

HOW FRENCH LIBERAL MIDWIVES DEAL WITH THE DOMINATION OF THE MEDICAL PROFESSION

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Abstract

In France, an increasing number of midwives are choosing to work as liberal professionals. They are being granted new powers, but their relationships with general practitioners (GPs) or gynaecologists are often strained. The domination of doctors becomes apparent from the outset of midwifery training, in which midwives are regularly put under pressure, and the situation prevails throughout their professional life. Doctors barely recognize the skills of midwives (which are very similar and liable to compete with their own) and many would like to restrict the latter's activities and subordinate their role. Liberal profession midwives must make do with the current situation and accept this domination as they are not in a position of power. Nevertheless, as staffing changes are taking place in their favour, they have not had their final say yet: the short supply of gynaecologists means that midwives will soon become indispensable and pregnant women or young mothers will have a genuine need to use their services.

Key words: Midwives, medicalization, liberal profession, health policy, domination of the medical profession

Résumé

Les sages-femmes, en France, sont de plus en plus nombreuses à choisir d'exercer en libéral, à leur compte. De nouvelles compétences leur sont attribuées mais leurs rapports aux médecins généralistes ou aux gynécologues sont souvent tendus. La domination de ces médecins se fait sentir dès la formation de ces sages-femmes, soumises régulièrement à rude épreuve, et continue tout au long de leur exercice professionnel. Les médecins peinent à leur reconnaître des compétences qui se rapprochent des leurs et qui seraient susceptibles de leur faire de la concurrence. Nombre d'entre eux voudraient les cantonner à demeurer sous leurs ordres. Ces sages-femmes ne l'entendent souvent pas ainsi. Pourtant elles doivent composer et parfois accepter cette domination dès lors qu'elles ne sont pas en position de force. Pour autant elles n'ont pas dit leur dernier mot puisque l'évolution des effectifs s'effectue en sens inverse. Bientôt elles seront incontournables et, faute de gynécologue en nombre suffisant, les femmes enceintes ou les jeunes mères devront bel et bien faire appel à leurs services.

Mots-clé : Sages-femmes, médicalisation, exercice libéral, politique de santé, domination médicale

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Rezumat

În Franța, din ce în ce mai numeroase moașe aleg să-și exercite liber, pe cont propriu, meseria. Li se cer mereu noi competențe, dar raporturile lor cu medicii generaliști sau ginecologi sunt adesea tensionate. Poziția dominantă a medicilor se face simțită încă din perioada formării lor, când sunt supuse la probe grele, continuate și pe parcursul exercitării profesiei. Medicii le recunosc greu abilitățile asemănătoare cu ale lor și care le-ar putea face concurență. Mulți medici ar vrea ca ele să rămână acolo unde le e locul, la ordinele lor. Dar moașele nu înțeleg să se comporte astfel. Totuși trebuie să se descurce și adesea să accepte dominația medicilor, fiindcă poziția lor nu e puternică. Până în prezent ele nu și-au spus ultimul cuvânt deoarece se constată o diminuare a efectivelor. Dar în curând ele vor fi căutate, iar în lipsa ginecologilor - în număr insuficient, femeile gravide sau mamele tinere vor trebui să apeleze la serviciile lor.

Cuvinte-cheie: Moașe, medicalizare, profesie liberală, politica sănătății, poziția dominantă a medicilor

Introduction

The distinguishing feature of French midwifery is that it is a distinct medical profession in its own right. Moreover, in recent years, the legislative and regulatory framework has helped to expand the duties of this profession. On this basis, since August 2004, midwives have been authorized to confirm pregnancies and to carry out post-natal examinations for normal childbirths. In addition to their competencies concerning physiological pregnancy care and managing the progress of normal deliveries, midwives also participate in the four-month ‘booking appointment’¹ that was made compulsory by the Law of 5 March 2007 reforming child welfare. Finally, according to another law – the “HPST” (hospital, patients, health, territories [*regions*]) hospital reform law of July 2009 – midwives are authorized to carry out consultations and routine gynaecological and contraceptive check-ups (including prescriptions) with healthy women – tasks that were previously assigned to gynaecologists and general practitioners (GPs). These ever expanding competencies are in line with the fact that France is one of the countries in Europe with the longest midwifery training courses (five years). It must also be noted that gender breakdown figures for the profession show that males make up 3% of registered midwives in France.

