

THE UNIVERSITY OF NEWCASTLE

Putting Women First: Interprofessional Integrative Power

Submitted by

Carolyn Hastie

RM RN, Dip Teach,

Grad Dip Primary Health Care IBCLC

A dissertation submitted in fulfillment of the requirements
for the award of Master of Philosophy (Midwifery)

~ March 2008 ~

School of Nursing and Midwifery, Faculty of Health
The University of Newcastle, Newcastle, NSW Australia

STATEMENT OF ORIGINALITY

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying subject to the provisions of the Copyright Act 1968.

I hereby certify that the work embodied in this Thesis is the result of original research, the greater part of which was completed subsequent to admission for candidature for the degree.

.....
 Signature of Candidate Date

ENDORSEMENT

.....

Signature of Supervisor	Date
-------------------------	------

.....

Signature of Supervisor	Date
-------------------------	------

ACKNOWLEDGEMENTS

I wish to give my deepest thanks to the wonderful doctors and midwives whose stories provide the database for this thesis. These people trusted me to do justice to their stories and to treat them with respect. I hope I have lived up to their expectations. I also wish to thank the many fine doctors and midwives I have met over thirty years who have taught me about the value of good relationships and kindness to one another. I am deeply indebted to your generous spirits.

Thank you to the amazing women whose birthing experiences provide us with such meaningful and precious opportunities to work well together.

To my supervisor Dr Kathleen Fahy, my heartfelt thanks for your enormous academic prowess and ability to help me to see my next step on this research path. Every step of the way, you were shining the light so I could see my way and nudging me in the right direction. Thank you to Dr Andrew Bisits for providing support, encouragement and a most noble role model of a colleague in every sense of the word. I've never been keen on the idea of cloning, but in your case I'd make an exception. Dr Kerreen Reiger provided a keen eye and disciplined approach to the essence of the work and ensured that, as far as possible, I was remaining faithful to the various fields of social enquiry I used to help understand midwife doctor interactions.

Thank you to Lee-Anne Bender for coming to the rescue when I was drowning under the sea of yet to be transcribed audiotapes. Thank you for being so prompt, so accurate and so professional.

And lastly, but not by any means least, thank you to my wonderful family and colleagues. Your support, encouragement and graciousness when I was preoccupied and focused on this work is truly appreciated and valued.

TABLE OF CONTENTS

List of Tables	vi
Abstract	1
Chapter One: Background to the Study	
1.0 Introduction	2
1.1 Problem Statement	3
1.2 Research Question:	3
1.3 Aims and Objectives of the Study	3
1.4 Thesis	4
2.0 Background to the Study	4
2.1 Historical Development of Maternity Services	4
2.2 Medical Dominance	4
2.3 Maternity Services in Australia	6
2.4 Health Care Reforms: The shift to a Primary Health Care Focus	8
2.5 Counterveiling Powers	9
2.6 Changing Models	10
2.7 Biological Basis for Improved Maternity Care Systems	10
2.8 Partnership-Based Midwifery Care Service Development	11
3.0 My Personal Background as a Midwife	11
3.1 My experience in Private Midwifery Practice	12
3.2 Bullying and Harassment Issues in Midwifery	13
3.3 A defining Moment in Hospital Midwifery Practice	13
4.0 Justification for the Study	14
5.0 Significance of the study	15
5.1 Midwifery Practice	16
5.2 Midwifery and Organisational Administration	16
5.3 Midwifery Education	17
5.4 Midwifery Research	17
5.5 Midwifery Theory	17
6.0 Overview of Dissertation	17
 Chapter two: Literature Review	
1.0 Introduction	18
2.0 Contextual factors	18
2.1 Midwifery and Medicine	18
2.2 Hierarchy Maintenance Work	20
2.3 Interprofessional Role Boundaries	21

2.4 The Partnership Model of the Woman-Midwife Relationship	22
2.5 Attitudes and Values of Midwifery and Medicine	23
2.6 Birth Territory Theory	24
3.0 Interactional Factors	27
3.1 Research Related to Nurse-Doctor Interaction	27
3.2 Interprofessional Collaboration	27
3.2.1 Ineffective Collaboration	27
3.2.2 The Doctor-Nurse Game	28
3.2.3 Bullying	29
3.2.4 Oppressed Group Behaviour	30
3.3 Effective Collaboration	31
3.4 Addressing the Health Service Culture	31
3.5 The Importance of Leadership	32
4.0 Intra-Personal Factors	33
4.1 Emotional Needs and Skills.	33
4.2 Emotional and Social Intelligence	34
4.3 Biological Basis of Emotional and Social Intelligence and Competence	35
4.4 Defence mechanisms	38
4.5 Strategies to Enhance Emotional and Social Intelligence and Competence	39
5.0 Conclusion	41

Chapter Three: Methodology

1.0 Introduction	42
2.0 Methodology	42
2.1 Poststructural, Feminist Philosophical Foundations of this Study	43
3.0 Research Design	45
3.1 Step 1. Framing the Research Question	47
3.2 Step 2. Deconstruction and Critical Analysis	47
3.3 Step 3. Capturing the Phenomena	48
3.3.1 Participant Selection and Recruitment	48
3.3.2 Data Collection: In-depth Interviewing	50
3.3.3 Data Management	52
3.4 Step 4. Data Analysis	52
3.4.1 Bracketing	52
3.5 Step 5. Construction	53
3.6 Step 6. Contextualisation	54
4.0 Adequacy of the Research	54
5.0 Ethical Considerations	54
5.1 Procedures Taken to Protect the Rights of Study Participants	54

5.2 Risk Protection for Participants	55
 Chapter Four: Analysis of Stories of Negative Interactions	
1.0 Introduction	57
2.0 Virginia	57
2.1 Discussion	63
2.2 Coda	67
2.3 Initial Analysis and Conceptual Integration from Virginia's Story	68
3.0 Belle	71
3.1 Discussion	76
3.2 Coda	79
3.3 Initial Analysis and Conceptual Integration from Belle's Story	81
 Chapter Five: Analysis of stories of positive interactions	
1.0 Introduction	84
2.0 Sarah	84
2.1 Discussion	86
2.2 Initial Analysis and Conceptual Integration from Sarah's Story	87
3.0 Jason	90
3.1 Discussion	92
3.2 Initial Analysis and Conceptual Integration from Jason's Story	92
 Chapter Six: Construction and Contextualisation	
1.0 Introduction	95
2.0 A Theory of Interprofessional Integrative Power	95
3.0 Background to Analysis and Conceptual Integration	96
4.0 A Theory of Interprofessional Integrative Power (Negative)	98
5.0 A Theory of Interprofessional Integrative Power (Positive)	105
5.0 Conclusion	110
 Chapter Seven: Conclusion	
1.0 Introduction	111
2.0 Recommendations	112
2.1 Midwifery and Organisational Administration	112
2.2 Recommendations for Midwifery and Organisational Administration	112
2.3 Midwifery Practice	113
2.3.1 Recommendations for Midwifery Practice	113
2.4 Midwifery Education	113

