ARTICLE

The Transmission of Values Specific to Midwifery and their Integration by Student Midwives

La transmission des valeurs spécifiques à la pratique sage-femme et leur intégration par les étudiants sages-femmes

Marty Laforest, PhD
Diane Vincent, PhD

ABSTRACT

Québec midwives adhere to a set of values viewed as essential. These values set midwives apart from other obstetrics professionals and play an important role in the formation of their professional identity. This article explores whether these values are transmitted to student midwives. To achieve our research objectives, we presented 21 student midwives with scenarios where a client's behaviour corresponds only more or less to midwifery values (as defined by the regroupement Les sages-femmes du Québec). Student responses were analyzed according to their level of correspondence with these values. The results show that regardless of the scenario, first-year students are most likely to form negative attitudes about the behaviour submitted to their attention and, contrary to their more advanced sisters, they base interventions with a client less on the need to refrain from judgment. Starting with the second year, the students' evaluations of behaviour tend to be neutral. The difference observed between the first-year cohort and the others leads us to believe that the start of the mentoring stage is the pivotal moment of training.

KEY WORDS

Attitude of health personnel; social values; social identification; professional identity; training.

This article has been peer reviewed.

RÉSUMÉ

Les sages-femmes du Québec adhèrent à un ensemble de valeurs jugées essentielles. Ces valeurs différencient les sages-femmes des obstétriciens professionnels et jouent un rôle important dans la formation de leur identité professionnelle. Cet article vise à examiner si ces valeurs sont bien transmises aux étudiants en sage-femmerie. Pour atteindre les objectifs de notre recherche, nous avons présenté des scénarios à 21 étudiants sages-femmes; scénarios dans lesquels le comportement du client correspond plus ou moins aux valeurs des sages-femmes (telles que définies par le regroupement Les sages-femmes du Québec). Les réponses des étudiants ont été analysées en fonction de leur niveau de correspondance avec ces valeurs. Les résultats montrent que peu importe le scénario, les étudiants de première année sont plus portés à adopter une attitude négative au sujet du comportement porté à leur attention. Contrairement aux collègues plus avancés, ils sont plus enclins à porter des jugements lors des interventions auprès des clients. En deuxième année, les étudiants ont tendance à être plus neutres dans leurs évaluations de comportement. Les différences observées entre la cohorte de première année et les autres cohortes nous porte à croire que le début de l'étape de mentorat est un moment charnière dans la formation.

MOTS CLÉS
Attitude du personnel médical et paramédical; valeurs sociales; identification sociale; identité professionnelle; formation.

Cet article a été évalué par des pairs.

In the period between its rebirth in the 1970s and the time it gained official recognition in Quebec, midwifery developed in a highly singular fashion. Since the profession enjoyed no legal status at the time, training institutions were non-existent. Midwife practitioners were self-taught or trained outside Québec, and their knowledge was often transmitted through mentoring. The reappearance of midwives, after the profession had become virtually extinct, was a direct result of the feminist movement, which inspired women to question medical authority and voice the need for greater autonomy in the field of health. Women who benefited from the services of midwives gave birth at home, and some members of the profession believe that it was these first clients who supplied the basis of their current philosophy. Accordingly, their practice developed because midwives adhered to a set of values viewed as essential. This includes the recognition that labour and childbirth should be owned by women and their families rather than by obstetrics professionals (a rethinking of the growing medicalization of childbirth) coupled with a respect for the diversity of women's needs. These values continue to set midwives apart, in their view, from other obstetrics professionals and play an important role in the formation of their professional identity.

The learning and practicing conditions of midwives changed completely after the profession acquired legal status and a university training program was established.[1] Today's generation of candidates differs from the militants of the 70s and 80s; they often have little knowledge of the recent history of midwifery, come to the practice in a variety of ways and receive a different form of training. Now that hospitals are slowly opening their doors midwives are being called upon to work in three locations homes, birthing centres and hospitals. In this last venue they must carve out a place in an environment that can be hostile to them.

Will the midwives of this new generation manage to preserve their identity under the pressure of approaches that can best be described as technocratic? The question is an urgent one, since the transmission of certain values guarantees the continuity of a concept of birth specific to midwives. This article aims to find answers by evaluating to what degree the profession's values have been adopted by student midwives as reflected in their discourse.

