The Gender Debate – is Midwifery Education 'Women's Work'?

Introduction

Understanding what it means to be a woman, as well as a midwife and/or a birthing person is central to midwifery professional expertise (Newnham and Rothman, 2022). In this article we expand our gaze beyond the profession itself to examine the work of midwifery *education* through the gender lens; a lens that, surprisingly, appeared to be missing from the RCM State of Midwifery Education report that inspired this article series (RCM, 2023). Midwifery is, as we know, female dominated with 99.7% of registered midwives (including Specialist Community Public Health Nurses) identifying as female (NMC, 2024). Midwifery within higher education (HE) is similarly female dominated; the UK Council of Deans for Health (CODH) report (CODH, 2019) states that over 90% of the midwifery HE workforce identify as female. Additionally, whilst men are in the minority in academic midwifery roles just as they are in clinical practice, they are better represented in leadership/senior positions in higher education as they are within leadership within the NHS (Council of Deans for Health, 2019).

This article seeks to explore this in greater detail, taking a feminist approach to examining the social and historical influences on the present-day challenges associated with a largely female workforce, teaching a largely female student body how to provide care to a largely female patient body, under disproportionately male leadership. We consider, that whilst previously discussed solutions of attracting more men into frontline nursing and midwifery roles may have value (Clifton et al., 2018; Thompson et al., 2020), that this is only part of the solution; our aim is instead to better understand and acknowledge the specific challenges the female workforce faces in order to promote their advancement and progression. This is even more pertinent in view of the male-dominated wider higher education sector (Higher Education Statistics Agency (HESA) data denoting a gender split of 44% females vs. 56% males across UK higher education academic roles (HESA, 2024). Are female midwifery educators starting from the same baseline and afforded the same support to progress as the majority male HE workforce? Importantly, we also examine if, as a female-dominated discipline, we are teaching curricula which include feminist theories, literature and research and if we are sufficiently seeking social justice for women (be they students or staff). Our students are our future clinical *and* education workforce, so how far does midwifery teaching transform or support the patriarchal status quo? Please note that for the purpose of this article when gender is referenced, we are including self-identification of gender within our scope.

Snowy white 'male' peaks?

Senior management and leadership within the NHS in the UK have long been described as the 'snowy white peaks of the NHS' (Kline, 2014) acknowledging the race inequalities therein (and this is crucially something we will return to in our next article looking at diversity in the midwifery HE workforce); however, it has also long been the case that these 'white peaks' could also be described as 'male'. On the 'shop floor', the NHS is a female dominated organisation, yet men consistently dominate senior board level positions (NHS Confederation, 2019). Similarly, whilst there are more females amongst the midwifery higher education workforce in general, there are proportionally more males within academia than there are caring for patients in clinical frontline roles (27.7% of the nursing, midwifery and allied health HE workforce are male compared to only 11% of those in clinical nursing and midwifery roles (CODH, 2019)). Additionally, when in academia, men appear to be in senior roles more frequently than women (Cleary et al., 2019; Evans, 2004). Men are therefore disproportionately represented in senior, management, leadership and specialist roles both in clinical practice *and* in HE. This gender divide of labour and seniority is an established barrier to

career advancement for women in both in the health service and in HE (Zacher et. al, 2019) and is (and should be) startling in the context of a profession that is female dominated.

Many of the barriers to female progression within midwifery education are well known and reflect the broader challenges women experience in almost any sector. Women provide twice as much unpaid childcare as men per year (CPP, 2022) against a cultural backdrop where the majority of the British public believe that women should stay at home or work part-time when there are pre-school age children in the home (Phillips et. al., 2018). Women also shoulder more of the burden of caring for elderly parents and/or family relatives. This is in addition to the health challenges of pregnancy, birth, breastfeeding and eventually menopause that can contribute to career stagnancy (Centre of Economic and Business Research, 2023). There are others. And this is before we explore any additional specific challenges within midwifery HE. It is therefore no wonder then that there are fewer women in Professor, Researcher or Fellow roles and therefore fewer women influencing research, policy and/or practice at senior levels within midwifery (Cleary et al., 2019; RCM, 2023).

Is midwifery innately gendered?