2.4.1 Recommendations for Midwifery Education	113
2.5 Midwifery Research	114
2.6 Midwifery Theory	114
3.0 Limitations of the Study	115
4.0 Conclusion	115
References	116
Appendixes	
1. Flyer	132
2. Recruitment Letter	133
3. Information Statement	134
4. Consent Form	138
5. Demographic Data Form	139
6. Midwives' Demographics	140
7. Doctors' Demographics	141
8. The Voices	142
8.1 Doctors' Stories of Negative Interactions	142
8.2 Midwives' Stories of Negative Interactions	161
8.3 Doctors' Stories of Positive Interactions	190
8.4 Midwives' Stories of Positive Interactions	206
List of Tables	
2.1 Birth Territory Table	26
2.2 Emotional and Social Intelligence and Competencies	36
3.1 Theoretical Assumptions Underpinning CII	46
3.2 Steps Involved in Creating Poststructural Feminist Interpretive Interactionism	47
4.1 Key Factors from Virginia's Story	69
4.2 Key Factors from Belle's Story	82
5.1 Key Factors from Sarah's Story	89
5.2 Key Factors from Jason's Story	94
6.1 A Theory of Interprofessional Integrative Power (Negative)	101
6.2 Model of Interprofessional Integrative Power (Negative)	104
6.3 A Theory of Interprofessional Integrative Power (Positive)	107
6.4 Model of Interprofessional Integrative Power (Positive)	109

ABSTRACT

For almost 20 years it has been known that the most common cause of preventable adverse events in hospital is communication problems between clinicians (1, 2). Within maternity services, ineffective communication has a strong relationship with adverse events for women and babies (3). Despite this knowledge, the ‘turf wars’ between some midwives and some doctors are a continuing concern. Although the link between poor communications and adverse events has been well known for a long time, no real change in how professions relate to each other has occurred.

This dissertation describes a project that was designed to answer the research question:

What factors affect interprofessional interaction in birthing units and how do these interactions impact on birthing outcomes?

Midwives and doctors from 10 geographically diverse maternity units contributed to this qualitative research project. In-depth interviews were conducted. Analysis and theorizing was guided by feminist Interpretive Interactionism. New findings, about how health services can strengthen interprofessional collaboration in maternity services, are presented and explained. I argue that organisational factors are more important than the personalities of the individuals involved in the interactions because organisational factors frame, direct and limit what discourses and therefore behaviours, are possible. The dissertation ends with some procedural guidelines that show how administrators and clinical leaders can create and maintain collaborative work settings for public sector midwives and doctors.

CHAPTER ONE: BACKGROUND TO THE STUDY

1.0 Introduction

Midwives and obstetricians in Australia would appear to have common objectives in providing safe and effective maternity care; however, the foundational philosophies, values and ethics underpinning the professions are quite different. These differences, in my experience, often result in power struggles and compromised care. The literature shows that as midwives struggle to establish autonomy over their area of expertise, doctors seek to maintain control of and direct the birth environment as well as midwifery practice (4-7). This power struggle has been maintained by the patriarchal nature of society and the gender-based division of labour (8). Other ideologies, such as paternalism, flourish in the climate of male centered values and perspectives and further serve to suppress emerging professions that have been traditionally woman based, such as midwifery and nursing(8). The result is that childbearing women are caught in the middle or left out (9).

The evolution of midwifery as a profession has seen the development of a midwifery ethics which declares that midwives can be distinguished from doctors by being ‘with woman’ (10). From this ethical standpoint, childbearing is positioned as a healthy, creative normal life event for a woman and her baby (10). Women are seen as able and birth is viewed as transformative for both mother and baby. Midwifery practice involves supporting a woman on her journey to motherhood (10). Medicine, for the most part, remains firmly grounded in a biomedical mechanical viewpoint of childbearing, in which pregnant women are seen as inherently faulty and unreliable, needing surveillance and intervention because babies are at risk (35). According to Murphy-Lawless (35 p.229), the twin themes of ‘risk’ and ‘death’ underpin the concerns and sciences of contemporary obstetric practice and ‘form the system of rationality of this medical specialty’. The negative medical construction about childbearing (35) positions women and their babies as adversaries (10) in a life and death struggle, instead of co-creators of a life giving process. This negative construction of childbirth is exemplified in a statement made by Dr John Newnam, an obstetrician, during his presentation at a fetal monitoring seminar I attended in Perth, Western Australia, in 1996. Dr Newnam stated “it is the obstetrician’s job to rescue the endangered fetus from the hostile uterus”. That attitude is still current as reflected in the comment of a female registrar who told me recently (January 2008) that ‘she was trained to worry’. These differences in perspectives, philosophy and practices has resulted in a history of often bitter and long standing conflict between midwives and doctors in the provision of maternity services (4, 6-7, 11-24).

This dissertation develops a theoretical understanding of the factors which affect interactions between midwives and doctors and what effect these interactions have on health outcomes

for women and their babies. Throughout this dissertation I sometimes refer to nurses rather than midwives for two main reasons. Firstly, midwifery has only recently begun to separate itself from nursing and distinguish itself as a discrete profession in Australia. This means that although midwives have their own registration, they are still tied to the various state Nurses Awards and still managed under directors of nursing within health services. The separation of nursing and midwifery is proceeding nationally with the Nurses and Midwives Council, but there is much to be done before the two professions will be fully separated. Secondly, much of the literature on interprofessional interaction has been done in the United States and refers to nurses and doctors where ‘nurse’ stands for both nurses and midwives who are employed in labour/delivery wards.

1.1 Problem Statement

For almost 20 years it has been known that the most common cause of preventable adverse events in hospital is communication problems between clinicians (1, 2, 25, 26). Absent or inadequate interprofessional interactions were shown to be closely linked to adverse events in the King Edward Memorial Hospital (KEMH) review (3). The KEMH review exposed the ineffective, disrespectful, and often absent interprofessional communication between doctors and midwives. The review demonstrated the way that inadequate interprofessional communication, coupled with poor interprofessional collaborative relationships were associated with a higher than expected rate of adverse events and outcomes. The UK Confidential Enquiry into Stillbirths and Deaths in Infancy (27, 28) had similar findings. The Health Care Complaints Commission’s investigative report into adverse events at the Macarthur Health Service (29) found defensiveness and lack of openness from health professionals within both Macarthur and South Western Health Services organisations in dealing with reported concerns about patient safety and treatment (29 p.ii).

