A review of midwifery leadership

Despite frequent reports criticising leadership skills in the profession, midwives have dedicated many years to increasing representation at the highest level. Elizabeth Maria Bannon, Fiona Alderdice and Jennifer McNeill explore the many decades of progress

Abstract

The ineffectiveness of leadership across maternity services in England has been a recurrent theme over a number of years, with reports continuing to identify the same issues. These reports reflect the concerns previously identified by the Healthcare Commission in its review of maternity services in England, which drew attention to the links between poor morale and ineffective or authoritarian leadership, as well as highlighting the overemphasis on financial pressures, all of which were concluded to be detrimental to the care provided for women. This article will explore the history of midwifery leadership, examining the reasons why midwives in particular have been perceived as failing to have developed the necessary skills to lead and manage maternity services.

Keywords

Leadership | Management | Midwifery | Maternity services

Manchester coroner Lisa Hashmi identified 'poor midwifery leadership and staffing levels as well as ambiguities in the Trust's guidelines' (Gray, 2016) as key factors in the death of a newborn baby when reviewing the case. These concerns are reflective of the findings in numerous reports into maternity services in England (Healthcare Commission, 2008; Francis, 2013; Kirkup, 2015; National Maternity Review, 2016). In a review of maternity services, the Healthcare Commission (2008) specifically linked poor morale; ineffective, domineering leadership styles; and an overemphasis on financial pressures with poorer care for women. Midwife managers in particular have been perceived as lacking the necessary skills to lead and manage the maternity services, thereby impacting on the quality of care delivered (Smith and Dixon, 2008). While there has been progress in improving maternity outcomes, Amess and Tyndale-Biscoe (2014) have reported that outcomes and quality of care remain inconsistent for women across all Trusts in England, with an 80% rise in maternity claims over the last 5 years.

These are difficult messages for midwives, who have sought to improve their leadership and managerial skills over many decades in order to provide quality maternity services for women. In 1964, the Royal College of Midwives (RCM) advocated for the role of a midwifery matron (Cowell and Wainwright, 1981), highlighting the importance of attracting and retaining leaders in the profession and in the newly emerging maternity hospital system. The RCM recommended that courses should be developed specifically for midwives to prepare them for leadership roles, but evidence suggests that this recommendation was never fully implemented, and midwifery literature has continued to highlight concerns at the gap (Coggins, 2005; Johnson and Dale, 2011). Given the overwhelming evidence for the link between strong and effective leadership and high quality care (Warwick, 2015), it is clear these concerns must be addressed.

The aim of this article is to review a range of issues that have potentially affected the development of midwife leaders and managers, namely gender, the profession of midwifery, organisational changes in the provision of maternity services, and management structures within the NHS. These issues will be addressed in the following sections, concluding with some consideration as to how the profession may move forward.

Gender

In general terms, the issue of gender and its effect on the career and management opportunities afforded to women in both corporate and organisational arenas has

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been commented on in the literature for more than 20 years (Weyer, 2007). Weyer (2007) describes the effect of the so-called 'glass ceiling', and acknowledges that, while some progress has been made to breach this barrier, it is limited, and unlikely to disappear until women are regarded by society as equal to men. Veale and Gold (1998) in their study identified the disparity between the numbers of men and women who were able to access management development, with men having more opportunity than women. Working mothers in particular reported difficulty balancing domestic responsibilities with inflexible working patterns. Millar and Clark (2008) found similar disparities a decade later. In addition, it has been highlighted that women believe they would benefit from women-only development schemes due to different managerial approaches (Lewis and Fagenson, 1995; Veale and Gold, 1998; Millar and Clark, 2008).

The impact of gender on career choices and opportunities is not unique to the UK. Mathipa and Tsoka (2001), for example, in an exploration of the barriers women faced securing leadership positions in the education system in South Africa, identified that women were underrepresented in senior management positions. They suggested that this could be directly linked to a society which has two sets of rules, one for men and one for women, in keeping with a view expressed by the French feminist Simone de Beauvoir (1949), more than 50 years earlier.

De Beauvoir concluded that the role and function of women in society was informed with reference to men who hold the position of power, which, as she asserted, was the result of Aristotle's theory that women were inferior to men. A concept that, she argued, has never really been discredited or rejected by society and has therefore afected women's life choices. She encapsulated her view in the following way:

> ***'Woman? Very simple, says the fanciers of simple formulas: she is a womb, an ovary; she is female—this word is sufficient to define her.' de Beauvoir (1949: 35)***

It is within this wider societal context the role of the midwives is considered. Midwives—whose title means 'with woman'—are mainly women, and focus on providing care to other women. It has been suggested that these two facts provide one possible explanation as to why midwives face barriers to fully participating in the management of maternity services (Donnison, 1988; Walsh, 2006).