Data and Methodology

Our analysis is based on data collected during interviews of undergraduate student midwives at the Université du Québec à Trois-Rivières that were conducted in 2002.[2] Appendix A contains a list of the 21 persons interviewed (identified by number to preserve their anonymity) as well as their age and level in the training program.

Each participant agreed to a semi-directed interview. The questionnaire used was based on previous interviews with three experienced midwives who had been pioneers in the profession and were currently acting as instructors. The interviews lasted an average of two hours, and all were transcribed.

To achieve our research objectives, we adopted a classic content analysis procedure similar to that of L'Écuyer.[3] The set of statements given by students was identified for each response (referred to below as response elements) and similar responses were grouped together with a view to highlighting significant categories of statements. We then proceeded to compile the data (quantitative analysis) and compare the responses of the four cohorts.

The specific values of midwifery of concern are those promoted by the Regroupement Les sages-

femmes du Québec as follows:

1. Respect for pregnancy and childbirth as normal physiological processes that have profound significance in women's lives,
2. Recognition that labour and childbirth should be owned by women and their families,
3. Respect for the diversity of women's needs and the many meanings that women, their families and their community attribute to pregnancy, birth and the experience of being a new parent,
4. Practice within the context of a personal relationship of equals, established through continuity of care during pregnancy, childbirth and the postpartum period,
5. Encouraging women to make informed choices about the care and services they receive and the way these are dispensed, and the recognition that it is the woman who makes the final decision,
6. Respect for the right of women to choose their health professional and their place for giving birth,
7. Recognition of the essential importance of promoting health during the maternity cycle, with an emphasis on prevention, including the judicious use of technology,
8. Conviction that the best way to ensure the well-being of mother and baby is to focus care on the mother,
9. Promoting support by families and the community as privileged ways to facilitate the adaptation of new families.

As formulated by the Regroupement, these values emphasize respect for the mother and her choices, the importance of an egalitarian relationship between mother and midwife, and the mother's right to correct and enlightened information.

To evaluate how these values were reflected in students' discourse, we analyzed a series of questions on behaviours or attitudes that did not correspond to the ideal promoted by midwives. These questions were all phrased in the same way: students were asked if they were mildly, somewhat, or very upset by a certain behaviour or attitude. The series consisted of 11 questions (see Appendix A). We analyzed five we considered good examples:

- two questions about a client's behaviour during pregnancy,
- one on drug use,
- one question on smoking,
- a question about the birth itself, dealing with the client's desire for programmed childbirth, (induction of labour), and
- two questions about the postpartum period, one on the desire for a rapid return to work and the other on the refusal to breastfeed.

The purpose of these questions was to present the student with a conflict to resolve: on one hand, the client's behaviour or attitude could prove harmful to the health of the mother and child, or could be viewed as undesirable in terms of the midwifery ideal of pregnancy and childbirth. In this sense, the behaviour or attitude was in conflict with proposal No. 7 of the Regroupement. On the other hand, respect for the client comes before all else, and the midwife must encourage the mother to make her own choices, as stressed in several propositions, notably, proposition No. 5. The responses of the students interviewed as to how they would handle the conflict allowed us to evaluate, to a point, whether or not they had integrated the core values of midwifery.

Analysis Procedure

The analysis procedure was identical in all cases. The spontaneous answers of almost all students included two elements:

a) taking a stand on the behaviour described in the question by means of an evaluative comment (for example, "This upsets me a little/very much…", "I find this sad", etc.), and
b) describing the type of intervention they would recommend for a client demonstrating such a behaviour or attitude.

With regard to stand taken, evaluative comments were divided into three categories:

1. Neutral - when the comment contained neither a positive nor a negative evaluation. Example: "This behaviour doesn't upset me."
2. Negative - when the comment reflected a negative perception (including the expression of feelings such as sadness). Examples: "This

goes against my values" or "I think to myself: poor little baby."

3. Very negative - when adverbs such as "very much", "terribly", etc. added a note of intensity to a comment that might otherwise have been placed in the second category (examples: "It upsets me very much" or "It upsets me terribly"), or when the negative evaluation was repeated or reformulated several times.