It is in this context that the following research question was developed:

1.2 Research Question:

What factors affect interprofessional interaction in birthing units and how do these interactions impact on birthing outcomes?

1.3 Aims and Objectives of the Study

The aims of the study are:

- 1) To produce an understanding of how each party to an interaction perceives their own experience and that of the other
- 2) Using their stories of positive and negative interactions to conceptualise a model that explains these interactional processes.

- 3) To provide some beginning suggestions for guidelines for promoting interprofessional relationships and collegiality in maternity units.

1.4 Thesis

In attempting to improve the way that midwives and doctors interact, I have found that organisational factors are more important than the personalities of the individuals. The focus for change, therefore, should be at the organisational level. This is because organisational factors frame, direct and limit what discourses and therefore behaviours are possible.

2.0 Background to the Study

Everyday conversations between people have inherent and unspoken assumptions about what is known by the interacting partners. Such “common ground”, or shared knowledge, beliefs and suppositions are vital in mutual understanding. Mutual understanding requires the interacting partners to be able to take the other partner’s perspective (30). Taking another’s perspective requires emotional maturity and an intention and willingness to do so (31). Doctors and midwives have different training, different status, different philosophies and different subtasks in the care of childbearing women. Mutual understanding and therefore communication, is more problematic when people who have such wide disparities in perspectives and socialization are cooperating on different subtasks (30, 32). Examining the history of the professions and the health care system gives insight into the way the differences and common ground between midwives and doctors has evolved and continues to evolve.

2.1 Historical Development of Maternity Services

Pre-industrialisation, health care was primarily delivered by women in the family whose methods were based on experience. Birth and death were seen as a normal part of life (7, 33). The emergence of the rational and scientific approach to ill health in the western world accompanied the grasp of power by the white, male professional elite (8). According to Glass & Brand (34), the advent of men in healing practices brought the use of superstitions, faith and heroic measures. Through politicking and manipulation, the new ‘scientific’ medicine ousted ‘untrained’ women as primary care givers in health matters. This included the potentially lucrative field of midwifery (15, 35). Man-midwives used poor and therefore powerless women as much needed practice to validate their claims of expertise for the paying, upper class women. The middle class man-midwives employed female midwives from the lower class to work in their hospitals and, as employers and doctors, directed the care they gave (36).

2.2 Medical Dominance

Medical dominance is cited as a structural feature of the subordination of other health care

practitioners (8). Nurses and midwives have been socialised into believing it is right and natural for male medicine to control the entire health care service (37). Childbearing women have been socialised to believe that hospitals are safe; to expect medical control of birth; to expect pain relief in labour and the “naturalness of childbirth” has been rejected by the majority in search for a sense of security (38). As patriarchal scientific medicine developed, healing was split into two functions, caring and curing (6, 7). The doctors took on the male, active interventionist role of curing, nurses and midwives were relegated the female nurturing, mothering role of caring (18, 21, 39). The female nurturing role of caring means that midwives’ and nurses’ main role is to take on the emotional labour associated with client/professional interactions (38). The assumption of the emotional role by nurses and midwives shields the masculinist professional and thus enables the doctor to maintain objective neutrality, which is promoted as the basis of true professionalism (38). John Heron (40) however, would suggest that this ‘objective neutrality’ is actually a defence mechanism. Rafael-Leff (41) cautions that such behaviour leads to treating people in depersonalised ways, causing a diminishing of caring, gratitude and satisfaction.

Capitalist industrialisation and Victorian culture provided the background for the development of modern day health worker roles; patriarchy and the development of the political economy provided the framework. Hospital and educational systems emerged from the male dominated church and army centred, medieval institutions. These church and army systems have a long history of ignorance about and denial of women and their relevance (39 p.322). Victorian ideas dictated that women’s role was to “serve men’s needs and convenience” (39 p.215). Victorian social mores forbade women to challenge male authority and so the Victorian cultural social system of domination, control and oppression was also transferred intact into hospital culture and instituted into the hierarchical system. Even though the health care industry is predominately female, women are still conspicuously absent from the ‘corridors of power’ --(42, 43). Hospitals and health care systems are still organised in a hierarchical manner along class, gender and racial lines and the ideology of patriarchy endures to support male medical dominance (21, 44).

Patriarchy and its self-perpetuating system of domination and control have been explored and dissected by Foucault (45). In Foucault’s interpretation, patriarchy ensures its survival by constructing knowledge that fits with its own ideology and setting up systems of surveillance that ensures the rules of patriarchal ideology are followed. Dominant groups tend to restrict autonomy by rules and social structures that allow those at the top to view all aspects easily, thus having a total picture. Foucault likened the ‘bird’s eye view’ of patriarchal management to the use of the Panopticon, a tall tower, situated in the middle of prisons where prisoners of war were held. The tower ensured large numbers of people could be observed by the few. The

observers (non commissioned officers-NCOs) were drawn from the ranks of the imprisoned community and, in the absence of leaders, keep control. The NCOs were more abusive and cruel than the leaders. According to Foucault (45), this coercive surveillance and control strategy is found in most western institutions, including hospitals.

The health system has been conceptualised by some as being similar to a family unit; the visiting specialist is the father figure, absent most of the time but making all the rules; the nurse, the mother, ensuring the rules are obeyed, doing the work, coping with and having responsibility for unforeseen occurrences; the other staff and patients being the children (39, 46, 47). The assumption made by doctors and society is that the other health care workers are carrying out delegated tasks and functions which a doctors could perform, but will not as it is an 'inefficient and expensive use of his time' as he has, by implication, more important things to do (39). The implication is that nursing and midwifery are viewed as a diluted form of medical care and not seen as important in their own right.

Non-recognition of nursing's and midwifery's actual functions and intellectual contributions is symptomatic of the deeply gendered nurse/doctor game identified by Leonard Stein in 1964 (48). The nurse or midwife is required to make decisions and contribute ideas whilst appearing passive, so that the ideas seem to have originated in the doctor (37, 49, 50). These games ensure that nursing and midwifery remain invisible. Brodie (51) writes that 'despite a growing body of high quality evidence that recognises the potential of the midwife as a significant and important contributor to maternity services, the role has neither been well recognised nor supported nationally'(p.6). A study to examine how structural and perceived medical dominance affects nurses workplace satisfaction found that nurses were very dissatisfied with their professional status and perceived that doctors were held in more regard, had higher satisfaction and more control than nurses (52).

