Claiming an Ethic of Care for midwifery

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Abstract
Background: The public domain of midwifery practice, represented by the educational and hospital institutions could be blamed for a subconscious ethical dilemma for midwifery practitioners. The result of such tension can be seen in complaints from maternity service users of dehumanised care. When expectations are not met, women report dehumanising experiences that carry long term consequences to both them and their child.

Objectives: To revisit the ethical foundation of midwifery practice to reflect the feminist Ethic of Care and reframe what is valuable to women and midwives during the childbirth experience.

Research Design: A comprehensive literature review is presented from the midwifery and feminist ethics discourse.

Ethical Considerations: Nil to report.

Findings: Women are vulnerable during childbirth as they need care, yet they prioritise elements of relationship in their experience. The Ethic of Care approach equalises the relationship between the midwife and the woman, providing the space for relationship building and allowing midwives to meet the expectations of their accepted responsibility.

Discussion: Some midwives manage to balance the demands of the institution with the needs of the woman. This is described as both an emotional and professionally challenging balancing act.

Conclusion: Until there is a formal acknowledgement of the different ethical approach to midwifery practice from within the profession and the Institution, midwifery identity and practice will continue to be compromised.

Keywords
Ethic of Care, feminism, midwifery, professionalisation, social model birth

Current context
Maternity services in the United Kingdom are frequently a subject of complaint and dissatisfaction from service users. Complaints range from a lack of continuity in care and disregard of birth planning to experiences of verbal abuse and un-consented physical procedures.1–3 This context persists despite significant service reviews by the Government4–7 that have culminated in revised practice guidelines. This political involvement has been supported by campaigns to promote normal birth with the aim of reducing intervention and improving the birth
experience for women and their families. However, increasing normal birth statistics is not the whole picture as research reports negative birthing experiences among women despite fulfilling the ‘normal birth’ criteria of a spontaneous vaginal delivery. Conversely, where the birth has required medical intervention, many positive attributes of an empowering birth experience have been described by the parturient.

The importance of the woman’s perception of her birth experience cannot be underestimated. It has been described as having the potential to impact significantly upon her sense of self and influence bonding with her infant, adjustment to parenthood and the woman’s future engagement with health services. Negative experiences have been recorded as evolving into persistent feelings of humiliation, social isolation and perceptions of failure as a mother. Such psychological experiences are rarely attributed as a consequence of the childbirth experience. This may be because they often manifest after engagement with maternity services is complete. Yet, research has shown that women vividly recalled the emotions and disempowering experiences of birth even after decades had lapsed.

The maternity literature reports positive feedback from birthing women about their experience when expectations surrounding childbirth are met. These expectations reflect the core elements of the Changing Childbirth report of the 1990s that aimed to radically reform maternity services. Principle expectations from the literature include having choices, being in control through decision making, and having support from a person they know and trust. The supportive relationship during childbirth is credited as a significant mediator of fear. If it is not present, it is a source of anger and dissatisfaction. It is linked with shorter labours, less augmentation, fewer interventional deliveries, more bonding behaviour between mother and baby and improved postnatal outcomes.

These expectations reflect a ‘partnership’ approach to midwifery care. The community setting has been seen to stimulate this approach as institutional constraints of practice are relaxed. In this context, the social experience of birth is emphasised with the birthing woman as the focus of events. It is also possible to deliver care that meets such expectations in the hospital environment, yet midwives admit the need to perform an emotionally challenging balancing act between institutional requirements and women’s expectations. The ethical tension in midwifery practice as it manages expectations while meeting institutional demands can be highlighted as a source of women’s dissatisfaction with maternity services. The historical context of midwifery’s professionalisation lies at the root of this tension.

**Historical context**

By the late 19th century, medical men were seeking to control all of obstetrics as a route to their own professional acknowledgement in the emerging profession of general practice. Alongside their use of instruments at delivery was their exclusive knowledge of anatomy. This knowledge was the key to skilful practice and allowed the male physicians’ expansion into obstetrics, to the detriment of female midwifery practice. After an unsuccessful battle by midwives to be responsible for attendance on all birthing women, a new tactic was taken to broker a compromise and ensure protection of the normal domain of childbirth for midwifery practice. Thus, with the patronage of supportive medical professionals, the midwifery radicals achieved their compromise. They could enter the public domain of practice under the control of the medical profession by attending normal births and prevent being forced out of practice by the expansion of general practice physicians into obstetrics.

