Maternity services in China and professional identity of the midwife

Abstract

Maternity services in China are highly medicalised and government policy for obstetric-led hospital care has resulted in marginalisation of the midwife's role. The broader historical, political and cultural context of Chinese society has also influenced how midwifery care is provided. By focusing on the professional identity of midwives, this article explores factors that impact on how midwives in China practice in comparison to midwives in the UK. The article concludes that midwives in China face significant challenges and are not adequately enabled to provide care from conception through to the end of the postnatal period. By comparing midwifery practice between the two countries, is it suggested that there are seven key factors that appear to promote and contribute to a strong professional identity. It is important to note that this is a personal view based on observation and reflection.

Keywords

Maternity services | Professional identity | Midwives | Obstetric-led care

Last November, the author of this article had the opportunity to participate in a professional tour looking at midwifery services in China, enabled by a scholarship from the Florence Nightingale Foundation. The role of the midwife in China is very different to the UK; this article will share some individual reflections on factors that have shaped the professional identity of midwives and the differences between both countries. While this scholarship offered the opportunity to visit several different maternity hospitals, inevitably these conclusions are drawn from a brief glimpse of maternity care in a rapidly changing society.

With a population of 1.3 billion (Worldometers, 2017) China is the third-largest country in the world, and its rapid social and economic modernisation is manifesting itself through the adoption of Western, predominantly North American, norms. The use of technology in healthcare is seen as progressive and desirable. Medical interventions in childbirth, such as elective caesarean sections, are commonplace; China has one of the highest rates of intervention without indication in Asia (Wang et al, 2012).

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This modernisation is taking place against the backdrop of post-revolutionary culture and the autocracy of a one-party state, which has only recently reversed its one-child policy. Cheung notes that 'although [China] has adopted a capitalist economic system, it still paradoxically clings to a Marxist communist ideology' (Cheung, 2009: 230). This has complex implications for midwives practising in a society that is attempting to reconcile these two outlooks. For example, China is now more exposed to Western ideas, and Cheung (2009) suggests that the US obstetric model has been emulated because it represents a progressive scientific approach to healthcare. However, this has resulted in the demise of midwives, who have been replaced by obstetricians (Cheung, 2009).

Since the 1980s, national maternity policy in China has endorsed a model of hospital care, provided by obstetricians and funded by private individual health insurance policies (Zhang et al, 2015). This includes antenatal, intrapartum, and postnatal care for all women. The system was taken up to reduce infant and maternal mortality rates, and has resulted in the growth of private women's hospitals with high levels of medical intervention (Cheung, 2009). The impact of this on the role of midwife has been deleterious. Midwifery care is no longer recognisable as the norm for low-risk women and midwifery-led antenatal care does not appear to be authorised; intrapartum and postnatal care is frequently provided by an obstetric nurse or doula rather than a midwife. In some circumstances, the act of childbirth has been reduced to a surgical procedure within the confines of a hospital setting, and there appeared to be a dearth of examples of community-based services where midwives would visit women in their own homes. It was not always clear how midwives were able to provide psychological and social support to mothers once they had left the hospital setting. It appeared that there was little professional support available for women to help with the wider social and psychological implications of the transition to motherhood.

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In contrast, the Royal College of Midwives (RCM) in the UK recognises that, 'high-quality care encompasses midwifery-led care for normal pregnancy, birth, and postnatal period. All women need midwifery care at every stage' (RCM, 2014: 6).

Similarly, the International Confederation of Midwives' vision is that 'every childbearing woman has access to a midwife's care for herself and her newborn', and promotes midwives practising autonomously as the most appropriate caregivers for women (ICM, 2014a). This approach recognises the importance of keeping birth normal for the sake of the health of women and their families. NHS England has made clear statements in the recent National Maternity Review about the importance of choice and personalised care for women, including access to a midwife for all women (NHS England, 2016). The contribution of midwives to maternal and child health is recognised and mandated by the government, both as a means of offering women choice and support, but also to promote maternal and infant safety.

A licence to practise

In China, midwifery schools existed until the Cultural Revolution in 1966 (Cheung, 2009). Until then the role of the midwife was recognised by the state, but the revolution's mission was to raze any symbols of the old regime. The midwife, along with other health professionals, was seen as an unacceptable part of society because of her association with the old order. There is no national professional regulatory system in place today in China, so the role of the midwife is determined locally by individual hospitals.

To practise as a midwife in the UK, certain regulatory requirements need to be met by the individual, and these were formally established in 1902 through the Midwives Act. Regulation includes registration with the Nursing and Midwifery Council (NMC) following the completion of an approved programme of midwifery education that meets nationally agreed standards. Regulation also means that the title of 'midwife' is legally protected, and the role of the midwife is clearly articulated through the Midwives Rules and Standards (NMC, 2012). Expectations of all registrants with the NMC are laid out in The Code (NMC, 2015a), which describes the professional standards to be met in order to maintain registration, and there are processes in place to remove midwives from the register in the event of serious health issues or professional misconduct.