In part, de Beauvoir (1949) was accurate, as the effect of gender on career choice and progression has been well documented (Porter, 1992; Behrend et al, 2007). Porter (1992) discussed how gender influenced nurses' working lives in the NHS, and concluded that it was one of the most important issues in their professional practice. Porter (1992) noted that, although female nurses were becoming more assertive, they were still some way from achieving equality, given the complex and changing power relationship between female nurses, male doctors and greater numbers of male nurses. Midwives have been particularly affected by the issue of gender. Historically, as women, they were the care provider for women until the middle ages, when men began to take an interest in the practice of midwifery (Donnison 1988; Drife 2002). Since that time, it seems that midwives have continued to struggle to maintain their role as autonomous practitioners and experts in normal pregnancy and childbirth (Ehrenreich and English, 1973; Donnison, 1988).

The interprofessional gender issues identified are equally applicable to other professions and countries. Millar and Clark's (2008) study of gender issues in the medical profession concluded that there were issues of discrimination against women, finding, for example, that trainee working patterns caused conflict for women as they sought to achieve a balance between their professional and personal lives. When combined with the culture of the health service, Millar and Clark (2008) concluded that this also affected career progression for women who attempted to combine motherhood with the practice of medicine. Conversely, for midwives, while career progression from a clinical to a managerial role has often resulted in improved working patterns, moving from shift work to more regular hours, the reality of undertaking these roles often does not improve midwives' work-life balance, due to the long hours, unsustainable workload demands, and lack of support to undertake the role (Buchanan et al, 2013).

The profession of midwifery

It would, however, be wrong to suggest that the sole explanation for midwives' failure to develop the necessary skills to manage maternity services is related to their gender. Other commentators (Hughes et al, 2002; O'Connell and Downe, 2009) have identified further challenges, such as the management system within the NHS, as a key barrier to progress. The

Healthcare Commission (2008) also drew attention to the organisational structure of the NHS and reflected that the structure itself significantly contributed to the absence of midwives at senior positions. To understand why this may be the case, it is necessary to look back at the history of midwives and their journey into the NHS.

The role of the midwife is considered to have existed before records began (Donnison, 1988), with knowledge handed down through the generations from mother to daughter. The first book of knowledge available to midwives was written by Soranus, the Greek physician, in the second century and was used for the next fourteen centuries (Sweet, 1988). Midwives were an integral part of society, practising without restriction until the middle ages, when the first indication of a desire by others to manage or control midwives' practice emerged (Donnison, 1988). It is unclear what specifically instigated the movement to control midwives' practice during the middle ages; however, reference to the fear of witchcraft and the role midwives held as wise women and healers have been suggested (Ehrenreich and English, 1973). Donnison (1988) proposes that it was linked to concern about the 'soul' of the unborn baby, should it die during childbirth without being baptised. Nevertheless, the Christian Church in Europe was politically strong in the middle ages and the bishops (who were male), used their power to require midwives to be licensed by the Church, which included swearing an oath to practice in accordance with Christian beliefs. It has been suggested that this was the beginning of the male (medical) challenge to the relationship between midwives and women, with a view to establishing men's authority and control (Ehrenreich and English, 1973; Donnison, 1988).

Women nevertheless continued to be the key providers of maternity care until the beginning of the seventeenth century, when a more fundamental development of the male role within childbirth began to emerge (Sweet, 1988; Donnison, 1988). Loudon (2008) suggests that, while the introduction of forceps and knowledge of medicine are often cited as the reason for men's involvement in midwifery, in reality, it was probably the opportunity to gain paid employment. Irrespective of the reason, 'men-midwives' were increasingly engaged by women to provide their care. As the power of the Church declined across Europe, the power of the medical profession grew and midwives became increasingly marginalised (Donnison, 1988). In England, although obstetrics was not viewed as a medical specialty, male midwives were able to access education and to develop their skills and knowledge including the use of forceps and thereby able to make a living (Donnison, 1988; Loudon, 2008). As a consequence, the majority of female midwives were uneducated, unregulated and generally used by women from the poorer classes.

A small number of women, such as Zepherina Veitch and Rosalind Paget (Cowell and Wainwright, 1981), were able to access education and they became increasingly concerned about the variations in the standard of care provided to women. They set out to secure education and legislation for midwives through the formation of the Matron's Aid Society to improve maternal outcomes (Cowell and Wainwright, 1981), and secured the Midwife's Act in 1902 in England and Wales (Donnison, 1988). This Act protected the title of midwife and established the principle that only a trained midwife or medical practitioner could care for a woman in childbirth. It set the direction for midwifery regulation for the next 70 years, with the establishment of the Central Midwives Board (CMB) and the supervision of midwifery practice to ensure the safety of women. This model of supervision was also seen as providing midwifery leadership and an element of control for the profession, as midwives engaged in annual discussion and audit of their practice (Lloyd, 2015).

