutions which did not acknowledge the importance of such caring work. Therefore, whilst midwives gave care, their role as professional carer discounted their own need for personal and professional support. In recent years, changes in the maternity services have encouraged women to expect appropriate care and support as a right. The midwives caring for them, however, did not perceive themselves as having parallel rights. In some cases, this deficit was reinforced by powerful role models:

Any model of women-centred care doesn’t help midwives to think about their own needs because in that culture midwives aren’t seen as women — they’re seen as the ‘lead professional’...It’s important to think about the women but we’re important too...And you’ve got to get the balance right because if you get midwives stressed out and burnt out then it affects the care for these women. That’s one criticism I would make of B (supervisor) — she is so nice and enthusiastic about everything that she sometimes puts us in a difficult position where we’re expected to be as self-sacrificing as she is... so when we’re short staffed and someone comes in labour, B just tells us to carry on because she doesn’t want to bother anybody else to call them in...And what can you say when she’s prepared to do it...? (F grade midwife)*

These midwives experienced a lack of mutual support as well as a lack of role models of support:

We don’t support each other...we don’t ever stand up for each other. (G grade midwife)

Such a culture, with deeply internalized values of service and self-sacrifice, together with midwives’ mutual pressures to conform, produced considerable guilt and blame. Self-blame was widespread and, whilst this may be a female characteristic in the wider culture surrounding midwifery, it had an undermining effect upon these midwives.

Many respondents, when invited to reflect on the need for support and on ways of looking after themselves, used the word ‘selfish’. Thus, the word chosen by midwives seeking to address their own needs, was itself an indictment in the caring, self-sacrificing, client-centred culture:

So I think we really need to be thinking about ourselves and be selfish at times really. But that really goes against the grain in midwifery. (F grade midwife)

In such a context, many midwives voiced a resigned acceptance of their lot and a low sense of their own worth. The general tone of their comments was of an overwhelming sense of helplessness, of low expectations and lack of support:

...to be quite honest, I’ve never known it...I think it would be quite amazing to have professional support. (F grade midwife)

Midwives interviewed made constant allusions to blame: usually directed inwardly at themselves, sometimes towards a midwife perceived as deviant or ‘selfish’, and sometimes towards managers, supervisors or clients. Where such blame was acted out on colleagues, it can be described as horizontal violence (Fanon 1963, Leap 1997).

In such a situation midwives experience isolation and what several described as ‘the fear factor’:

We all work as individuals and there is this huge, scary thing about ‘covering yourself’. It makes you choose carefully who you discuss things with... and there is also this very scary phrase that midwives repeat when they are scared of doing something. They say ‘it’s your registration you’re risking’ and that brings a lot of fear. You hear it repeated as students... and you hear it repeated to mothers when they do something the midwife or the doctor doesn’t agree with. They say ‘you’re risking your baby’ and then the mother gets very anxious and frightened.

Thus, their experience of a culture of powerlessness equipped midwives to disempower their clients, since they lacked the confidence or sense of their own power that is needed before power can be shared.

Midwives who sought change did so in complex and devious ways, whilst appearing not to challenge the existing culture. This ‘doing good by stealth’ could bring about change in particular circumstances but concealment prevented concerted action leading to major change. Only on rare occasions did midwives and supervisors seek to challenge this culture in more open ways.

The cultural context profoundly influenced midwives’ needs and experiences of support. Amongst the NHS midwives studied there was very little evidence of reflection, analysis, or planning to meet their support needs. Needs were simply listed. The patterns which emerged can be examined under the following headings which are not in order of priority.

**Listening/being there**

Within a culture where midwives experienced muting of their voices as practitioners, it is not surprising that many midwives described their need for support through listening. Throughout this project, midwives expressed a widespread need for someone who would listen, to whom the midwife could ‘off-load’ her worries and who would ‘be there’ in a supportive capacity. Many saw this as an important part of the role of the supervisor:

...it’s somebody to go to and I really need that with the stress I’m under in this job. I need to be able to go to someone for advice and help and to generally off-load. (Community midwife, G grade)

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*In the staff grading system currently used for midwifery staff in the NHS, F and G grades represent levels of responsibility. They equate approximately to the former categories of staff midwife and sister.*
Some midwives, however, voiced this same need but felt that a supervisor could not be trusted to provide this support. Whilst there is some evidence that midwives give each other support of this nature (Curtis 1992), for the NHS midwives interviewed many support needs remained unmet.

