

“Midwife with a Capital M”  
Professional Identities of Midwives in England and Scotland

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## ABSTRACT

In the United Kingdom, a majority of babies are delivered by midwives, whereas in the United States, midwives attend less than ten percent of births. As the standard of maternity care in the U.K., midwives practice in all birth settings, ranging from hospitals to homebirths. This thesis explores how practicing in a variety of settings within the context of a nationalized healthcare system affects midwives' professional practice and interpersonal relationships. Thematic analysis from twenty-nine interviews provides insight into midwives' nuanced perspectives on relationships to institutions, the effects of dissimilar practice settings, and relationships to other healthcare providers. Through analysis of midwives' professional experiences, this thesis will reveal the heterogeneity in the field of midwifery, despite the typically homogenizing effects of professionalization. Upon examination, this diversity among midwives may strengthen the profession amidst ongoing challenges.

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## INTRODUCTION

*You need to hold onto these people, because they are really valuable assets. And I think unless you change and give midwives a slightly higher status—and I don't mean pay-wise, although that would be nice—I mean respect and nurture them, for the profession. Because, I mean, this is our future.*

Jill lives in a small rural community in Northern England and works at a surprisingly modern community hospital, built only three years prior to when I met her. The hospital is small, but contains a minor injuries unit, rehabilitation gymnasium, pharmacy, and a variety of community clinics, including the clinic where Jill works as a community midwife. Here, she holds prenatal appointments with pregnant women<sup>1</sup>, and unless complications arise during pregnancy, Jill and her midwife colleagues are the only healthcare professionals a woman will see for the entirety of her pregnancy and birth. No births take place at the community hospital, so women in the area either deliver with a midwife at one of the larger hospitals—about 25 miles away—or at home, with two midwives from the community hospital, though Jill says only about three percent of the women seen at their clinic decide to have a homebirth. After the birth, almost all mothers and babies will be visited at home by the community midwives, preferably the same midwife who provided the mother's prenatal care.

Thirty years ago, Jill worked at an obstetrics-led maternity unit in London, meaning the unit was led by doctors who specialize in medicine and surgery surrounding childbirth and maternity care. Now, Jill works at the community hospital where there are no obstetricians present, and all maternity care is midwifery-led. When asked about the differences between the two settings, Jill said:

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<sup>1</sup> Throughout this thesis, I will use the term “women” to refer to pregnant and birthing people. However, I also want to acknowledge that this term highlights the experiences of cisgender women and does not include the pregnancy and birth experiences of transgender men and people who identify as non-binary.

I mean the obstetric unit...that intensity and that complexity of cases is interesting. But ultimately, I like normal midwifery. That's a personal thing for me. I like to be with a woman and not necessarily in charge, more of a partnership...And even when I was training in London, the consultants [doctors] would say, "You know if you want a nice normal delivery with an intact perineum...you need a midwife."<sup>2</sup>

Jill's response reveals more than just the difference between two work settings; she feels that when care is led by midwives, there is more equality and less hierarchy in her relationships with women compared to when it is led by doctors. The introductory quotation and this excerpt from my interview with Jill summarize much of what I heard from midwives throughout my research about the challenges of practicing midwifery in a large nationalized healthcare system where those challenges are not always appreciated or reflected in midwives' professional status. However, I argue that the diverse experiences of midwives across the U.K. better equip them for facing those challenges and advancing the midwifery profession.

During our conversation, Jill also explained the value of midwifery care by describing the differences she sees in a birth attended by a doctor versus a midwife:

You might not get the casual dip in about breastfeeding, you might not get the chat about what clothes have you bought, what equipment have you bought, all the things that we know as women, and as mothers perhaps as well...because I think it helps them realize that actually they're not just a baby machine. There is a woman in there who has these choices. Whereas—I don't know, maybe I'm being a bit disingenuous to some of the consultants [doctors]—but I think some of the consultants just view this as a pregnancy. They forget that there's a woman attached to it at the same time.

Jill's reflections recalled for me the works of midwife and anthropologist Deborah Fiedler, who characterizes a midwife as a birth attendant who "perceive[s] birth to be an inherently normal physiological process with powerful emotional and spiritual dimensions" (Fiedler 1997:163–164). She goes on to explain that the midwifery model of birth "assumes a holistic, integrating

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<sup>2</sup> Ellipses signify excised text.

approach that treats the woman as a subject and does not produce a dualistic separation between the woman's body and mind or between the mother and infant" (164). Fiedler's emphasis on the connective nature of midwifery care is echoed in Jill's explanation that midwives are dedicated to fostering the mother-infant bond and combatting the tendency to separate a pregnancy from the woman experiencing it.

### **Project Rationale**

I spent my first eighteen years of life in the state of Alabama, a place with a vibrant history of midwifery. However, in 1976 the state legislature effectively eliminated midwifery practice by no longer issuing midwifery licenses (Kitzinger 2000:146). Today, to legally practice midwifery in Alabama, a prospective midwife must complete nurse-midwifery training, which requires completion of nursing school and a masters' program in nurse-midwifery (of which there are no programs in the state), in addition to identifying an obstetrician who will agree to sign a collaborative practice agreement to supervise her work (Cleek 2014). Thus, it likely comes as no surprise that, until two years ago, the word midwife brought to my mind images of Biblical birth attendants, instead of modern-day healthcare professionals. Upon moving to attend the University of North Carolina, I learned of many local groups of midwives who practice both within and outside of the university hospital setting. Additionally, I took courses that explored the history of midwifery, explaining how the 20<sup>th</sup> century marked a branching point for midwifery in the United States compared to European countries. While midwifery as an autonomous profession was being outlawed in the United States, midwifery became a more formal, standardized profession in Great Britain and continental Europe (Kitzinger 2000:146).

I became especially fascinated by the differences in maternity care between the United States and the United Kingdom. Given that the U.S. and U.K. often collaborate in medical research and produce many of the world's highest-impact medical journals (Catalá-López et al. 2014), I was surprised to find significant differences in maternity care models between the two countries. Midwifery is the standard for maternity care in the U.K., while in the U.S. it is often viewed as the less-acceptable alternative to the biomedical model. In the years 2013-2014, U.K. midwives delivered greater than 55% of all babies and saw more than 93% of mothers in their first trimester (Community and Mental Health Team 2015:5). Additionally, since the midwifery model of birth stands in stark contrast to the biomedical model (Fiedler 1997:164), I found it interesting that in 2012, 87% of births in the U.K. took place in obstetrics-led units where midwives work alongside obstetricians who traditionally subscribe to the biomedical model (Cumberlege et al. 2015a:20). These unexpected findings led me to wonder about U.K. midwives' identities as autonomous professionals working as colleagues with obstetricians and nurses (Mander and Murphy-Lawless 2013:39; Kitzinger 2005:141). Do midwives struggle to maintain a separate professional identity apart from their biomedical colleagues within a field dominated by biomedicine? If so, how are they working to maintain or create this identity? Secondary to these queries, I wondered if a better understanding of midwives' experiences in the U.K. would shed light on the potential future of midwifery in the U.S. However, my results from speaking with U.K. midwives indicate little uniformity across the field. In most aspects of midwifery care—ideal practice setting, relationship to biomedical colleagues, etc.—I discovered that a broad spectrum of thoughts and opinions exists among midwives.

## **Methods**

To answer these questions, I conducted semi-structured interviews with twenty-nine individuals in seven cities across England and Scotland during June and July of 2016. Twenty-five of the participants were midwives, two were student midwives, and two maternity support workers. All participants have been given pseudonyms in this thesis to maintain confidentiality. These interviews included questions about the participant's professional background, current practice, ideas about and goals of childbirth, interactions with other healthcare providers, and perception of maternity care in the U.K. compared to the U.S. The average interview lasted 47 minutes (though they ranged from 10 minutes to 2 hours) and took place in participants' work settings, which were mostly hospitals, birth centers, or community clinics. Less frequently, interviews were held in other locations such as a local coffee shop or university building; lastly, two interviews took place via Skype call. To recruit potential participants, I started with a small number of U.K. midwives that I contacted through friends and university connections in the U.S. Additionally, I contacted individual clinics or small groups of midwives via email and phone to share information about the study. From there, I relied on snowball sampling to identify additional participants in the cities where I had already made connections. These seven cities will not be named to maintain participants' confidentiality; however, they range from large urban cities to mid-sized urban, semi-rural, rural, and remote areas.

The participant midwives varied in their current practices, education levels, managerial roles, and work experience. Approximately half worked in hospitals, while the others worked in birth centers, community clinics, attended homebirths, or practiced independently. Depending on the model of care in each location, many midwives' work spanned across multiple settings. All

midwives in the U.K. receive three years of standard training, or the equivalent with a nursing degree, though participants in my study ranged from one to thirty years of experience.

Participants in my study included midwives in more managerial positions, such as supervisors of midwives, consultant midwives, and labor ward or community matrons. Furthermore, two participants were researchers working on their own dissertations. Lastly, three participants had specialized as safeguarding, screening, and lactation midwives—meaning they possessed advanced skills in referring vulnerable women into social care, organizing tests and scans for pregnant women, and assisting women with infant feeding, respectively.

Given the wide variety of participants in my sample and enormous variety of midwives in the U.K., there is an impressive spectrum of beliefs surrounding contentious subjects among midwives. In this thesis, I describe these differences and analyze how the heterogeneity among midwives both enables and inhibits the professionalization process. Additionally, my thesis will draw from the anthropological and sociological literature on professionalism, healthcare systems, and midwifery to argue that midwives in the U.K. both struggle against and benefit from aspects of professionalism while working within a healthcare system that promotes solidarity. As a result, some may resort to rejecting those values in order to practice in a way that feels consistent with their identity as an autonomous professional.

## **Overview of Chapters**

In Chapter One, I describe the way in which midwives relate to larger institutions, such as the U.K.'s National Health Service. I employ arguments by Murray Last and Deborah Stone to examine the cultural values that accompany this healthcare system. Additionally, I examine how

the culture of a national healthcare service both supports and challenges the midwifery profession. In Chapter Two, I analyze midwives' interpersonal relationships through the lens of professional practice settings. A variety of settings prove useful for evaluating similarities and differences in midwives' relationships, both with one another and with practitioners of the biomedical model. In each chapter, theories about professional identity by Murray Last and Eliot Freidson will guide my analysis of midwives' professional experiences. I will conclude by looking to the future of the midwifery profession in the U.K., relating findings back to the United States, and offering suggestions for further research.

## CHAPTER ONE:

### INSTITUTIONAL RELATIONSHIPS WITHIN MIDWIFERY

The National Health Service (NHS) is the United Kingdom's system of socialized healthcare (Webster 2002: 255). As is expected with any system its size, the service receives both praise and criticism from patients and professionals alike. An independent midwife, Maribel, explained why she quit working for the National Health Service, because she was unable to structure her caseload and schedule in the way she believes midwifery requires. She said:

[In the National Health Service], you couldn't guarantee that you would be there for [a woman's] birth. So the continuity of care was not quite there...But it's definitely the lack of being able to give that guaranteed continuity of care to women—which is, as I said, what they want. It's what the research all suggests. It is, again, your gold standard of care. And without being able to give that, I didn't feel I was giving my gold standard of care, which I wanted to give. So I had to come away.

