

Midwives in England and in Italy: two realities compared

C. Dell'Omodarme¹, G. Bocci², G. Troiano², S. Rossi², L. Kundisova², N. Nante^{2,3}, L. Alaimo¹

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Abstract

Background. Midwives have the responsibility to provide assistance to pregnant women for non-complicated deliveries. The aim of this study was to identify the distinctive features of midwives in Italy and in England in order to provide interesting comparisons.

Methods. From September to October 2015 we administered an online questionnaire to groups of Italian and English midwives. The questionnaire was composed by a part trying to collect the sociodemographic information and a second part to define the attitudes of care and the type of approach to birth and degree of attained professional autonomy. The questions were used to create a score for 5 macro areas: "Midwifery: who is the midwife?", "Education: how much does the midwife know?", "Responsibility: what does the midwife do?", "Ethics: how does the midwife act?", "Social acknowledgment: the midwife and the other people". Results were loaded in a database and analyzed using the using STATA.

Results. 183 Midwives (100 Italian and 83 English) completed the questionnaire.

92% of Italian respondents said to have a "Bachelor", 6% a "University Diploma" and only 2% a "Diploma". 80% of British midwives had a "Midwifery Degree" and 8% attended a "Midwifery Short Program", a degree course in Nursing with an additional specialization of a year and a half in Midwifery. 34% of the Italian claimed to have also a "1st level Master", 16% a "Full Degree" and the remaining 50% attended post degree training courses. Only 23% of the English sample had a "Master of Science" and the remaining 67% reported to have "other" general qualifications.

72% of Italian midwives declared to work and, in particular, in a "III level point of birth" (35%), "II level point of birth" (25%), "I level point of birth" (17%), or in "private health facilities" (4%), in "professional offices" (6%) or "counseling ambulatories" (5%). 46% of the English midwives who participated in the study worked in hospitals; 21% as employees of the NHS in territorial structures. 12% worked in birth centers and 11% had a private profession. There was a statistically significant difference between Italian and English Midwives, for all the macro areas (except for the first), with better results for English Midwives.

Conclusions. English Midwives tend to consider their professional role and their professional skills more acknowledged and appreciated than Italian Midwives. Actually Italians tend to be not very satisfied. However, the Midwives of both countries feel very close to women and have the same conception of themselves and of their profession.

¹ Nursing and Midwifery College, University of Siena, Italy and Department of Molecular and Developmental Medicine, University of Siena, Italy

² Post Graduate School of Public Health, University of Siena, Italy

³ Health Service Research Laboratory, University of Siena, Italy

Introduction

According to Elena Spina (2009), Midwife is one of the oldest figures in history, and traces of her presence can be found since the formation of the first organized human society. In the ancient Egypt, exclusively women could have this role and the midwifery was recognized as a typically feminine occupation (1).

In the late nineteenth century in Italy and in England the physicians controlled the reproductive process and made midwives mere “assistants to the physician”. When gynecology was recognized as a medical specialty, the government didn’t feel the urgency to provide midwives with an appropriate, independent scientific training (1).

Florence Nightingale (1820-1910) (2, 3) was an English nurse who is universally considered the pioneer of the modern profession. She claimed that midwifery should remain a purely feminine profession and that should be practiced by *intelligent* and *educated* women. This revolution caused a sudden numerical increase of graduated midwives, the opening of the maternity wards and the constitution in 1872 of the Obstetrical Association of Midwives, and then of the Obstetrical Ladies College, which granted women the access to Medical Schools (1).

In 1966, the World Health Organization (4) defined the midwife “a person qualified to practice midwifery. Empowered to give assistance during pregnancy and childbirth and the postnatal period, to complete physiological deliveries under her/his own responsibility and to provide first aid to the newborn. Contextually she/he must be able to recognize the symptoms of possible anomalies and the emergence of conditions that require medical intervention, and to manage emergencies in the absence of the latter. She/he can exercise the profession in the hospital, at the local clinics or at the domicile of the mother.

Midwives provide care and support to non-complicated deliveries, and the quality of their cares are important factors affecting childbirth outcome (5-7).