**Vulnerability and the need for protection**

Midwives on all the sites expressed their need for support in terms of protection. Sometimes this was seen as protection in the face of increasing levels of complaints and litigation: ‘because as midwives we are more out on a limb legally. We do need that support’ (E grade midwife). Often this plea for support was combined with a plea for protection both within the midwifery culture and within the wider organizational culture which many respondents saw as swift to blame and to punish:

I feel that we need a lot of protection. We always talk a lot about the women — how the women need this and that... but people forget about staff and their morale and that we really need a lot of protecting right now. (G grade midwife)

Many midwives spoke about their efforts to implement woman-centred care, often in situations where midwifery management failed to recognize that midwives were women too and also needed to be supported and facilitated if they were to provide a good standard of care to clients.

**Needs for advocacy and facilitation**

The need for protection was closely linked to the need for a supporter who would speak up for midwives. On all sites, the need for advocacy was highlighted together with the need for someone with ‘clout’ who would support the midwife in the wider management arena. The midwives spoke of two closely linked needs: reassurance that they had an advocate, and facilitation towards empowerment:

Supervisors as women have to be strong and they have to know who they are defending and why. They have to feel they are capable of supporting other women...but they also have to know they have backing when they are addressing difficult issues. Over the years women have been disempowered and they need midwives a lot more, but midwives also have been disempowered so I suppose that is where supervisors could come in — to empower the midwives. It is hectic down there on CDS [central delivery suite]...it’s quite dangerous at times so you start to practise defensively instead of in a caring and compassionate way...supervisors have to really love and care about the midwives...caring is an essential ingredient for a supervisor. (G grade midwife)

The midwife quoted above demonstrates her awareness of the parallel support needs of women, midwives and supervisors. Midwives were also aware of the potential for skilled support and facilitation to enable midwives, like their clients, to develop their individual capacity to cope and to care and thus to change their experience from one of powerlessness to one of choice and direction:

...you really need somebody to make you realize what you really want to do; like where you’re going and the best way to go about getting there...They also need to be tolerant as we are all midwives of different characters and at some point we are going to want to express that character, as without that opportunity, frustration sets in and people get burned out and tired...and if we’ve no-one to relate to and because we’re not able to work in the way we really enjoy...that’s why people spend so much time in the toilet — or off sick! (E grade midwife)

Changes in the organization of care were perceived as threats by some midwives and many midwives spoke of support needs linked with change and conflict. These midwives reacted to change by wanting to be protected rather than perceiving themselves as having the power and skill to negotiate change. They lacked an advocate from whom they might learn negotiation skills, whilst experiencing protection.

**The danger of dependency**

There were examples of inappropriate ‘caring’ for the midwife by the supervisor: a ‘nannying’ which does not enable the recipient to grow as a midwife. The supervisor reminding the midwife of her need for statutory updating for example, as distinct from the discussion of how to make best use of such updating for professional development, falls into this category. ‘Nannying’ is, of course, expected by some midwives, which is understandable within the culture here described and where midwives feel a strong need for protection, for someone of whom they can say ‘she is obligated to look after me’.

Many supervisors worked hard to facilitate midwives’ autonomy although this was not always easy as, ‘they expect you to do everything for them...but I just put that right back to them...they can organize that for themselves’ (G grade supervisor). Only very rarely were supervisors explicit about ‘not creating a dependent relationship...I’d like them all to be able to challenge with confidence’ (supervisor). Supervision on one site was seen to have progressed a long way in this direction and had empowered midwives to feel in control of their work situation. It is interesting that, as this control increased, they also gained respect for the limitations of their supervisors.

**Support and trust**

Two conflicting discourses run throughout the data collected from midwives within the NHS. The first concerned midwives’ need for support. The second
concerned the issue of trust and the many ways in which midwives felt unable to trust supervisors, managers or colleagues.

One barrier to trust was the phenomenon of horizontal violence which was experienced or feared by some midwives in this study. Past experience of confidence betrayed or horizontal violence experienced, seen in action against a colleague, or simply envisaged as logical within the culture of midwifery, served to undermine trust. Thus, there is a real contradiction between the expressed need for support and the surrounding culture which was so often described as undermining the trust which is needed before support can be accepted. It may be this very contradiction that led midwives to be muted in terms of developing their discourse on support beyond an unstructured list of needs.

