Commentary

Midwifery and the LGBT midwife

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Abstract

Objective: to identify, through searching the published literature, midwifery's attitudes to gay and lesbian midwives.

Design: a selective literature review.

Findings: UK-based material was sparse. Items on midwifery and nursing and medicine and on midwifery in non-UK countries were accessed. Issues emerging include the salience of 'coming out', of education, of culture, of forming relationships with childbearing women and the difficulty of authoritative research.

Key conclusions: the midwifery literature on LGBT colleagues corresponds with that identified in nursing almost three decades ago. The lack of recognition of LGBT midwives carries personal and organisational implications.

Implications for practice: discriminatory attitudes may be difficult to resolve by education. Research on LGBT colleagues is fraught with difficulties. Various aspects of culture affect the acceptance of the colleague who is gay or lesbian. It is uncertain whether the midwife–woman relationship is less easily achieved by the gay or lesbian midwife.

Introduction

I heard you were quite normal.

This comment, demonstrating heartfelt relief, greeted a midwife arriving in a new clinical area, because he was the first male midwife to work in the local maternity services (Walsh, 2009). It was this account of being welcomed in such a manner that provoked us to rethink midwives' perceptions of their midwifery colleagues who are lesbian, gay, bisexual or transgender (LGBT). Clearly 'normal' is open to various interpretations, and we should consider what this welcome was actually saying. It may be taken to mean that he had two hands and was presentably turned-out; but we should question whether these words carried a more sinister sub-text. One possible interpretation includes the stereotype of the male carer as is seen presented all too frequently in the popular media (Gay Belfast, 2010).

The introductory example may demonstrate that homophobic anxiety features in the perceptions and interactions of some midwives with their colleagues. Despite this, based on our own experience, we would argue that the significant contribution of lesbian midwives has long been recognised at an individual level. However, there is a sense that disclosing ones sexual orientation within a midwifery context may prove more problematic than for professionals in other health-care settings. For these reasons, we seek to examine what has been published about the recognition of gay and lesbian midwives as colleagues in midwifery within a health-care system.

At the time of writing, this aspect of life, especially in the work place, is addressed in the United Kingdom (UK) by the Equality Act (Sexual Orientation) Regulations 2007 (SI 2007/1263). This Act amalgamated a number of items of antidiscriminatory legislation enacted since the 1970s. A new Equality Act was, however, passed by the UK parliament in April 2010, with a view to implementation in the four countries within a year (OPSI, 2010). This new legislation lists the aspects of personality, or ‘protected characteristics’, which are addressed by this act; these include age, disability and religion/belief, as well as sexual orientation. The latter is defined in terms of orientation towards a range of persons. It does not make any assumption, however, that the orientation be manifested in the form of either relationships or behaviours. Thus, sexuality and sexual orientation are recognised as infinitely more than bodies and what they do or do not do and with whom.

Because of our interest in staff generally and midwives particularly as human beings in the organisation which is a health system, we sought to consider whether the midwifery profession as part of a health system recognises the contribution of the LGBT midwife. A literature review was undertaken to investigate the scholarly attention given to lesbianism in midwifery and to LGBT midwives. We consider why other, not unrelated, occupational...
groups appear more open and comfortable addressing issues concerning their LGBT members. We draw together these findings by discussing the issues which have emerged and conclude by reflecting on progress to address discrimination.

Methods

To access relevant literature, we used CINAHL, Google Scholar and PubMed and the search terms ‘midwife’, ‘midwives’ and ‘midwifery’ in combination with ‘lesbian’, ‘gay’, ‘homosexual’, ‘LGBT’/’GLBT’ and ‘homophobia’. Because our early background reading suggested a generally rapidly changing environment, we avoided papers written before 2000, although occasionally it was necessary to extend this limit. On scrutinising the papers identified, we found that few included any discussion of issues associated with midwives as members of an occupational group. For this reason, we widened the search to include occupational groups who bear comparison with midwives. The terms ‘nurse(s)’ and ‘nursing’ produced a small number of items, and ‘medical’ and ‘health professionals’ produced similar results. We followed this electronic search by searching the references in the items identified. This process produced items focussing on developed countries; it is necessary to surmise that midwives in less-developed countries have different experiences.