While we do not subscribe to the notion that midwifery is innately gendered, it cannot be ignored that as one of the oldest professions, much of the knowledge that underpins it is based on hundreds of years of gender exclusivity. We are all aware of the origins of midwifery and whilst there is some mention of men assisting in childbirth out of necessity in the Paleolithic era, men were thereafter largely excluded from childbirth (Barnawi et al., 2013). Female midwives combined tradition, medical knowledge and spiritual wisdom to attend women in childbirth until Medieval times when the advent of male physicians led to the exclusion of most midwives. This continued throughout the Renaissance; childbirth shifted towards medicalisation, evidence, and a focus on anatomy, physiology and the mechanics of birth (ibid). As scientific knowledge expanded throughout the Industrial Revolution, so too did the domination of men in birth. Birth moved concretely from home into the hospital and the traditional and experiential knowledge and expertise of midwives gained over centuries was gradually sidelined. Women were also in the minority in universities and education where new knowledge was created, the first degrees awarded to women from a British university commencing in 1878 (Dyhouse, 2016). It was not until the Midwives Act of 1902 that midwifery began to be recognised as its own (female dominated) profession however, this was only achievable by conforming to the standards, regulation and values as defined and overseen by men.

Seminal feminist critique might suggest that this professionalisation merely served to reinforce patriarchal power structures, marginalising women who could not afford or access formal education and reinforcing hierarchical structures within the profession that mirrored broader societal gender hierarchies (Donnison, 1988). Where we have landed is, arguably, a profession that has evolved from and continues (to this day) to be led by male-informed structures (WHO, 2019). And while women continue to dominate front-line ‘caring’, ‘nurturing’ roles in midwifery (with men disproportionately represented in senior roles and leadership), theory would suggest that this continues to support a sort of ‘benevolent sexism’ that reinforces gender inequality; women being positively viewed only if they embody traditionally gendered conventional roles and do not seek to disrupt male power (Glick & Fiske, 2001).

Midwifery has, however, a long history of just such disruption. Empowering women to take control of their reproductive health against a long history of women’s bodies being controlled and medicalised is a disruptive and feminist act in and of itself (Hawke, 2021). And much of this disruption has effected real meaningful change for birthing women; advocating for female bodily autonomy, woman-centred care, informed consent, shared decision-making to name but a few.

However, what the gender imbalance in leadership illustrates is that this disruption has not been successfully affected internally, either within the clinical workforce or that of HE. We are better at advocating for the women in our care than for each other. Some of the barriers to this are considered below.

Barriers to Progression

In addition to the well-documented broader challenges that work against female career progression, there are some very specific barriers within midwifery education. We will return to discussion of the perception of midwifery as a 'non-academic' discipline in a future paper, but it is worthy of note here that there exists an inequality in relation to the qualification baseline expected of academics in subjects like nursing and midwifery and more 'traditional' male-dominated academic subjects. Whilst it may be common for academics in these traditional disciplines to possess a doctoral qualification (and HESA (2023) data to 2021-22 sets this as 68.7% of UK academics who do), this is far from the case for midwifery educators. The RCM (2023) report states that only 12% of the midwifery HE workforce have a doctorate and only 43% have Masters level qualifications. Whilst this appears startling, surely the question to ask here is if we *should have* the expectation that midwives entering academia hold a doctorate?

Midwives (and perhaps also nurses) typically come into academia from clinical practice, not following years spent, for example, in an archive obtaining a doctorate. Is this clinical experience inherently 'less than' the research experience gained during doctoral study? We do not propose that it is, although the RCM report (2023) also indicates that the midwifery education workforce is getting younger and entering academia with relatively *less* clinical experience. In the absence then of either further study or significant clinical experience there is clearly a gap to fill. This is a question we will again return to in a future paper, where we consider the skills needed in the midwifery HE workforce in contrast to the legacy perception of more traditional academic roles. The reality, however, of the sector expectation for doctoral and/or Masters qualification to support career progression pathways may nonetheless have a career limiting effect for those entering HE from a clinical background (Albarran and Rosser, 2014).