There was no positive evaluation because the behaviours in question were a departure from the "ideal" behaviour according to midwifery values.

Regarding the description of the intervention with the client, we identified 11 categories of response elements likely to appear separately or together:

a) check the reason for the client's behaviour or attitude,
b) provide information (advantages, disadvantages, risks, etc.),
c) respect the client's decision (know and say that one cannot "force" anyone to do or not do something),
d) listen, support, show compassion, "be on the client's side",
e) refrain from judging the client or making her feel guilty,
f) suggest alternatives, little tricks, that might encourage reflection or induce a small change in behaviour (for example, cut down on smoking or try breastfeeding),
g) obtain or propose the aid of specialists (for example, a psychologist),
h) try to convince the client to make a complete change in her behaviour or thinking (for example, stop smoking),
i) denounce societal demands for perfection regarding pregnant women as well as societal pressures on a client,
k) terminate follow-up on the client,
l) any other response (for example, not knowing what to do).

Some of these response elements directly reflect the values of midwives, for example, that concerning a client's informed choice, which appears in categories (b), (c) and (e). Others show a certain departure from interventions that represent ideal compliance with precepts of the profession, for example, attempts to change a client's thinking (h).

These 11 response categories were then grouped into four types of reaction characterized by the degree of intervention (Table 1):

1. Passive reactions (type 1) are those that do not initiate action: the midwife supports the position of the client and does nothing more;
2. Active egalitarian reactions (type 2) include response elements that mark initiatives by the midwife that depend on maintaining a relationship of equals with the client;
3. Rift reactions (type 3) include response elements that mark a rift or change in the unspoken "contract" between midwife and client. The word "rift" must be understood here in the broad sense of the term: it may involve a rift in the equality of the relation (for example, when the midwife exercises power over the client by trying to persuade her to change her behaviour), in the exclusiveness of the relation (as when another professional is called in to the rescue) or in the relationship itself (if the midwife terminates follow-up)
4. Any other reaction (for example "don't know"), that is, any response element that does not allow us to identify a type of intervention (type 4).

After both the evaluative and descriptive parts of each student's response had been categorized, we attempted to determine if responses varied according to level of training by comparing the

Table 1: Regrouping of categories of responses relative to description of recommended intervention

Passive Reactions (Type 1)	Active Egalitarian Reactions (Type 2)	Rift Reactions (Type 3)	Other (Type 4)
Respect the decision	Check reasons for behaviour	Propose the aid of other health partners	Any other response
Listen, support	Inform	Try to change client's thinking	
Don't judge	Propose alternatives	Terminate follow - up	
Denounce society			

Table 2: Student's position regarding client's use of drugs or tobacco

Evaluation	1st year	2nd and 3rd year	4th year
	% (n = 12)	% (n = 21)	% (n = 6)
Neutral	33	52	100
Negative	33	48	--
Very negative	33	--	--
Total	99	100	100

(n = total number of response elements obtained for both questions)

analyses of students in each cohort.

Results

1. Harmful Behaviours during Pregnancy: Use of Drugs and Tobacco

The first two questions analyzed dealt with the use of substances harmful to the foetus during pregnancy drugs and tobacco. The results (Table 2) show that smoking and drug use by a pregnant client is very negatively evaluated by first-year students only, and that a neutral attitude tends to become more frequent as the student advances (although the smaller number of fourth-year respondents weaken the result somewhat.)

With respect to the intervention recommended, questions referring to the use of drugs and tobacco prompted 70 response elements from the 21 respondents (Table 3), which indicates that these students provided complex answers characterized by a series of possible reactions to the behaviour. Active egalitarian reactions based on discussion and information and passive reactions based on acceptance and understanding appear in the same proportions.

Table 3: Description of intervention with client using tobacco or other drug

Type of intervention	Response elements mentioned	Total group % (n = 70)
1. Passive reactions	- **Don't judge** - Denounce society - Respect the decision - Listen, support	41
2. Active egalitarian reactions	- **Inform** - Propose alternatives - Check reasons for the behaviour	41
3. Rift reactions	- Propose the aid of other health partners - Terminate follow-up - Try to change client's thinking	10
4. Others	- Don't know what to do	7
Total		99

n = total number of response elements obtained for both questions. The response elements in boldface are those most frequently mentioned in the category.

