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'Stones can make people docile': reflections of a student midwife on how the hospital environment makes 'good girls'

Using sociological theory, in this paper Anna Bosanquet illustrates how locating birth, maternity services provision, and midwifery training in the hospital setting impedes the development of midwifery as an autonomous profession, and the delivery of woman-centered care. Only by acknowledging how the hospital environment can shape our identity and our actions, can we develop strategies to challenge its negative impact.

The place of birth has a powerful effect on both women's experience and on the style of midwifery care. Birth in the United Kingdom (UK) has traditionally been at home, and it is only since the second half of the 20th century that confinement has been moved to the hospital. The 1970 *Peel Report*[1] was instrumental in the amplification of this trend, and in reinforcing the views of health professionals and public opinion that hospital-based, high-technology obstetric intervention would ensure the highest quality of care and the best possible health outcomes. Such claims have since been successfully challenged and, as a result, policy documents, such as the *Winterton Report* in 1992[2] and *Changing Childbirth* in 1993,[3] made recommendations concerning reorganisation of maternity services. Emphasis was placed on new developments in the community, women's right to choose, continuity of service provision, and an individualised approach to care. Despite these recommendations, currently over 98% of babies in the UK are still being born in a hospital setting,[4] and obstetric-led hospital units remain the focal point for the delivery of service and for the professional training of midwives.

As childbirth moved to hospitals, it became very difficult for midwives to maintain any degree of control over their work content and physical and social environment. In spite of its public respect, midwifery in the UK has serious problems of recruitment and retention of both trained staff and students.[5] Midwifery journals express many concerns. There are reports of high levels of professional stress and burnout, low morale, absenteeism, financial hardship, and also of bullying and victimisation in the work place.[6-11] Many writers provide a very pessimistic view of the current and future state of midwifery. For example, O'Connor in a recent series of articles entitled *'Good Girls'* or *autonomous professionals*[12-14] discusses how increasing statutory supervision and governance of midwives can have a detrimental effect on their autonomy, and even lead to the denial of their civil rights. Others describe how midwives work in a 'climate of fear', and how their specialist knowledge of normal birth is marginalised by technological obstetric management.[15-16] Ashcroft[17] shows how 'women's choice' and 'woman-centred care' are a myth, as there rarely are alternatives to the hospital-based, obstetrician-led service. There are also reports of high levels of dissatisfaction of women with their experience of maternity care. Robinson[18] in her discussion of women's negative view of midwives considers why midwives are 'turning nasty'. Kaufmann[19] suggests that both women and midwives should use the 1998 Human Rights Act to enforce their right to humane treatment, choice (eg to have a home birth), and freedom from coercive style of management or intervention. Taylor[20] argues most convincingly that the 'death of midwifery' may be much closer than we think.

As a second year direct entry student midwife I often wonder if the situation of midwives is as desperate, and the future of midwifery as bleak, as described by some? Are we, a future generation of midwives, being trained to be 'good girls' — complacent and compliant within the highly governed, medicalised culture — or are we to become autonomous practitioners, developing new models of service and providing woman-centred care? Will we maintain our initial idealism and romantic notions of 'being with woman' or, as our training progresses, are we likely to 'turn nasty' and start engaging in highly routinised, impersonal care?

Most of our training is hospital-based. Research has shown that new employees of hospitals and other large institutions, including medical, nursing, and midwifery students,

progress through a process of 'organisational socialisation'.[21-23] Most start with unrealistic expectations and idealistic view of their future careers and of the professionals to whose status they aspire. The initial encounter is a time of surprise. A reality shock may occur, often resulting in the loss of idealism and a rise in cynicism. This is followed by a phase of acquisition of new knowledge and skills, resolution of the initial role conflict, and creation of new identity. To be assimilated into the organisation, an individual has to fit into its culture. This can be only achieved through absorbing values, accepting the power structure, and modifying one's own behaviour in order to 'fit in'. If a person is unable to meet the requirements, the assimilation will not take place and he or she will leave.[24-27]

What does this mean for student midwives? It implies that in order to qualify and continue to practise, we have to become 'good girls', 'know our place', and assimilate the culture of a hospital we work in. We have to absorb and accept its hierarchical, medicalised values, and we have to modify our behaviour to fit in with the insitutionalised goals and routines. There are many reports of problems experienced by midwifery students. The growing intake of mature entrants and the new university setting of education increase the tension in values between the new recruits and 'institutionalised' and 'medicalised' staff.[8,10,23,27] This often results in students experiencing a reality shock, consequently leading to a departure from the profession. Those who stay either become socialised into the organisation or develop strategies allowing them to detach themselves from conflict. Such strategies may work in the short term, but eventually they lead to increased rates of absenteeism, low morale and burnout.