¹ The so-called “4-month booking appointment” takes place with the future mother/couple and must be systematically offered to the pregnant woman by the midwife who confirms the pregnancy. The appointment may be arranged any time from the first trimester of pregnancy onwards and is the object of a written report. This meeting also serves to identify information needs, define parental skills requiring development, review the medical care and birth plan, identify any vulnerabilities of the mother and father, provide information on community-based care and how it functions, where necessary, to direct the pregnant woman/couple to aid and assistance measures and finally, to plan individual or group prenatal sessions.

Students wishing to enter the midwifery profession must now obtain the necessary ranking, just like doctors and dentists, based on the nationwide *numerus clausus* (student quota) following the competitive examinations of first-year health studies (*PAES*). They then follow a four-year course leading to the State qualification which enables them to work in hospitals and clinics and also to directly obtain liberal professional status to work independently. Their activities are extremely varied² and patient fees are regulated by a national Agreement signed by the midwifery unions and national health insurance funds. As such, midwife consultations are covered by social welfare schemes and 100% reimbursed.

The lack of improvement in indicators of perinatal health over recent years is a cause of concern for French Health Authorities: since 2005, the infant mortality rate has been stagnating, with an overall rate of about 3.8 deaths per 1000 live births, whereas it is decreasing in other European countries. Deaths during the first week of life have risen from 1.6 per 1000 births in 2005 to 1.8 in 2009, and from 2.5 to 2.6 deaths per 1000 births during the first month of life. Preterm births (babies born alive before 37 weeks of pregnancy are completed) accounted for 6.6 per cent of births in 2010 compared to 6.3 per cent in 2003. Although the stagnation of the infant mortality rate is worrying, not all of its determinants have been identified. Within such a context, and given the decrease in the number of gynaecologists, obstetricians and GPs, public policies aim to develop the competencies of midwives and strengthen their role in the area of perinatal care. Moreover, the results of the latest national perinatal survey in 2011 (Blondel, Kermarrec) highlight that the role of midwives (both salaried employees and liberal professionals) in the monitoring of low-risk pregnancies has developed. Perinatal policy also emphasizes the need for increased coordination between the different actors in the field, particularly by fostering cooperation between midwives and doctors.

However, this coordination cannot be organized by decree and the domination of doctors, who regularly show unwillingness to recognize midwives' competencies, soon becomes apparent.

This paper will focus on the relationship between doctors and liberal midwives. In France, midwives tend to make their voices heard, particularly in the media, and must also face the ignorance (or denial) of the local GPs or specialists with whom they work. To date, this research has been based on the exploitation and analysis of an initial corpus of exploratory interviews conducted with 40 practicing liberal profession midwives working in four *départements* (two in the west and two in the

² In particular, they carry out pre- and post-natal consultations, obstetric ultrasounds, oversee care in normal pregnancies, offer birth preparation classes, the monitoring of women presenting an at-risk pregnancy (on a doctor's prescription) to avoid or reduce the hospitalization of pregnant women, home deliveries and post-natal monitoring during early home visits from the day of discharge from the maternity clinic up to the seventh day of life (without a doctor's prescription), perineo-sphincter rehabilitation exercises, contraceptive consultations and gynaecological examinations.

east) in mainland France. It will update the nature of these relationships and analyze the effects of domination that hinder doctor-midwife interactions at a time when the boundaries between these health care professionals are being redrawn: doctors are fairly confident of their right and primacy, whilst midwives are trying to assert their competencies and to showcase everything that now forms an integral part of their functions.

1 Training period and the initial effects of domination

Original midwifery courses lasted three years, this period was then increased to four years and the current duration stands at five years. Unsurprisingly, the effects of domination are not long in coming for trainee midwives who are at the beginning of an already long and intense course of studies. A rather troubling observation here is that except in rare cases, all refer to this training period as difficult and sometimes even painful. *“They treated us like kids”*; *“They considered us to be their lackeys”*. There is a long anthology of bitter memories among the midwives interviewed. At this stage, gynaecologists are mentioned in various ways. Judging by the midwives’ discourse, some gynaecologists are not directly involved in midwifery training, whereas others are not only very visible, but also very authoritative: *“Everybody was scared of Doctor X’s department. In class, he was a passionate, interesting, but terrifying teacher, he liked to humiliate you. Whenever you bumped into him, he would ask you questions. Visits with that Head of Department were a bit scary; he would ask you questions all the time. We all tried to keep a low profile”*; *“One teacher was the School Director, a leading light in the medical world, brilliant, but it was better to remain in his good books, and above all, not bring in ideas from elsewhere. And as for protocols – it was CHU’s [the University Hospital] way or the highway”*; *“Their reports from this teacher would come back with a little smiley or sulky face drawn on them”*.