Differences nevertheless exist among cohorts, as shown by the three elements most frequently mentioned by first, second, third and fourth-year cohorts. Beginning students stand out: they are the only ones who admit their uncertainty about what to do in some cases. For the others, the response elements mentioned most frequently by all students are those concerning "informed choice" for clients – inform and propose alternatives or "tricks" to limit damage to the fœtus while respecting the mother's freedom of choice – rather than insist on convincing her to give up a harmful habit. The most advanced students are the only ones to offer a large number of passive reactions (type 1). The more advanced the student, the more her responses focus on these elements.

The relation between the evaluative part (thoughts about the behaviour) and the descriptive part (attitude towards the client) of the responses is also interesting. The less training the student has, the more the evaluations are negative and the less the element "don't judge" appears in the description of the intervention. Conversely, advanced training has the effect of making the evaluations less weighted in favour of the negative and introduces a refrain from judgment into the description of the intervention.

2. Choice of Programmed Childbirth (Induction of Labour)

Programming the moment of childbirth (when not motivated by the state of health of the mother or child) is an act that strongly conflicts with the values of midwives, who respect the natural process

of birth. Furthermore, it does not correspond to what midwives consider a judicious use of technology. The results show that the choice of programmed childbirth meets with strong resistance from the students. In these responses the evaluative part represents a higher proportion of the response than does the description of intervention with the client. Furthermore, of all the behaviours submitted to the students, this is the only one to receive a very negative evaluation from advanced students (more precisely, from a third year and a fourth-year student). For the rest, the tendency remains the same the more advanced the student, the more neutral the evaluation.

The description of the recommended interventions prompted only 20 response elements from the 21 students, which indicates that answers to this question were not well developed. Once again, passive and active egalitarian reactions appear in similar proportions, although active interventions occur a little more frequently. However, one particular feature of the answers should be pointed out: denunciation of societal pressure on pregnant women is the most frequently occurring response element (half of the response elements categorized as "passive reactions"); students maintain that society is responsible for conveying the idea that all of life can be planned, to the point where childbirth, too, can be written into the agenda. Denouncing this attitude is a way of not condemning the individual who wishes to plan an event over which, in principle, we have no control.

3. Postpartum Behaviours: Refusal to Breastfeed and the Rapid Return to Work after Childbirth

The two last questions analyzed address women's choices which affect the life of the newborn, that is, the decisions not to breastfeed and to return to work soon after giving birth. The more advanced the student, the more neutral the evaluations, with very negative evaluations disappearing after the first year.

Regarding the description of the intervention recommended, no differences were observed among the cohorts. The number of response elements (66) reveals that students' answers are well-developed and complex. In fact, all students appear to adopt the same attitude: the reasons for the client's choice are verified so as to better understand the context in which she operates, inform her of the advantages and disadvantages of the option she is considering and respect her decision (these three response elements are by far the most frequent). Active egalitarian reactions predominate.

Synthesis

When we consider the set of responses given to the five questions whose responses have been analyzed, we obtain the results presented in Table 4:

As might be expected, a relationship exists between the neutrality of the evaluation and the student's level of training: the most advanced students show much less disapproval in their response, which is based on other aspects.

We note, however, that the progression of neutrality is not linear: third-year students evaluated the behaviours more negatively than those in second year, but without returning to the attitudes of beginning students. One might say that, after the heavy progression in neutral evaluations observed from the first to the second year, students tend to revert to their original position before arriving at the very high degree of neutrality observed at the end of training. It would be interesting to see if experiences during the third-year internships might explain this irregular progression. It is also necessary to verify if the regression is a result of individual behaviour that is not representative of the group.

