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MIDWIVES' PROFESSIONALIZATION: A COMPARATIVE APPROACH. AN INTERPRETATION OF THE PHENOMENON OF CHILDBIRTH MEDICALIZATION

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Abstract: *The paper studies the problem of increasing medicalization of pregnancy and delivery, a phenomenon that started in Italy between the 1950s and the 1960s owing to deep political, social and cultural changes. The main aim of the study is the understanding of the origins of the phenomenon by investigating the causal relationships between medicalization and medical dominance.*

Key words: *childbirth medicalization, process of midwives' professionalization.*

1. Introduction

The present historical period is characterized by a growing trend towards the medicalization of deviant forms of behaviour. The phenomenon is on the increase and has gradually been expanding to other sectors of human life, such as birth and death, though these are not properly parts of the concept of disease. This brings forward considerations on the existence of a general process of life medicalization that distorts life natural development by forcing people to comply with a whole series of obligations. By medicalization we mean excessive and inappropriate human\ medical intervention on non pathological events.

The present study analyzes this phenomenon with specific reference to the processes of pregnancy and delivery.

It is extremely complicated to establish the causal relationship between medicalization and the diffusion of scientific-medical thought, and that between the emergence of new needs and the induction of care demand. Wagner (1998) attributes the origin of pregnancy and childbirth medicalization to childbirth hospitalization and to the implementation of antenatal care programmes (gradually developing into childbirth care). According to him, the two factors aroused the interest of medicine in reproduction, whose jurisdiction was then transferred from a social to a medical area of competence.

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Foucault studies this aspect in depth and speaks of "indefinite medicalization", maintaining that "today, no field is any longer extraneous to medicine", since "the predominance attributed to pathology has become a general form of society regulation" (2001, 159).

This last aspect raises questions on the correlation between the need for medical intervention and the inducement of demand for medical intervention.

In fact, if on the one hand the need to reduce maternal and child mortality and the pathologies connected with pregnancy has legitimated medical intervention, on the other hand it is not completely clear how and why that intervention has been extended well beyond its real needs. It would be important to understand how much influence has been exerted by the socio-cultural and economic and political changes on the management of the childbirth process, with reference to authoritarian medical power and its ability to impose itself "as an act of authority on each individual, both healthy and ill" (Foucault, 2001, 156).

The question is not easy to answer, since a complex series of diverse factors intervenes in the definition of the problem: technical and scientific progress, the slackening of solidaristic links, the crisis of once consolidated institutions such as the family, the deferral of women's child-bearing years, etc.

All these factors are linked in their turn with wider processes that have gradually modified individual and collective habits and life styles.

2. Objectives and Methodology

The objective of the present study is the individuation of institutional answers to the problem of pregnancy and childbirth medicalization. The starting points of the analysis were WHO recommendations formulated more than 20 years ago (May 1985) and concerning the appropriate use of technology. Those recommendations were based on empirical evidence (EBM) and were aimed at the naturality of childbirth and at reduction in the practises of medicalization (limitation in the number of caesarean sections within a range of 10-15%). Starting from the assumption that birth is a physiologic event, WHO recommendations were also suggested by the need to limit health care expenses, continuously growing owing to the increase in the number of surgical interventions and the length of post-partum hospitalization.

These recommendations were implemented in different periods and differently interpreted by the various countries. The differences are due to a whole series of different factors, ranging from the existence of different historical traditions, to the consolidation of very different cultural trends on the theme of childbirth, from the organization of social services to the sedimentation of different models of professionalism.

On the basis of such assumptions, the present study tries to investigate the actual causes of the present extreme medicalization, in order to evaluate possible alternatives so as to face the problem of medicalization at the institutional level.

The choice has been to study this phenomenon through the analysis of the historical evolution of the midwife's role, in the opinion that the inclusion\exclusion of this professional figure on the scene of delivery reflects the prevailing approach to maternity within a certain context.

A historical-comparative perspective has been adopted, taking into consideration two different countries: Italy and England which, though showing some analogies, are deeply different under other aspects.

The analysis has made use of qualitative methodology, and is based on two distinct research strategies: the ethnographic method in the study of the Italian case and interviews in depth to study the British case. The empirical phase has been preceded by careful secondary analysis of international literature on the phenomenon, and the relevant social and health care policies, and also by the interpretation of statistical data concerning delivery typologies and modalities, and the professions involved (ISTAT statistics, WHO, NHS, etc.)

The information acquired during the two phases of the research (the phase of theorical research and the empirical phase) has individuated two distinct social-health care and professional models and then the description of the organization of maternal care services in the two countries.

The historical and cultural reasons underlying such models were investigated as well as the motivations on the basis of the choices adopted.

3. Research Outcomes

The organization and the situation of maternal services help explain the importance attributed to childbirth and its underlying process.

When comparing the offer, and above all the range of alternatives available in the two countries, there emerge two different organizational models reflecting the different aims of the relevant socio-medical policies.