Findings

It is intended that the focus of this paper is on the health-care provider, i.e. the midwife, who is gay or lesbian. It is likely, though, that the reception which this midwife faces may be comparable with that encountered by lesbian clients, a contention supported by Australian research (Irwin, 2007). For this reason, it is occasionally useful to refer to research focussing precisely on lesbian clients’ experiences. Additionally, as mentioned already, it became necessary to widen the literature search to include other occupational groups, to obtain a picture of how gay and lesbian colleagues are regarded. In order to integrate this material, we consider the various groups’ literature before discussing the common themes emerging.

One of the problems which bedevil consideration of LGBT issues is the possibility of stereotyping the members of the various groups. We have to emphasise at the outset the need to recognise the diversity of the members of these groups (Irwin, 2007: 71). As with non-homosexual people, LGBT people are represented, albeit more or less openly, in every stratum and aspect of society. All of the usual social differences apply, be they ethnic, socio-economic or any other form. Additionally, we should bear in mind that LGBT people are far more than that, having a wealth of other attributes. So, although we may be considering a lesbian woman as a midwife, she may also be a mother or a carer to a lover, partner or parent (Manthorpe and Price, 2006). Thus, it is crucially important to avoid the ‘cardboard cut-out’ mentality.

Midwifery

The attention given to the lesbian or gay midwife in the research and scholarly literature is notable by its absence. This situation is comparable with that identified by Rose as long ago as 1993 when preparing for research using a midwifery and nursing perspective:

‘lesbians and gay men who are nurses are rarely mentioned (1993: 50).’

The exceptions to this observation are found in the work of Karen Jackson and of the late Tamsin Wilton, as they illuminated, albeit briefly, issues associated with the lesbian midwife’s experience. These references, however, emerged only in the context of the problems encountered by the lesbian client, with a view to improving her midwifery care (Wilton, 1999: Wilton and Kaufmann, 2001; Jackson, 2003). In her earlier paper, Wilton bemoaned the unpreparedness of the caring services to address the needs of the lesbian service user. She went on to expand on this observation by drawing comparisons with the services’ unwillingness or inability to support lesbian members of the profession (Wilton, 1999: 155). Thus, Wilton clearly endorsed our suggestion, opening this section, that parallels may be drawn between the lesbian client’s experience, with that of the lesbian midwife. Such experiences are explicitly linked by these authors to a health-care system featuring institutionalised homophobia.

Following Wilton’s initial exploration of homophobia experienced by lesbian clients (1999), a mixed-methods study was undertaken to investigate lesbian mothers’ accounts of UK maternity care (Wilton and Kaufmann, 2001). Unsurprisingly, the lesbian midwife did not feature in this research. The recommendations arising, however, included the need for some consciousness-raising among midwives:

‘Midwives to be aware that not all pregnant women are heterosexual (Wilton and Kaufmann 2001: 209. Italics in original)

Although these researchers did not use the terms, the need for this recommendation clearly resonates with the phenomena known as heterosexism and heteronormativity. The former comprises discriminatory assumptions that all human beings favour and participate in only opposite-sex relationships. Kitzinger (2005: 278) has defined the latter as socio-legal, cultural, organisational and interpersonal ‘practices that derive from and reinforce a set of taken-for-granted presumptions relating to sex and gender’. Kitzinger found heteronormative practices to be rife in health care and, as they have been identified in nursing (Röndahl, 2005), they are likely to be relevant to midwifery.

An interesting exception to this bleak picture is found in a personal account of a US nurse practising in ‘Labor & Delivery’ (Stephany, 1992: 120), which addresses many of these interpersonal midwifery-oriented issues.

Midwifery and nursing

Although, in the latter part of the twentieth century, midwifery and nursing shared many aspects in common due to shared educational preparation, these parallels have weakened to vanishing point (Mander, 2008). There are longstanding differences, though, which have facilitated nursing’s earlier recognition of the significance of sexual orientation among, first patients, and subsequently nurses themselves. As long ago as 1987, an authoritative literature review prepared for research on nurses’ knowledge about and attitudes to sexuality (Webb and Askham, 1987). As well as demonstrating the lack of attention to sexuality in the adult nursing curriculum in England, this review attached great significance to the position of men in nursing and the stereotypes attributed to them. Comparing men in nursing with women in medicine, Webb and Askham twice state:

‘Men entering a predominantly female profession seem to be perceived as more deviant than women entering a predominantly masculine profession (1987: 77 & 79).’
It may be that nursing’s acceptance of men into its ranks before midwifery required nurses to address such issues sooner. With Webb’s important research raising their consciousness, nurses’ attitudes to sexual orientation soon began to be addressed. A survey, though, in which a postal questionnaire achieved a 40% response rate, painted a bleak picture (Rose, 1993). Lesbian nurses in England discussed the difficulties which they encountered with self-disclosure, or ‘coming out’, at work. These difficulties were not only for the respondents themselves, but also their friends who, they feared, might also be ‘labelled as a dyke’ (Rose, 1993: 52). Students and junior grades were particularly anxious that declaring their sexual orientation would jeopardise their career progression. Homophobia was reported being experienced by both patients and lesbian nursing staff. Although lesbian nurses were unprepared to state that they were discriminated against on the grounds of their sexuality, many reported experiences indicating that this was happening. Respondents considered that they experienced a form of oppression, which may have been self-imposed, as it was associated with the lesbian nurses’ difficulty in socialising with (non-homosexual) colleagues and their difficulty conversing about leisure activities. The non-recognition of lesbian nurses was interpreted as aggravating feelings of being oppressed:

The conspiracy of silence is a continuous state of oppression (1993: 52).

Rose concluded that nursing should be proud that issues pertaining to the care of gay and lesbian patients were being addressed. On the other hand, she expressed serious regrets about nursing’s poor record of looking after its own by providing ‘care for the carers’ (1993: 52). Rose’s findings of enforced secrecy are endorsed as continuing by an international study between New Zealand and USA (Giddings and Smith, 2001). These researchers’ innovative methodology comprised data collection by ‘life history’ and focus groups involving five nurses who self-identified as lesbians. As found by Christine Walsh in Australia (2007), these women’s life histories demonstrate the complex emotions associated with decisions to ‘come out’. Like Rose, though, this research shows the awful isolation experienced by lesbian women lacking a supportive network. For some this isolation was ‘resolved’ by a virtually schizoid existence, which prevented them from revealing their sexual orientation at work. Paradoxically, such an arrangement was found to carry some degree of safety, despite the isolation which resulted from being unable to mention ‘leisure’ activities. Experiences of workplace discrimination were found to be associated with stereotypes of lesbians as sexually predatory, men-hating, motorcyclists.

Giddings and Smith draw conclusions concerning the image of the ‘good’ or ‘real’ nurse as held by the public. This is widely perceived as Nightingale’s ‘angel/Madonna’–like figure (Jinks and Bradley, 2004), although images of spinsters or whores also feature in traditional representations. As Giddings and Smith correctly observe, these public images of midwifery and nursing certainly do not make any allowance for the nurse to be the stereotypical lesbian mentioned above. These researchers identified some perception of oppression among the lesbian nurses, through which their heterosexual colleagues sought to silence them about their lifestyles and impose outdated stereotypes of the ‘nice and caring’ nurse (2001: 19). Effectively, lesbian nurses were regarded as threatening the public persona which their colleagues sought to project, because:

lesbianism is contrary to the image of nursing as a humanistic and caring profession (2001: 19).

Medicine

UK medicine’s paradoxical situation involves progress with professional LGBT issues while being pilloried by lesbian clients for homophobic attitudes:

- my GP … was very disappointing. She stated outright that a woman should not consider childrearing unless married to a man (Wilton and Kaufmann, 2001: 205).
- he did not agree with two women bringing up children (Wilton and Kaufmann, 2001: 205).

Homophobia is operationalised as discriminatory practices, manifest as humour, limiting referrals, denying job opportunities and disadvantaging students/trainees (Burke and White, 2001). Despite some positive developments, career choices and progression remain problematic, possibly due to training programmes’ directors harbouring homophobic attitudes (2001: 423). Educational and CPD challenges persist and Saunders highlighted the complicity of the General Medical Council, medical royal colleges and deans of medical schools (2001).

Other practitioners

A majority of practitioner-related literature is directed towards homophobic attitudes, so the focus on LGBT health-care practice in a UK-based qualitative study was unusual (Riordan, 2004). The sample comprised mainly medical practitioners (13/16) with no midwives. The focus was the LGBT practitioner’s identity management during an unspecified ‘clinical examination’. Unsurprisingly, the findings showed the practitioner’s disclosure of their sexual orientation, or being ‘out’, in clinical settings. Hence, the many issues about self-disclosure or ‘coming out’ converge in this paper, showing the practitioner occasionally self-disclosing to improve rapport with a client unhappy about their sexuality: a teenager had taken an overdose … because he was gay … [I] felt it was important to act as a kind of role model (Riordan, 2004: 1228).