2.3 Maternity Services in Australia

In the early days of the New South Wales colony, midwifery was part of the women's subculture and a lay craft. In the first few decades of the settlement, women had their babies with the help of other female convicts at the Female Factory until it was closed in 1848 at the end of the transportation era. Women who practiced midwifery were called a 'fingersmith', the colloquial word for midwife in the colony. Rich and poor free settlers had their babies at home with the help of a neighbour (53). Around the turn of the 19th Century 'granny' midwives ventured out on horseback, foot or sulky, regardless of 'weather, payment or terrain' to help women with birthing their babies (53 p.34). Many stayed with the women for two weeks, helping out around the home. Some midwives opened their homes as maternity homes to birthing women. These lying-in homes provided the basis for 'a private maternity hospital system in

NSW' (53 p.42). Over the years, women were encouraged to have their babies in hospitals and domiciliary midwifery gradually dwindled to 0.3% of the childbearing population (53).

Medicine's opportunistic expansion during the economic, political and social upheaval at the time of industrialisation was the cause of a bitter and acrimonious struggle between doctors and midwives as each group sought to establish its 'turf' in the hospital setting. That struggle still has not been resolved (7). The unequal class structure between midwifery and medicine was enshrined in law in Australia when the Medical Registration Act passed in 1862 excluded unqualified practitioners, meaning midwives. It however allowed the registration of practicing man midwives with a 'grandfather clause' (7). The subordinate position of midwifery in the hierarchy of health care was set with the establishment of midwifery training in the same year under medical supervision. The hierarchical structure of hospitals was reinforced by the ideology of professionalism and promotion of the creed that 'effective health care can only come from doctors' (8 p.36). The challenges associated with the establishment of fledgling specialty of obstetrics and its amalgamation for practical reasons with its counterpart, gynaecology, are outlined by Rosemary Pringle (18). She writes 'what gave obstetrics respectability and broke the hold of the midwives was its incorporation within a surgical specialty' (p.50). Pringle (18) explains how midwives, having lost ground with the new hospital specialties, found themselves 'recast as obstetric nurses, working under the authority of male obstetrician-gynecologists'(p. 50).

Since the early part of the 20th Century, maternity services in Australia have been, with few exceptions, hospital based. Public hospitals are funded through State and Territories health budgets. These services are obstetrically dominated and doctors have traditionally had great power in determining how services are organised and provided across the country (54). Not only are these services driven by the needs of doctors, they are also generally fragmented and women may see up to 30 different health care providers over the course of their childbearing experience. General practitioners, midwives and obstetricians, general nurses and in remote communities, health workers, are all involved in providing antenatal care in both community and public hospital settings. Urban public hospitals provide free antenatal clinics staffed by midwives and hospital employed doctors. GP's and obstetricians are also employed on a sessional basis in many of these public hospital antenatal clinics. The Federal government provides a fee for service for items of obstetric care provided by general practitioners and obstetricians as primary care providers in the public health system. This includes services given during pregnancy, labour and birth and the postnatal period up to six weeks postpartum.

Increased incentives for remote and rural GP's to provide obstetric care were announced in 2007 (55). Under this plan, GP's receive a \$25,000 yearly bonus (on top of the Medicare

payment) for providing antenatal care for 20 or more pregnant women. Hospital administrators encourage pregnant women to have shared antenatal care with general practitioners in the community because it allows 'cost shifting' from the hospital's state funded budget, to federal funding as the fee is paid to the GP's from the federal coffers. There is no such arrangement for primary maternity care provided by midwives. Many GP's in rural Australia do not bulk bill and there are no public hospital antenatal clinics available either. Rural women are disadvantaged if their GP does not bulk bill because they have to pay for their antenatal care at each visit with the GP and claim the rebate from Medicare. Many women can not afford the upfront payment, nor the gap in the price between the GP's fee and Medicare rebate, which means that many rural and remote women do not access antenatal care. Despite the problems with antenatal care provision, the establishment of free, midwife-run antenatal clinics at local hospitals in rural areas is often vigorously resisted by local GP's (56, 57).

No matter what form of antenatal care women receive, they are attended by midwives throughout labour in every public and private maternity service in Australia. The majority of labouring women are cared for by midwives they don't know. Privately insured women (33% of all birthing women) (58) are attended by their obstetrician or associate for birth. Uninsured women may have staff specialists, registrars and resident doctors involved in their labour and birth. In the postnatal period, women may be cared for by a variety of practitioners, including midwives, doctors and nurses, including mothercraft, enrolled and general nurses. Women are demanding more personalised and appropriate care from maternity services (57, 59-61). Wide spread dissatisfaction with the state of maternity care has prompted state and federal reviews of maternity services (62-66). The rising rate of surgical births is causing alarm in health related circles in Australia and elsewhere. The rising alarm is coupled with an increasing recognition and acceptance that, for the majority of women, childbearing is a healthy normal function, requiring minimal, if any, intervention and services need to be organised so the normality of the process can be supported (67-71).

2.4 Health Care Reforms: The Shift to a Primary Health Care Focus

Conceptualisations of health and wellbeing are changing. The World Health Organisation's Primary Health Care Declaration at Alma-Ata (72) stated that health is a "state of complete physical, mental and social wellbeing ...and not merely the absence of disease or infirmity." 'Health for all by the year 2000' was chosen as slogan by The World Health Organisation in 1978 to promote the primary health care focus adopted by its international signatories, of which the Australian Commonwealth Government was one. Wide spread health care reforms are occurring in most industrialised countries following the First International Conference on Health Promotion and the signing of the Ottawa Charter (73). The Ottawa Charter called for government systems that enabled community development and for people to "increase control over and improve their health".

Application of the primary health care principles to maternity services means a shift to community based care close to where women work and live (67, 74). It also necessitates a shift in philosophy from the biomedical approach and focus on disease to the social model of health with the emphasis on a “secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices” (73). Many women have been left hurt and dissatisfied by the erosion of personal power and agency that is often associated with the medicalisation of childbirth and its drive to obliterate death at all cost (35 p. 264). These shifts in focus of attention from disease to health and in the establishment of small, personal, local, community based sites for maternity care provision, require changes in relationships, roles and perceptions from all stakeholders, from health care policy makers to health care managers to midwives, doctors and the women and their families who access maternity care. A move to a primary health care approach to maternity services will displace the ‘hegemonic grasp of obstetrics’ (35 p.264) to models of care which involve reflexive knowledge about childbirth and women’s multiple subjective realities in all their social diversity (35). Despite the clear benefit of midwifery models of care for healthy childbearing women (75, 76) and the disadvantages of the medical model (77, 78), the medical model of childbirth dominates and is deeply etched into the hearts and minds of the Australian population. That domination is however, being challenged from many quarters.

2.5 Counterveiling Powers

Heather Hartley (79) a sociologist, uses the *counterveiling powers* framework to illustrate how the relationships among relevant parties in the United States health care system can be understood as a *system of alignments* which challenge medical dominance in a complex manner. The counterveiling powers framework situates professionals within a field of institutional and cultural forces and parties. Hartley (2002) has conducted an in depth case study of interprofessional competition between certified nurse midwives (CNM’s) and physicians in select state policy and managed care contexts in the United States. Hartley (79) advises that competition between doctors and CNMs are only one node in the system of alignments which is eroding medical power and dominance in the US health care system.