I later explained Maribel's perspective to Olivia, a midwife in the NHS, and asked for her thoughts on independent midwifery providing the “gold standard of care.” She replied:

See I completely disagree with that...Not because they [independent midwives] don't give great care. I know they give great care, and I know independent midwives. But...I think care needs to be free at the point of need. And I could never do that; I just couldn't. I couldn't just look after people because they have enough money to pay me. And I know that it's not just rich people who choose independent midwifery. I know that some people will save and save and save and they'll borrow money from family and stuff. But they shouldn't have to do that. They really shouldn't have to do that. This service should be available on the NHS...Everyone will benefit from continuity, but really it's the most vulnerable, I think, who will benefit the most. And they're the ones we should be focusing this service on, I think.

This disagreement between Maribel and Olivia—though not representative of all midwives' opinions within and outside of the NHS—presents an interesting debate over quality versus access. Maribel finds the quality of her midwifery care of the utmost importance, while Olivia feels that equal access to healthcare is her primary concern as a midwife, though quality should

not be sacrificed in the process of providing equitable care. The difference of opinion presented here is only one example of the controversies I encountered repeatedly throughout my research. These controversies will be explored further in this thesis, but in order to understand them, one must first understand the NHS within the context of its national medical culture as a social insurance system of healthcare.

### **Cultural Values Reflected in Healthcare Systems**

A nation's values regarding healthcare provision are often reflected in what medical anthropologist Murray Last calls "national medical cultures." Last asserts that these cultures exist at the intersection between a nation's political philosophy and the ways in which a government decides to respond to its people's health needs (Last 1996: 376). While some nations enjoy relative stability around their system of healthcare, others are presently undergoing changes in their national medical culture.

As a student-researcher in the United States, I am immersed in the current debate about our market-based system of health insurance. In the U.S. political landscape, liberal politicians generally support policies that favor universal access to healthcare, such as the 2010 Affordable Care Act, while conservative politicians have largely supported the market-based model and prefer to limit government regulation of the market (Levitt 2016). Public opinion polls show a nearly even split. In 2016, 52% of Americans responded that they believe the federal government is responsible for ensuring healthcare coverage for all citizens, while 45% disagreed (Gallup, Inc. 2016). Especially with the continued debate over the Affordable Care Act in 2017, the disagreement around our national medical culture is ever apparent.

The view of healthcare coverage as a responsibility of the government—while fiercely debated in the United States—is a founding principle of the system in the United Kingdom, which operates on a social insurance model. In this model, there is consensus in a society on which needs merit social aid, and the government then sets out to ensure that these needs are met for all citizens (Stone 1993:291). To say that citizens should have equal access to healthcare—regardless of their ability to pay or their degree of healthcare consumption—is a hallmark of social insurance systems, present primarily in large welfare states such as the U.K. and Canada (Dao and Mulligan 2016:8; Stone 1993:291). These insurance systems accomplish many things: “distribute risk broadly, create a shared sense of community, ensure access to medical services, and protect citizens from financial calamity in the event of a medical crisis” (Dao and Mulligan 2016: 8). In fact, respondents of public opinion polls cite many of these same features as reasons for their support of the U.K.’s National Health Service (NHS). In 2015, 60% of respondents reported being “very or quite satisfied” with the NHS, with the three main reasons being that the care is high quality, free at the point of use, and includes a variety of services and treatment (Appleby and Robertson 2016). These features of the NHS did not come about by accident, of course. At the time of the service’s founding, these values were fought for amidst great debate over which type of health insurance model the country would pursue.

### **National Health Service History**

At the end of World War II, most western governments were considering how to modernize their healthcare systems and provide for the health needs of veterans and civilians alike. In the U.K., where war casualties exceeded one hundred thousand, public anxiety over poor health during

reconstruction led to transforming the wartime Emergency Medical Service and Emergency Hospital Scheme into a permanent healthcare system (Webster 2002: 6–8, 255; Light 2003). Charles Webster, the official historian of the NHS, in no way suggests that this process was a smooth or inevitable one. In fact, he says that transforming the “haphazard assemblage of pre-war health services [into] the NHS” was inundated with “totally divergent and incompatible ideas” (Webster 2002:3, 8). However, due in large part to the aspirations of the Minister of Health, Aneurin Bevan, the National Health Service was founded in 1948 (Webster 2002:1). Webster writes that it was considered at the time “the most radical experiment in healthcare in the western world” (Webster 2002:255).

At the time of its creation, the NHS enjoyed widespread support across the nation (Webster 2002: 8, 25). Professionals and other staff working for the NHS felt “a sense of corporate unity...that they were part of a prestigious national service, capable of achieving in peacetime something like the feats of collective action and patriotic sacrifice recently witnessed in the special circumstances of total warfare” (Webster 2002:29). However, in its nearly seventy-year existence, support for the service has waxed and waned. In the 1997 general election, the deterioration of the NHS became a central issue as voters realized that the government’s “ceaseless preoccupation with ‘reform’ [was] a smokescreen, calculated to detract attention from a long history of neglect” (Webster 2002: 256).

Today, questions of market-based approaches and private sector influence still pervade political discourse in the U.K. (Webster 2002: 258; Mander and Murphy-Lawless 2013: 2). For example, recent changes in NHS funding include more Public Private Partnerships and Private Finance

Initiatives, in which the government leases hospital facilities that are owned by private entities (Mander and Murphy-Lawless 2013:2). Many residents of the U.K. fear that these movements toward privatization will transform the NHS into a healthcare system with different principles than those built into the foundation of the service (Webster 2002:258; Mander and Murphy-Lawless 2013:113). Rather than prioritizing the needs of citizens, some worry that privatization will instead prioritize private entities' duties to their shareholders (Mander and Murphy-Lawless 2013:113).

Webster discusses how corporate interests and other efforts to increase efficiency shape morale around the NHS. Interestingly, the obstacles faced by the NHS encourage collective feelings that reinforce the values of a social insurance system:

Countless public health issues provide reminders for the importance of a unified effort, but the pressure for uniformity permeates the system considerably more deeply. Realities of federal structures, economic unions and the global economy impose pressures for uniform approaches to social provision... Everywhere, constraints of the economic system and corporate interests exert pressure for reductions in public expenditure and provision of all services according to the norms of the market. In this situation non-conformity becomes intolerable (Webster 2002: 254–255).

While Webster writes about uniformity, other anthropologists say it is a shared sense of community, and some call it solidarity—though each description similarly reflects the nature of social insurance systems to connect a population of people (Stone 1993: 291). Solidarity in social insurance systems means the society has decided “sickness is one of those contingencies when society should rally around the individual” (Stone 1993: 292). While this solidarity affects all members of the society—as both taxpayers and beneficiaries—it is felt acutely by the professionals working to provide this service. The midwives participating in my study, like Maribel and Olivia, were no exception. We will later explore how the national medical culture in

the U.K. affects midwives' professional identities, but first, we will look at the role midwives play in the NHS.

### **Midwives and the National Health Service**

The NHS has more than 1.5 million employees (About the National Health Service (NHS) 2016). Approximately 26,000 of those employees are midwives (Health and Social Care Information Centre (HSCIC), Workforce and Facilities Team 2014: 6), and they are spread out across the four countries of the U.K.—England, Scotland, Wales, and Northern Ireland—roughly in proportion to the sizes of their populations.<sup>3</sup> Midwives employed by the NHS work in the public sector, though a tiny minority of midwives are employed in the private sector. There are approximately 150 private (independent) midwives currently practicing in the U.K. (National Childbirth Trust 2016). Despite their title as 'independent,' these midwives must undergo the same training, supervision, and practice review as public sector midwives (National Childbirth Trust 2016).

As is evident in the accounts from Olivia and Maribel, midwives hold a range of opinions about the NHS. Of course, their disagreement over the tensions between quality and access is most apparent because of Maribel's decision to leave the service; however, of the twenty-nine midwives who participated in my study, all had worked for the NHS at some point in their career, and two had some background in independent midwifery. Olivia and Maribel represent an interpersonal difference of opinion, but most midwives I interviewed individually maintained a degree of both support and criticism for the service.

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<sup>3</sup> Approximate number of midwives by country: England 22,000 ; Scotland 2,400 ; Wales 1,300 ; Northern Ireland 1,100 (Royal College of Midwives 2015)

I most often heard support for the NHS, surprisingly enough, in response to the question: “If you could change something about midwifery and maternity care in the United States, what would you change?” It seemed that even the notion of non-universal access to healthcare was enough to inspire praise for the NHS. Most people’s opinions were based on what they had seen in the news and popular medical television shows, rather than on personal experience; however, almost everyone I interviewed was aware of the fact that the United States does not have a health insurance system that is free at the point of use. Many people seemed bewildered about how a market-based system could operate—asking questions such as, “What happens in America when you've got your poor souls, your young teenage mums who maybe don't have any money, what do they do?” Although I consider myself well informed about the U.S. healthcare system, I found it difficult to articulate why our nation’s complex system operates the way it does.

Most midwives were proud of the accessibility of the NHS. Laurel and Samantha, coworkers whom I interviewed together, shared this candid conversation:

Samantha: I guess one of the big differences between the U.K. and the U.S. is that still everything’s free here. And all women can access the same services whereas...

Laurel: ...[In the U.S.] you’re going to get the women that die are going to be the lower socioeconomic groups that don’t seek maternity care, medical help...

Samantha: ...well, can’t afford it.

Laurel: ...or they just turn up in one of your ERs that don’t have enough staff to deal with it.

Samantha: And I think for all the things that we throw at the U.K., we do have a universal system that is the same for everybody.

In this exchange, Samantha and Laurel focus on the accessibility of healthcare regardless of a person's socioeconomic status—a notorious barrier to healthcare access in the U.S. (Andrulis 1998; Weinick, Byron, and Bierman 2005). These two midwives especially know about the social vulnerabilities of birthing women, because their midwifery specialty is in safeguarding. As safeguarding midwives, they advise other midwives whose patients have been referred into social care (for drug addiction, domestic violence, etc.), in addition to serving as a liaison between midwives and social workers. Samantha and Laurel's experience in safeguarding affords them a deep understanding of the health-related challenges of vulnerable women; thus, their position helps to demonstrate the importance of equitable access to care in the U.K.

Other midwives boasted of the affordability of the NHS in comparison to other nations. Olivia, whose views on the gold standard of midwifery were referenced previously, commented that the U.S.'s private insurance system seemed “utterly insane” to her. She also stated:

The NHS is one of the best values for money in terms of health. So I feel very, very proud to work for the NHS, and I wouldn't have it any other way. I mean, I just don't understand why everyone doesn't have it.

She argues a fair point. On average, the cost of the NHS is one-third the amount of money that Americans spend on healthcare (Light 2003:27). In terms of affordability and access, midwives see the NHS as having much to be proud of. However, Olivia also holds plenty of criticism for the service:

There are issues at the NHS. It's a behemoth. It's very inflexible—that makes it very difficult for innovation to happen—it's very difficult for change. It's very difficult to promote people who are innovative unless they're doing the management track, and I think that's a massive problem. And it's a problem with large healthcare companies in the [United] States as well, but because they're private, some of them can look to change those things. The NHS finds it very difficult to build flexibility, and it's one of the reasons why research takes—I think it takes a long time everywhere to get in, to be honest—but definitely it takes us a long time to embed and to make changes.