Although cautious self-disclosure was common, other practitioners would do the opposite to avoid homophobic reactions. This involved ‘passing’, when a demeanour diametrically different from the stereotype of the ‘discredited group’ was assumed:

I have grown my hair longer so as not to look so harsh and not so dykey (Riordan, 2004: 1228)

Ethico-legal problems arise out of the heteronormativity or heterosexual assumptions of the UK National Health Service (NHS) (Acker, 1990; Riordan, 2004). These include a female chaperone as forestalling accusations of inappropriate behaviour. Clearly, the existing literature, although tending to ignore LGBT midwives, raises issues relevant to her or his recognition and functioning.

Discussion

The literature has shown that LGBT nurse and medical practitioners have been shown to, at least, be recognised in the literature. The recognition of midwives, including the UK LGBT midwife, however, appears to be seriously deficient, being found only in chatrooms (e.g. Student Midwife Net, 2008; RCM, 2009). In this discussion, we address the implications of issues raised for the LGBT midwife. We next consider culture, a topic which implicitly underpins much of the literature. We finally draw together the themes and assess whether progress to counter discrimination is happening.
The issue of self-identification is significant on both a personal and an organisational level. It is crucial to bear in mind, though, that self-disclosure is neither a ‘once and for all’ act, nor an absolute, as ‘degrees of outness’ are proverbial (Steele et al., 2006). Because of the hetero-centred assumptions made in the work place and in everyday life, coming out for the gay or lesbian midwife is a repeated and repeating act (Ward and Winstanley, 2005).

Assumptions about sexual orientation are made in everyday language and if ‘out’ need to be challenged. This constant challenging has implications for the individual who, as high-profile employees calls on the General Medical Council, the statutory body responsible for ‘maintaining proper standards’ (GMC, 2010) for recruitment, a nominated sample or snowball technique. In turn, though, this causes problems due to the informants sharing certain common features, in this case support group membership, which would negate any generalisability in the findings.

Research

Researching the influences on midwives’ and midwifery students’ attitudes towards their LGBT colleagues and clients may be less easy than initially assumed. Difficulties in undertaking research into lesbian and gay issues in health care have been found challenging by experienced researchers. Preparing for a quantitative study on sexuality and nursing, Webb and Askham (1987) identified potential methodological problems. A major difficulty is the unconscious tendency of respondents to alter their responses to, first, fit the agenda which they perceive as socially desirable and, second, create a favourable impression with the researchers. These problems are likely to make designing a reliable questionnaire particularly difficult.

Quantitative approaches were also considered by Burke and White, who doubt the possibility of obtaining a representative sample; accessing personnel, who may be reluctant to disclose their sexual orientation, presumably underpins these problems (2001). Similar predicaments were identified in Stewart’s (1999) research on midwifery care of lesbian mothers. She overcame them to some extent by using a qualitative approach employing, for recruitment, a nominated sample or snowball technique. In turn, though, this causes problems due to the informants sharing certain common features, in this case support group membership, which would negate any generalisability in the findings.

Culture

The visibility or otherwise of gay and lesbian health-care providers in general and midwives in particular would appear to be determined by the culture of the clinical setting. It has been suggested that midwives constitute a relatively disempowered occupational group, tending to behave as subservient and lacking in autonomy (e.g. Kirkham, 1999). It may be that this occupational characteristic is also a feature shared with gay and lesbian midwives.

The aspect of occupational group culture linked to the clinical culture, as mentioned above, is the group’s self-image (Giddings and Smith, 2001). These researchers argue that nursing harbours specific criteria to which the ideal nurse adheres, one of which comprises presentation of a heterosexual public image. These researchers argue that this image is denied to a woman who is openly lesbian. It is necessary to contemplate whether such criteria are applied to lesbian midwives by their heterosexual co-professionals. A further example would be the highly desirable midwifery characteristic of ‘matrescence’—a professional form of motherliness (Walsh, 2007b: 82). This term may not fit the stereotypical image of the lesbian midwife to the extent that ‘lesbian’ and ‘mother’ have been described as oxymoronic (Giddings and Smith, 2001: 18). For reasons such as this the lesbian midwife may choose to remain closeted.

Another aspect of culture which is likely to be relevant in this context is the concept of the wider culture on a local and national level. This selective review of the literature has shown that published material on gay and lesbian nurses is largely non-UK and that the lesbian midwife is not recognised in the literature; such a finding, though, leads to accusations of ‘eurocentrism’ (Giddings and Smith, 2001: 19). The impact of national culture was made clear to me when conducting a series of conversations in New Zealand, where the observation was made that the lesbian midwife is more easily accepted in Australia.