Unlike Italy, in England the midwife is considered a dynamic figure with ample space for professional growth and career advancement. She operates independently and is fully responsible for her actions, although she works in harmony with other healthcare and professional figures (8, 9).

This study aims to describe the figure of the midwife in Italian and English context, in order to identify the distinctive features of the professional midwife in Italy and in England and to assess similarities or differences between them.

Methods

We conducted a cross sectional study in the period September - October 2015, administering a questionnaire to English and Italian midwives, using an electronic platform (Google Drive®). The survey was online for 8 weeks from September to October 2015 and the participation in the study was anonymous and on a voluntary basis. The internet questionnaire had the questions that were displayed in the same order and format, and was proposed in several English and Italian online midwifery forums, accessible only to midwives. A little explanation about the aim of the study and the procedures to ensure the anonymity of participants preceded the questionnaire together with the consent form that should be filled before beginning the survey.

The questionnaire was composed of two parts:

I) the first part included questions about sociodemographic and job situation

II) the second part consisted of a series of questions intended to investigate professional habits and attitudes, the approach to birth, the degree of professional autonomy and the

relationship with other health professionals. The questions referred to 5 macro-areas (built according to Halldórsdóttír e Karlsdóttír's scientific theory of professionalism in midwifery and according to the International Ethic Code of Midwives) (10, 11):

1) "Midwifery: who is the midwife?" (8 questions)

2) "Education: how much does the midwife know?" (8 questions)

3) "Responsibility: what does the midwife do?" (8 questions)

4) "Ethics: how does the midwife act?" (7 questions)

5) "Social acknowledgment: the midwife and the other people" (9 questions)

The questions could have "one or two" choices, multiple choices, or a 4 point Likert scale. For some questions it was possible to choose up to three answers. The scores for each macro area derived from the sum of the points for each question, assigned on the basis of the above mentioned documents (10, 11). The first macroarea consisted of 8 questions: 5 had multiple choices with a score ranging from 0 to 3; 3 questions had two choices (with a score 0 or 1 assigned on the basis of the given answer) or a Likert Scale with the answers "agree" and "strongly agree" that had a value of 1, the other answers 0. The second, the third, the fourth and the fifth macro area consisted of questions with two choices (score 0 or 1 assigned on the basis of the given answer) or with a Likert Scale where the answers "agree" and "strongly agree" had a value of 1, the other answers 0. So for the first macro area the maximum score could be 18; for the second 8; for the third 8; for the fourth 7; for the fifth 9. The data collected from the questionnaires were organized and processed using the software Stata® SE, version 12.1 (StataCorp, College Station, Texas, USA). Shapiro-Wilk test was used to assess the non normal distribution of the data. So we decided to use the Mann-Whitney test to highlight significant differences. Significance level was set at $p < 0.05$.

Results

We collected information from 100 Italian (98 women and 2 men) and 83 English (82 women and 1 man) midwives who spontaneously decided to fill the questionnaires in the period of study. The average age was 29.3 years for Italian midwives, and 34.6 years for British midwives.

92% of Italian respondents said to own a "Bachelor", 6% a "University Diploma" (like a Bachelor, introduced in Italy in 1990 and suppressed in 1999) and only 2% a "Diploma."

80% of British midwives had a "Midwifery Degree" (like a Bachelor) and 8% attended a "Midwifery Short Program", a degree course in nursing with an additional specialization of a year and a half in Midwifery.

34% of the Italian claimed to have also a "1st level Master", 16% a "Full Degree" and the remaining 50% attended postgraduate training courses.

Only 23% of the English sample had a "Master of Science" (equivalent of the Italian 1st level Master) and the remaining 67% reported to have "other" general qualifications.

72% of Italian midwives declared to work. In the group of working midwives, 35% worked in a "3rd level point of birth", 25% in a "2nd level point of birth", 17% in a "1st level point of birth", 4% in "private health facilities", 6% in "professional offices", 5% in "counseling ambulatories", 8% in other structures.

46% of the English midwives who participated in the study worked in hospitals; 21% as an employee of the NHS in territorial structures; 12% worked in birth centers, 11% had a private profession, 10% in other structures.

Table 1 shows the final average scores for each macro-area.