Organisational changes in the provision of maternity care

By 1948, and following the birth of the NHS, midwives were responsible for the majority of deliveries (mostly home births) in an organised and regulated system of maternity care (Cowell and Wainwright, 1981; Loudon, 2008). Midwives often worked with GPs in community areas, while obstetricians practised within 'lying in' hospitals that were generally used for women with complex needs.

The NHS, with the principle of 'care, free at the point of delivery', meant that women were able to choose their caregiver without concern about cost. Initially, this lead to tension between midwives and GPs as they competed for the women's service; however, gradually, this changed as women opted for care by midwives with support provided by the GP (Loudon, 2008; Donnison, 1988).

The focus of Government policy to increase efficiency in the NHS, improve hospital bed usage and address a falling birth rate, combined with pressure from the Royal College of Obstetrics, resulted in the 1970 NHS review, which recommended that all women should give birth in hospital, despite the lack of any evidence to support this policy direction (Campbell and MacFarlane, 1994). This was also reflected in a shift of emphasis, from the wellbeing of the mother to the outcomes for the baby. As O'Sullivan (2006) describes, maternal mortality had improved significantly throughout the second half of the twentieth century as a result of factors such as improved housing, nutrition, employment and antenatal care. With the development of knowledge about neonatal care, drugs, and technology, more could be done for babies born prematurely or with health problems.

Before regulatory changes in the 1970s, hospital births tended to be the exception, rather than the norm

For midwives, the system in which they practised was fundamentally changed. The Salmon Report (Salmon, 1966), which was commissioned to raise the profile of the nursing profession in hospital management, compounded the situation, and Salmon ignored midwifery as a separate profession. With the movement of the majority of midwives into the hospital setting, and the failure to acknowledge the different professional focuses of nursing and midwifery, difficulties were inevitable. The influential report of the Committee on Nursing (Department of Health, 1972) which was established to review the role of nurses and midwives and was chaired by Asa Briggs, focused almost exclusively on nurses' roles, education and career issues, with almost no acknowledgement of midwifery or its professional supervisory framework.

Midwifery regulation today

This conspicuous absence was reinforced in 1979 when the CMB, the regulator for midwives, was stood down and midwifery regulation became linked to nursing with the formation of a single regulator for both professions, the United Kingdom Central Council (UKCC) (Borsay and Hunter, 2012). This fundamental failure to acknowledge the differing focus and population of each profession has continued today with the establishment of the Nursing and Midwifery Council (NMC), successor body to the UKCC, in 2002. The NMC recommended the removal of statutory midwifery supervision from legislation, as it was perceived to be an additional level of regulation—which nurses do not have. Despite evidence of the positive effect that supervision has on midwifery leadership and on the safety of women, its continuation was not accepted and the legislation has been amended accordingly (Merrifield, 2017). As a result of these changes, midwives have struggled to be a visible presence within the NHS organisational structure (Healthcare Commission Review, 2008; National Maternity Review, 2016) and there has therefore been no clear mechanism for maternity issues to be raised at Trust boards, with the resultant lack of impact on women's care.

Management structures within the NHS

Originally, Government policy gave the key role in leading the new NHS to doctors (Whitney, 1988). GPs were to be the gatekeepers for the public to access the NHS, and the method of referral from doctor to doctor secured their position as the most influential people in the service (Harrison and Pollitt, 1994). This system made

no provision for women to contact their local midwife directly as they had in the past (Worth, 2002), and as midwives had no voice at the managerial table, there was no opportunity to influence decisions. The situation was compounded by hospital information systems, which were established to identify medical productivity through patient activity, coded under the medical consultant to whom they were referred. As a result, the provision of midwifery care was not visible in the system.

Since 1948, however, each Government in turn has faced increasing costs, complexity and demands from the NHS, which led to a complete re-organisation of management arrangements and the introduction of a general management structure in 1984. The general manager was to take overall ownership and accountability and, while not clearly articulated, the former pattern of medical-led management was stood down (Harrison and Pollitt, 1994). In the Government's view, a general manager with no clinical affiliation would ensure that the NHS was managed effectively and within budget (Harrison and Pollitt, 1994). Subsequently the NHS Graduate Management Training Scheme was introduced, to target individuals who were destined for NHS management posts (Hague, 1985). The scheme, which has evolved over the years, takes approximately two years to complete, during which the participants are facilitated to get the widest possible exposure to all aspects of the NHS. Sambrook (2009) would suggest that these management trainees are encouraged to believe that health professionals do not have the skills to manage the NHS, irrespective of their clinical expertise. The Healthcare Commission (2008) identified, however, that the strategy of excluding health professionals from management positions was flawed and did not deliver the expected changes. Nevertheless, with the absence of managerial developmental pathways for clinical professionals to become managers, they remain unlikely to attain appointments to senior positions where they could influence change (Johnson and Dale, 2011).