An additional barrier exists in the long-debated casualisation of the higher education workforce and, once again unsurprisingly, women appear to be more likely than men to be on a fixed-term, zero-hours and/or hourly-paid contract (UCU, 2021). This is again a topic we will pick up in a future article looking at the pay and conditions of the HE workforce where we will examine some of the drivers for this casualisation, but it is nonetheless a clear obstacle to female progression; casual workers do not have the same career support, progression, mentoring or funding to progress in comparison to permanent colleagues (Halcomb et al., 2010). More specific data relating to this casualisation within the midwifery HE workforce would additionally inform the RCM's State of Midwifery Education analysis.

Breadth of the Role

The role of a midwifery educator is also in and of itself a barrier to progression; it is simply a broader remit enacted over a longer period allowing little scope for research or further study. Midwifery programmes run over a longer academic year where the students are afforded in the region of 7 weeks of annual leave (in comparison to circa 18-24 weeks of leave for most standard academic courses (postgrad.com, 2024)). This creates considerable difficulties for both staff and students. For our students, we know that their ability to work part-time to cope throughout a cost-of-living crisis is

severely restricted. For education staff, it makes further study and research more challenging above the teaching load.

In addition, midwifery educators must embody multiple roles alongside teaching and lecturing. They are often academic assessors tasked with regular reviews of extensive practice assessment documentation, link tutors for NHS trusts required to be present to support both students and clinical staff in assessing and recording student proficiency, and personal tutors to a student cohort who are often struggling and (even pre-pandemic) requiring increasing support (Oates et al., 2019). Educators must also meet the requirements of NMC registration and revalidation. This is all in addition to the teaching load, outreach work, admissions administration and internal quality assurance and enhancement work that all disciplines must contribute to.

Just as the burden largely falls on women to take on multiple roles and duties within a social context (childcare, caring for elderly relatives, housework and the well-reported 'emotional labour' of managing the domestic and family environment) so too is this happening within the midwifery HE workforce. We appear to be doing much more and with less downtime (and yes, much of this supportive work for students is 'nurturing', 'caring' work too). This leads female educators to sacrifice personal gain and progression. The pandemic provided the perfect petri dish to analyse this in more extreme circumstances; the increased domestic and education demands resulted in a global decrease in articles and grant proposals submitted by women in comparison to male peers (Franca et al., 2023)

Despite the evidently broad and comparatively greater workloads experienced by females working in NMC regulated programmes such as midwifery, women are held to the same standards as academics (both male and female) that have a much less extensive baseline workload (and are thus able to focus on scholarship and progression as they wish, particularly over longer holiday breaks). There is both cultural and structural sexism at play here, first considered by Millett in the 70's (Millett, 2000) but evident now over 50 years later. What can we do to begin to challenge and disrupt the endemic sexism at play? We suggest that this may start with those we educate.

Teaching to transform or support patriarchy?

Are we as women, teaching women (and men) in university how to become midwives via curricula that includes feminist theories, literature and research? University knowledge should be individually transformational and collectively support greater social justice, therefore in the health professions where most of the workforce is female our teaching should centre material about women's experiences. The importance of incorporation of both the female voice and feminist theory in midwifery education has been long argued as crucial to understanding and participating in the midwife/woman relationship and core to the profession itself (Jefford and Nolan, 2022; Walsh et al., 2015; Walsh, 2016). This is particularly the case when considering women from different backgrounds: intersectionality reinforces that race, ethnicity, age, class, sexuality, and ability overlap with gender and further compound experiences of disadvantage (Crenshaw, 2017). How does the curricula we teach transform or support the patriarchal status quo that we have seen above inhibits the progression of those doing the teaching?

Above we considered the feminist perspective that the professionalisation of midwifery merely served to force midwifery to conform to patriarchal power structures. It is interesting to consider midwifery curricula through this lens to observe the structures that are still at play. One of the tenets that is core to the profession is that of reflection, it being a requirement of both the NMC standards and of continuing registration that both student midwives and registered midwives