Is this a case of the transfer of domination from gynaecologists to supervisory midwives? Do trainee midwives find themselves in a world that has fully integrated hierarchical layers and the “dirty work” (Hughes, 1996) imposed on the lower levels? This may be true to a certain extent because almost all interviewees described a tense relationship with many of their supervisory midwives during their internships. Interviewees spoke of humiliation (a term that is used often) and frustration, recalling and giving examples of how they were put to the test on numerous occasions. These memories are still extremely vivid even years later: *“They treated us like we were thick in front of the patients”*; *“It was up to us to clean the basins with a toothbrush”*; *“They barely gave us enough time to get something to eat and drink between the rounds”*, etc.

Of course, there are some divergent opinions, and younger midwives are slightly less categorical, but the fact is that learning the trade was not an easy experience by any means.

There are recurrent remarks about various “bêtes noires”. All new intakes are warned about these infamous internship supervisors and advised to be on their guard. Sometimes this goes as far as formal complaints and legal proceedings, but these so-called “bad treatments” are perceived as inevitable: “*Some of them were horrible*”; “*We all share the same memories*”; “*We were quickly put in the picture*”. Therefore, the majority merely accept the situation: “*We were happy to get our diploma and then it was all over*”. Sometimes, however, insecurity created as to their real competencies or the reality of their vocation act as destabilizing forces: “*From day one of Midwifery school, it’s drummed into you that you are thick and you end up believing it. I was ready to change career*”.

It may be too easy to make the homology with the rites of passage analyses first identified by Van Gennep (2011) and further analyses need to be carried out on the meaning of these virtually unanimous assertions and the significance of these complaints that seem to have existed for decades and which never, or rarely, change. In all cases, immersion in the medical world was a rude awakening: “*It was like the old military service for men*”; “*In the beginning, we were the baby midwives, the baby students*”. How do they explain this state of affairs? The most common analysis is certainly somewhat short-sighted, but in its way provides an insight into the realities of a working environment: “*I was mistreated, broken, now it’s my turn to mistreat and break people. Given a rough time by the gynaecologists, they are dishing out the same treatment to students*”, “*We had a really hard time during our training and so we need to give the others a hard time as well*”.

A significant proportion of the midwives interviewed in this study originally began a year of medical studies and some of them retook this first year. It is reasonable to believe that failure and a change of direction also contributed to the comments made, especially as the first year largely consists in nursing internships that come with their fair share of traumatising situations in departments where suffering and pain are commonplace, where deaths occur and where medical domination is blatant in the relationships between future nursing auxiliaries, nurses, or midwives: “*Every evening I couldn’t wait to meet up again with my uni friends from the medical department*”. It is unknown why these domination effects are so much more difficult to live with for women from “good backgrounds”, with a scientific baccalaureate, and with relatively good school grades, but is a question that warrants further investigation.

2 Transition to the liberal sector

All or nearly all newly qualified midwives enter the profession in the different maternity services in hospitals or private clinics. However, change is taking place and a trend has been emerging over the last couple of years for young midwives to become a liberal professional as soon as their studies have finished. This is not

really a great step forward in itself as first jobs have long since tended to be an extension of first-year internships through staff replacements during the summer holidays, etc., but it does mean that from this point onwards, midwives are in direct contact with the more or less all-powerful gynaecologists. Again, there is no doubt that the message has come across and the situation has been accepted. Midwives do not seem terribly surprised when confronted with somebody who treats them as “minions”, or when they encounter arrogant and self-important interns. To put it simply, this is the way things are. Furthermore, midwives do not appear to be too concerned when situations take a worrying turn for novices: “*Well, there’s always the gynaecologist, you know, the stressed type, one who flies off the handle easily, throws things at you, but it’s a bit like that everywhere to be honest*”.

Nevertheless, it cannot be said that when midwives quit salaried positions it is the result of a tense relationship with the gynaecologist. When this does happen (this was heard on several occasions during the present study) it is the exception rather than the rule. Rather, the determining factors for their transition to liberal professionals are due to the overall context of rationalization, protocolization and the above-mentioned staff shortages, all of which we identified a few years ago when we studied the reasons behind the outflow of liberal profession nurses from the hospitals and clinics in which they worked (Douguet, Vilbrod, 2007). Another factor which must be taken into account is a first job in French overseas *départements* and territories (Guyana, Reunion, Mayotte, etc.) which offers midwives the opportunity to gain experience and acquire skills in a wider range of fields than is possible in mainland France.