Olivia's major criticisms, especially as a university researcher, are about inflexibility and resistance to change. Concerns over resistance to change are echoed in Webster's writings about the history of political negligence toward the NHS (Webster 2002:256). Although, other scholars note that for a large government-run system, the NHS has implemented more recent changes at a "remarkable" pace (Light 2003:28).

By far the most common concern I heard from midwives was related to NHS funding. Midwives used a variety of terms to describe the current financial situation of the service: "overspent," "under pressure," "not transparent," and "very tight." Recently, the British Medical Journal reported that the transition from 2016-2017 was financially "one of the toughest winters on record," with a £900 million deficit at the end of the year (Iacobucci 2017). Jill explained how the lack of funding is affecting morale around the NHS:

It's related to funding; it's also related to government interference, I think. And not just this particular government, but successive governments have interfered too much, I think, and tried to make it market-led, and it can't be market-led. It's not going to work. I believe that you can't make money out of people's illnesses, or people's need for healthcare.

Given that NHS funding is acquired through taxation, the prominent metaphor for NHS funding is that there is one large pot of money which requires equitable apportioning. Often in my interviews, if a midwife mentioned needing more funding, she was quick to step back and acknowledge that other areas of healthcare draw from the same pot as midwives, who can only receive their fair share of funds. For example, Carrie questioned the fairness of lobbying for one's particular area of the NHS:

You've always got a class of women that are very self-motivated. There will always be lobbying from time-to-time for things, which you don't necessarily always get from the older generations, because they don't have the wherewithal. They're a little bit more

vulnerable. And I think as an NHS, we do need to be mindful that just because we have the ability to shout loud, it doesn't mean to say that we should get the biggest share of the money. You know, if we've only got so much in the pot, we've got to be very careful how we share it.

The struggle of deciding how to share the money is one that your average midwife does not encounter. Jo, a midwife in a somewhat more managerial role as a supervisor of midwives, explained to me:

Even in the job I do, the mystery about the funding is another thing. Because you never actually particularly appreciate how much things cost...For most people the establishments and staffing and everything is a mystery.

Other midwives, on the other hand, know the daily struggles of managing funds. Lisa, a labor-ward matron is the staff member on her ward who is tasked with being a responsible steward of the funds. Listening to her describe the tangible effects of the NHS's lack of funding made the job of reducing a £900 million deficit sound insurmountable:

That's why the focus is on normal, because it costs less to have a normal delivery than it does to have an instrumental delivery or a section. The stock that we use, we have to make sure that we're not over-stocking...So sometimes that can be quite challenging. You know, equipment, making sure that equipment is replaced and it's fit for use. Making sure that the staffing levels are well-staffed that you're not over-staffed or under-staffed, because if a ward's under-staffed then you're paying people extra or overtime, which is costly. So you try to make sure that people are put in a post in a timely fashion. That can be quite stressful, and you end up in a vicious circle with staffing. If the place isn't staffed right, it becomes more stressful, the more stressful it becomes, the more sickness you have.

Lisa's explanation clearly demonstrates the effect that a lack of funding can have on staffing.

From a systemic standpoint, a journalist writing for the *Independent* in 2011 wrote, "Nationwide, more than one-third of heads of midwifery have been told to cut staffing levels; two-thirds say they haven't enough people to cope with current pressure" (Mander and Murphy-Lawless 2013:59).

More than just heads of midwifery are familiar with staffing challenges. For the average midwife, low staffing levels affect her day-to-day workload. One of the easiest ways to reduce expenditure in the NHS is through minimizing the number of staff that require payment.

Reduction in staffing levels often occurs through the decision to not re-fill a post when a midwife has left or retired; however, the colleagues that are left behind are then expected to divvy up and share her workload. Indra, a midwife who has been practicing for twenty-seven years and nearing retirement, spoke of the changes she has seen in midwifery over the course of her career. The increased workload that results from having fewer midwives and more women to care for was one of her biggest challenges:

We're terribly short-staffed. It's stressful...And the generation of midwives that I belong to have the option of retiring at fifty-five because of the scheme that we joined way back then. And I'm not far off that now, and I'm thinking I can't wait to go, because I don't have the energy anymore to do it. And soon, midwives coming behind us will have to work on, and I actually don't know how they will physically manage, because it's physically energetic as well as mentally energetic.

Indra's fears about the decreasing ratio of midwives to women were shared by many. A major concern in the field of midwifery is that a large subset of midwives are nearing retirement. In England, 30% of midwives are 50 years of age or older, and in Scotland, this age group makes up an even greater 42% of the midwife population (Royal College of Midwives 2015:5, 9). In 2014, the Royal College of Midwives reported a shortage of 2,618 midwives in England—a number only expected to increase as a large subset of midwives approach retirement (Royal College of Midwives 2015:7). Thus, the problems of midwives being understaffed and overworked are projected to worsen in the coming years.

An additional aspect of the NHS that places pressure on midwives is the focus on preventative care. Throughout the history of the NHS, putting energy towards public health initiatives has

been viewed as a way to prevent future healthcare spending. For example, in 1979, the Labour government started an initiative entitled *Prevention and Health: Everybody's Business*, which encouraged healthier lifestyles with the aim of reducing NHS expenditure (Webster 2002:137). Though criticized for placing undue pressure on the individual to improve her or his health, the initiative's title "*Everybody's Business*" is indicative of the focus on solidarity that is present in social insurance systems of healthcare. Since everyone is drawing from the same pot of money, everyone has a responsibility to improve their health to minimize the amount of strain on the system.

And it is not just patients who feel this pressure for solidarity. Professionals become part of the initiative through a requirement to engage their patients in conversations about smoking cessation, obesity, alcohol use, etc. Some midwives, like Carrie, feel that there is an enormous benefit to incorporating public health into regular midwifery appointments. Carrie explained that pregnant women are often more receptive to conversations about healthy lifestyle changes, since they now are growing a new life inside them. For other midwives, these public health requirements, while valuable, are often additional boxes to check during appointments that are already pressed for time. Indra described how added public health measures take a toll on midwives and other healthcare professionals over time:

But now there's such a political, health promotional aspect to the job that they keep on handing out all the kind of health promotional stuff: smoking cessation, alcohol, brief interventions, you know. So it's actually become a bit of a tick-box...And you lose the interpersonal aspect of it. And working here, it's so busy that you daren't let the woman get a chance to say much, because otherwise your clinics will run late...And I think people who go into caring professions do actually keep going until they hit burnout, because they've got such a drive to get it right, to do it right, to perform well, and then you've lost your resources...And it's not just midwifery, because I hear all the time people that just want to move from the NHS—retire mainly. Because it's the government

that give these recommendations and then don't put anything into it. Squeezed out is what we're getting.

Although measures for improving public health are important and sensible in a system based on solidarity and equitable access, Indra's statement reveals that these measures can impose strains on healthcare professionals who are already drained of their physical and mental resources.

Midwives' perceptions of the NHS indicate that while its affordability and access are a significant source of pride, funding and staffing shortages and growing pressures to improve public health are real causes for concern that affect midwives' daily lives. But even beyond issues relating directly to the NHS, I found that the national medical culture in the U.K. affects midwifery as a profession in a variety of ways, often resulting in divergent opinions among individual midwives. In order to consider the spectrum of midwives' professional experiences, we must first look to the literature on professions.

### **The Anthropology of Professions**

In comparison to the medical anthropological literature on patients, there is a relative lack of writing on professionals, medical or otherwise. Anthropologist Laura Nader refers to this trend broadly as "studying down" (Nader 1972:289). Anthropologists tend to study those with less power—the disenfranchised, poor, and those typically from Non-Western countries—likely an outcome of anthropology's roots in the colonial period (Nader 1972:305). For instance, the anthropological literature on midwifery often focuses on lay midwives in non-Western countries (Fiedler 1996, Kuan 2014, Price 2014). This logic can be extended to explain anthropologists' tendency to focus on patients—the party possessing less power in the healer-patient relationship (Vollmer and Mills 1966:209). In contrast, Nader encourages anthropologists to "study up" by

instead examining those who hold power in Western societies (Nader 1972:289). A useful place to begin is by studying those people who are afforded power in our own societies, with one such type of person being the professional. While many anthropologists have continued to focus on the patient perspective, in the years since Nader identified this gap in literature, medical anthropologists have also begun to acknowledge the importance of studying medical professionals (Rivkin-Fish 2005; Kleinman and Benson 2006; Lindenbaum and Lock 1993; Good 1999). Thus, this thesis adds to the growing body of anthropological literature on professionals, specifically those in the healthcare field.

Professional status confers many benefits to an individual. Anthropologist Murray Last writes that healthcare professionals are a “self-conscious grouping of healers with defined criteria for membership (whether through licensing, certification, or registration) and an expertise over which it seeks primary control” (Last 1996:375). Last writes from the perspective of indigenous healers and the ways in which they seek professional status amidst a more dominant biomedical culture. Though he is more concerned with traditional medicine practitioners—which midwives in the U.K. are not—connections can still be made based on their historically contentious relationship to the more dominant field of biomedicine (Last 1996:377; Barnes 2003:264).

Regarding the process of professionalization, Last argues that this process is one way in which practitioners respond to “unequal competition” from other healing systems (Last 1996: 376). Since professionalization asserts that a group of practitioners have autonomy and access to a particular sphere of knowledge, seeking professional status is a bold way of asserting one’s place in the field, potentially in competition with a more powerful group.

Since the anthropological study of professions is lacking, many sociological writings prove useful when analyzing midwifery's position within the national medical culture of the U.K. Eliot Freidson's *The Profession of Medicine* provides valuable insight into the power of the professional. Freidson agrees with Last's assertion that a hallmark of professionals is the autonomy to control their own work; however, he claims this autonomy is dependent on the state's recognition of their profession (Freidson 1970:23). He writes, "The most strategic and treasured characteristic of the profession—its autonomy—is therefore owed to its relationship to the sovereign state from which it is not ultimately autonomous" (Freidson 1970:23–24). Since professions require political power to establish and maintain control, professions are only autonomous insofar as their authority is sanctioned by the state. Professions form lobbying groups that attempt to influence legislation, which, if successful, results in authority and legitimacy granted by the state. This is particularly relevant in the U.K., where the government decides which health services will be covered under the NHS (Last 1996:383). Therefore, much of midwives' autonomy as professionals hinges on the power afforded to them by government institutions.

The benefits of professionalization—primarily in the form of autonomy—appear abundant. However, there are disadvantages that accompany professionalization as well. Not all alternative healing groups agree on the decision to seek professional status. While professionalization may result in greater recognition for an alternative system, alliance with the dominant model also provides additional support for that model while driving other alternatives further towards the margins (Last 1996:382). For example, a case study on acupuncturists in the United States reveals significant tension among practitioners over the decision to professionalize. While some

practitioners support formal standardization, others see the process as imposing limitations on the pluralistic nature of traditional Chinese medicine (Barnes 2003:262, 265). Last also describes this homogenizing effect of professionalization, writing: “In the process an orthodoxy comes into being, consisting of a standardized body of knowledge that has been developed, disseminated, and accepted” (Last 1996:388). Although professionalization can result in greater power and autonomy for the group of individuals, these examples demonstrate how standardization may be viewed as a limitation on the individual practitioner.