Education

Education is widely considered to be, if not a panacea, at least key to the solution of problems with homophobic attitudes in health care. The argument has been advanced that homophobic and discriminatory attitudes among medical practitioners’ and medical students’ reflect those of the general population, from which they originate (Saunders, 2001). Whether this is so is open to discussion, but this argument forms the basis of a plea for ‘specific [educational] opportunities to foster an awareness of, and to deal with, their own homophobic attitudes’ (Saunders, 2001: 425). A similar entreaty may, probably with better justification, be made on behalf of other health-care providers.

The potentially universally remedial role of education, however, deserves attention, having been called into question, as those who organise and provide education may be part of the problem, rather than the solution. This conundrum has been linked, in an Australian midwifery and nursing context, with educators’ unrecognised prejudices and sublimated anxieties, which manifest themselves in the form of homophobic bias (Irwin, 2007), an argument strongly endorsed as applying to UK medicine. In his tirade against the medical establishment, Saunders calls on the General Medical Council, the statutory body responsible for ‘maintaining proper standards’ (GMC, 2010) through education and registration, and deans of medical schools ‘to face up to their own homophobia and challenge and eradicate it’ (2001: 425).

Having eliminated the input of medical personnel as well as the requirement for midwifery students to hold a nursing qualification, midwifery education may no longer be influenced by nursing and medical attitudes to LGBT practitioners. In response to this point, it may be necessary to consider the cultural system of which the student midwife becomes a part and in which medical practitioners and nursing attitudes, if not nurses, feature. This cultural system influences profoundly the student midwife’s attitudes towards LGBT colleagues and clients. The interaction between this systematic influence and the student’s formal education, which may be more or less homophobic, deserves research attention.

Relationships with childbearing women

The midwife’s ability to form a supportive relationship with a client is fundamentally important to midwifery practice (Wheatley, 1998). This centrality means that midwifery shares

‘Coming out’

...to find that ‘out’ employees showed no difference from closeted employees in terms of job stress.
more in common with mental health (MH) nursing than adult nursing, making the work of Christine Walsh in New Zealand particularly relevant (2007a). As has emerged here, she found that the issue of self-disclosure is crucial to the MH nurse, linked as it is to an ‘internalised homophobia’ (Saunders, 2001).

Relationship formation has been found to be more difficult for the gay or lesbian practitioner who is not ‘out’, which may be due to not addressing GLBT issues (Albarran and Salmon, 2000; Saunders, 2001: 425). Christine Walsh found, however, that the strength and authenticity of the lesbian nurse’s relationship with the client is unaffected by whether she chooses to self-disclose or not (2007a). Thus, it may be that the lesbian midwife does not need to ‘come out’ with her client, constituting a further reason for the invisibility of the gay or lesbian midwife. On the other hand, the midwife’s open and frank relationship with the childbearing woman may be jeopardised by such lack of honesty (Stephany, 1992). These difficulties are likely to be compounded by the nature of the woman–midwife relationship, which is crucially different from that of other carers, in that the sexual connotations of care are never far from the surface. Thus, lack of openness about sexuality, on either side, may be interpreted as dishonesty.

Conclusion

The literature which we have identified endorses the view that issues relating to LGBT midwives are, for various reasons, not well-addressed. Compared with publications from non-UK countries and from other occupational groups, UK midwives’ position appears to lag by almost two decades. It is clear that midwifery as an occupational group is moving towards recognition and acceptance of lesbian clients. It is necessary to question, though, whether, and if so when, full recognition of the lesbian or gay midwife will follow. Because of their organisational contribution, not to mention personal implications, this full recognition is long overdue. Such non-recognition is deplorable as the staff member not belonging and lacking commitment means that the organisation is deprived of that person’s maximum contribution.

That Queen Victoria questioned the very existence of lesbians in 1885 (Manthorpe and Price, 2006), is probably due to her upbringing and social milieu. What is particularly disturbing and a sad reflection on the attitudes of midwives and midwifery, though, happened almost a century later when one of us (RM) found herself challenged about lesbians’ existence by a midwife educationist. The time is long past for midwifery to move out of the nineteenth century and to give its lesbian and gay members the recognition, respect and support which is richly deserved.

Conflict of interest statement

There are no conflicts of interest.

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