Enhancing midwives’ confidence

Midwives gave examples of a number of ways in which their confidence was enhanced. Some of these were very simple and centred upon the midwife feeling valued. ‘It’s quite inspirational when people appear interested in you… it spurs me on… I feel motivated’ (F grade midwife). Midwives were amazingly heartened by being praised by a supervisor or manager. Most never expected praise and many expected blame because this was their habitual experience. In such circumstances, the expression of praise and thanks can initially change the atmosphere and ultimately be a move towards changing the culture.

Midwives also wanted to be respected:

...respect for each other — personal as well as professional respect. I’d want [supervision] to be supportive, to be able to handle criticism but in a constructive way — not make me feel that I have done something wrong. (F grade midwife)

Most of the midwives spoke of a need for their efforts to be acknowledged and recognized. Many did not experience this. Where it was experienced, the effect was profound.

Support towards flexible and sustainable caring

The data contain a very small number of examples of supervision aimed at changing the culture of midwifery, enhancing midwives’ confidence and professional flexibility:

I feel very strongly about not creating a dependent relationship...I don’t want them to be dependent on me. I’d like all of them to be able to challenge with confidence, to challenge the structure, to challenge me…I hope I show them that we can have meaningful discussions about practice issues and challenge each other respectfully…I’ve noticed they are often embarrassed by my approach initially, but then it gradually becomes a shared philosophy so that we all become accustomed to being challenged and being accountable...it becomes the normal thing to do...I think good supervision is tied up very closely with good leadership... anyone can carry a title and not be at all visible themselves but you can still see results in the development of the midwives... I really don’t want midwives to look on me as just someone to go to because there’s a problem...I really don’t want to be seen as a fix-it-up person.

They all know that I will challenge them and be up front about it. But I do it quietly, confidentially and privately, so it’s not a public thing. (Clinical lecturer/supervisor)

Such challenging was seen, by all concerned, as a catalyst for the professional development of the midwives involved. The midwives who experienced such supervision noted an increase in confidence. They felt they were nurtured as well as challenged and saw professional and personal development flowing from it. It was, however, rarely seen.

Midwives outside the NHS

Independent midwives and privately employed midwives reported planning and developing support structures for themselves and saw the support they gained from colleagues, clients and members of other professions as very important for their personal and professional development and well-being. They did not therefore express the support needs with regard to supervision that were expressed by NHS midwives:

I think a key issue for us is that since we’ve been in a group practice — the guiding/counsellor/friend aspect of supervision has been completely taken care of amongst ourselves...If we need support we turn to each other…our first point of reference would always be to each other. (Self-employed midwife)

This difference in trust and in sources of support may be because these midwives have opted out of the NHS and its culture of midwifery, or it may be that their very different models of midwifery practice increased both the need and opportunity to develop appropriate support networks.

DISCUSSION

Skills towards empowerment for midwives and mothers

Parallels can be seen between the support midwives give to clients, invisible in terms of institutional priorities and resources, and the support which midwives themselves seek. If midwives support needs are to be met, they need to be helped to ask themselves the questions from which they can develop a support strategy. Posing the right questions can only follow the supportive listening which midwives seek. This is the question-posing technique of...
the mother who seeks to develop her child or the midwife supporting a woman writing her birth-plan. It was also the technique of Socrates and it has a very long tradition as a skill of drawing out the potential in others; it is something in which many women excel (Belenky et al. 1986). When exercised in private, as on one of the sites, this technique protects, whilst empowering, the person questioned. Yet, the privacy which ensures safety and success also makes this skilled and powerful technique invisible and little acclaimed. In midwifery, the use of such empowering techniques restores our practice to a motherly, developmental tradition established long before our present culture of practice. Similar techniques may now be needed to facilitate clients’ decision-making on increasingly complex issues.

Such supportive drawing forth of individual potential is fundamental to the practice of midwifery in its original meaning of being ‘with woman’. The culture implied in our name can be reclaimed. In an era of evidence-based practice, we also have a duty to research, develop and render visible such vital skills for the better support of both mothers and midwives.

Other techniques, such as giving praise, where due, can enhance midwives’ confidence and thereby lead to change. Giving praise and thanks does not require extensive psychotherapeutic training; it takes little time and makes midwives feel valued. Creating the habit of praising can be an empowering experience for the midwife who gives the praise, since she is also likely herself be the victim of the current culture of powerlessness and blame.

Other simple techniques can help to create an atmosphere of support and respect. One such practice, from a similar context, is that of cultivating ‘equality of esteem’. This term was coined by Charlotte Williamson (1997a, 1997b) in the context of the liaison between service providers and service users in primary care. Whilst efforts to hold all parties in equal esteem will not dissolve power differences, they should lead to people being consciously treated as equals. This practice, in its giving and receiving, may help to dissolve some of the disabling expectations of blame which midwives carry with them in so many situations.