Table 1 - Mean scores for English and Italian midwives

	Italian		English		Difference
	Mean	SD	Mean	SD	P value
Midwifery: who is the midwife?	12.61	2.60	12.24	2.50	0.39
Education: how much does the midwife know?	2.70	2.32	4.84	2.37	<0.01
Responsibility: what does the midwife do?	1.96	1.97	6.43	1.42	<0.01
Ethics: how does the midwife act?	4.17	1.76	5.26	1.93	<0.01
Social acknowledgment: the midwife and the other people	3.67	2.01	5.82	1.97	<0.01

Midwifery: who is the midwife? (acceptable score: 10): This indicator included questions about the professional autonomy, the principles considered fundamental for midwives, and the elements they considered useful to increase their professionalism.

Education: how much does the midwife know?(acceptable score: 4): This indicator included questions about the professional experiences of midwives.

Responsibility: what does the midwife do? (acceptable score: 4): This indicator included questions that analyzed midwives' autonomy: midwives were asked if they could manage directly pregnancies and deliveries at low risk, and the role of the gynecologist in their hospital.

Ethics: how does the midwife act? (acceptable score: 4): This indicator included questions about the education and the courses that the midwives attended to improve their knowledge and the quality of cares.

Social acknowledgment: the midwife and the other people (acceptable score: 5): This indicator included questions that asked midwives if they felt satisfied of their role, and if the hospital and the other professional figures recognized their professional skills.

Discussion and conclusions

Although with some limits, due to the small number of respondents, our study allows some comparisons and considerations about this important figure in England and in Italy.

For the first macro area "Midwifery: who is the midwife?", there was not a statistically significant difference between Italian and English average scores (12.61 and 12.24 respectively). Therefore there is not a substantial difference between the two groups about the conception of themselves and of their profession. They feel very close to women and consider motherhood as a natural process to be respected and encouraged and which doesn't need to be corrected or controlled by them.

One of the most important results of our survey is that Italian midwives show a higher level of education, compared to the English

colleagues. In fact, 92% of Italian midwives had a bachelor and 34% a 1st level Master. These data are strongly in contrast with the results of the second macro area "Education: how much does the midwife know?": the Italian group had a mean score of 2.70, the British group 4.84 and the difference between the two scores is statistically significant with $p < 0.01$. Although they should manage extremely diversified situations and should improve constantly their knowledge with mandatory training programs (12, 13), Italian midwives tend to consider the birth as a risky process, difficult to manage in total autonomy, and - unlike England which offers a "woman-centered" assistance to pregnancy and childbirth - in Italy a highly medical-dependent concept of women's care persists.

The third macroarea ("Responsibility: what does the midwife do?") shows

significant differences regarding autonomy and responsibility: in England it is accepted that midwives could manage low-risk pregnancies and childbirth in complete autonomy and responsibility (14). Contrariwise, Italian midwives often appear to feel forced and limited in the exercise of their profession.

There are also differences in the fourth and the fifth macro areas: “Ethics: how does the midwife act?” and “Social acknowledgment: the midwife and the other people”. Italian midwives tend to behave, to act and to have connections with the other healthcare professionals in a different way compared to English midwives, and tend to be less satisfied too.

As shown, English midwives tend to consider their professional role and their professional skills more acknowledged and appreciated than Italian midwives. So Italians tend to be not very satisfied especially because of their relationship with the gynecologist and with other health professionals who do not recognize their power and prestige. However, a recently published study by the Royal College of Midwives reported that stress affects more than 50% of English midwives. Stress is a problem for many of the 5268 midwives who responded to the study, with 46% saying they had suffered it in the past year. The results also revealed that 69% of midwives had felt pressure in the last three months to attend work when they were feeling unwell (15).

Through the collection of questionnaires, we designed a picture of Italian and English midwives: although some information were well known we better understood problems of identity, ethics, autonomy and professionalism, especially for Italians.

In Italy the elimination of the “*Istituto della Condotta Ostetrica*” (that could be translated as “Institute of midwifery”) and of its autonomy, led to an increased medicalization of the assistance to birth, with the decline of midwives’ role. A change

of the organization of maternity services could make the midwife a “key driver”(16) of healthcare, and could give back the “lost dignity” to this profession.