Midwives who “set up in practice” also learn to carefully handle the decision-making bodies of their former maternity departments. In fact, it will mainly be the department managers (gynaecologists in particular) who will be responsible for referring their first patients and clients and possibly continue to direct young mothers to the liberal midwife for matters such as breast feeding and perineal re-education. The classic trope “*It’s word-of-mouth that matters*” was often heard during the course of this study, which evidently stems from the relationships that liberal midwives have with their former colleagues, but also with the gynaecologists and GPs who appreciate their competencies: “*I had already established a professional network, especially when I was a manager*”.

3 An independent practice which is still subject to medical power

It must be highlighted that the transition from salaried employee to liberal professional can take many forms. Among the midwives that set up in practice, some of them still work part-time in maternity wards, at least until their business becomes stable and the break-even point achieved. We also met – a good domination example – midwives who had set up practice as a liberal professional after having being urged to do so by gynaecologists. In particular, this involves

gynaecologists working in private clinics who want to have a variety of follow-up services at their disposal but do not wish to provide these themselves or are no longer able to. These tasks therefore fall to the midwives who are at their beck and call: *“I work with the gynaecologist who advised me to become self-employed. He carries out the first and the final pregnancy consultation and the three ultrasounds, and for everything else, he refers the women to liberal midwives. I think that this must enable him to see more people, that means more ultrasounds...it’s got to be financially interesting for them. The fact is that I get 90% of my patient clientele through this means”*. What can also happen – a situation that came up several times – is that the liberal midwife’s office happens to be on the premises of the very clinic itself, in an office let by the management. Therefore, it is difficult to generalize.

Once their midwifery practice is open, their relationships with private GPs or liberal profession gynaecologists are less frequent and sometimes even non-existent. However, it must be remembered that local midwives and doctors regularly accompany, in parallel, the same patients throughout their pregnancy. The interviewed midwives referred to their relationships with the “good” doctors as “polite” at best, but never any more positively than that. When there is contact, it is essentially done by telephone or in written form (sending mails, exchanging information *via* patient files). Face-to-face meetings remain exceptional.

On the whole, these professional interactions are fraught with the effects of domination of the medical profession. As such, according to the liberal midwives, GPs and specialists are, or claim to be, unaware of the extent of their skills, and in particular, of their new legal competencies, some even going as far as to think that *“midwives are good for nothing”*. Those who are more informed about the progressive broadening of midwives’ competencies regard these changes in terms of competitiveness rather than complementarity: *“Local gynaecologists were under the impression that midwives were going to pinch their work: first, the confirmation of pregnancy, then the gynaecological follow-up, then IUD insertions”*. All of this is coupled with the ignorance or denial surrounding the level of midwifery training: *“They think that we’ve only got two years of university studies behind us”*.

In relation to the perceived downgrading of their knowledge and know-how, midwives denounce forms of retention and/or diversion of patient clientele by liberal profession doctors. A lot of doctors do not refer patients to liberal midwives, or deliberately do not inform them of the possibility of using such midwifery services: *“They [the GPs] don’t recognize the existence of private midwives”*; *“They [the gynaecologists] don’t even talk about birth preparation”*. These observations are corroborated by reports from women who consult private midwives not via a doctors’ referral, but through recommendations from close friends and family (most often friends): *“She [the gynaecologist] gave me no information whatsoever (...) my gynaecologist didn’t offer me anything”*. What can also happen, especially in the case of pathologies, is that the midwife refers the pregnant woman to the doctor who *“keeps the patient for themselves”*.

Criticisms made about local practitioners related to birth preparation and more often to the physiological monitoring of the pregnancy: “*We’re not very involved in the pregnancy monitoring*”. Doctors may try to maintain a monopoly of this activity with regard to its more medical aspect and thus grant it the status of what Hughes refers to as *respectable work*: “*It bugs them that midwives monitor pregnancies*”. Midwives believe that the monitoring of low-risk pregnancies is at the heart of their work and wish to develop this activity; currently, the activities of liberal midwives are still mainly directed towards birth preparation classes and perineal re-education (Cavaillon, 2012). As for doctors, they would prefer to transfer to midwives the so-called “less noble” tasks, the *dirty work*, to cite another expression from Hughes (1996). Against such a background, a moral division of work is being created between liberal professionals working in the perinatal field: “*They do the brainy stuff, and I do all the leg work*”. Doctors monopolize the most technical activities and in some ways, hand over the psychological and social support to midwives: “*My role is one that the doctors don’t do: for the patients, I am a good mother, I nurture them*”. Doctors do not seem to be very interested in patients, as Camus and Dodier (1994) highlighted, as regards the functioning of the hospital and those tagged as bad patients can be the object of the same delegations “*It’s only when they’ve got a woman who’s a bit bonkers that they think of us*”.