Throughout my training, there have been opportunities to observe women's, students', and midwives' behaviour. I was surprised at the strength of the effect the hospital environment had on my own actions and sense of identity. A confident, professional woman before I began my training, once I put on my student uniform and became a novice at the bottom of a hierarchical structure, all my confidence, previous knowledge and life experience disappeared. I

found myself being 'invisible', referred to as 'this girl', told off by junior doctors (half my age), and blushing at a sight of a consultant. Assertive before, now I put up with being publicly humiliated by some of my seniors, and remained silent when witnessing poor standards of care. I noticed how proud many of my student colleagues were of their uniforms, how unquestioningly they accepted all the official rules and regulations, and how neatly they fitted into the hierarchy. I also wondered why so many women, even those with birth plans in their hand, become so undemanding and compliant on their arrival to the hospital. Why are these women, brought up in the UK at the end of the twentieth century, behaving in such an unassuming manner throughout one of the most significant events of their lives? And I also watched the midwives. Some are wonderful. But many are fully socialised into the hierarchical hospital culture, providing routine, impersonal care.

What are the causes of such behaviour? Using sociological theory, I illustrate in this paper how locating birth, maternity services provision, and midwifery training in the hospital setting impedes the development of midwifery as an autonomous profession and the delivery of woman-centred care. Only by recognising how environment can shape our identity and our actions, can we develop strategies to challenge its negative impact.

Hospitals as bureaucracies
Modern hospitals can be described as 'bureaucracies' — large organisations ruled by the 'officials' and serving a specific purpose.[28-29] Although bureaucracies are seen by some as a 'model of carefulness, precision and effective administration', they are more frequently associated with 'inefficiency, wastefulness and red tape'.[28p287] Weber[30] describes how in bureaucracies there is a clear-cut hierarchy of authority — each job has an exact hierarchy and a fixed salary label affixed to it, and tasks are distributed as official duties through a top-down chain of command. The conduct of 'officials' is governed by written rules, but for senior staff, such as consultants, there is flexibility. 'Officials' like to keep appearances of being busy, and therefore they 'informally expand the scope of what they do', so that the 'work expands to

fill the time available for completion', so called 'Parkinson's Law'.[31] Because the performance of tasks is re-delegated down the hierarchy, officials must spend a lot of time 'supervising their subordinates who in turn must spend a great deal of time writing reports and memoranda for them'.[28p287]

Women, as well as student midwives, find themselves at the bottom of the hospital hierarchy. Care of each woman becomes a 'task' which has to be completed, re-delegated by the 'chain of command', and strictly supervised down the hierarchical ladder (with the obstetric consultant at the top, followed by the specialist registrar, registrar, house officer, midwifery manager, midwifery sister, midwife, and care assistant). All the actions have to conform closely to the hospital protocol, designed by 'committee members', at a local or national level. Any deviation from the protocol, especially by those down the hierarchical ladder, is not permitted, and can be severely punished by disciplinary action — even to the extent of losing statutory right to practise. How can such a bureaucratic monolith, a 'baby-processing factory',[32] be conducive to woman-centred practice?

Hospitals as total institutions
Hospitals can also be described as 'total institutions'. A total institution is defined as 'any social organisation in which the members are required to live out their lives in isolation from wider society ... In these organisations there is no possibility of any complete escape from the administrative rules or values which prevail...'.[33] What happens when women arrive to give birth at a typical obstetric unit in a hospital? Their experiences could be seen as similar to the disempowering experiences of the inmates of a 'total institution' such as a prison, army, monastery or asylum described by Goffman.[34-35] On their arrival, women are put through a series of 'status passages'. They follow a typical 'patient career', starting with the confirmation of labour by a midwife or a doctor ('initial diagnosis'). They progress to admission routines of the labour ward ('admission procedures'). Throughout their labours they are subjected to a number of protocol-driven medical interventions ('treatment routines'). Their 'patient

career' culminates in the delivery of a baby and discharge from the hospital ('the outcome').

'Initiation rituals' aim at enforcing women's new patient status. In a mental health setting, Goffman describes these as the 'betrayal funnel', the 'mortification of self' and the 'status degradation ceremony'. On admission women are usually instructed to undress, to replace their own clothes with the hospital garment stamped with a label 'property of the NHS' and, more frequently then not, to stay in bed. They have a name band with their hospital number put on their wrist. They have to endure a number of vaginal examinations, often by different people, to which they do not always give a fully informed consent.[36-37] In the past they would also have a pubic shave and an enema. While the women in labour are unlikely to know any of the staff, the staff themselves have access to the most intimate parts of their bodies, and information about their personal circumstances and social history. Unless they arrive with a partner, they become socially and physically removed from the outer world. Although Goffman's work concentrated on the experiences of the inmates of long-stay psychiatric hospitals, and women on a labour ward stay only for a short period of time, his critique is still relevant. During labour, women's perception of time is vastly distorted and, in fact, their 'initiation process' into the 'patient career' starts early in the pregnancy, as soon as they come under hospital care.