This compromise became enshrined in the Midwives Act of 1902. It decreed all uncomplicated birthing women were to have trained attendance by a midwife by 1910. This law legitimised the role of the trained midwife in public practice while moulding the profession through education and licensure to reflect the dominant values of the science-based medical profession. Thus, conditions of the institution were imposed upon the midwives and their social model of birth practice. Institutional accountability has since
become a significant director of practice as midwives must adhere to the policies and procedures of the organisation to which they are contracted.  

While securing a respectable profession for educated middle-class women, the traditional attendants previously called for at delivery were pushed out of practice. These women did not share the educative privileges of the powerful group of midwifery radicals and were seen as fair sacrifice to secure the new profession of trained midwives. Midwives were now formally mandated to look after women experiencing normal childbirth and would call the doctor if there were any complications.

As a result of the dominance of medicine in society, midwifery was forced to assimilate itself to the norms and values of the dominant culture to survive. Their practice compromise allowed them the opportunity to move out of the private world of the family into the public world of education and practice. 

Tronto describes how the powerless must convince the powerful to allow them to enter their domain by convincing them that they are the same or that they have something valuable to offer. In the case of midwifery, the similarities lay in the educated, moral group of women trying to break away from the low-class image of midwifery practice. They shared social categories of class, education and background with the medical fraternity. The added value they offered to this powerful group was to attend the numerous normal births that would not further scientific knowledge or add experience for medical practitioners. This would remove a large proportion of the ‘routine’ practice from the caseload of doctors.

The social model of birth

The basis of medical practice and decision making since the 1800s had been the moral philosophy of Kant (1724–1804) and is based on the belief that individuals are autonomous agents. Decisions are made from an impartial position, applying universal principles of morality. This philosophy is reflected in the set of fundamental bioethical principles that govern all medical and allied professionals’ practice; respect for autonomy, beneficence, non-maleficence and justice. In this version of society, decision making is uncorrupted by personal views, interests or networks. This arrangement is described as fair, where all stand equal before the rules governing society.

Tronto describes this impartiality thinking as ‘moral colonialism’ because subjects disappear behind impartially applied context-free policies. It both denies and represses difference. Since ethics is concerned with how power is used, how an individual’s story is heard and acted upon, this approach naturally reflects and reinforces the authority and power the policies encode. It fits with institutional relations among peers or the context of public interaction that reflects the privileges and power of men in society. The powerful in society are unconstrained by social boundaries and dependencies. Their privilege is reproduced within the institution of medicine. As a result, institutional childbirth is increasingly isolated from the social realities that condition the lives of the women experiencing it.

As midwifery has moved from the private domain of the home to the public space of the institution, the ethical foundation of practice has moved from relational ethics to one of universal principles. Institutional practice has enveloped the social model of birth and constrained it through its rules and philosophical isolationist approach. Consequently, institutional midwifery is increasingly described as ‘technocratic’, with technical interventions becoming absorbed into the experience of ‘normal’ birth. This reflects an attitude of control, treating all births according to standardised timelines while ignoring the rhythms of labour unique to each woman. This surveillant model of childbirth is often accused of sacrificing the relationship element of care. 

Childbirth is a social phenomenon and its success depends upon social processes. These processes are constructed by relationships and responsibilities. Both midwives and women are found to prefer the social model of childbirth. This involves forming a relationship between the midwife, woman and birthing partner and an acceptance of responsibility by the midwife to facilitate the woman’s birth expectations. This relational model as an approach to interaction has been gendered and identified as an Ethic of Care.
embodies a feminist approach to morality in contrast to the masculine ascribed framework of impartiality and universality. However, care alone is not enough. An *Ethic* of Care is required that encourages reflection and education of caring feelings to ascertain the best moral course. It addresses issues arising from relations between the unequal and the dependent, such as a woman in labour and her midwife.