Freidson writes about another potential disadvantage of professionalization: the inevitability of hierarchies in interprofessional relationships, particularly in relation to medicine. Since biomedical professionals are dominant, all other professionals are considered “paraprofessionals,” such as pharmacists (Freidson 1970:47). To minimize competition for the dominant profession, paraprofessionals are relegated to a lower status in the division of labor (Freidson 1970:49), but two factors can increase the potential for conflict between professions: each profession’s degree of autonomy and the overlap between their professional work. Thus, for autonomous midwives attending births alongside obstetricians, the potential for interprofessional conflict is great.

An additional aspect of professionalization that can confer both benefits and disadvantages to a field is the ability to self-regulate. Freidson writes, “The profession bases its claim for its position on the possession of a skill so esoteric or complex that nonmembers of the profession cannot perform the work safely or satisfactorily and cannot even evaluate the work properly” (Freidson 1970:45). In claiming a monopoly on a set of skills and knowledge, a profession also

earns the right for only members of the profession to regulate one another. However, the requirement for a profession to involve standard protocol and self-regulation can also pose threats to the autonomy of the individual practitioner. Given the posed benefits and potential disadvantages surrounding professionalization, it is unsurprising that midwives hold a range of views about their professional status in the U.K.

### **Midwifery as a Profession in the United Kingdom**

With the passage of the Midwives Act of 1902, midwives in England and Wales gained specific legal status, establishing formal limits for training and regulating the broad spectrum of birth attendants at the time (Stevens 2008; Reid 2007:188). While viewed by some as elevating the professional status of midwives, others assert that the act was another avenue for male doctors to control medical competition with midwifery (Mander and Murphy-Lawless 2013:58). Today, the debate about whether standardization helps or hinders midwives is still alive and well.

One avenue for standardization of midwifery is through the National Institute for Health and Care Excellence (NICE)—a nation-wide authority that sets evidence-based healthcare guidelines (National Institute for Health and Care Excellence 2017). NICE guidelines are implemented widely across the NHS and are mentioned so frequently in conversation that I often heard them referred to as just “the guideline.” Midwives spoke of them both positively and negatively. On some occasions, the guidelines gave a midwife authoritative power during a dispute with a doctor or another midwife. For example, Janna recalled having disagreements with doctors who wanted to prescribe medications to speed up a woman’s labor:

And they'd be saying to me, "You can't argue with what I'm saying." And I would say, "If you're happy to go in that room...put the drug up yourself, and explain to the woman that

you're doing this and it's not evidence-based, then go ahead. But I am also happy to document what you're doing and tell the woman it's not evidence-based." And then all of a sudden they would change their minds.

On these occasions, the NICE guidelines can support a midwife's professional expertise and enable her midwifery practice. However, the same midwives who invoked the guidelines also spoke of how they are too rigidly enforced. Janna later said:

You know, what they do in traditional cultures, I think, "God that makes sense."...So I'd like more of that. Just using your intuition, and thinking sensibly, and using common sense. But we need to get away from the institutionalized policies, guidelines, facts and figures.

Since the midwifery model of care highlights both evidence-based care and the importance of individual women's experiences, it is not surprising or inconsistent that Janna believes practitioners can place too much emphasis on abiding by the numbers. Instead, Janna's opposing statements presented here demonstrate how standardization can both support and impede midwives' professional practice.

Another effect of professionalization within midwifery is seen in the Nursing and Midwifery Council (NMC), the major regulatory body for all nurses and midwives in the U.K. The council's goal is to ensure that midwives and nurses are fit to practice. Some midwives view the conflation of nursing and midwifery on one council as nonsensical, since the two models of practice are different in numerous ways, particularly in their degree of autonomy. When speaking about the NMC, Olivia expressed her frustration at mixing the two models:

The problem is it's always been overwhelmed by nurses, because there's a lot more nurses than there are midwives [in the U.K.]. So they've always been the heart and the power center of the NMC...It's a very, very different way of practicing. You know, we [midwives] practice autonomously. I mean, even in hospital we are practicing autonomously. So you know, if a doctor says, "Give this injection," and you give it, and it's a drug error, that's your drug error. You know, it's their drug error as well, but it's

actually your drug error. You can't say, "Oh well, the doctor told me to do that." You are absolutely responsible for your own practice.

Anthropological and sociological theorists regard autonomy as the trademark of a profession.

Therefore, by highlighting the distinction between these two occupations—one with autonomy and one without—Olivia reiterates how autonomy is a major factor in a professional's identity.

Despite this distinction, midwives continued to be regulated by an institution that is increasingly made up of people who do not share a key feature of their profession.

In conjunction with autonomy, a vital aspect of a professional group is self-regulation. Freidson writes: "Just as autonomy is the test of professional status, so is self-regulation the test of professional autonomy" (Freidson 1970:84). Despite the dwindling number of midwives represented on the NMC board, midwives have retained a degree of self-regulation through supervisors of midwives who report to the NMC. Josephine, a supervisor of midwives, described her job as having two parts: one as a support figure for her colleagues and the second as a regulator—ensuring everyone is fit to practice in addition to investigating malpractice incidents. The NMC is in the process of removing this supervisory role so that all questions of fitness and investigations are handled directly by the NMC. Josephine conceded that the change is probably wise, since the two roles do not necessarily sit well together. However, she also lamented the change:

I guess the thing is it's probably bringing midwifery in line with nursing practice. Whereas for years it's been set aside, and I think it's always felt as if [midwifery is] a little bit more exclusive. So the kind of specialness of that exclusivity, because nobody has it, only the midwives have that, and the nurses don't have the same.

Even though Josephine believes that maintaining supervisors of midwives may not be ideal, it is clear that exclusivity and self-regulation are important to her sense of professional identity as a

midwife apart from nurses. In contrast, Adrian, another supervisor of midwives, thinks the change for supervisors is overdue. Since doctors do not investigate one another, nor do nurses, she thinks the current system of supervision in midwifery creates too many possibilities for conflict between colleagues.

Nadine Edwards, a midwife researcher and vice chair of the Association for Improvements in the Maternity Services, wrote in 2004 that the NMC claims to protect the public through ensuring nurses and midwives' fitness to practice. Edwards disagrees, stating that the best way to keep birthing women safe is to support their autonomous decision-making by transforming the “‘restrictive climate’ in which midwifery operates...into a ‘can do’ culture” (Mander and Murphy-Lawless 2013:143). Edwards' statement is another example of midwives advocating for better representation of the midwifery model within the body responsible for professional regulation.

Through legislation, standardization, and regulation, we see that midwives' practice can be both supported and impeded by aspects of professionalization. Depending on a midwife's perspective and set of experiences, she may hold one of many nuanced viewpoints about the professional identities of midwives. However, these identities do not exist in a vacuum, but instead exist in relation to other healthcare professionals and midwifery colleagues. The next chapter will address midwives' relationships and their effect on professional identities.

## CHAPTER TWO:

### Interpersonal Relationships within Midwifery

#### **The Midwifery Model of Care**

Prior to the 1970s, scholars—including anthropologists—left issues surrounding reproduction relatively unstudied, in part because they were seen as “women’s topic[s]” (Browner 2000:773; Davis-Floyd and Sargent 1997:3). When anthropologists did begin to study this field, their studies often focused on women’s birthing and reproductive experiences, particularly in non-Western cultures (Jordan and Davis-Floyd 1993; Sargent and Bascope 1996; Mead and Newton 1967). Their research less often looked at the experiences of midwives from Western cultures; however, the 1980s and 1990s marked growing attention for midwifery in industrialized societies (Ginsburg and Rapp 1991:322). In addition to the anthropology of midwifery, some scholars are looking to other fields to fill the gap of literature on Western midwifery. Nursing researcher Anne Mulhall writes about the intersection of anthropological thought with nursing and midwifery values. She writes that within the three fields there is a “natural alliance,” a shared view of “the body as being both a physical and symbolic artefact which is naturally and culturally produced—a mindful body” (Mulhall 1996:632). Mulhall states that more attention should be paid on behalf of anthropologists to the work of nursing and midwifery researchers, given the numerous connections among the fields and the insight they provide into the healthcare field (Mulhall 1996:633). Thus, this thesis will also draw on the works of midwifery researchers to gain perspective from within the field (Robinson 1990; Henley-Einion 2003; Campbell and Macfarlane 1990).

### *Authoritative Knowledge*

An essential concept in the anthropology of midwifery is that of authoritative knowledge. Robbie Davis-Floyd, perhaps the most notable anthropologist who has focused her work on midwifery in both Western and non-Western settings, has written much about the concept of authoritative knowledge. Along with midwife Elizabeth Davis, they define authoritative knowledge as “the knowledge on the basis of which decisions are made and actions taken” (Davis-Floyd and Davis 1997:316). Though authoritative knowledge may appear natural and reasonable, it is a product of cultural and social construction, and much of its power is due to the fact that it is often unconsciously reproduced and reinforced (Jordan 1997:57–58). As anthropologist Brigitte Jordan writes, “The power of authoritative knowledge is not that it is correct, but that it counts” (Jordan 1997:58).

In the context of childbirth, the possessor of authoritative knowledge holds the power to shape the birth experience. From Davis-Floyd’s perspective, the midwifery model of care is characterized by shared authoritative knowledge between the birthing woman and the midwife. In their research with independent midwives in the United States, Davis-Floyd and Carolyn Sargent find that midwives “honor women’s own authoritative knowledge about birth in a lateral way that makes the woman and the midwife equal collaborators in the birthing enterprise” (Davis-Floyd and Sargent 1997:21–22). The authors contrast the midwifery model of care with that of the biomedical—or technocratic—model. They write that the biomedical model “objectifies the patient, mechanizes the body, and exalts practitioner over patient in a status hierarchy that attributes authoritative knowledge only to those who know how to manipulate the technology and decode the information it provides” (Davis-Floyd and Sargent 1997:8). Since the

biomedical model is heavily reliant on technology and a sphere of knowledge that is largely inaccessible to those without medical training, the biomedical approach to childbirth creates a hierarchy between the birthing woman and the doctor who possesses authoritative knowledge. Thus, Davis-Floyd concludes that the biomedical model is characterized by an imbalance in authoritative knowledge, while the midwifery model seeks to balance the scales between woman and midwife.

Davis-Floyd's work has focused on the experiences of North American midwives, but it is important to recognize that the history of midwifery in the United States is unlike the history of midwifery in the United Kingdom. At the beginning of the twentieth century in the United States, as biomedicine gained strength, midwives were viewed in competition to biomedical obstetricians. Thus, obstetricians attributed poor maternal and infant mortality rates to midwives and portrayed midwifery as a public health hazard, despite midwives having statistically better birth outcomes (Kitzinger 2000:142–143). Throughout the twentieth century, individual states in the U.S. adopted different policies regarding the issuing of midwifery licenses. Even today, there are still states that do not issue licenses, and some midwives resort to practicing outside of the law (Kitzinger 2000:146). This history of criminalizing midwifery practice is not shared in the United Kingdom. With the Midwives Act of 1902, a registered midwife's presence at birth became mandated; however, their practice was restricted to attending only 'normal' (low-risk) births (Henley-Einion 2003:176). Midwifery became an increasingly standardized, regulated profession, undergoing a period of professional consolidation around the 1940s and 1950s (Robinson 1990:71). Thus, it follows that midwives in the U.K. experience different challenges

from those in the U.S., and those differences should be considered when employing the works of anthropologists who focus on North American midwifery, such as Davis-Floyd.