Using this framework it can be seen that shifting fields of influence and alliances are driving the changing models of maternity care in Australia. These intersecting fields are made up of different groups such as consumers, policy makers, financial planners, government departments, health service managers, quality organisations such as clinical governance, media, professional groups and academics. As in the US (79), escalating health care costs in Australia are shifting health care provision from a provider-led to a buyer-driven system as administrators closely monitor and control health care spending. Changing consumer patterns are also influencing the way that health care administrators make decisions as consumers become an increasingly

important countervailing force in the consumer sensitive health care arena.

Consumers from certain socioeconomic groups, such as those with higher incomes and more education, are increasingly accessing complementary therapies and alternative practitioners. Hartley (79) found that those groups who were accessing alternative practitioners are increasingly seeking nurse-midwife care. Hartley's conclusion is that more managed care leads to more interprofessional competition, increasing CNM's market share and physician resistance. She notes that in highly managed care environments, administrators are more willing to challenge physician resistance because there are higher incentives to expand nurse midwife programmes in response to consumer forces. Whilst Hartley's work is based on the US health care system, similar shifts and reactions can be seen in the Australian scene.

2.6 Changing Models

Changes in government thinking, economic realities (78), workforce issues (Health Workforce Strategic Committee (80), evidence-based practice (68, 74, 81-84) and women's choices (59, 85) are paving the way for changes in the way maternity care is being provided in Australia. These changes have seen a fierce debate in the media and within health system establishments. Some medical doctors have pulled out all stops in a vilification campaign, claiming there will be increased death and damage to mothers and babies from the proliferation of midwifery run maternity services. Despite the rhetoric of some Australian medical practitioners (11, 24, 56) against the establishment of midwifery run maternity services, many obstetricians are supportive of change (24) and are working to provide a publicly funded maternity care system that meets the needs of women.

2.7 Biological Basis for Improved Maternity Care Systems

There is increasing recognition that labour and birth happens optimally when women feel safe and are undisturbed in labour (86). It is increasingly understood that mammalian parturient behaviour does not fit comfortably into an industrialised, efficiency-oriented approach to childbirth (87). Modern medical childbirth practices, such as speeding up natural processes, interrupting normal gestations, and separating newborn infants from their mothers are not part of our biological heritage and the resultant rising caesarean section rate is causing alarm in many sectors. Comparisons with other mammals and emerging research in domains such as neuroscience, epigenetics, psychobiology, neuro-immunology, endocrinology and molecular biology demonstrate far reaching negative effects of such practices (88-93). These lessons are still to be applied to the way that birth is generally managed in Australian hospitals, although the negative effects on human babies, breastfeeding, mother-baby relationship and attachment caused by disruption to biological rhythms are being noted in many disparate fields and raised in various scientific forums (94-99). There are signs that a more humane approach to mater-

nity care is occurring as increasing numbers of midwifery models of maternity care are being implemented across Australia.

2.8 Partnership-based Midwifery Care Service Development

Health services are responding to economic imperatives and increasing pressure from the community to provide services that women want, with the advantage that women are being treated as individuals. To provide women with choice, control and continuity of carer, various health services are increasing the availability of relationship-based, midwifery models of maternity care. For example, at the time of this writing, Northern Sydney Central Coast Area Health Service (NSW, Australia) has established midwifery units at Ryde and Wyong; Hunter New England Area Health Service (NSW Australia) has a free standing, women centered, midwifery option at Belmont and two caseload models of midwifery care at John Hunter Hospital Birth Centre. Publicly funded birth at home is an option in three Australian states and one territory (NSW, SA, WA and Northern Territory). These services are popular with both women and midwives. In NSW, midwives in these services have undergone the NSW Midwives Association credentialing process to ensure that they have the skills and abilities to manage a full range of potential complex situations with healthy birthing women. Midwifery model of care options, including birth at home, will be more common as the different state Department of Health policy guidelines are implemented across the country (100-103).

3.0 My Personal Background as a Midwife

As a young midwifery student in the 1970's, I came from a nursing background and I did what I was told. I didn't question the way women were treated in pregnancy, nor did I question the strict routines we were taught to follow in the labour ward, nursery and postnatal ward. Some examples of these routines included: universal genital area shaves and enemas, even when the woman's labour was well advanced; partners being excluded from the birth areas; immediate separation of mothers and newborn babies; nursery routines of nasogastric tubes, glucose water feeds, anal temperatures and a full "Steriskin" wash of newborn babies; postnatal routines of "tinct benz co" applications to cracked nipples, elaborate nipple washing and feed timing rituals for breastfeeding women. I saw midwives hold the heads of birthing babies "in" until the doctors arrived. I saw women slapped and told to behave themselves and 'stop that noise'. I also held screaming newborn male babies down for circumcisions and was told in response to my queries that babies couldn't feel pain. Although often puzzled, I accepted everything I was told as I thought and believed that doctors and senior midwives knew everything. My attitudes and behaviour were, in retrospect, typical of my fellow students and indeed, registered midwives.

As a young midwife, I read several books that started to change the way I viewed the birthing

world. Books such as “Birth without violence” by Frederick Leboyer (104); “Spiritual Midwifery” by Ina May Gaskin (105) and ‘Immaculate Deception’ by Suzanne Arms (106) opened my eyes and mind to another reality. I began to question our practices and was quickly “put in my place” by both midwives and doctors. I worked in labour wards, as they were called then, and learned the value of lying. The ‘anterior lip’, a thickened bit of cervix, the presence of which could be used to ‘buy time’ before medical intervention was used to expedite birth, became my best friend. ‘Buying time’ through lying like this is part of the ‘midwife-doctor’ game, a version of the nurse-doctor game. I learnt that working nights meant doctors only came when they were called, so I became a night duty midwife.

Avoiding doctors, shielding the women and seeking to keep women off the medical ‘radar’ are other integral parts of the ‘midwife-doctor’ game. For this part of the game the midwife actively avoids communicating with the doctor about the woman’s progress. I also learnt how to time the doctors’ arrival with ‘crowning’, a signal of imminent birthing, to ensure the least interference in the birthing process. Getting the timing right was also important for reducing medical wrath because if the doctors were rung too late and they missed the birth, there was ‘hell to pay’ as they were generally angry about missing their ‘delivery’. In every place I worked, I learnt exactly how long it took each doctor to come at night, even when they were staying in their weekender.