**The Ethic of Care**

Action and judgements within an Ethic of Care approach are concerned with contextual details, interpersonal relationships, and the role of care and responsibility. Networks of social relations are part of what constitutes an individual’s identity. In this care perspective, judgements are tied to individual context rather than applying general principles. It balances care with responsibility to ensure compassion and that no one will be hurt or excluded. Care thinking has been taken as a feminist mode of moral reasoning emphasising moral commitments to individuals and presupposes awareness of social identities and the influence of contextual identity. Although this perspective has been culturally assigned to the female gender, studies in ‘non-western’ cultures have exposed this caring approach to morality in the decision making of both males and females. This discounts Gilligan’s original assertion in ‘A different voice’ that caring in moral decision making is of the female psyche alone. Thus, a more subversive colonialism of ‘western’ culture is suggested, to reflect the principles of Kant. The school of identity theorists link a person’s approach to moral decision making with their concept of self. This concept is a reflection of society as individuals react to interpretations of social meanings. If the concept of self includes connectedness and relationship, the expectations and interpretation of social interaction will reflect and consider both connection and relationship. Conversely, if the concept of self reflects impartiality and universalism, this will be mirrored in social interaction.

Held argues that moral decisions are made in response to the interpretation of events, to an experience. Morality is not only about what is thought but what is perceived, acted and reproduced between individuals. What is valued is shown by making people accountable to each other for it. To be accountable, one must accept responsibility, and as women have become disenfranchised from birth and deskillled in what was once ‘women’s business’, trust and responsibility have been handed to the medical and midwifery professions to control the unknown of childbirth. If the supportive relationship is being obscured and devalued in midwifery practice by the imposition of policies and procedures of the institution, the door is opened to technocratic dominance and disregard for the expectations of the childbearing woman. The associated long-term consequences of this disregard have already been described.

**Refocusing practice**

Refocusing midwifery practice back to a foundation built on the Ethic of Care could alleviate and reverse this decline into dehumanised care, as the moral force of responsibility and relationship is stressed. As this responsibility has been taken by the midwifery profession, there is a moral requirement to fulfil it. The main component of responsibility is our ‘understanding’ of the relationship, between mother and midwife, and the capacity to act. Goodin’s responsibility ethic argues our primary responsibility is to those who stand in a special relationship to us. It is not about voluntarily assuming responsibility rather it is based on the vulnerability of others. It is their vulnerability and not our promise to act that imposes a special relationship. One is obliged to do as promised because others are dependent, and to need care is to be vulnerable. Vulnerability belies the political myth of independence and autonomy that is embodied by the institution. Thus, this part of human experience is hidden in the private sphere. To be responsive to this vulnerability, an individual’s position needs to be considered as it is expressed without any presumption. This unfulfilled requirement can explain the oft reported mismatch between practitioner interpretations of a birth experience in comparison to that of the woman.
Walker\textsuperscript{59} narrows vulnerability to ‘circumstantially dependent upon’. This fits the experience of childbirth as women are temporarily vulnerable during labour and childbirth as they come from a paradigm of wellness. Expectations of women for a continuation of the social experience of pregnancy into the childbirth event can be linked to this temporal relationship between vulnerability and expectation of the midwife to do as promised. Goodin\textsuperscript{57} describes it as ‘inviting reasonable expectations’ (p. 777). It could be argued that the majority of women in the United Kingdom experience pregnancy as a relational phenomenon, enhanced by the social protection of motherhood and development of the family. This relational support naturally extends to the childbirth experience and is reinforced by the midwifery discourse about high levels of choice, and empowering women to be in control of their birth experience through birth planning.\textsuperscript{6–8}