From the perspective of an anthropologist of British midwifery, Sheila Kitzinger writes about the ongoing controversies in the field of midwifery in the U.K. She writes that many NHS midwives are dissatisfied with their work, and their departure from the service is often attributed to low pay and strenuous working conditions (Kitzinger 2005:144). However, these explanations fall short, because many midwives feel greater dissatisfaction with their inability to provide the woman-centered care that true midwifery requires. Kitzinger explains, “they did not go into midwifery to spend their time filling in forms, manipulating machinery, and having to switch their attention between three or four women in labour at the same time... They entered midwifery to give woman-to-woman care. Mothers often do not receive this quality of care, and midwives are denied the opportunity to give it” (Kitzinger 2005:144). Drawing on Davis-Floyd, since midwifery care relies on sharing authoritative knowledge between woman and midwife, the relationships of woman-to-woman care that Kitzinger emphasizes are key to practicing true midwifery.

While Kitzinger’s work is insightful, her activist perspective should be taken into account. In the introduction to her book *Rediscovering Birth*, she writes about the importance of understanding women’s bodily power and supporting midwifery care (Kitzinger 2000:7). As a piece of activist work, she potentially downplays the experiences of midwives who are satisfied with their work and their status within the current system. This chapter will seek to represent the experiences of a broad spectrum of midwives, while still drawing from the perspectives of activist midwives.

### *Commonalities Among U.K. Midwives*

As this chapter will explore differing perspectives among U.K. midwives, it is important to acknowledge the commonalities encountered in my research around the midwifery model of care. Throughout my research, two questions frequently generated similar answers among midwives. There was almost uniform consensus around responses to these two questions: What does a good birth mean to you? And what do you find most rewarding about midwifery work? To the first question, there is general consensus among midwives that, of course, you want a healthy mom and a healthy baby, but that baseline is not enough. From the perspective of three different midwives, to be a good birth, you also need “a woman that feels empowered after it,” a “mum [who] is happy with her birth experience,” and a woman who has “done what she set out to do.” In order to create an empowering birth experience for women, though, positive relationships are also necessary, which brings us to the second shared view among midwives.

In my research, midwives almost invariably agreed that the relationships they form with women make their work rewarding. Ruth talked about the value of her relationships with women as a community midwife, being fully in charge of the antenatal and postnatal care for her caseload of women:

The fact that you've got total care. Seeing them from the very beginning right through to the very last day—all the way through. So I see her when she comes in saying she's pregnant. I see her all the way through her pregnancy. Sometimes I'm lucky enough to see her through delivery, and then I'm there to see her afterwards and see her finishing up with her baby in arms... That's part of the reason why you do it, because you want that continuity. You want to get to know your ladies. You want to see them coming back with their second and their third child.

In this statement, Ruth summarizes many midwives' sentiments about the real value of midwifery care being in the relational aspect. Ruth also emphasizes that having continuity of care is vital, because it is difficult to build relationships unless you see the same women routinely over a long period of time. From her perspective, continuity of care enables the most rewarding midwifery practice for both midwives and women:

I think because you get into a room you can tell when they're walking in the door if there's something not right with them, or how their mood is, or something like that. So when you don't have continuity, that all goes out the window.

Her colleague Betsy chimed in:

And with continuity I think that trust is a big thing as well, because they tell you more, they say much more, so you can care for them more, and give more back.

Despite continuity of care being such a vital aspect of the midwifery profession, Ruth and most midwives I met agreed with Kitzinger's sentiments that midwives are finding it increasingly difficult to provide full continuity of care in their practice; instead, they are spending more time filling out charts, adapting to new technology, and providing for more women as the ratio of midwives to women shrinks. These responses about rewarding relationships are also echoed in Davis-Floyd and Davis' writings about the value of midwifery care. They write, "midwives' deep connective, woman-to-woman webs, woven so lovingly in a society that grants those connections no authority of knowledge and precious little conceptual reality, hold rich potential for restoring the balance of intimacy to the multiple alienations of technocratic life" (Davis-Floyd and Davis 1997:339). Davis-Floyd and Davis assert that the relational aspects of midwifery care can be a remedy for some of the work biomedicine has done to separate the physical from the emotional and spiritual aspects of childbirth. Since relationships are essential to the midwifery model, amidst a system in which midwives are prevented from cultivating relationships with women to the fullest extent, it follows that midwives' authoritative knowledge,

which depends on relational work, is not held in as high regard as biomedical authoritative knowledge.

### *Postmodern Midwifery*

In order to build meaningful relationships and facilitate good births for women, midwives must work both in alliance with and opposition to the biomedical model—what Davis-Floyd calls postmodern midwifery. The term came about in response to mid-twentieth century doctors’ promotion of the “modern birth,” the notion that childbirth should be pain-free, hospitalized, and involve frequent intervention (Davis-Floyd and Sargent 1997:10; Davis-Floyd and Davis 1997:319–320). To counteract the lasting impact of this system, postmodern midwives must simultaneously operate within the biomedical system and subvert it for the good of the women they care for. Davis-Floyd and co-authors explain how postmodern midwifery relates to the biomedical approach to childbirth:

Recognizing the limitations and strengths of both the biomedical system and her own system, the postmodern midwife moves fluidly between them in order to serve the women she attends. Lacking or actively rejecting a sense of her practice as structurally inferior to that of biomedicine, she is free to observe the benefits of traditional midwifery practices common in many cultures...She concludes that biomedicine does not recognize the value of the midwifery approach; and she develops a sense of mission around preserving midwifery in the face of biomedical encroachment (Davis-Floyd, Pigg, and Cosminsky 2001:5).

While the theme of both alliance and opposition to biomedicine was one that surfaced frequently in my research, Davis-Floyd’s writings assume that midwives are more similar than they are different in their approach to midwifery care and its relationship to biomedicine. This chapter will demonstrate how the midwives I encountered in the U.K. hold a variety of often contradictory views on how midwives should relate to the dominant biomedical model and how

they should assert their own authoritative knowledge within the diverse array of settings in which midwives work.

### **Midwifery Practice Settings and their Effects on Relationships Among Midwives and Obstetricians**

In the United Kingdom, women have the option of delivering in one of four settings: hospital obstetric-led units<sup>4</sup>, “alongside” midwifery-led units (adjacent to or within hospital), “freestanding” midwifery-led units (separate from hospital), or at home. NHS midwives can work in any of the four settings, depending on the hospital trust’s chosen model of midwifery care and their own work setting preferences. Additionally, many midwives work in the community where they provide primarily antenatal and postnatal care, though community midwives may also occasionally or regularly take shifts in birth settings. Concerning midwives’ relationships to the biomedical model and to one another, most of the observed variation could be attributed to midwives’ practice settings. Comparison across the settings reveals how midwives utilize authoritative knowledge in varying ways, indicating that there may be more heterogeneity among postmodern midwives than previously assumed.

#### *Birthplace*

In 2012, approximately 87% of births in England occurred in an obstetric-led unit, 9% in alongside midwifery-led units, 2% in freestanding midwifery-led units, and 2% at home (Cumberlege et al. 2015b:20). The fact that a vast majority of births take place in an obstetric-led

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<sup>4</sup> The term “obstetric-led” refers to the presence of obstetricians on the labor ward; however, laboring women are always attended by midwives who practice autonomously, even if their care is being overseen by an obstetrician.

unit is consistent with the medicalization of childbirth that occurred throughout the twentieth century. In fact, in 1970, the Standing Maternity and Midwifery Advisory Committee, led by surgeon-gynecologist chairman Sir John Peel, stated that medical technology had come far enough to justify 100% of births taking place in hospital, citing safety for mother and baby as the main reason (Campbell and Macfarlane 1990:218). However, a broadly-supported study from 2011—commonly referred to as the “Birthplace Study”—provided evidence that directly contradicted the Peel Committee’s recommendation. The Birthplace Study found that for non-first-time mothers having low-risk births, there was no significant difference in adverse perinatal outcomes when the birth took place at home or in midwifery-led units compared to when they took place in obstetric units (Birthplace in England Collaborative Group 2011:4). Furthermore, women giving birth at home or in midwifery-led units were significantly less likely than those in obstetric-led units to experience interventions such as cesarean section, instrumental delivery, and episiotomy (Birthplace in England Collaborative Group 2011:4). The results were so significant that in 2014, the NICE guidelines for intrapartum care changed, emphasizing that more women should be encouraged to give birth in non-obstetric settings.

When asked about their thoughts on the Birthplace Study, nearly every midwife I interviewed spoke very highly of the findings. One midwife called it “the biggest piece of evidence we have” for encouraging women to consider all of their birth setting options. Many explained that midwives have always known that women are often safer out of hospital, and it is more a matter of having the scientific evidence to convince the medical community. I asked community midwife Jill whether the study felt revolutionary or whether it was something midwives knew all

along. Her response also reveals how the Birthplace Study often became a launching point in my interviews for other conversations:

Well, yeah, we did. And I think it's convincing the authorities, or the establishment if you like, and convincing the women. Because from the mid-60s...it was accepted practice to move women out of community and put them in a hospital setting to deliver. And a lot of that was about power... You know, obstetricians are mainly male, and they like to be in control. And I think so in some respects, midwives relinquished that as well. So we aided and abetted our own—not demise exactly—but a change of role. Loss of status, if you like.

For Jill, the trend of giving birth in hospitals—where the biomedical model is dominant—is about the power of biomedical practitioners. Her statement is consistent with the biomedical use of authoritative knowledge, in which the practitioner holds power and knowledge over the patient. The Birthplace study seems to represent to Jill not only a shift in practice, but the potential for a shift in midwives' professional status and assertion of their own authoritative knowledge in the healthcare system, as well.

Private midwife Janna expressed her general enthusiasm for the study, in addition to her perception that it has generated some controversy among NHS midwives:

I thought it [the Birthplace Study] was great. We, mainly the private midwives, weren't as happy with the fact that some papers and things had picked up on the fact that it more emphasized second-time mums are safer at home—just because the research wasn't quite directed to emphasize that aspect of it really. But overall, it was great. And it has given the promotion of home birth a boost...I know a few NHS midwives who thought that it was a risky statement to make that it's safer to have a home birth, and it did kind of cause the other camp to jump out and say, “Actually, you know, you're not safer of this, this, and this.” And they kind of wanted to pick it apart as much as they could. But on the whole, I think it was quite positive, really.

Though I never encountered a midwife who spoke negatively about the Birthplace Study, Janna's perspective demonstrates how the broad spectrum of midwifery practice settings can be a source of contention among midwives. For private midwives like Janna who work primarily in

homebirth settings, the Birthplace Study may not have gone far enough in endorsing homebirth for all women, including first-time moms. On the other hand, for hospital midwives who are unfamiliar with homebirth, the recommendation may be seen as a risky endorsement. The Birthplace Study represents an interesting form of support for the midwifery model, while at the same time generating some disagreement among midwives practicing in different settings. With an understanding of the Birthplace Study and its effects on midwives in different birth settings, we can now look to individual settings for a better understanding of both intraprofessional relationships and midwives' relationships to biomedical practitioners in each setting.