Table 4: Students' position (by cohort) concerning the set of behaviours submitted to their attention

Evaluation	1st year	2nd year	3rd year	4th year
	% (n = 29)	% (n = 28)	% (n = 24)	% (n = 14)
Neutral	28	57	37,5	86
Negative	48	43	37,5	7
Very negative	24	--	25	7
Total	100	100	100	100

p = 0,0006
n = total number of response elements obtained for the five questions

Table 5: Percentage of negative or very negative evaluations of behaviours analyzed

Behaviour evaluated	% of negative or very negative evaluation				
	1st year	*2nd year*	*3rd year*	*4th year*	*Group total*
1. Programmed childbirth	100	67	80	33	74
2. Drug use	83	50	80	--	71
3. Rapid return to work	67	40	60	50	56
4. Refusal to breastfeed	67	20	60	--	42
5. Tobacco use	50	33	25	--	32

The five behaviours evaluated by the students did not all meet with the same disapproval. A major convergence of results is observed from one year to another of training: classification is almost the same for all groups, with scope of disapproval constituting the main distinguishing factor. The pregnant client's use of drugs and desire to program childbirth are the most difficult behaviours to accept for all students, with the exception of those in fourth year, who are more upset by the desire for a rapid return to work than by drug use. Table 5 illustrates the degree to which each behaviour is condemned. The particular character of third-year evaluations (on the whole less negative than those of the first year, but more so than those of the second year) is highlighted in almost every case.

The two behaviours with the highest disapproval rating are very different in nature. Drug use is harmful to both foetus and mother and is accordingly frowned upon by future midwives, health professionals and the population as a whole. However, the desire to program childbirth is, to a certain extent, more a question of ideology rather than a health issue. This is not to say that induced labour is without risk, simply that there is no general consensus regarding this risk, since programmed birth is a relatively standard practice and is becoming commonplace. The convergence of negative evaluations given to programmed birth are even more negative than the evaluations for drug use. This shows that from the start of training, students adhere strongly to one of the fundamental precepts of the midwifery philosophy – a "respect for pregnancy and childbirth as normal physiological processes" – in which intervention should be kept to a minimum. Behaviours 3 and 4 (rapid return to work and refusal to breastfeed) also reflect values, in the sense that they do not involve a calculable risk for the baby's health in themselves; midwives simply consider them (always from the viewpoint of minimal intervention in natural processes) as behaviours that are not optimal for the baby's development (whether physical or emotional) and, in the case of a

Table 6: Description of intervention with client for all five behaviours submitted

Response element	Response elements mentioned	% 1st year (n = 43)	% 2nd to 4th year (n = 115)	Total group % (n = 158)
1. Passive reactions	-Respect the decision -Don't judge -Listen, support -Denounce society	35	44	42
2. Active egalitarian reactions	-Inform -Propose alternatives -Check reasons for the behaviour	51	45	47
3. Rift reactions	-Propose the aid of other health partners -Try to change client's thinking	7	7	6
4. Other	Don't know	7	3	4
Total		100	99	99

n = total number of response elements for the five questions. The response elements in boldface are those most frequently mentioned in the category.

rapid return to work, for the recovery of the mother or her adaptation to her new role. Midwives disapprove of these behaviours more than they do the use of tobacco, where the risks are high, long recognized and well-documented. It thus appears that for student midwives, the scale of values is a specific one and that it is recognized and shared by all members of the midwifery profession in Quebec.

As for the intervention recommended, four types of reactions are present in similar proportions in all cohorts (Table 6). Only the first year cohort differs from others owing to a slightly higher proportion of active egalitarian and "other" reactions (as when students admit they don't know what to do).

There are more pronounced differences among the cohorts with respect to the four response elements most often mentioned (Table 7). The elements "don't judge" and "listen, support" begin to appear frequently only during the third year of training. Even among fourth-year students, listening and support replace the proposal of tricks or alternatives, the element present in the responses of all other cohorts. The importance, given these elements, should be viewed in relation to students' lower rate of disapproval. It appears that the less disapproval is expressed, the more students feel it is essential to support the client in all circumstances without passing judgment (support may of course involve proposing alternatives). Thus, the advanced student does not allow her viewpoint to dominate her description of the recommended intervention. To a greater degree than the beginning student, she presents herself as the ally of her client. A frequent comment in the discourse of these students, moreover, stresses their confidence in their client.