3.1 My Experience in Private Midwifery Practice

After several years and different hospital experiences as a hospital-based midwife, in 1984 I went into private practice with a midwifery colleague. Private practice revolutionized my midwifery work, because I learnt what being ‘with women’ really meant. I learnt to work in partnership with women and to understand the ethics (see Chapter 2) of being with women through their journey to parenthood. I continued to work part-time in a labour ward in a public hospital. Working in these two worlds was like walking a tightrope. In each capacity, that is, as private midwifery practitioner or hospital midwife, I was treated differently by both doctors and midwives. I also behaved differently. As a private midwifery practitioner, I collaborated with several ‘flexible’ obstetricians, who supported me supporting women and their needs. Our relationship was respectful and collegial. These obstetricians genuinely respected women and midwifery care and only came to the birth if there was a medical necessity. Otherwise they would be ‘on call’.

Interestingly, some of the core midwives in labour ward were often isolating and unhelpful to us as private practitioners, even being obstructive and punitive at times. An example is my midwifery partner being called back from home in the middle of the night, to the labour ward to empty a bin after a very long time supporting a birthing woman. Usually, we would get no

assistance from our hospital-based colleagues to “clean up” after a birth, as they would if I was working for the hospital. We private practitioners would have to do it all. There were a couple of midwives who would willingly help, despite being given a ‘hard time’ by the other, unhelpful midwives. Sometimes these helpful midwives would be forbidden to assist us. They subsequently told me they felt as though there was no choice but to obey the senior midwives. In contrast, working as a hospital employee, I was considered a “legitimate” member of the midwifery team. In this role I was obligated, as per hospital protocol, to call the doctors to attend births.

3.2 Bullying and Harassment Issues in Midwifery

Our treatment at the hands of some of the senior midwives was borne rather stoically by us at the time. We accepted that it was just what we had to put up with to do what we wanted to do. Years later, when I was seeking to understand why a young, idealistic midwife committed suicide, it became obvious that bullying behaviour is a widespread problem in midwifery and nursing cultures, damaging many practitioners and in particular, young practitioners (107-111). In seeking to understand this behaviour, I explored Paulo Freire’s (112) ideas about oppressed groups and Foucault’s ideas about power (45). Midwifery and nursing both display many characteristics of oppressed groups (113-115). I also explored various psychological theories of human behaviour such as transactional analysis (115) and in particular, emerging ideas about social and emotional intelligence (116-118). Knowledge and understanding from these areas of human enquiry led me to probe the literature on quantum physics and the fields of endocrinology, psychobiology and neuroscience with their rapidly expanding explanations of human behaviour. My explorations gave me insight into my own unconscious behaviour and how I played the game of self sabotage and collusion with medical domination. It was a shock to recognize and understand the unintended negative effects that my behaviour was creating. I expand on these ideas and their relevance to doctors’ and midwives’ interprofessional interactions in Chapter Two.

3.3 A Defining Moment in Hospital Midwifery Practice

During my time of working in a dual capacity, as both a private and a hospital-based midwife, I often worked with obstetricians who did not support independent midwifery practice at all. In fact, they were often overtly hostile. A memorable and pivotal experience I recall was with an obstetrician called “Tongs Txxxx”. He was well known for his custom of performing episiotomies and using forceps. I made a timing mistake one night and he arrived just before the baby was ‘crowning’. This baby was the woman’s second child and she took slightly longer to “push up” than I had anticipated from her behaviour.

As “Tongs” rapidly put on his rubber gumboots, apron and gloves, I sought to protect her

and said how wonderfully well the woman was doing, how beautifully her perineum was stretching and said to the doctor “Isn’t she wonderful, Dr Txxx? Hasn’t she coped well... isn’t she doing well? Her perineum is stretching so beautifully!” etc. What I was implying was that I felt concerned for the woman and whilst willing her to birth quickly to avoid a clinical error of unnecessary episiotomy, I had a sinking feeling in my heart.

The doctor shoved the student midwife aside and proceeded to sharply ‘chin’ the baby so that the woman’s upper labial and perineal areas tore from the manually applied, upwardly directed force. After the baby was born, he filled her genital areas with excessive amounts of local anaesthetic, saying “oh dear, what a pity, if only I’d been here earlier, I could have avoided all this...” The doctor then sewed up every little graze and tear, pulling very tightly. I had the distinct impression that he was abusing the woman to get back at me. Not only had the interprofessional interaction broken down badly, I believe it made the situation worse for the woman. I knew that women admitted in his name would not be safe if I was looking after them in future. I resigned from my hospital position.

What is particularly interesting about this situation is that at no time did I think about reporting his behaviour as abusive and unethical, even though I felt very distressed and disturbed by his actions. It never occurred to me to speak to him about his behaviour, nor did I feel able to speak to the woman about her treatment at the hands of this man. I am no longer willing to stay silent in the face of such treatment of birthing women. I would have no hesitation now in asking this doctor to step outside and discuss his treatment of this woman. I also would have no hesitation in writing a letter to hospital management outlining my concerns and observations if a similar situation occurred today.

4.0 Justification for the Study

This study aims to enhance interprofessional interactions which is important because ineffective interaction wastes time, upsets staff and causes or contributes to preventable adverse events, including patient deaths (119). In Australia, interaction breakdown has been associated with 17% of system problems and of these 84% were deemed potentially preventable (120). Only 2% of the activity in intensive care units consisted of verbal interaction between doctors and nurses, however, these interactions accounted for 37% of error reports (2).

Dr Maggie Haertsch’s report *Safe Staffing and Patient Safety: A Literature Review for the Australian Council for Quality and Safety* (26) critiqued thirty one (31) papers scrutinising the relationships between hospital staff and safety within health care organisations. She identified a number of themes that are of specific interest for this study. Firstly, inexperienced staff combined with problematical interprofessional interaction increases the potential for adverse events (p.24). Secondly, sub-cultures within an organisation such as professional groups

or particular workgroups have an impact on teamwork and effectiveness (p25). Thirdly, improvements in interprofessional interaction enhance safety with an organization (p.25).

Problematic interprofessional interactions and their impact on client safety was identified in the Health Care Complaints Commission's investigative report into adverse events at the Macarthur Health Service (29, 121). The HCCC's report (29) states patient safety is dependant upon "a critical mass of highly skilled, knowledgeable health professionals who work collaboratively in a clinical team" who trust each other and who are trustworthy (p.6). The HCCC (29) report urges the health services to "invest in strategies that will develop and improve relationships and communication between individuals and professional groups that constitute clinical teams" (p.15).

Likewise, the effects of poor interpersonal interaction in maternity services are documented in the 2001 report of the Inquiry into the King Edward Memorial Hospital (KEMH) (3). The report describes how adverse events at KEMH were frequently related to ineffective, even absent, interprofessional communication. A number of other studies and reports provide further evidence that poor interpersonal interaction within nursing and medical practitioners is a frequent cause of systematic error leading to adverse events and outcomes in the health care system.