### *Homebirth*

In an ideal form of the homebirth model, a woman receives all of her prenatal care in her home, delivers at home, and then receives postnatal care at home, as well. I was surprised to find that, although homebirths are not recommended for high-risk<sup>5</sup> pregnancies, if a woman chooses to give birth at home against medical advice, the NHS cannot deny her a midwife to attend her birth. Of the midwives I interviewed who had experience making home visits and attending homebirths, many spoke highly of the experience for women. In contrast to an obstetric or midwifery unit setting, women birthing at home may feel more relaxed, have more freedom to move about, and enjoy the intimacy and privacy of their own space. The homebirth setting has an effect on midwives, as well. Janna explained how she is more focused on observations at home, whereas in a hospital, she has to utilize a different type of information to satisfy her coworkers and superiors:

[With homebirths] it's a lot more observations—like looking at somebody. Whereas in the hospital, you know that someone's going to come and ask you in four hours' time,

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<sup>5</sup> Many factors can place women in the high-risk category: existing cardiac problems, seeking a vaginal birth after a previous cesarean section (VBAC), gestational diabetes, pre-eclampsia, etc.

"How many centimeters is she?" They're not interested in "Oh the noises she's making have changed"... They're not interested in that; they just want facts and figures. So there's a lot more documentation and numbers when you're in a hospital than at home... [Relying on observations,] it's a lot more relaxed. You tend to be more receptive to things going wrong. I don't think things tend to go wrong as often, because you're not intervening, and the woman feels a bit safer I think, because she feels that you must trust her, because you're not intervening all the time.

In Janna's example, the midwife has not changed, only the setting has. In the homebirth environment, she is using both her own knowledge and the information (sounds, expressions, etc.) that the birthing woman provides her. This matches the midwifery model of authoritative knowledge—a shared knowledge between the birthing woman and midwife. Janna's statement demonstrates that the homebirth environment can enable a midwife to assert midwifery authoritative knowledge, potentially because she is under less pressure by practitioners in a biomedical setting who place more value on the technocratic model of birth.

While the homebirth setting is ideal in many respects for adhering to the midwifery model, providing the service has become increasingly difficult for NHS midwives. A hospital I visited once had a designated homebirth team, in which specific homebirth midwives managed the care of all women seeking a homebirth. To support continuity, the homebirth midwives used to be on-call twenty-four hours per day, five days a week. However, four years ago, the number of midwives on the homebirth team began to dwindle to an unsustainable level, demonstrating the difficulties involved in maintenance of such a service. The hospital's matron of community midwifery services explained that working as a homebirth midwife can be exhausting, demanding, and nerve-wracking; thus, it was difficult to find enough midwives who were up for the challenge. Although there is still a designated team of homebirth midwives, now the midwives primarily work on the labor ward, and whenever a woman seeking a homebirth is in

labor, whichever homebirth midwife has a shift at the moment will attend her birth. The change has resulted in a loss of continuity, especially because women seeking homebirths are now seen antenatally and postnatally by the community midwives, but the change was viewed as the best available solution for maintaining the homebirth service. Due in part to the Birthplace Study, many trusts—or regional groupings of hospitals—are striving to increase their homebirth rate; however, it has become increasingly difficult in some places for midwives to balance the demands associated with providing homebirth services.

Not all midwives are comfortable with the idea of homebirth, however. Olivia explained what she perceives as the reason for this:

You need very experienced practitioners to be brave enough to do it, to be honest. Because you know you're out there on your own, you're making decisions by yourself. I mean, you get a second [midwife] in for the birth, but a lot of the time [during labor], you're just sitting there thinking, "Right, is this right? Is it okay? Is it safe? Can we carry on?" And you need to be able to hold your nerve and have confidence, really, to do that.

While the independence of homebirth can allow a midwife to assert her authoritative knowledge unchallenged by biomedical practitioners, it can also feel intimidating to have that much freedom without other professionals around to weigh in. I asked Olivia later to expound on why she thinks some midwives perceive homebirth as unsafe. She offered this response:

I don't know that they think it's unsafe, but I think there is a bit of sort of suspicion between, unfortunately—and not all of them—but between a lot of the obstetric-unit midwives and the homebirth midwives. And they find it very difficult to understand how the other works. So the labor ward midwives generally only see some of the homebirth midwives when they're coming in because there's been a problem at home. So they tend to think there's problems at home, because they don't see all the ones that go well. So it's like, "Well what are you doing? You're irresponsible midwives keeping people at home, and then you bring them in like this." So I'm not saying that's what they're saying, but there's a sort of feeling that perhaps some of them think that. And in the same way, there's just as much prejudice. You know, some of the homebirth midwives say, "Well here are all these midwives on labor ward just being little automatons and not really giving women-centered care." Which again, is not fair either. So yeah, it goes round and round.

Olivia explains that homebirth can be a contentious issue for midwives as it can create divisions among colleagues based on their practice setting. While labor ward midwives may only see the homebirths that require transfer to the hospital, homebirth midwives may view their colleagues on the labor ward as “handmaidens” for obstetricians (Kitzinger 2005:141). The division is compounded by both groups’ unfamiliarity with the other’s setting and the unique challenges faced while practicing midwifery in each setting. Next, we look to the challenges experienced by labor ward midwives, especially as they relate to working alongside biomedical practitioners.

### *Obstetric-Led Unit*

In contrast to the homebirth setting, midwifery looks very different in a hospital labor ward where the biomedical model is dominant, like it is in all other areas of the hospital. As a researcher from the United States accustomed to hospital labor wards, I was most familiar with the three obstetric-led units I visited. A variety of staff members moved about—doctors, midwives, maternity support workers, labor ward coordinators, etc.—and the presence of advanced medical equipment was normal. Although the labor ward is officially called ‘obstetric-led,’ at any given time on the unit, a number of women with pregnancies deemed ‘low-risk’ will not require care by an obstetrician, and a midwife will be the lead professional in her care. As Olivia said to me, “Everyone needs a midwife; some people will need a doctor as well.”

For trusts that do not have a midwifery-led unit (either alongside or freestanding), anyone not seeking a homebirth will give birth in the hospital setting where they may differentiate the low-risk (midwifery-led) pregnancies from the high-risk (obstetric-led) pregnancies. Of the three

hospitals I visited, two used a color system to designate the different pathways (e.g. blue vs. red), while another reserved three rooms at the end of the sixteen-room unit for the low-risk pathway.

A midwife Cameron explained how she thinks the system at her current hospital works better than at her previous place of employment due to the ease of involving obstetricians in care:

It's great [here] because you don't feel like you have to switch in between [the pathways]. So you don't have to go from low-risk to high-risk to get them [the doctors] involved. Sometimes you have people that are borderline—they're still midwifery-led care, but there are the few signs that you think might lead them to be obstetric-led care. And you're able to just come out of your room and have a chat with them when you assess and you think, "This is not quite going to plan, what do you think about it?" And it's that we alert them that there's potential before it even happens...And doctors are amazing, because I think that's the main thing—not getting involved when they don't have to get involved...It's like, "You'll come to me when I need to know. So I don't want to get involved." Which is great, because that means they trust us.

For Cameron, having women with low-risk pregnancies in the same setting as obstetricians is helpful because the midwives can easily escalate care when abnormalities arise. However, she also recognizes that in her previous workplace, the doctors were too involved in the low-risk pathway, to the degree that they were "trying to make women high-risk," resulting in conflict with the midwives whose goal was to "protect normality." In her new workplace, though, Cameron expresses feeling both independent from the obstetricians and well-supported by them. Like Cameron, other labor-ward midwives I met also shared that they enjoy practicing in a hospital because they feel more comfortable in an environment where high-risk care is readily available.

In contrast, other midwives have had different experiences in hospital settings. Shelley, a midwife who has worked in all types of midwifery settings, feels that placing low-risk pregnancies and high-risk pregnancies on the same unit results in a blending of the biomedical and midwifery models to women's detriment. She described her experience on an alongside

midwifery-led unit that, due to a single door separating it from the obstetric unit, “function[ed] like the low-risk end of a labor ward with a few birth pools.” She provided a story that explained her experience with blending models of care:

It's not that there was direct tension with the doctors, it's just different philosophies of care. So, for example, you would have a midwife who was a little bit nervous, so she palpated this woman and the woman seemed to be measuring big. Now measuring big at the start of labor is not an indication for anything. It's not an indication for transfer, the NICE guidelines don't say transfer care, you don't get opted out of birth center care because you're big. She was just worried...But because she was a bit nervous and not used to practicing autonomously, she asked the registrar [doctor]...So the registrar comes through and palpates and says, "Yeah she's big. So because she might have a shoulder dystocia, she can labor here on the birth center, but then she needs to come through to the labor ward and give birth in stirrups for second stage." And then I come in and upset the apple cart, because I'm like, first of all, what is the doctor doing on the midwifery-led unit? I mean, either you transfer her if you feel that we have gone outside of guidelines, you now transfer her to the consultant-led unit, or you care for her. You know, and really the person that you should be consulting should not be a registrar, it should be a senior midwife who can tell you, well this is something that is relevant or this is something that is not.

Shelly sees the ready availability of obstetricians on the unit not as an advantage, as Cameron saw them, but as a threat to maintaining normality and the autonomy of midwives. Shelly is not opposed to transferring to obstetric-led care when the situation meets the guideline for transfer; she is opposed to mixing models for the reason that women who are still within the low-risk category easily slip into the high-risk category when doctors who are high-risk specialists occupy the same space.

Shelley's anecdote highlights the important distinction between the biomedical and midwifery models of care, as the two are forced to coexist in a hospital labor ward. Prior to beginning my research in the U.K., I expected to find uniformity among midwives with regard to their relationships with biomedical practitioners, such as obstetricians. Given the emphasis on collective teamwork that is found in social insurance systems such as the NHS, I hypothesized

that midwives would work closely in amicable teamwork relationships with obstetricians. However, I found a great deal of variation in midwives' experiences. Some had generally positive experiences with obstetricians—feeling that they respect midwives and the differences in their models of care. Others felt that the obstetricians with whom they have worked pose a threat to the normality of birth, as Cameron said, often “trying to make women high-risk.” In my research, I found that a number of factors can affect relationships between midwives and obstetricians: individual personalities, the regularity of professional contact, the duration of the relationship, the degree to which hospital managers prioritize time for team building, etc. Thus, there is no precise formula for creating positive interprofessional relationships.

Another way to approach the question of midwife-obstetrician relationships is to consider how the many institutional factors of a hospital setting can affect both professionals' types of practice. In all other areas of a hospital setting, the biomedical model is dominant. However, on a labor ward where both the midwifery and biomedical models are represented, there is greater potential for conflicting perspectives between the two types of professionals. In an essay on the topic of labor ward relationships, midwifery researchers discuss how they perceive the presence of both biomedical and midwifery models as affecting midwifery practice:

There are two major competing models of labour, each of which implies a different professional relationship. One model assumes that labours are normal until proved abnormal. Most therefore start off as the responsibility of the midwife, and it is up to her to decide if and when to involve a doctor. However, the usual medical model implies a quite different professional relationship. This model adopts the basic premise that every labour is potentially abnormal until it is over ... The consultant must therefore take responsibility for the progress of labour, and the junior doctors and midwives must act as the consultant's deputies and in accordance with his policies. There is no room for the midwife as an independent practitioner for normal labour, since a normal labour can only be recognized in retrospect (Kitzinger, Green, and Coupland 1990:152).

This excerpt asserts that the presence of the dominant biomedical model on a labor ward often does not promote normality, leaving midwives to be the constant protector of normality, or else conform to the biomedical model.