The differences do not only refer to the places where care and assistance are given, but also to other aspects, equally important in promoting a specific approach. Among the most relevant factors, the following are to be pointed out:

- the caregiver's identity and role, that is the profession directly and priority involved in the process, and all the tasks it is called to perform:
- processes concerning maternity socialization and the empowerment process of the main actors involved in the event. We mainly refer to the implementation of programmes aiming at health promotion, and thus at pregnancy and childbirth considered in their physiologic dimension as moments of individual psycho-emotional growth;
- the level of socio-medical integration, that is the level of coordination between the various policies (social policies, health policies, social security policies, etc.) linked with maternity.

At this point, it seems necessary to study in detail the characteristics of the subjects in charge of the assistance to pregnancy and to physiologic delivery, and the places where these subjects perform their professional activity.

In Italy midwives are mainly employed in health structures, whether public and\or private, that have maternity units (operative units of obstetrics and gynaecology), inside which midwives perform both functions of childbirth assistance and more typical nursing tasks. In the former case, they devote themselves to clinical procedures related to labour and delivery; in the latter case, on the contrary, they look after women patients admitted to the ward for diverse reasons.

A midwife's activity can also be carried out outside the hospital and precisely:

- in territorial structures , in particular in consulting rooms,
- in private studies and\or maternity houses, where they work as independent professional people.

These two latter contexts offer a wider opportunity to autonomously perform one's professional activity.

As a matter of fact, the description of the operative settings introduces one of the most relevant aspects of the professionalization process concerning professional autonomy. In a hospital, that is inside a bureaucratic context structured according to hierarchical logic, an individual's discretionary power is reduced and autonomy margins are limited owing to a series of different factors, among which the existence of forms of hierarchical and functional dominance exerted by the medical profession.

The analysis of the British case does not confirm this aspect. The present configuration of a midwife's services, in fact, is totally different, and reflects deep cultural differences as far as maternal health care is concerned. Also in England midwives can opt for independent professional activity or for activity inside the NHS. The option, however, does not create any fracture among the members of the profession, and it does not seem to depend on the need to perform one's tasks more autonomously. In both cases, in fact, a midwife is acknowledged a wide range of competences that are granted and respected, also thanks to the accuracy with which they are listed and stated in the Guide Lines, the official papers that state each profession's jurisdiction limits, thus avoiding any possibility of dominance of one profession over the others.

Thus midwives can be employed:

- in hospitals, where their presence is scheduled in four different wards: a) antenatal ward, b) postnatal ward, c) foetal assessment units, d) labour wards. In the first three wards , devoted to the care of gynaecological patients, they perform nursing tasks; in the labour ward, reserved to physiologic childbirth, midwives express their professional potentialities at their best and manage the operative unit autonomously;
- in community health services, as community midwives, in which case they deal with physiologic pregnancy attending expectant mothers until delivery. The implementation of the one-to-one model implies that each expectant mother has her personal midwife that looks after her psycho-physic wellbeing;
- in public and\or private birth centres. These centres are managed by midwives; they accept low risk pregnancies and the delivery experience is lived as a totally natural event;
- in research institutions and\or universities where midwives perform academic activities not only in midwifery courses but also in medical faculties.

Another quite peculiar aspect of British midwifery is "mobility". Midwives are actually encouraged to periodically change their work environment, not only to facilitate the acquisition of a wider range of competences but also, and above all, to avoid the onset of professional diseases due to stress, such as burn out.

The two countries also show deep differences as for intra- and inter-professional conflicts.

In Italy cohesion among the members of the category is impaired by the absence of any corporative spirit owing to the lack of recognition of universally shared

principles. Midwives do not acknowledge a common identity basis, a feature that is typical of consolidated professions. The lack of cohesion determines at a systemic level the lack of that very professional pride that is perceived only at an individual level, thus eliminating any possibility of common strategic actions.

British midwives, strengthened by a successful path of midwifery socialization, make up a close-knit group, able to face any external challenge.

Despite internal fractures due to different access modalities to the profession which oppose direct entries to those with a different study background, this horizontal fragmentation is not strong enough to weaken the group corporate spirit, and the category places itself at the same socio-professional level as the medical profession. This influences the relations between the members of the two groups positively, so that their relations are not governed by logic of dominance and power: midwives and obstetricians are aware and respect their limits of competence and establish relations based on mutual exchange, cooperation, and esteem.

In Italy this situation is precluded by a whole series of factors attributable to the non-acceptance of the socio-professional role performed by midwives on the part of the medical profession.

The corporative strategies enacted by the medical profession have created a form of antagonism between the two categories which is latent and unexpressed but that has led to the dominance of one group over the other and to the existence of relations of reciprocal tolerance.

Further differences in the scenarios of the two countries are also due to the different relationship with health service users.

In most cases, in Italy there is no one-to-one relation with the pregnant woman on the part of the midwife (particularly in big hospitals) and the two parties only meet during the last phases of the pregnancy.