Hospitals as carceral organisations

Foucault[38] describes 'carceral' organisations where individuals are held confined specifically for the purpose of punishment or correction. Can a labour ward be seen as a carceral institution? Outwardly, women are not admitted to the labour wards to be punished or corrected: they arrive there to receive care. As citizens they are free and able to discharge themselves. But many writers have described hospitalisation as a form of punishment. In particular, feminist writers see hospitalisation of

women as an act of male dominance and oppression. Women are admitted to hospitals to be punished for their 'reproductive superiority', and to have their bodies — and their minds — controlled and corrected, so that these become less threatening to men and conform to the 'ideal' standard set up by them.[39-43] Women's admission to the obstetric-led labour wards and the active management of the birth process can be seen as an attempt to control and 'correct' natural physiological function.

Foucault[38, 44] talks of the disciplinary power of modern societies, applied through 'surveillance' and defined as the monitoring, supervision and superintendence by the modern state of the activities of its citizens. He describes a reformatory 'colony' for adolescents, a model application of the 'disciplinary power' in mid-nineteenth century France, and there are many parallels to current practices on a labour ward. For example, in the correction camp, all the information on each of the inmates was publicly displayed on a centrally placed, highly visible board. This could be seen as equivalent to the practice on labour wards by which information on each woman is publicly displayed and regularly updated on a large board placed centrally next to the 'midwives station'. In some hospitals cardiotocograph (CTG) recordings from all the rooms are displayed on the computer next to the information board: the women and the fetuses are continuously under surveillance even when the staff are not physically with them.

Detailed information on women and their 'progress' has to be kept as one of the rules of professional conduct for midwives.[45] Detailed note taking is presented as a benefit to women through gains in continuity of care, and is also seen as essential, given

risks of litigation. Clinical notes contain increasing amounts of personal information. For sociologists, clinical notes are a symbol of the disciplinary power that increases even further with the 'holistic' approach to care.[44-46] Inclusion in the notes of intimate, personal and social information, and wide access to this information through the computer network and inter-professional communication leads to further tightening of the surveillance mechanism and widens the scope of medicalisation.

The hospital rooms to which women are admitted are unfamiliar to them. They are dominated by medical equipment and lacking in privacy. There are no inside locks on the doors, but there are viewing windows on each door, through which people in the corridor can look into the room. This leaves many women feeling vulnerable, and immediately places the staff, familiar with the physical and social environment of the place, in control. Foucault in his description of the Panopticon — a 19th century prison — has shown how the architecture of organisations becomes their dominant feature. The Panopticon, with its architecture similar to that of the labour ward, served "to permit an internal, articulated and detailed control — to render visible those who are inside it ...to transform individuals... to provide a hold on their conduct, to carry the effects of power right to them, to make it possible to know them, to alter them. Stones can make people docile and knowledgeable"[38,47p19]

In addition to architecture, various devices have been used in hospitals and asylums throughout the centuries to physically constrain certain patients. Some authors argue that these physical constraints have been recently replaced by more subtle methods — psychological coercion and drugs to alter behaviour.[48-52] Although, in theory, labouring women are free to move within the hospital, and could even leave, in practice they are often fastened tightly to the bed by the straps of the CTG or intravenous infusions. The CTG can be seen as one of the most ingenious forms of bodily constraint. It works on both the physical and the psychological level. Despite the

Midwives have no authority to challenge medical decisions

lack of evidence on the clinical effectiveness of continuous CTGs for achieving better neonatal outcomes,[53,54] not only are women physically attached to the monitors, they are also emotionally coerced to comply. What kind of a mother would risk compromising her baby's well-being by rejecting the CTG? Similarly, pharmacological methods of pain control, such as pethidine and epidurals, can be seen as an obstetric equivalent of physical constraints and behaviour-altering drugs used to control and confine patients in mental hospitals.

In large institutions staff as well as patients are controlled and corrected. They progress through a similar sequence of 'status passages' and 'initiation rituals' leading to re-creation of their new 'organisational' identity. According to Foucault[38] there are two types of staff surveillance: direct supervision of the work of subordinates by supervisors, and a more subtle type — keeping employee files, case histories and records. Both are prevalent in midwifery management structure, professional supervision and governance. Examinations during training, at entry into the profession, and as a part of statutory-prescribed continuing professional development, enforce compliance to the prevalent ideology and accepted code of practice. Uniforms, although seen by some as merely 'professional' and 'practical', serve to depersonalise people, increase anonymity and enforce the hierarchy.