A review by the Joint Commission for Hospital Accreditation (US) 'revealed the primary root cause of clinical errors in over 70% was communication failure'(122). The sobering and compelling fact is that in 75% of the cases reviewed the people died (p.i86). A large and 'ever present cultural barrier' to effective interactions 'between doctors and nurses is the deeply embedded belief that quality of care and error free clinical performance are the result of being well trained and trying hard' (i86). The authors noted that such beliefs mean that inevitable errors are viewed as personal failures 'with the predictable result that these events are minimised and not openly discussed' (p.i86) thus reducing the likelihood that practitioners learn from experience (122).

5.0 Significance of the Study

This study contributes to enhancing interprofessional interactions and reducing related clinical errors by providing a theory that is grounded in data gained from in-depth qualitative interviews. This theory describes, explains and predicts the way in which the various factors; contextual, personal and interactional, interrelate to produce either functional or dysfunctional patterns of interactions. The theory provides a framework for university educators, maternity managers, clinical educators and clinicians to be able to understand what is producing some of the current patterns of interprofessional conflicts and stand offs so that we can bring about positive change.

There are five domains of midwifery that will benefit from this study.

5.1 Midwifery Practice

This study provides insight into ways to improve collaboration between midwives and doctors and increase the coordination of care for birthing women, thus reducing the potential for clinical error.

5.2 Midwifery and Organisational Administration

The theory generated by this study provides a compelling rationale for moving to an individualised, woman centred approach to maternity service provision. The theory illustrates the need to remove the silos of professional separateness and dismantle the medicalised, hierarchical approach to maternity care. As a result of this study, operational guidelines can be developed, setting the collaborative nature of the culture in place and giving managers unambiguous responsibility for identifying and effectively managing conflictual situations. It provides guidelines for the development of explicit policies and strategies to deal with situations of harassment and bullying in the birthing unit. These guidelines and policies will help lower the clinical error rate and support good risk management. Fostering of emotional and social intelligence in the workplace is promoted in this study.

5.3 Midwifery Education

This study provides a blueprint for acceptable interprofessional behaviour and important emotional, social and communication skills that can be taught to doctors and midwives so they know how to relate to each other better. The blueprint demonstrates how we can work more collaboratively and improve collegiality in the interests of reducing clinical errors and improving women's and carers' experiences.

5.4 Midwifery Research

This study begins, hopefully, a research agenda which involves multistate and multicentre sites, together with a combination of quantifiable as well as qualitative data to determine if the conclusions from this study can be applied to a broad population of midwives and doctors.

5.5 Midwifery Theory

This research has drawn upon and strengthened birth territory and midwifery guardianship theory (123). I have developed new theory about power and how power is used in the workplace. The study can also contribute to social theory in particular to health service organisation theory.

6.0 Overview of Dissertation

The dissertation consists of five chapters. In Chapter Two, I review the literature of direct relevance to the research question. The chapter is in two parts: firstly there is a thorough critical review of the research literature. In the second part of the chapter I present the theories that are most relevant to the research questions. These theories have been used to help guide analysis and interpretation of the stories of doctors and midwives. The methodology of the study is explained in Chapter Three. This involves discussing the philosophical foundations of Critical, Post-structural Interpretive Interactionism. The study design and research methods are then detailed and finally, the ethical dimensions of the study, together with the values and principles guiding the research are articulated.

In Chapters Four and five, I present the stories of interprofessional interaction together with the beginning analysis and theory development. In Chapter Four, the narratives about negative interactions from the perspective of a midwife and then, from the perspective of the doctor are provided with a table of the factors identified during analysis. Chapter Five contains the stories of the positive interactions from each profession, including the table of factors from my initial analysis. Chapter Six sketches the theory as developed by keeping analysis and interpretation closely related to actual data. Chapter Seven is where I review the entire dissertation, outline the information and draw conclusions. In this chapter the limitations of the study are explained and recommendations for the five domains of midwifery are found.

CHAPTER TWO: LITERATURE REVIEW

1.0 Introduction

A review of the literature around the working relationships between midwives and doctors demonstrates a long history of rivalry and competition, ineffective communication, and lack of collegiality (4, 6, 7, 13, 15-17, 19, 20, 22, 23) with women caught in the middle or “left out” (9). Poor communication and collaboration between health professionals has been shown to affect both morbidity and mortality rates in maternity services (3). Whilst there is plenty of evidence that problems exist in the working relationships between doctors and midwives, there has been very little attention paid to whether better relationships would improve the outcomes for childbearing women and their babies.

This review is organised by the research question so that literature that is most relevant to the question is considered under the following headings: Contextual, Interactional and Individual factors that are thought to enhance or inhibit interprofessional interaction between midwives and doctors in the care of birthing women.

2.0 Contextual Factors

Key contextual factors include the historical context of midwifery and medicine in relation to each other. The historical context was explored in detail in Chapter One as part of the background to this study. Knowledge and understanding about the history of the emergence of modern day midwifery and obstetrics explain the origin of much of the tension between the two professions in the provision of contemporary maternity services. I refer the reader to Chapter One for an examination of those areas of interest to this topic. Other key contextual factors are outlined in this next section. I explore the philosophical differences that underpin the sub-cultures of midwifery and medicine in the western health system. I also discuss beliefs and values that emerge from those philosophical and cultural underpinnings. Terrain and power issues are examined through the lens of a new theory, the theory of Birth Territory and Midwifery Guardianship (123). Finally, concepts of social and emotional intelligence (116, 117, 118) are explored and their application to doctors, midwives and the way that maternity services are provided are suggested.

2.1 Midwifery and Medicine

Moves by the NSW Department of Health to provide midwifery-led maternity options to increase women’s choice, continuity, and control over the birthing process have led to ongoing resistance from medical practitioners (11, 24, 56, 124, 125). At the heart of the dissension is the difference in foundational philosophies, values and ethics underpinning the professions of

midwifery and medicine (10, 35, 126, 127). These differences in perspectives, philosophy and practices has resulted in a history of often bitter and long standing conflict between midwives and doctors in the provision of maternity services (4, 7, 8, 11, 12, 15, 21, 24, 36, 74, 128-133). The differences are on a continuum which ranges from the consideration of childbearing as a normal life event (a view commonly associated with midwifery) to the medical perspective which contends that childbirth must be medically managed because it is unpredictable, inherently dangerous and only normal in retrospect (7, 8, 35, 131). An illustration of these differences and their impact on midwives and their care is found in the report of a US study by Sleutal, Schultz and Wyble (134). They found that these differences cause ethical dilemmas for expert intrapartum nurses because they are caught between their role as providers of a nurturing, calm environment for birthing women and their obligation to cater to what they often see as inappropriate physician practices of hastening and controlling labour (134). Hastening and controlling labour can be seen as part of obstetrics efforts to control the unpredictable and dangerous possibilities of death in childbirth. Murphy-Lawless (35 p.264) argues that obstetrics' drive to overcome 'death once and for all' has done profound violence to women.