The impossibility of creating a strong confidence link can induce frustration feelings in the midwife and reduce her social legitimation. Compliance is an absolutely central element also for those who perform their task in an independent professional regime. They can create lasting relations based on the sharing of the same approach to childbirth and thanks to the characteristics of the women who ask for their help, that usually have different expectations and are usually more prepared to risks.

Both factors facilitate the building up of prolonged care relationships, based on repeated interactions that facilitate compliance. The fiduciary link does not consist in a delegation of functions, but rather in a continuous exchange that is functional to the enhancement of the expectant mother's competence on the one hand and to the midwife's professional enrichment on the other hand.

The acquisition of fresh motivational stimuli and the realization of expectations make up the core of the activity of a British midwife, independently from her work setting and from professional modalities. However, it is evident that the organizational structure of services can facilitate operators' involvement in their relationship with patients and can develop the possibility of setting up "a close and supportive relationship". The research confirms the existence of actual reciprocity between the actors of the relationship and

shows how the very operators feel the conditioning exerted by their patients.

Reciprocity consists in the continuous acquisition of new knowledge, handed down by one group to the other, thus increasing the cognitive and moral\emotional world of both groups.

Assuming that the final purpose consists in the successful outcome of the birth process, it is evident how attention is focussed on the social determinants of health and on the emotional components as tools to reach wellbeing, considered as psycho physic balance.

For midwives to be able to give their patients this consciousness, it is necessary that the latter can trust midwives completely and, above all, that sharing is total and pervasive.

Thus, the importance given to communication as an involvement and participation tool, is clear and evident.

Interviews showed how identification with the principles on which midwifery is based, brings the sharing of a common approach that is not only professional, but which involves much wider dimensions. This highlights the centrality of path dependent variables and the conditioning exerted by the general context and, in particular, by a type of culture that devotes motherhood particular attention, a part from any care and assistance modality. Presumably, this latter aspect is one that should be considered to really understand professional dynamics and to give a critical evaluation of the differences emerging when comparing the two different contexts.

4. Conclusions

The use of a comparative approach allows to interpret the causes of the professional and organizational differences between the two countries under consideration. The study seems to confirm the hypothesis of a path dependent variable that allows to understand the divergence of the professionalization paths and the different features of maternal services.

Looking at the offer of maternal services and the professions involved, some further considerations may be useful: data [1] show that in both countries midwives outnumber gynaecologists (17,000 in Italy, 27,770 in England). However, there is a striking difference in the ratio between the two professional groups: while in Italy the ratio is 1.3 midwives to 1 gynaecologist, in England the number of midwives rises to 8.7. This prompts two considerations. The first is the political-cultural factor underlying the differences between the two countries, in particular the different policies concerning maternal health care. In the United Kingdom the implementation of the one-to-one model implies that each expectant mother has a dedicated midwife offering personalized answers. This strengthens the professional group in terms of corporative identity. Besides, by proposing the midwife as caregiver to physiologic pregnancy, there is allowed the actual exertion of all competences that the law reserves to this professional figure, while implementing, at the same time, the naturality of the birth event. The compliance with norms does not exclusively depend on the ability of the professional category to exact their observance, (something that depends on the group's power and prestige). It seems to depend, above all, on a different approach to childbirth and on the attention paid to this event. In Italy this prospect clashes against the difficulty to translate norms into operative praxis. This difficulty seems to be due to the strength of the medical profession that, taking advantage

from the unfulfilled enforcement of rules, actually prevents midwives from playing the role the law assigns to them.

Owing to this situation, it can be said that if the British solution to pregnancy and delivery is to be found in the supply of personalized care and in the empowerment of obstetrical psycho-prophylaxis, Italy seems to prefer alternative channels, such as the diffusion of analgesia during the delivery process.

As a matter of fact, the Italian solution seems more sensitive to the need of reducing the incidence of caesarean sections (whose percentage amounted to 37.8% in 2008) rather than to childbirth demedicalization, a trend that favours medical intervention, thus even increasing the number of medical people at the moment of delivery.

The second factor to be taken into consideration is linked to the strength of corporative power.

Though sociological literature on professions states that the bargaining power of a professional group does not depend on the number of its members and that a limit in their number, guaranteed through access barriers to the profession, is one of the basic conditions to ensure the keeping of a given status, it is evident that the number dimension cannot be totally ignored.

The fact that midwives are so numerous in England weighs on the strengthening of corporate spirit, on the implementation of corporate strategies that are functional to the keeping of the acquired socio-professional position, and to the diffusion of a form of culture that is alternative to the medical and medicalized praxis.

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Notes

[1] The data, concerning the year 2007, derive from the data banks of Federazione Nazionale dell'Ordine dei Medici (The National Federation of the Medical Association), of the Federazione Nazionale dei Collegi delle Ostetriche (The National Federation of Midwives), of The General Medical Council, and The Nursing and Midwifery Council.