engage in practice reflection (NMC, 2023; NMC, 2021). Interestingly this reflective requirement seems to be mirrored in other professions where women dominate front-line roles that are perceived as 'caring' (e.g. nursing, social work, counselling, allied health roles, and education (Clegg, 2010; Connolly, 2018)). Invariably, however, the heavyweights who dominate the reflective frameworks we direct our students to are those developed by white men (think Gibbs, Johns, Schon, Driscoll, and Kolb). Whilst this is not to say that these models do not have value, it is fair to say that feminist perspectives considering elements of power, control, intersectionality and social justice for women are not standard foci within the reflective cycles described. Feminist approaches to reflection are far less established or well-known but ultimately aim to centre the female experience to challenge gender-based inequalities (Ackerley, 2008; Clegg, 1999; Coia, 2017; Connolly, 2018). These approaches to reflection are messy, however, not falling into neat sequential diagrams or NMC templates. They are more reflective of the conversations (both internal and external) that students might have in response to their experiences. There is work to be done here in making something both representative but more accessible and usable for our students.

We might also wish to consider our language in teaching, particularly that which pertains to anatomy and physiology. Midwifery has a sexist problem with both eponyms and negative derivative terms. Reference to 'Sims forceps', 'Fallopian tubes' and the 'pouch of Douglas' remain in common use; these are descriptions of female anatomy or instruments used on female anatomy that are named after deceased white men (one of whom has had serious ethical concerns raised relating to forced surgical procedures on black female slaves (Spettel and White, 2011). The Latin origins of female anatomical structures are similarly alarming; the Latin verb 'pudere' (the root of 'pudendum' and 'pudendal nerve') translates as 'to be ashamed'. Even 'hymen' and 'vagina' have uncomfortable origins when their etymology is analysed (Draper, 2021). Whilst our students may not necessarily know this or be affected by it, surely it is our duty to seek to change our language, reference points and revered historical figures to those that support, reflect and promote female equality and empowerment? At the very least these terms would be better understood if they were descriptive of function over fame; 'uterine tube' saying far more about the purpose of the structure for a learner than 'fallopian tube'. These are simple examples but there are many more once we begin to view our curricula through a feminist lens.

Conclusion

This article has highlighted some of the inequalities experienced by the majority female midwifery education workforce and the impact of these, exploring how they are symptomatic of many of the inequalities women experience more generally within patriarchal structures. We conclude that midwifery education is not necessarily women's work, though it is founded on female knowledge and embodies elements of caring and nurturing that, as within midwifery itself, contribute to a benevolent sexism that keeps women at the caring coalface. These elements combined can impede progression in leadership, research and scholarship for midwifery academics. We have also begun to consider how we can begin to unpick elements of midwifery curriculum to practice what we preach in developing feminist midwives who can contribute to dismantling inequality for both the women they care for and the women within the profession as educators. We affirm that the aim here is not to misalign men or the male contribution to midwifery nor is it to give women unfair advantage; women make great leaders universally and we must reclaim this for midwifery by more fully understanding and removing the unique blockers to progress.

Summary

- Women dominate both the midwifery clinical and higher education workforces however men are proportionately better represented in senior leadership and specialist roles in both arenas.
- Whilst midwifery and midwifery education are not innately gendered, they are based on a history of knowledge built by gender exclusivity and highly influenced by benevolently sexist concepts of women as 'carers'.
- Many of the constructs and frameworks within midwifery and midwifery education support the patriarchal status quo rather than celebrate, empower and develop the majority female workforce.
- Midwifery HE can begin to transform this by applying a critical lens to curriculum content; questioning the origins of knowledge and the theoretical frameworks used with students.

Things for Student Midwives, Midwives and Midwifery Educators to Consider

1. Transform approaches to student reflection by using feminist approaches, models and frameworks where possible rather than relying on male-dominated, traditional models without further question (see Clegg, 1999).
2. Consider removing eponyms from the midwifery lexicon; resources like the 'Eponymictionary' (Cadogan, n.d.) can be used to find alternatives to anatomical and physiological structures named after historical male figures. Consider using more meaningful functional descriptive terms (e.g. 'uterine tube' over 'Fallopian tube').
3. Cast a critical eye over education reading lists, links and employed resources; is the female voice centred? Are diverse female groups represented amongst authors and creators?
4. Leaders in academia should seek to review rigid academic progression pathways to ensure clinical skills and experience can be considered alongside more traditional academic scholarly activity where appropriate.
5. HE institutions should consider how they support female educators balancing family/caring responsibilities; this may positively influence a move away from casual working and thus support better female progression in the discipline.

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