Olivia, who previously explained how homebirth midwives may view labor-ward midwives as “automatons,” described how the constant pressure of advocating for women on a labor ward can lead to a change in midwifery practice:

Well, I think, you know, all midwives are trained to be people's advocates, and they should be people's advocates. But I think, and especially if you're working in the ward environment which is very pressured in terms of time and in terms of moving people through the system, you know, sometimes it's difficult to advocate. And you tend to be slightly more with-institution than with-woman.

In contrast to Kitzinger's passage, Olivia's statement shifts responsibility for the change in practice away from individual consultant obstetricians and toward the work environment, instead. For example, Shelley, whose perspective on mixing midwifery and biomedical models I presented previously, said:

Well, you see, I don't actually see a lot of the cultural difference [between labor wards and midwifery-led units] as up to consultants. I actually think a lot of the cultural differences are down to busy-ness...Because the senior midwives on labor ward, they are like station managers...You know, and they have so much that they're coordinating, so understandably they tend to be in a kind of hyped-up run 'em through, because there's a lot of pressure and they're under pressure if the ward closes, and they're just very busy.

Both Olivia and Shelley explain that midwifery practice changes in the obstetric-led environment, but rather than attributing the change to poor midwife-obstetrician relationships, they see the busy-ness of the hospital environment as the more significant factor.

In a statement comparing the obstetric unit setting to the homebirth setting, a labor ward midwifery manager named Charity used language that struck me as indicative of the strong biomedical presence in the labor ward environment. She explained:

I also think it's something around that power shift. When you're in a hospital, the women are on your territory, so to speak, they're in your hospital. So there's a bit of a power change. When you're at home, you're like a visitor in their home.

I remember being somewhat surprised by this statement at the time, because the terms “power” and “territory” are more often associated with the biomedical model of care than the midwifery model. The writings of Davis-Floyd and Sargent concerning authoritative knowledge are relevant here. In the biomedical model, authoritative knowledge is possessed by the doctor, resulting in a hierarchy where the doctor possesses more power than the birthing woman. In contrast, the midwifery model relies on authoritative knowledge being shared laterally between the midwife and the birthing woman (Davis-Floyd and Sargent 1997:8, 21–22). In theory, this shared authoritative knowledge prevents the creation of a power hierarchy between the two. However, midwives' statements about the labor ward setting raise the question of whether adherence to midwifery authoritative knowledge is even possible in the hospital environment, where the biomedical model abounds.

Olivia explains that for labor ward midwives, the lack of relationships with women can prevent a midwife from being an effective advocate:

If you don't know the woman, it's very hard to advocate for her because you don't know what she wants. You don't know anything about her past... So you know, I think the vast majority of midwives will definitely be trying to advocate for their women, but it gets harder.

Since midwives' authoritative knowledge relies on shared knowledge between midwife and woman, when a midwife cannot form relationships with the women for whom she cares—or

must form those relationships in a matter of hours on the labor ward— she may find more difficulty in asserting this form of authoritative knowledge. Furthermore, in a hospital setting where advocating for women is already challenging and biomedical authoritative knowledge is already dominant, it may be easier for some midwives to avoid conflicting models by subscribing to biomedical authoritative knowledge instead.

Still, this is not to say that it is impossible for midwives to work in teams with biomedical practitioners and confidently assert midwifery authoritative knowledge. I visited one hospital that a community midwife referred to as “the most obstetric-based place I’ve ever been.” Her hospital colleague Adrian defied expectations by explaining to me how important she believes it is to both have positive relationships with obstetricians and also to maintain separation and autonomy in their practice:

I think our relationship is so important, because I need to know if I have a problem that I've got somebody behind me who when I say, "I need you to come now," they know me well enough to know that she means it...And I think it is about understanding each other's boundaries, because also as midwives, it's about taking accountability as a practitioner and as a midwife and saying, "This is my scope of practice, this is normal," and not referring when it doesn't need to be referred. Because I think that's the unique thing in a way about midwifery is that you're an autonomous practitioner, and you're accountable.

Adrian demonstrates both clear respect for her biomedical colleagues' work in addition to strong belief in midwifery authoritative knowledge. Despite working in a heavily obstetric-led environment, she believes midwives can and should assert their authority within the realm of their practice.

An interesting contrast to Adrian's opinion is presented by her colleague. Labor ward midwife Cassandra also believes that midwife-obstetrician relationships are important, but her explanation reveals underlying thoughts about midwives' professional status:

I think in the old school, the consultant very much was the boss, and they made the decisions years ago, whereas we're becoming skilled practitioners now. Our role is developing more all the time. We're doing a lot more, and I think they respect that. And I think the relationships have changed massively in that respect, that we're becoming more clinically-skilled.

While Adrian attributes positive interprofessional relationships to a mutual understanding of midwives and obstetricians' disparate roles, Cassandra explains recent improvement in the relationship to midwives' increasingly advanced clinical (biomedical) skills. Cassandra's statement demonstrates that she associates biomedical authoritative knowledge with higher professional status; thus, in her efforts to cultivate positive relationships with obstetricians and attain higher professional status, she may be hindered in asserting midwifery authoritative knowledge.

Through a variety of midwives' perspectives, we see that attempts to reduce midwifery practice in an obstetric setting to all-or-nothing categories can oversimplify the nuances and challenges experienced by midwives working in an environment with both biomedical and midwifery models present. While categorizing the "two major models of labour" (Kitzinger, Green, and Coupland 1990:152) may be a useful way to distinguish the midwifery from the biomedical view of childbirth, the categorization of midwives to either "consultant's deputies" or "independent practitioners" demonstrates that the literature has the potential to mask the diverse experiences of midwives in obstetric-unit settings.

### *Midwifery-Led Unit*

Given the many challenges presented by working in biomedical environments, the existence of midwifery-led units is understandable, as they may offer a middle ground between homebirths and obstetric-led units. Midwifery-led units are for women with low-risk pregnancies, and they are staffed entirely by midwives and midwifery support workers. In fact, midwives in hospital settings often lamented not having a midwifery-led unit within their trust nor the funds to build one, reasoning that they could do a lot more in the way of normalizing birth if women with low-risk pregnancies had the option of birthing in a fully midwifery-led environment. Two types of midwifery-led units exist: alongside and freestanding (or standalone); an alongside unit is connected to a hospital with obstetricians on staff, whereas a freestanding unit is not, though midwives did not seem to make a significant distinction between the two. I visited one alongside and one freestanding unit during my research, but their disparate locations may highlight their differences more than would happen in a similar geographic area.

The alongside midwifery-led unit was built four years prior to my visit, and its modern, thoughtful design is apparent. Ruth, the consultant midwife in charge, gave me a tour of the birth center where each of the spacious rooms contains a large pool, mood lighting, and a double bed for both the birthing woman and her partner. All medical equipment is hidden behind cabinetry to create a more home-like and less medicalized environment. Additionally, at the end of the hallway lies a special set of elevators that go directly to the obstetric unit in case of abnormality. A unit of this kind, however, was not built solely with NHS funds; Ruth led significant fundraising efforts to build such an impressive unit.

In this setting, where only midwives are present, asserting midwifery authoritative knowledge may be easier compared to an obstetric-led unit. Ellen, a midwife at the birth center, explained how her experiences compare on the midwifery-led unit to the occasions when she has assisted upstairs on the obstetric unit:

It is different [upstairs], because then you have doctors kind of knocking on your doors just sort of seeing what's going on, and that's quite strange when you are so autonomous down here to have that input. And I just think sometimes because they're dealing with such high-risk ladies all the time...it's remembering that generally there's something wrong with the mom, something wrong with the baby, so things do have to be adapted. But it is quite different up there.

Ellen's statement suggests that she experiences a decrease in autonomy when working on the obstetric-led unit; however, she also takes into account that high-risk pregnancies require more high-risk care that involves specialists in addition to midwives. The change in her autonomy reinforces many midwives' sentiments about the need for separating biomedical and midwifery models. Additionally, Ellen explained that she has experienced generally positive relationships with obstetricians on the obstetric-led unit. The nature of her relationships is due in part to her working on the unit for more than ten years, giving her time to build relationships with the obstetricians, even though she sees them infrequently. Thus, Ellen's experience in the alongside midwifery-led unit is characterized by autonomy in her practice and positive relationships with the obstetricians on labor ward.

The freestanding midwifery-led unit that I visited was in a remote and rural location, a two hours' drive from the nearest obstetric unit. Despite being located within a small hospital, it is considered a freestanding unit because there are no obstetricians on staff and no capabilities for performing surgeries such as a cesarean section. In this region of the country, many birth settings are freestanding midwifery-led units, because the vast rural landscape concentrates most

obstetricians in the centrally-located cities. The unit I visited staffs eleven midwives, and each midwife is on-call approximately two nights per week. They have a single birth room for the whole unit, containing a pool and other necessary equipment, although it felt significantly less lavish than the alongside unit I visited in an urban setting. The room is also equipped for video chat, in case a midwife needs to call an obstetrician located a hundred miles away. While visiting the unit, I spoke with two midwives, Meredith and Kate, in a joint interview. They compared their experiences in a midwifery-led setting to those of midwives on obstetric units. Kate said:

Midwifery's more an art than a science here than it is in a consultant unit...We don't prescriptively do an internal examination on a woman every 4 hours. We will watch the woman, we'll see how she's reacting. We'll see what her body language is. It's a watching thing.

When asked if they practice more autonomously compared to obstetric-unit midwives, their responses were “one-hundred percent” and “absolutely.” Meredith spoke about how midwives on obstetric units have the privilege of ready access to advanced medical care should a woman require it:

If they think that something's going wrong, they pull a buzzer and they have a senior midwife, and then there'll maybe be a staff grade, and then perhaps a registrar, and there's a consultant, and everybody's there. So what do you actually learn from that? Whereas here, if we think something's going wrong, we have to recognize the potential that something's gone wrong and then make the decision.

Meredith feels more autonomous than her obstetric-unit colleagues, because she must make her own decisions and rely on her own knowledge, without the comfort of high-risk care at a moment's notice. The decision to transfer to high-risk care weighs heavily on these midwives, because it involves a two to three-hour ambulance ride—or sometimes a helicopter ride—for a pregnant woman who is likely in serious discomfort. Meredith and Kate also explained their autonomy in relation to their diverse set of skills. As the only source of maternity care in this part

of the country, the midwives on this unit see women continuously throughout the antenatal, perinatal, and postnatal periods. They view the necessity to be skilled in all areas of maternity care as evidence of their increased autonomy in comparison to labor ward midwives, who only need to be skilled in one area.

Additionally, Kate and Meredith described their relationships with both midwives and obstetricians on the obstetric-led unit as fairly negative. They explained that a lack of understanding and respect for their work in the remote and rural freestanding unit has led to “bad relationships” between their respective units. Kate explained:

I think the consultant units who have satellite units like us, community maternity units, I think they all should come to see how we work... Because it's distressing for us, if we have a laboring woman who things are maybe not going quite as well, and we're having to make the decision to transfer that woman, we're worried and anxious and stressed to then make a phone call and then have somebody be really dismissive and downplay your concerns and your worries, is not helpful. It's not good. And it just makes for bad relationships between the two places.

Meredith and Kate feel that since many of their obstetric-led colleagues don't know about the challenges faced in a remote and rural setting, their relationship could be improved by making site visits to become better acquainted with one another and their work settings. They added that even knowing the person's voice on the other end of the phone helps to ease some anxiety about transferring care. Compared to the freestanding midwifery-led unit, relationships seem to be more positive in the alongside unit—potentially due to the proximity of practice and frequent contact between different care providers.