Once a supportive atmosphere is established, techniques for planning and building appropriate support can be explored in education and in practice. Specific skills to develop power-sharing (Boal 1979, Baker et al. 1997) and techniques to enhance reflection (Kirkham 1997) are just some ways of triggering a creative spiral of powerful change.

**Leadership**

Clearly, the development of supervision and, more widely, of midwifery leadership, is crucial if midwifery is to move towards a caring and generative culture. It is likely that the nature of this study, as part of a research project on supervision, encouraged midwives to discuss support in that context. The existence of supervisors as individual sources of support, together with the hierarchical structure of midwifery within the NHS, also encourages midwives to look to powerful individuals within their workplace for support. Yet, the very structures and culture of the NHS create the factors which may stop these individuals from offering appropriate support or, when support is offered, lead midwives to feel unable to trust or accept it.

As practice changes, so must leadership. Where supervisors consciously modelled assertive and trusting behaviours, this had a powerful effect upon midwives. Midwives want their leaders to move away from the rigid defence mechanisms of the past:

As midwifery practice changes, so must the role of the supervisor as there is more demand for advocacy. If midwives put themselves on the line for women, so must supervisors put themselves on the line for midwives. (Midwife)

Another area where leadership is needed is in facilitating new models of care:

It is possible that the key to moving out of a midwifery culture where horizontal violence persists can be found in developing models of midwifery care that offer autonomous and positive interprofessional collaboration with ensuing increased self-esteem for midwives, and a breaking down of hierarchies (Leap 1997 p. 689).

Brodie (1996) has shown that where midwives work in ways that allow closer relationships with women, the needs of the women become paramount, with a resulting lessening of allegiance to profession or employer. This lessening of restrictive allegiances allowed scope for the development of new support networks. This was probably also true of the non-NHS respondents in this study. It may well be the case that continuity of carer is therefore important for midwives in that it brings about closer, more equal and potentially more supportive relationships with immediate colleagues, as well as with clients.

**Learning from clinical supervision**

There is certainly a need to foster mutual support amongst midwives, yet it is hard to reverse the vicious circle whereby those who feel powerless lack the confidence and impetus to build the support networks which would be empowering. Once it is in place, such a support network of colleagues is increasingly useful. Practices such as clinical supervision may be useful here. In part of one unit studied, group clinical supervision was practised alongside statutory midwifery supervision and the midwives involved viewed clinical supervision very positively.
In psychiatric nursing, clinical supervision has been shown to provide the ‘feeling of safety’ (Wilkin 1998a, p. 2) and to model the building of trust and support (Wilkin 1998b) which was sought by midwives in this study. Such supervision provides the opportunity to exploring the potential for empathetic ‘being with’ (Faugier 1992, Wilkin 1998a, 1992) which is so crucial in midwifery (Kirkham 2000) and in motherhood (Winnicott 1975, 1989). This experience is likely to enhance the repertoire of responses and relationships from which midwives can draw in being ‘with woman’ (Deery & Corby 1996). It may also provide safe space within which defence mechanisms can be addressed (Taylor 1996).

The findings of Wilkin’s research on clinical supervision echo both the positive aspects of our study and the spirit of Changing Childbirth (DoH 1993).

It is from within a cluster of regulating and controlling frameworks and traditions...that a mandate has been created which has given us as a Team the opportunity to build a vehicle for empowerment (relationship-based clinical supervision) within a system of power. (Wilkin 1998b p. 78)

Midwives can be wary of learning from other traditions, with good reasons. Yet the findings from this study show that the supervision of midwives can be such a ‘vehicle for empowerment’ and can facilitate the building of other such vehicles and other, very different, ways of moving towards empowerment.

CONCLUSION

At a time of upheaval and staff shortage, it is essential that the midwifery workforce is sustainable and flexible. To achieve this, the current culture of midwifery must change and midwives should receive the support they need. Midwives themselves can achieve this empowerment, as colleagues and as leaders. This research has shown glimpses of paths towards a nurturing and generative culture for midwifery. Taking and developing such paths is a process of political, as well as cultural, change: of power sharing within midwifery as well as with women.

As childbirth changes, midwives have the need and the opportunity to recreate a tradition of midwifery, realizing our voice and power, developing our vision and replacing horizontal violence with developmental support.

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