The women who personally chose to consult liberal midwives all place emphasis on the personalized relationships with these professionals – relationships which they believe would not have existed with doctors. Terms such as “trust”, “listening”, “closeness”, “friendliness”, etc., are often used. As well as the relational aspect, women who used these professional services also evoked the fact that midwives are more available than doctors: “*She would say, ‘you can call me whenever, I may not be able to answer each time, but leave me a message’*. And it’s true that after the birth I had a question, and I called, and she called me back afterwards. I know that I would never have dared to do that with my gynaecologist, and as a result, I think that a closer link was created. They’re not doctors, even if they’re nearly at the same level, but midwives, they’re different”.

More specifically, compared to liberal profession gynaecologists, there are numerous arguments in favour of midwifery services including the reduction of congestion in hospitals, lower health insurance costs, single point of contact for patients, etc. This explains their claims for more equal treatment, since, like doctors, they consider themselves to play a major role in the perinatal sector. They state that given the decreasing number of gynaecologists, it would be logical for these specialists to refocus their activity on the management of high-risk pregnancies and for midwives to manage non-pathological pregnancies. These arguments also try to demonstrate that in reality, midwives provide higher quality services than doctors: their consultations are longer (they spend the time) and they provide “comprehensive” patient care. In line with the prevailing ideology in the scope of activities for health professionals, midwifery is on the “relationship” side,

whereas gynaecology is on the “technical” side and is often criticized for its excessive medicalization: “*Gynaecologists look for pathologies so of course, they end up finding them.*” In this respect, it must be noted that resorting to this rhetoric varies from midwife to midwife: some base their professional identity on this human dimension of care to set themselves apart from doctors, as Schweyer (1996) highlights, and some try to distance themselves to reaffirm their professionalism in comparison to the first group: “*People consider us to be like that as well, they think that a midwife doesn't really know how to do anything*”.

It is understood that in such a context, condescension is often unavoidable: “*There is the doctor, and then there's the midwife*”; “*They don't put us at the same level*”; “*You, little midwives*”. The effects of the domination of the medical profession lead to regular tensions between midwives and doctors (GPs just as much as specialists). On several occasions we heard stories of conflicts between medical practitioners and midwives, with the former accusing the latter of going beyond their skills, encroaching upon medical activities and not doing their job properly. These criticisms are given directly over the telephone in a manner that can be quite heated and insulting, or indirectly through the intermediary of a patient in common: “*The other day I was showing some yoga positions to a woman because she was suffering from sciatica. When she came back for her next appointment, she said that her doctor was dealing with the sciatica, and it was no longer any of my business*”. Another stumbling block between these two professions is the issue of medical certificates entitling pregnant women to be signed off work (*arrêts de travail*): midwives are not authorized to issue such certificates for periods exceeding 15 days – this must be done by doctors – and as a result, patients may call into question the initial certificate provided by the midwife and not appreciate the need to renew the initial request.

It would seem that the older generation of doctors are more likely to discredit midwives, as young medical practitioners are more open to the collaboration. The nature of doctor-midwife interactions may also depend on a temporal aspect, i.e. the number of years of experience and who was set up in practice first. For example, long-standing GPs in a particular sector may not celebrate the arrival of a midwife on “their” territory. Conversely, approaches are facilitated when doctors (young doctors in general) set up in the same area as a midwife who is already practising.

At a time when the numbers of both professions are changing in favour of midwives, the midwifery profession still lends itself to what Freidson (1984) calls a paraprofession in the sense that “it is still only partially autonomous because it proceeds and is limited by the dominant profession”. Recent changes, such as an expanding scope of practice, training reforms, increased numbers of liberal midwives and improved job attractiveness are not enough to reverse the decline of the profession's image, or even to re-establish its independence in relation to the

medical profession – a point which has mainly been highlighted by Kniebielher (2007) or by Jacques (2007). This is a midwife's lot: constantly caught in the middle and working in a profession whose definition remains unclear to outsiders. As medical professionals in their own right, midwives follow an ethos, conform to rules, and like doctors, belong to a demanding professional category. From this point of view alone, it lies in sharp contrast to the work of a liberal profession nurse. On the one hand, midwives are strong advocates of female emancipation, since they are ideally placed to gauge the extent to which masculine domination still pervades the areas of birth and newborn health care. On the other hand, although fully aware of the effects of the often masculine domination of the medical profession, they prefer to make the best out of the situation and avoid any direct confrontation: “*We don't want to get their backs up*”. Midwives know that, as things stand, when power is unequally distributed, the balance is not in their favour.

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