Cumulatively, these measures provide public protection. The public are able to access the register and refer concerns directly to the regulator for investigation. The author's observation is that in China, the loss of professional regulation of midwifery comparable to that in the UK has not just resulted in the loss of public protection. It has also removed the other safeguards we have in this country to support and maintain the concept of midwifery as a profession, both for midwives and the general public.

The role of the midwife

The role of the midwife in China has been significantly affected by government policy on maternity services. When all maternity care became obstetric-led and hospital-based, the role of the midwife was no longer considered necessary. Midwifery training was phased out in 1993 and only reintroduced recently (Cheung, 2009).

As in other parts of the world, the elective caesarean section rate is high, in some parts of China as much as 100% (Cheung, 2009). It is considered to be the safest and most progressive method of childbirth, particularly in a country where until recently, only one child per family was permitted, and where midwives were perceived to be contributors to poor outcomes (Cheung, 2009). The health insurance system enables Chinese women to choose their hospital and care package, but the state has no duty of care for those who are uninsured.

A significant amount of the maternity care that would usually be provided by a midwife in the UK is carried out by an obstetric nurse or an obstetrician. Antenatal, postnatal, and neonatal follow up is undertaken by obstetricians and community paediatricians, supported by obstetric nurses through hospital-based clinics. It is usually not possible for midwives to practise independently of this system. While this policy ensures that women receive clinical care, it is out of step with the international vision of the midwife as the lead professional and advocate for a safe and fulfilling experience. In the UK, midwives provide social and psychological support for women during a major life transition that Baroness Cumberledge described in the National Maternity Review as, 'life-changing for a mother and her whole family… a time of new beginnings, of fresh hopes and new dreams, of change and opportunity' (NHS England, 2016: 2). There is no equivalent national model of midwifery care in China, and it appeared difficult for midwives to offer an alternative model of care for women anywhere but in a hospital setting.

Despite these constraints, some Chinese midwives are working to restore the role of the midwife to allow women greater choice in maternity care. In 2013, the ICM facilitated a development workshop in Hangzhou (ICM, 2013b), with the aim of supporting midwives and midwifery by strengthening the Confederation's three pillars: Education, Regulation and Association. During visits to two hospitals for women in Hangzhou, the author met with midwives who are now able to offer midwifery

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intrapartum care for low-risk women, and are supported through a new National Midwives Association. However, the numbers of midwives employed in China remains small. For example, in a tertiary unit with 7000 births per year only 20 midwives were employed, which reflected not only the difficulty with recruitment but also the limited demand for low-intervention births. This was a more progressive hospital, where midwives have been employed to offer a different model of care for low-risk women—including water birth—and have support from obstetricians.

Midwives we met told us there was no government mandate to practice other than within an obstetric hospital model, unlike the UK where current healthcare policy clearly articulates and values the midwife's expected role in maternity services. While we met midwives who were leading new models of intrapartum care, these innovative services appeared to be contingent on support from obstetricians with whom they worked.

The significance of a unique body of knowledge

While there has been a long history of midwifery in China—with some early records showing practising midwives during the Imperial period—there has been no culture of recording the history of the profession, or how practice has developed over the years (Cheung, 2009). Midwives in the UK are able to access many resources that describe the history of midwifery practice, such as Hunter and Leap (1993), Worth (2009), and Borsay and Hunter (2012). They also enjoy a professional heritage that sustains their identity, both for themselves and the general public.

In both the UK and China, undergraduate education of midwives takes place in a university setting and leads to degree level qualification. Midwives in the UK are able to work as an autonomous practitioner from the point of registration, and provide a full range of midwifery care. However, it appeared from discussions with staff in China that midwives did not always qualify with the ability to conduct normal births, this skill being gained through further experience and assessment after qualification if required by the hospital employer.

In the UK, reflective practice and continuous improvement is underpinned by the new NMC revalidation processes, and it is expected that midwives will seek to develop their practice during their career through continuous professional development. The NMC guidance suggests this can be met through activities such as peer review, clinical audit, enquiry-based research and learning events as well as structured study as these all contribute to a culture of 'sharing, reflection and improvement' (NMC, 2015b).

In China, there is no national framework to support these activities; it is dependent on the culture in individual hospitals as to how much ongoing professional development midwives can access. Although we were introduced to a midwife who had been able to study

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abroad at doctoral level, and met midwives who were collecting data on outcomes of their practice, this appeared to be exceptional. Nationally, there are still state restrictions on access to information, including the Internet, and culturally it is extremely difficult for staff to challenge a model of care prescribed by government policy; we were told this could be perceived as dissent.

It was difficult to see the influence research and evidence of best practice had on care, with the introduction of different birthing options, such as water births, seemingly driven by association with Western 'progressiveness'—promoted through hospital literature for potential patients—and by each option's potential for income generation.

