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Professional role and identity in a changing society: Three paradoxes in Swedish midwives' experiences

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Abstract
Objectives: to explore how experienced midwives understand and experience their professional role and identity after the continuing changes that have taken place within their working domain over the last 20–25 years.
Design: four focus group interviews with 20 a total of participants in total were conducted and analysed by thematic content analysis
Setting: one university hospital in mid-Sweden.
Findings: two main themes were conceptualised: (1) organisation of and situation at the workplace; and (2) the societal context. Three paradoxes became apparent. The midwives felt that their professional role in childbirth care had decreased in favour of other professionals, but they had a better dialogue with physicians and auxiliary nurses, which led to better teamwork and joint decisions. Secondly, the midwives expressed a strong professional identity on the basis of self-confidence and long experience, but their handcraft skills and clinical experience have become less valued due to increased medical technology and organisational changes that contributed to loss of locus of control. Finally, the midwives described a more humanised childbirth care and better collaboration with women/couples over the last decades. The couples are, however, more knowledgeable and enquiring, and the midwives expressed a fear that professional competency could be set aside. Furthermore, lack of trust in the normal birth process among women also affects midwives and the risk of litigation influences practice.
Key conclusions and implications for practice: the midwives had experienced both positive and negative changes, but generally felt that their role had become more limited and their professional identity challenged by technology, other professionals and contemporary parents. A loss of locus of control may increase the risk of illness and burn-out symptoms, and must be considered by supervisors and managers.

Keywords Midwives; Focus groups; Professional role; Professional identity

Introduction

During the 20th Century, pregnancy, childbirth and postpartum care have changed dramatically in Sweden. The role and working conditions of midwives have thereby undergone transitions, hand in hand with changes in society such as urbanisation and industrialisation. At the beginning of the 20th

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century, almost all babies were born at home with the help of a community-based midwife. Gradually, more and more births took place in hospitals, and home births are now very unusual (<1% of all births in Sweden) (Social Board of Health and Welfare, 2004). The shift from home births to hospital births aimed to obtain maximum safety through medical assistance (Axelsson, 2003; Odlind et al., 2003). In comparison with other countries, Sweden has low infant (2.35 per 1000 live births; Social Board of Health and Welfare, 2005) and maternal mortality rates (2 per 100,000 live births; UNICEF, 2006). Midwives have always been responsible for care during pregnancy and during and after childbirth for healthy women with normal pregnancies, and doctors have had a less dominant role in Sweden compared with other countries (Swedish Midwives Association, 1995).

Katz and Kahn (1978) clarified the difference between the professional role given to individuals within an organisation and the professional role experienced by the individuals themselves. They highlighted the dynamics between the formal organisational expectations of the individual and the positive or negative personal motivations at the individual level. Individuals may not always be aware of how the professional role is constructed and imposed on them (Habermas, 1984, 1987).

The professional role of a midwife is to provide care and support to pregnant women during pregnancy, childbirth and the postpartum period. Midwives are expected to promote the normal birth process and not intervene unnecessarily. In Sweden, midwives have autonomous responsibility for care during pregnancy, childbirth and the postpartum period for women with uncomplicated pregnancies and deliveries. They can also prescribe hormonal contraception, insert intra-uterine devices and hormonal implants, and manage complicated deliveries such as breech, forceps and vacuum extraction (Swedish Midwives Association, 1995). During the last 20–25 years, enormous improvements in medical technology, equipment and information technology have increased the demand for control over childbirth. A growing body of knowledge from research by midwives has resulted in new professional domains such as counselling and support for women who voice their fear of giving birth, parents after stillbirth and parents with special needs. In addition, patients' increasing demands and rights have had an impact on the professional role of midwives (Berggren, 2003; Hellmark-Lindgren, 2006)

In Sweden, important organisational changes in relation to childbirth have taken place over the last 25 years. Many smaller childbirth units where midwives were the main care providers have closed, and the number of doctors, both obstetricians and neonatologists, has increased in the larger units. Auxiliary nurses, who undergo shorter general nursing training, were introduced and work in close collaboration with midwives. They play a supporting role and are responsible for the basic nursing care of mothers and newborn babies. Increasing demands on midwives to care for several women in labour simultaneously, coupled with less autonomous responsibility for childbearing women, resulted in conflict between the different professions. Typical duties of midwives, such as management of breech and multiple births and initial examination of newborn babies, were taken over by doctors. Owing to the conflict, negotiations took place regarding the roles and responsibilities of the different professions, and consensus guidelines were developed. These guidelines were presented as a working draft in 1993 and were finally confirmed and established in 2001. These guidelines indicated that doctors had the right:

- to get information about and follow the progress and state of normal deliveries. All cardiotocographs, normal and abnormal, should be signed by a doctor;
- to make the decision who (doctor or midwife) should manage each complicated childbirth, such as breech, vacuum extraction and manual removal of the placenta, with a clear priority for the gynaecologist under education; and
- to be present during deliveries of twins (Swedish Midwives Association, 1993, 2001).

Professional identity is created in interaction with others and in a social sense of coherence within the profession. It has been argued that the efficiency of an organisation depends on the existence of a profession's sense of coherence (Erikson, 1956; Pingel and Robertsson, 1998). Changes in the professional role affect the professional identity. Organisational changes have a bearing on the working climate and may have an impact on the health of individuals due to loss of locus of control, which may result in stress and stress-related symptoms (Karasek and Theorell, 1990; Nyberg et al., 2005).

The aim of this study was to explore how experienced midwives understand and experience their professional role and identity after the changes that have taken place within their working domain over the last 20–25 years.