Table 7: Response elements most often mentioned (by order of frequency) in description of intervention with the client for the five behaviours submitted

Most frequent response element	1st year	2nd year	3rd year	4th year
1st	Inform (28 %) (Type 2)	Respect the decision (19 %) (Type 1)	Inform (26 %) (Type 2)	Respect the decision (22 %) (Type 1)
2nd	Respect the decision (19 %) (Type 1)	Propose alternatives (17 %) (Type 2)	Don't judge (16 %) (Type 1)	Don't judge (17 %) (Type 1)
3rd	Check reasons for the behaviour (12 %) (Type 1)	Inform (15 %) (Type 2)	Propose alternatives (16 %) (Type 2)	Inform (17 %) (Type 2)
4th	Propose alternatives (12 %) (Type 2)	Check reasons for the behaviour (13 %) (Type 1)	Listen, support (12 %) (Type 1)	Listen, support (11 %) (Type 1)
% for these elements	71 %	64 %	70 %	67 %

Conclusion

Training in midwifery involves not only the acquisition of knowledge, but also a particular attitude toward women and a particular view of pregnancy and childbirth. As a result, the basic "people skills" (the "know-how-to-be" rather than the "know-how-to-do") are learned in a birthing centre, the future workplace of most of the students interviewed, through contact with experienced midwives. At the moment almost all of the latter belong to the generation of militants who fought to have their profession recognized as such. The students understand that close, prolonged contact with their successive instructors is the most decisive element of their training.

The great importance of internships becomes obvious in our analysis of the transmission of the profession's fundamental values, an analysis based on the student's reactions to scenarios where a client's behaviour corresponds only more or less to a certain ideal. Whatever the situation, the reaction of the student midwife adheres, generally speaking, to the same pattern. First-year students are the cohort that stands out most sharply: the beginning student is generally alone in formulating very negative evaluations of the behaviour submitted to her attention and, contrary to the more advanced students, bases her

description of intervention less on the need to refrain from judgment. Starting with the second year, the students evaluations of behaviour tend to be neutral, although this progression is irregular, a phenomenon we are at a loss to explain; students use less space to express their personal opinion about behaviour x and more to describe themselves as their client's allies, who accept her as she is. The difference observed between the first-year cohort and the others leads us to believe that the beginning of the second year is the pivotal moment of training. It is precisely this moment that marks the start of the mentoring stage, and clinical training in a birthing centre is in all probability the main vector of change. It is therefore reasonable to suppose that the profession's fundamental values are transmitted and integrated little by little into each student's value system through "impregnation", that is, through contact with the instructor.

Acknowledgements
We wish to thank the Social Sciences and Humanities Research Council of Canada for the financial assistance that made this research possible. We also thank Huguette Boilard for her stimulating comments on an earlier version of the text.

REFERENCES

1 Bourgeault, I.-L, Benoît, C, and Davis-Floyd, R. Reconceiving Midwifery. Montreal & Kingston: McGill-Queen's University Press, 2004.
2 Laforest M, Vincent D. with the collaboration of Robert J. La perception de la formation à la pratique sage-femme et l'intégration des valeurs fondamentales de la profession. Trois-Rivières, UQTR, 2004. Unpublished report.
3 L'Écuyer R. L'analyse de contenu: notion et étapes. In Deslauriers JP, ed. Les méthodes de la recherche qualitative. Sillery : Presses de l'Université du Québec ; 1987. p. 49-66.
4 Regroupement Les sages-femmes du Québec. Philosophie de la pratique sage-femme. Pochette de présentation du RSFQ. 1997.

AUTHOR BIOGRAPHIES

Marty Laforest *is full Professor of Communication at the Université du Québec à Trois-Rivières (Québec, Canada). She is a member of the LaSIC (Laboratoire de sociopragmatique des interactions et de la conversation see www.ciral.ulaval.ca/lasic). She specializes in discourse analysis. Her research interests include family discourse, talk at work, conflictual discourse, health care discourse, misunderstandings, and other phenomena related to the negotiation of meaning in talk-in-interaction.*

Diane Vincent *is full professor of linguistics at the Université Laval (Québec, Canada). Her fieldworks turn around questions on sociolinguistics, conversational analysis and discourse analysis. Her sociolonguistic works carry on discourse markers, reported speech and narrative and argumentative strategies. Her recent works on discursive and interactional construction of everyday life in private and professional spheres concentrated on insults, lyings, rebukes, verbal violence and social norms.*