The impact of policy on outcomes

In China, it was difficult to get a clear picture of clinical outcomes. This was further frustrated by a lack of consistent methodology in collecting information, and cultural norms that do not encourage or tolerate challenge and debate (Mander, 2010). Having one child, which was until recently government policy, means women have less ongoing engagement with maternity services—whereas a driver of progression in UK-based midwifery has been women reflecting on their birthing experiences, and wanting things to be different for the next pregnancy and birth.

Many Chinese women perceive the process of childbirth as a difficult medical procedure to be endured, and consequently opt for caesarean section (Wang et al, 2012). There do not appear to be opportunities to bring women together to lobby for change, as this would be discouraged and potentially perceived as an unwelcome challenge to the one-party state. In the UK, the collective voice of women has resulted in changes being made to maternity care. Pressure groups such as the Association for Improvements in Maternity Services (AIMS), established when a mother publicised the poor maternity care she had received, provide information on choices and campaign for women's rights by submitting evidence of women's views to the government. These campaign groups also recognise and support the role of midwives as the lead care givers and advocates for low risk maternity care.

In the UK, providers of maternity care are required to collect and review the outcomes of childbirth at local and national level, via the national Maternity Services Data Set. In addition, national systems such as confidential enquiries into perinatal and maternal mortality are subject to independent review and scrutiny. Lessons learned from these reviews should influence education curricula, clinical protocols and national policy. It is expected by regulators that maternity units have programmes of clinical audit and serious incident reporting, giving the opportunity to learn lessons from incidents and improve care. Midwives are encouraged to be involved with these processes at every level.

Equivalent processes in China are not well developed, and there are issues with the ability to collect data effectively and concerns about its accuracy (Mander, 2010). Mortality rates appear to have improved in recent years and the assumption is that this is due to the obstetric care policy, rather than other factors, such as better public health and better access to healthcare as people migrate from rural areas to the cities (Mander, 2010). However, Mander (2010) noted it is difficult to get reliable data because of the lack of infrastructure in rural areas, and noted that data is subject to less peer review and scrutiny.

Mander suggests that maternal mortality is linked to the position women hold in society and how that translates into safer childbirth. China remains a strong patriarchal society, despite its rapid economic growth and increased interest in modernisation. The desire for a son in preference to a daughter is still strong. Once married, women are expected to leave the family home to live with their husband's family and become the main care givers for their in-laws, while their own parents are left behind to care for themselves.

Anecdotally, we were told that the current demographic imbalance between men and women is significantly skewed, with an estimated 30 million missing girls lost to society, probably due to illegal termination, infanticide or abandonment; this sex selection is confirmed by Fang and Kaufman (2008). In such a society, midwifery practice is seen as women's work, historically carried out in domestic settings and therefore undervalued; and because it is carried out by women, who themselves are not valued, this inevitably affects perception of the role of the midwife.

Caza and Creary (2016) report on the construction of professional identity, suggesting that professional groups have specialist skills and knowledge and 'are therefore unique from others in what they can do' (Caza and Creary, 2016: 6). Chinese midwives have been disabled from being able to fulfil their role which has been diluted, and it is now very difficult for them to demonstrate their unique contribution through data and audit.

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Key points

- The Chinese state supported midwifery as a profession until the 1966 Cultural Revolution
- Midwives have since been inaccurately linked to poor patient outcome and replaced with obstetrician-led care in a hospital setting, with caesarians accounting for as many as 100% of births in some areas of China
- A lack of evidence gathering or recording of best practice has hampered the profession's ability to refute the judgements made against it
- UK-based midwives can, and should, articulate their value and impact using the long-term data and best practice information available to them

Conclusion

Many Chinese midwives are now in a precarious situation and will struggle to demonstrate their value and contribution in a highly medicalised and business orientated maternity service. By looking at what has led them to this position, midwives in the UK have an opportunity to reflect on influences that sustain their professional identity. I feel the following factors are significant:

- The importance of a national regulation system which contributes to professional identity for both registrants and public, enables the profession to share values and behaviours through a shared code, and sets standards of education and revalidation
- A mandate from government to provide care that recognises the value that midwives bring to maternal and child health, from conception to the end of the postnatal period
- Support from professional organisations and campaign groups, some of which represent women and midwives working collaboratively to improve practice
- High quality education programmes that result in practitioners who are able to take on all aspects of the midwife's role at the point of qualification
- A culture which values continuous learning and improvement, through opportunities to reflect on practice and collaboration with other professions
- The ability to contribute to a body of knowledge unique to midwifery through clinical audit and research
- Systems and processes to share data on both clinical outcomes and women's experiences, and the opportunity to debate and challenge findings.

A professional group unable to articulate its worth to society is potentially vulnerable. In China, midwives were considered to be a contributing factor to high infant mortality rates, and were unable to counteract this perception—not just because of an inability to take cohesive action, but also due to a lack of evidence for rebuttal. This made it easy for obstetricians to offer an alternative model of care that has now become government policy at the expense of women's choice. In the UK, where NHS resources are increasingly scarce, it is imperative that midwives are able to articulate what their profession can offer to policy makers, to other professions, and ultimately to women. BJM

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