Moving forward

The most recent review of maternity services, *Better Births* (National Maternity Review, 2016) restated the need for improved leadership, management and team working within the maternity service, in order to improve outcomes and women's experiences. In light of women's continuing negative experiences, as highlighted by Amess and Tyndale-Biscoe (2014), this recommendation must be implemented. As midwives hold a unique role working with women, they are well placed to make a real and sustainable difference to the health of the mother and her family at a local level. Through role managing and leading maternity services they can use this knowledge strategically to influence policy and service direction.

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Handy et al (1988) explored how other countries addressed these challenges and identified various models, for example, in Germany, where having an in-depth knowledge of a profession was perceived as advantageous in obtaining senior management positions. Chris Ham (The King's Fund, 2011) also recommended a new approach, highlighting that the failure to develop clinical professionals to manage and lead within the NHS in a sustained way has resulted in poor care. The recent maternity review in England (National Maternity Review, 2016) reinforces this position, linking the lack of clinical leadership with poor outcomes for women.

Preparing midwives for management

Handy et al (1988) recommended that development opportunities must be set within midwives' experiences, and identified evidence of good outcomes where programmes were based on internal learning opportunities. An integral part of any management development intervention for midwives must ensure they understand the language and structure of the system in which they practise, in order to build managerial competences and ability. The language is necessarily different to clinical practice, with a focus on finance and resources, workforce planning, modernisation, safety and quality. Midwives need to increase their knowledge of the broader corporate management issues, and in order to develop and understand the integration of policy direction and commissioning, they need to take opportunities to experience the wider health care system. Observing and acquiring skills of negotiation, persuasion, influence and political astuteness need to be acknowledged as essential components of midwives' leadership and management development within the NHS.

Key aspects of maternity services are currently delivered in the acute hospital environment, but this is only one aspect of the wider public health arena in which midwives practise. As identified in *Midwifery 2020* (Chief Nursing Officer of England et al, 2010), the drive is to develop community-based models for the future. The initial findings from ongoing research by the

Key points

- The ineffectiveness of midwifery leadership has been a recurrent theme in reports published over a number of years
- Midwifery managers in particular have been singled out as lacking the necessary skills for effective leadership, despite midwives striving for many years to improve outcomes for women
- As a profession with a large female workforce, midwives have historically faced challenges to their autonomy and authority, including today's problem of the 'glass ceiling'
- Changes to the organisation and regulation of maternity care have resulted in greater focus on GPs, and the exclusion of midwives from hopsital records systems and managerial environments
- The National Maternity Review has stated the need for midwives to learn management skills, to enable midwives' experiences to be heard.

authors around midwifery management and leadership in Northern Ireland would suggest that the skills and knowledge necessary to lead and manage in the NHS are acquired in an ad hoc manner. This highlights the need for a strategy to ensure a consistent approach to midwives' management and leadership development.

The continuing effect of gender

While the issue of the 'glass ceiling' should no longer be an obstacle to midwives' progress on the basis of gender, the evidence would suggest that this may still be a factor for women seeking management positions within the NHS—especially in the context of family commitments, whether as mothers, carers or partners (Millar and Clark, 2008; Warwick, 2015). Coggins (2005) suggested that these barriers could be overcome through the creation of work-based experimental learning opportunities, which could incorporate mentorship, role modelling and coaching into management and leadership development. Warwick (2015) has emphasised how important it is that the NHS recognise that new models and greater flexibility are needed in developing managers and leaders for the future, to ensure that midwives will be enabled to fully contribute.

Conclusion

The real challenge and measure of success will now be for midwives to secure appointment to senior management positions, and to demonstrate their ability to fulfil all aspects of those positions, especially managing change, which Pashley (1998) suggests is a key element of leadership and management. As identified through a number of reports, midwives and maternity services need to be adaptable and open to change (Amess and Tyndale-Biscoe, 2014; National Maternity Review, 2016). Recent publicity around the RCM's decision to end its campaign for normal birth attracted a high level of challenging media attention (Harley, 2017). The Chief Executive of the RCM (a midwife) offered an exemplary role model for how to manage a difficult situation, maintaining professionalism by accepting responsibility for the need for change but keeping the focus firmly on the safety of women and babies and improving practice. Given the National Maternity Review's (2016) recommendation that there should be a 'champion' for maternity services participating at Trust Board level, it is vital that midwives identify and learn from strong role models in order to fulfill this role.

Midwives cannot rewrite history, but must learn from it, demonstrating though action their willingness to complete management and leadership development programmes and question the system. Once they secure promotion, equipped with the requisite knowledge and skills, the challenge will be for midwives to have their voices heard, ultimately contributing to improved maternal and infant outcomes. **BJM**

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