This conversation with Meredith and Kate is reminiscent of Olivia's previous statement about the mutual skepticism between homebirth midwives and labor ward midwives. Since neither

group is familiar with the other's practice, they cannot appreciate the challenges the other group faces. Thus, it becomes easy to categorize midwives into distinct black and white groups, when in reality, there may be more commonalities if effort is taken to explore the gray area.

### **Practice Settings and the Spectrum of Professional Identities**

This chapter has explored the various settings of midwifery practice and examined how authoritative knowledge and professional relationships are affected by different work environments. After considering the challenges and benefits of practicing in each setting, we see that midwives represent a diverse group of professionals who observe significant dissimilarities across their profession. Highlighting the important role that work setting plays in a midwife's practice, Olivia explains, "The same midwife will practice differently depending where she's practicing." She suggests that the primary differences among midwives may not lie in their ideology, but in how dissimilar practice settings affect their work. Sociologist Raymond DeVries writes about the spectrum of professional identities among midwives:

If we organized midwives along a continuum, with those who use all the tools of modern technology at one end and those who are non-technological in orientation at the other, those on the extreme ends of the continuum would not recognize each other as members of the same occupation (DeVries 1993:132).

While DeVries focuses on the differences in technology use among midwives, I identified work setting as a more comprehensive factor, since it incorporates not only the availability of technology, but also other professionals' presence and the environment surrounding a midwife's practice. Nevertheless, his point about the spectrum of midwifery practice rings true with midwives' descriptions of their relationships across practice settings. In the conclusion, I will discuss the effects of these differences on the professional status of midwifery.

## CONCLUSION

### **Midwifery Response to Intraprofessional Differences**

Having explored the intraprofessional differences of midwifery in the U.K., one may wonder how these differences are likely to affect the trajectory of the profession. Sociologist Andrew Abbot has written extensively on the subject of the division of expert labor and how internal differences can affect professional status:

Internal differentiation can generate or absorb system disturbances; a challenged profession can respond not only by fighting a contest or changing its level of abstraction, but also by changing internally (Abbott 1988:117).

As seen in Chapter One, a major challenge faced by midwives is that of protecting core aspects of midwifery, such as continuity and autonomy in their care, amidst a large social insurance system that emphasizes unity and occasionally sacrifice for the greater good. Abbot's work suggests that the heterogeneity among midwives can either create disturbance or absorb it. On numerous occasions during my research, I observed the latter response—midwives responding with unity to intraprofessional differences.

When asked about whether women experience a difference in obstetric-led versus midwifery-led care, community midwife Jill responded that she trusts midwives in obstetric-led settings to normalize birth and offer women their full range of choices:

I think midwives working with obstetricians should be able to—you know, it's not rocket science to point that sort of stuff out... So I think they have the confidence in their own experience to say, "Well hang on a minute, we could do it this way." So I still think my hospital colleagues are still midwives with a capital "M," not obstetric nurses.

While Jill acknowledges that her colleagues in obstetric-led settings face different challenges and may lose aspects of the midwifery model in this setting, she maintains that they are autonomous

midwives who advocate for women, just like midwives out of hospital. Maribel, an independent midwife who primarily attends homebirths, expressed similar sentiments. She spoke of her labor ward colleagues:

I say “us” and “them,” but it’s not really. But it can feel like that sometimes. But when they spend the time talking to us, they realize, “Oh they’re just the same as us.” Because I believe all midwives that are in there [the labor ward] are all fighting for the same cause—same as we are. We’re all fighting for that gold standard of care for women and for their partners and babies.

Both Jill and Maribel’s statements support midwives from different practice settings, referring to them as colleagues working towards a common goal. Their support for midwives with different experiences demonstrates the potentiality for absorbing differences within the profession.

While some midwives are advancing the profession by gaining more recognition in a biomedical setting, others are fighting for the midwifery model by encouraging midwifery work outside of hospital settings. Though Murray Last explains that professionalization has a standardizing—or homogenizing—effect, maintaining heterogeneity within the profession may enable midwifery to withstand a diverse set of challenges. To revisit a previous example, acupuncturists in the United States face similar challenges of professionalization, engaging in an ongoing debate over the degree to which they should standardize and ally themselves with biomedicine. In her study, anthropologist Linda Barnes concludes that professionalism is a dynamic process, and acupuncturists’ most forceful form of resistance to biomedical appropriation will be the “definitional messiness preferred by the discipline itself” (Barnes 2003:294). In this instance, the diversity among acupuncturists’ practice is an advantage against homogenizing pressures. From this perspective, although midwives may sometimes view their work as at odds with one other,

the dynamic relationship between standardization and resistance may be key to maintaining a robust midwifery profession.

### **Professionalization of Midwifery in the United States**

As a researcher from the United States, my original vision for this project was a cross-cultural comparison of midwifery in the U.K. and U.S. However, upon beginning my fieldwork, I quickly saw that midwifery in the context of the U.K. alone was already ripe for comparative analysis. Despite limiting the scope of my original study, I believe there are still lessons to be learned in the U.S. from the experiences of midwives in the U.K.

As explained by Robbie Davis-Floyd and Sheila Kitzinger, midwives in the U.S. and U.K. have divergent histories. At a time when midwifery in the U.K. was undergoing professionalization and standardization, midwives in the U.S. were outlawed and prevented from practicing. Brigitte Jordan draws on the work of Paul Starr in her writings about the history of medicine and midwifery in the U.S. She explains:

Well into the twentieth century, medical care was provided by a multi-stranded, pluralistic medical system within which the knowledge held by barber surgeons, homeopaths, folk healers of various kinds, midwives, and other empirically based practitioners was considered authoritative by different parts of the population (Jordan 1997:57).

She goes on to describe how these healing practices changed as the biomedical model asserted its dominance:

[It was] a transformation that quickly delegitimized all other kinds of healing knowledge, putting the newly defined medical profession in a position of cultural authority, economic power, and political influence (57).

Since the healthcare system is dominated by biomedicine, it has not historically tolerated practices viewed as alternative to biomedicine. The long-lasting effects of excluding alternative healing models are still seen in the U.S. today. Murray Last describes how the market-based system of health insurance promotes the biomedical model while ousting other models:

The American model seeks to modify, through strict and detailed regulation at the state (not national) level, a free medical market...greatly [enhancing] the privileges of the dominant medical subculture, hospital medicine, at the expense of alternative systems and practices...The result is a competitive market within the medical profession rather than a market between the medical and other therapeutic professions (Last 1996:382–383).

Last's explanation of the U.S. healthcare system emphasizes the freedom of independent states to legitimize biomedicine and delegitimize everything else. Midwives can be included in Last's "alternative system", since they attend only approximately 8% of all births in the U.S. (American College of Nurse-Midwives 2016). Although the culture is beginning to change somewhat to incorporate more alternative care models into the mainstream healthcare system (Maizes, Rakel, and Niemiec 2009), the dominance of the biomedical model compared to the midwifery model is still apparent.

Midwives in the U.S. are by no means a homogenous group. There are three types of legally-recognized midwives: certified nurse midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs). Each group maintains different standards for training, clinical experience, degree level, recertification, etc., and each group's practice is regulated differently depending on the state. In fact, the distinctions between each group are so complex that the American College of Nurse-Midwives published a three-page chart to help clarify the differences between midwifery credentials (American College of Nurse-Midwives 2014). Some prefer to simplify the complex groupings of American midwives by categorizing them into two groups:

CNMs and everyone else, called “direct-entry” midwives (Rooks 1998:316). Individual state regulations of different midwifery practices are particularly relevant to midwives’ professional status, since professionals are only professionals to the extent that the government affords them autonomy to practice (Freidson 1970:23–24). CNMs—who make up a vast majority of U.S. midwives—can practice legally in all fifty states, although the extent of their autonomy may be limited. In twenty-seven states (not including the District of Columbia), CNMs practice independently, but in the remaining twenty-three states, midwives may be required to enter into a written practice agreement with a doctor or practice only under one’s direct supervision (National Council of State Boards of Nursing 2016).

Since some midwives have more state-granted autonomy than others based on their certification and geography, midwives’ professional status exists along a spectrum. For midwives with less autonomy, it may be argued that as long as they are supervised by members of the dominant biomedical profession, they cannot claim the jurisdiction and power that are characteristic of a profession (Abbott 1988:136). An ongoing debate in the field of U.S. midwifery concerns whether all midwives should standardize and professionalize to the degree that CNMs have. While many direct-entry midwives recognize the benefits of professionalizing in the form of autonomy and legality, others would prefer to “remain true to their counter-hegemonic practices and ideals” (Davis-Floyd, Pigg, and Cosminsky 2001:5). As the effects of this debate continue to unfold, midwives in the U.S. may find the professionalization of midwives in the U.K. as a useful point of reference.

Though all midwives in the U.S. may not possess the professional power or government-granted autonomy necessary to alter state legislation, other factors internal to the field of midwifery are important to consider as some midwives question further professionalization. Some degree of internal division is inevitable in a profession, but when groups become stratified into higher-status and lower-status professionals, degradation of the profession can occur, resulting in complete division between the groups (Abbott 1988:125–126). Degradation, and ultimately division, within a profession acts in opposition to a core aspect of professions—the standardization of practice through controlled education, training, and licensure (Freidson 1970:77). Among midwives in the U.S., varying types of certification have resulted in stratification among CNMs and direct-entry midwives, where CNMs are generally afforded higher status, as seen in the larger jurisdiction of their practice. If U.S. direct-entry midwives decide to undertake further professionalization in the future, existent internal stratification may present an obstacle, since current divisions and disagreements over professional requirements would need to be dissolved in order to create a unified profession.

This analysis of midwifery in the U.S. should not be used to assume that the field will necessarily follow a trajectory similar to midwifery in the U.K. It is important to consider that midwifery as a profession in the U.K. has developed amidst a national medical culture with values very different from those in the U.S. Although, as the debate among U.S. midwives continues, they should look to the experiences of their colleagues in the U.K. to anticipate potential positive and negative outcomes. Recent writings among U.S. midwives reflect an understanding that alliance with the dominant biomedical model may result in advancement of professional status, though potentially at the expense of midwifery authoritative knowledge

(Davis-Floyd and Johnson 2006). However, it may be less understood that midwives in the U.K. have managed to professionalize and standardize while maintaining significant heterogeneity in the field. Future ethnographic research of U.S. direct-entry midwives should observe movement toward or away from professionalization amidst the U.S.'s changing medical culture.

## **Conclusion**

This thesis argues that midwives in the U.K. hold a range of nuanced opinions over how their professional status has affected the practice of midwifery, in relation to both larger institutions and interpersonal relationships. Despite the homogenizing effects of professionalization, midwives have retained diverse perspectives in their field concerning institutions and professional relationships, particularly as they differ based on midwives' practice settings and relationships to the biomedical model. This heterogeneity among midwives may enable them to withstand challenges in their profession, such as those experienced as a part of a massive social insurance system like the National Health Service. Though midwives face many constraints on their practice, the range of positions among midwives has created a more robust profession—one that is potentially better prepared to weather future challenges, both utilizing and resisting their professional status to protect and advance the authoritative knowledge of midwives.

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