One of the most important limit of our study was the small sample size, due to technical problems connected with the choice to use an electronic platform. Couper in his review (17) of Web surveys suggested that Web surveys may improve the response rate and lower the cost of surveys. On the contrary, another study demonstrated that internet questionnaires resulted in a significantly lower response rate than a traditional mailed survey (18). However we couldn’t obtain the personal email of each participant, especially of English midwives and we were forced to use this method to conduct the study.

It would be better to complete this study through a new multicenter study (obviously enlarging the sample size) in order to make interesting comparisons with other realities. Moreover, it would be interesting to evaluate also the quality of life of the participants (19-21) in order to have a more complete picture of the problems that our study highlighted as far as personal and professional lives of midwives are concerned, and to identify interesting and useful solutions to resolve them in the best way.

Riassunto

Ostetriche in Inghilterra e Italia: due realtà a confronto

Introduzione. Le ostetriche sono responsabili dell’assistenza e sostegno al parto alle madri in gravidanze non complicate. Lo scopo di questo studio è di identificare i tratti distintivi di ostetriche in Italia e in Inghilterra al fine di effettuare confronti interessanti.

Metodi. Abbiamo somministrato da settembre a ottobre 2015, un questionario online a ostetriche italiane e inglesi. Il questionario era composto da una parte per la raccolta di informazioni socio-demografiche e da una seconda parte volta a definire gli atteggiamenti di assistenza e il tipo di approccio al parto, nonché la percezione del

grado raggiunto di autonomia professionale. Le domande sono state usate per creare un punteggio per 5 grandi macro aree: “Ostetricia: Chi è l’ostetrica?”, “Educazione: Quanto conosce l’ostetrica?”, “Responsabilità: che cosa fa l’ostetrica?”, “Etica: come agisce l’ostetrica?”, “Riconoscimento sociale: l’ostetrica e le altre persone”. I risultati sono stati inseriti in un database e analizzati utilizzando STATA.

Risultati. 183 ostetriche (100 italiane e 83 inglesi) hanno completato il questionario. Il 92% delle intervistate italiane ha dichiarato di avere una “Laurea di primo livello”, il 6% un “Diploma Universitario” e solo il 2% un “Diploma”. L’80% delle ostetriche inglesi aveva un “Midwifery Degree” e l’8% aveva partecipato a un “Midwifery Short Program”, un corso di laurea in infermieristica con una specializzazione aggiuntiva di un anno e mezzo in Ostetricia. Il 34% del campione italiano ha affermato di aver anche a “Master di 1° livello”, il 16% una “Laurea Magistrale” e il restante 50% ha frequentato corsi di formazione post-laurea. Solo il 23% del campione inglese aveva un “Master of Science” e il restante 67% aveva riferito di avere “altre” qualifiche generiche.

Il 72% delle ostetriche italiane ha dichiarato di essere dipendente e, nel particolare, lavorare in un “punto di nascita di III livello” (35%), “punto di nascita di II livello” (25%), “punto di nascita I livello” (17%), in “strutture sanitarie private” (4%), in “studi professionali” (6%), “consultori” (5%). Il 46% delle ostetriche inglesi che ha partecipato allo studio lavora negli ospedali; di queste il 21% in qualità di dipendente del National Health System o nelle strutture territoriali. Il 12% lavora in punti nascita e l’11% ha una professione privata. C’era una differenza statisticamente significativa tra italiane e inglesi per tutte le macro aree (eccetto la prima), con risultati migliori per le ostetriche inglesi.

Conclusioni. Le ostetriche inglesi tendono a considerare il loro ruolo professionale e loro competenze professionali più riconosciuti e apprezzati di quelli delle ostetriche italiane. Per questo le italiane tendono a non essere molto soddisfatte. Tuttavia le ostetriche dei due paesi si sentono molto vicine alle donne e hanno la stessa concezione di se stesse e della loro professione.

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Corresponding author: Gianmarco Troiano, MD, Department of Molecular and Developmental Medicine, Area of Public Health, University of Siena, Via A. Moro 2, 53100 Siena, Italy
e-mail: gianmarco.troiano@student.unisi.it or gianmarco-89@hotmail.it