Time-tabling is an additional mechanism of control, and in maternity care it controls both women's bodies and staff behaviour. *"Discipline is promoted ... by the precise scheduling provided by the detailed time-tables... Time-tables regulate activities across time and space, efficiently distributing bodies around the organisation."*[38,47p231]

Midwives' and student midwives' shifts and work allocations are determined for them by their superiors, with very little flexibility for change. The 'performance' of pregnant and labouring women is continuously monitored, publicly displayed, and judged by the adherence to time criteria. Any deviation from average timing results in 'correction' by the staff through a protocol-driven intervention. Even for women who

arrive on a labour ward with a carefully written birth plan, because of the power relations between women, doctors and midwives, it is most likely that the birth will proceed according to the staff's routine rather than the woman's wishes.

Many women are traumatised by their hospital-based birth experience.[55-57] Only a few resort to making an official complaint, and usually these complaints refer to the social environment in which birth took place, rather than the specific clinical skills of the practitioners or treatment errors. Women report being treated in an impersonal, unsympathetic and degrading manner; they report that the care they receive makes them feel vulnerable, angry, and disempowered. Although only a small proportion initiate legal action, the growing threat of litigation leads to the further tightening of the surveillance and control of the reproductive processes, and to increased medicalisation. This results in even more impersonal and more inflexible provision of care.

Conclusions

Within the context of the hospital environment, what is the future of maternity care? Will those who enter midwifery full of enthusiasm for 'natural childbirth', 'women's empowerment', 'women's choices', and 'woman-centred' care, become socialised into the institutionalised, obstetric model of service? According to the sociological theories discussed in this paper, if midwives continue to work and train in the hospital environment, they will not be able to free themselves from its political and ideological forces. Such a bleak picture is supported by the pessimistic views about midwifery, discussed at the beginning of this paper.

Sociological theories applied in this analysis can be criticised for their fatalistic view of medicine and society, for giving an over-deterministic account of the effects of social and physical environment, and for the lack of acknowledgment of personal differences and ethical principles held by individuals. However, they have had some positive effect. Because of their strong social impact, these theories contributed to the reorganisation of mental hospitals and development of new models of psychiatric care in the past few decades. They have also been

influential in the initiation of changes in the management style and redesign of the physical environment of other institutions. Critical application of these theories to maternity care and to our current practice could help to identify sources of midwives' low morale, student disillusionment, and women's dissatisfaction, and therefore assist in change.

In parallel to the forces that intensify the medical and State control over midwifery practice, there are some contrasting developments which offer hope and opportunities to 'reclaim' childbirth by women and their midwives.[58-61] These include strategies to expand community-based maternity care and to increase the number of home births, to invest in continuity of care, and to raise public awareness of alternative models of care. Resources were recently made available to make the hospital environments more woman-friendly.[62] New consultant midwife posts have been created. Although some fear that these positions will reinforce the hospital hierarchy, they may also lead to an increase in midwives' autonomy and professional status, thereby altering the power-balance and improving professional communication with doctors. Similarly, the extension of the midwives' role, along with pilot schemes for withdrawing senior house officers from obstetric units (as at St George's Hospital in London) and development of new skills by midwives (such as ventouse deliveries[63]) can increase professional confidence and job satisfaction. Although critics fear that such role extension will lead to further medicalisation of midwifery and neglect of the 'normal', if used wisely and with caution these additional skills can significantly increase midwives' autonomy. Most importantly, these new skills give opportunities for continuity of carer and care, often at a time when women are at their most vulnerable. This could result in much higher levels of women's satisfaction with their childbirth experiences, and could also widen their choices, as — potentially — the extended midwives' role could make out-of-hospital birth more feasible.

For some women and their babies obstetric involvement and hospital delivery are necessary, and could be life saving. A good working relationship with our colleagues is essential: but instead of working for the doctors, we need to learn how to

work *with* them. Closer links with universities and university-based training can accelerate the growth of midwifery knowledge and the further development of evidence-based practice. We should be more pro-active in sharing this knowledge with the medical profession. Within the current atmosphere of the public's dissatisfaction with maternity services, and the political and managerial pressure to lower caesarean section rates, doctors might be more receptive to our suggestions than they were before. There are now more direct entry students and mature entrants into midwifery, many with professional experience and a sense of vocation. They may have a positive effect on changing the organisational structure and power balance.

Although difficult times, these could also be very exciting times for midwifery. We need to pull down the stones that make us docile. We need to stop being 'good girls'. If we find the strength to acknowledge and challenge the wider forces influencing our practice; if we make ourselves heard by policy makers, the general public, and doctors; if we turn words into action and move maternity services and training out of the hospitals back into small friendly units and mothers' own homes — then we shall be able to reclaim our knowledge of 'normal' and be truly 'with women' once again.

The author would like to make it clear that the content of this article does not relate to any particular individual or hospital.

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