The woman-centred care discourse and the Midwives Rules and Standards for Practice\textsuperscript{60} recognise the risk of power imbalance between the woman and the midwife. The relational component of care is framed as ‘partnership’ to remove the order of inequality that is a risk factor for dehumanised care. Within a childbirth context, Leap and Edwards\textsuperscript{12} report childbearing women to generally agree with care providers in labour through a subliminal avoidance of antagonism. This illustrates a socially learned response to institutional power and a gendered response to authority. This authority is justified by a judgement of the other being less responsible due to their social position, devaluing the identity of the birthing woman.\textsuperscript{35} Lupton\textsuperscript{61} describes this as engaging in practices of the self by the woman, vital to her own perceived well-being and freedom from discomfort. However, it is easily abused by practitioners as the woman is dependent on the midwife for her basic needs to be met.\textsuperscript{62} The asymmetry of the relationship is emphasised and potentially abused, as the birthing woman may be kept in the dependent status against her will. This could result from lack of control in the birthing environment or in decision making, consent to examinations, birth position and medication administration. Goodin\textsuperscript{57} describes such a scenario as immoral.

The main tenet of the partnership approach is to treat the woman and her birth experience as unique and individual. It embodies the principles of the Ethic of Care as care has evolved from treating everyone the same to being mindful of what makes them unique.\textsuperscript{63} Treating people as individuals is seen as the key to dignified and respectful care and a key part of quality services.\textsuperscript{64} This model is based on a relationship of trust, sharing of control and responsibility through mutual understanding or solidarity of purpose.\textsuperscript{63,65} This solidarity equalises the relationship even in a situation of vulnerability. The primary relation is with the woman, but the institutional context can clearly create tension where the structures and mechanisms do not allow a different view of the body.

It has been recognised that the midwife needs to feel empowered and confident before she can facilitate these qualities in the labouring woman.\textsuperscript{66} If she is working in an environment that emphasises universality and obscures the value of the relationship through industrial models of care, practice becomes a case of ‘doing the best you can’.\textsuperscript{31} If the Midwife–Mother relationship is unequal and these structural factors subliminally make their impact, the promotion of control and shared decision making in childbirth will remain elusive. Consequently, Price and Shildrick\textsuperscript{67} warn of the danger that medical solutions become the only solutions as new norms of motherhood are created and midwives slide deeper into institutional affiliation.

Midwives were autonomous workers in the homes of women, creating relationships and contracts with women and their families. As practice moved into the institution, the cultural identity of the midwife and her network of relations has become obscured by technocratic procedures and marginalised by the constraints of institutional demands.\textsuperscript{57} Maintaining the identity and social position of the midwifery group in the face of such ethical and practice incursion can result in violence. This is a last resort action to try to maintain the practice position of the group as other avenues to express themselves are restricted.\textsuperscript{35,68} This can result in emotional detachment from the relationship and a retreat to impartiality and objectification. It can also manifest as horizontal violence, with midwives bullying each other and attempting to dominate the women in their care.\textsuperscript{69–72} This fragmentation of group behaviour erodes the respect that is necessary to maintain the
position of practice authority over normal birth. Such negative behaviour can develop a culture of practice, where hostile actions become routine among practitioners. This behaviour serves to illustrate the condition of the group’s oppression73 and results in dehumanised care.69

Conclusion

Revisiting the ethical foundation of midwifery practice to reflect the Ethic of Care would refresh what is valuable to women and midwives during the childbirth experience. Women are vulnerable during childbirth as they need care, yet they prioritise elements of relationship in their experience. When these expectations are not met, women report dehumanising experiences that carry long-term consequences to both them and their child. The Ethic of Care approach equalises the relationship between the midwife and the woman, providing the space for relationship building and allowing midwives to meet the expectations of their accepted responsibility. However, if the impartial philosophy of institutional practice continues to obscure that core element, then women and midwives have been failed. Some midwives manage to balance the demands of the institution with the needs of the woman. However, until there is a formal acknowledgement of the different ethical approach to midwifery practice from within the profession and the institution, midwifery identity and practice will continue to be compromised. Midwives and women prefer the social model of birth but need to publicly reclaim it. This would start by revisiting the ethical foundation of practice and lead to the development of educational tools and an accountability framework to enact it. This would provide the professional and political space to support humanised care in the institutional childbirth experience.

Conflict of interest

None to declare.

Funding

This research received no specific grant from any funding agency in the public, commercial or not for profit sector.

References