As discussed in Chapter One, it is well documented that hospitals and health care systems are still organised in a hierarchical manner along class, gender and racial lines (135). The ideology of patriarchy, together with gendered power relations as they are embodied and practiced by both midwives and doctors, create professional 'silos' and endure to support male medical dominance (34, 138). These factors underpin the widespread and deep tensions between medicine, midwifery and nursing (4, 21, 44, 136-138). Despite the widespread awareness of these ongoing issues and their effect on professional activity and health outcomes, there are contrary viewpoints requiring consideration. Pringle (18), for example, dismisses the story of patriarchal dominance of women's bodies in gynaecology (139, 140) and maternity care (135) and relegates the struggle for autonomy by midwives as efforts to "keep alive older folk traditions" and labels the story of domination as "a political rallying cry" (p.43). Pringle suggests that the feminist version of history has been constructed as a story of a "battle between good and evil, alluring in its simplicity". Following her research into the experiences and perceptions of women doctors, Pringle argues that the foundational story has outlived its usefulness for either group, claiming that contemporary health care has moved beyond an "account which concentrates on two sides locked in permanent combat" (p.43).

Lane (138) agrees it is time to change to a more collaborative model between midwives and doctors, but suggests that for true collaborative care to emerge, three factors need to change. First, midwives need to "vacate the high moral ground of guardians of the normal" upgrade their skills and be fully accountable for their practice. In Lane's view, one to one midwifery care would enable that objective to be realised because in that model of care, midwives take full

responsibility for their practice. The second aspect which Lane suggests needs to change is that “doctors need to need to jettison the burden of sole arbiter and architect of birth outcomes... relinquish the moral high ground of heroic medicine and systematically construct an ongoing dialogue with midwives and mothers in deciding the *modus operandi* for every birth” (138). The third factor suggested by Lane is the development of a management structure which removes professional ‘silos’, disbands a hierarchical approach to management of maternity services and encourages wide distribution of responsibility for childbearing women’s care and outcomes. The challenge here is the way that obstetrics as a ‘closed and unreflexive science’ has positioned itself as ‘heroic’ (35) and created a compelling and all consuming discourse around safety and danger for childbearing women. Litigation and poor outcomes are twin foes that obstetrics seeks to vanquish and in their efforts to do so, have positioned women as needing the best possible obstetric care because of ‘ongoing bodily deficiency’ (35 p.245). The discourse about safety and danger has created a fear filled and risk averse culture for both medicine and the general public, creating a double bind that medicine is struggling to control. Within this culture, the spectre of litigation looms large.

While Lane has suggestions for how midwifery can change, there is no comparable strategy for medicine’s metamorphosis into a collaborative model. Interprofessional education is one strategy which has been suggested as a way of eliminating barriers between midwifery and medicine (22). A recent quality audit on fourth year medical students’ experience in their delivery suite rotation (141), indicates the potential of interprofessional teaching in breaking down interprofessional barriers. One student wrote:

“Being made to feel welcome and part of the team and having midwives give of their time for teaching has made my experience very positive. It is an excellent investment in the future doctors that midwifery staff will be working with, if medical student’s birthing suite experience is positive. It is the only time in our training where we participate in a normal physiologic process. It is important for us to understand this as it not only helps us to recognise abnormal but equally importantly gives us a sense of the wide variety of “normal” and therefore trust in that process enough to be comfortable *not* intervening; Also builds trust at a professional level. Thanks for making this experience positive for me”.

These comments point a way to improving relationships and understanding between doctors and midwives.

2.2 Hierarchy Maintenance Work

Green, Kitzinger and Coupland (142) used observation, interviews and work diaries to study day to day operations at three hospitals (UK) that have a traditional three-tier structure (Senior House Officer (SHO), registrar, consultant) and three hospitals (UK) that have a new two-tier arrangement which misses out the registrar grades. The authors found that midwives have a

much more relaxed and direct relationship with the consultants in two-tier units. In the two – tier units, midwives had greater job satisfaction, were more empowered and demonstrated greater decision making and extended roles in tasks. In general, midwives felt that they had more input into policy. They felt that their opinions were taken seriously, their skills respected, and that they had better relationships with consultants.

In the traditional, three tier structure, the authors found that midwives were involved in a great deal of ‘hierarchy maintenance work’ to preserve the status of the relatively inexperienced, but technically in charge, SHO whilst ensuring that their own practical knowledge and experience were taken into account. The registrars tended to present themselves as the consultants’ ‘right hand’ and apprentice. Ambiguity of status, coupled with the traditional status hierarchy and the differences in skill and experience between midwives and SHO’s, led to the emergence of competition between the two groups. The SHO’s tended to initially resent the increased recognition of midwives’ skills. The authors suggest that the power to make decisions is “central to the doctors’ professional self-image” and therefore reallocating decision making to midwives is more contentious than allocating more tasks to midwives.

2.3 Interprofessional Role Boundaries

A study by Snelgrove & Hughes (143) on interprofessional relationships between doctors and nurses focused on perceptions of roles and interprofessional relationships. The data suggested that both nurses and doctors perceived a ‘clear dichotomy in their respective work roles along traditional lines, but that some boundary blurring was taking place as nurses assumed some of the new technical-medical tasks. In terms of how doctors and nurses justified the expanded role of nurses, nurses emphasised increased knowledge and training, whereas the doctors emphasised the nurses’ experience because in their view, it compensated for the lack of medical training.

Whatever subject positions are assumed by nurses and doctors and however they perceive their roles, responsibilities and day to day demands, Halford and Leonard (144) found that even still ‘the demands on doctors’ and nurses’ performances and identities are shot through with gender’(p.158). These researchers discovered that being a man or a woman made “an enormous difference in the way that nurses and doctors thought, talked about themselves and behaved at work (p.158). Halford and Leonard (144) discovered that, as well as shared regimes of negotiated gendered working identities for men and women, new forms of management and “the ascendancy of concepts such as ‘efficiency, productivity and quality’, together with tools such as ‘clinical governance’, ‘audit’ and ‘risk assessment’ are widely associated with particular versions of masculinity, not only in theoretical sociology, but in the routine accounts of every day working lives” (p.159).

Good relationships between midwives and medical personnel have been found to facilitate

midwifery autonomy, but the ongoing dominance of the medical model still provides a major barrier (145). The rise in midwifery led units is one way of promoting midwifery autonomy, but may not have the desired effect of better care for birthing women. Walker, Hall & Thomas (146) reviewed a (UK) midwife led unit in 1995. They found no evidence to show that categorising women as either high or low risk improved clinical outcomes. What they did find is that such categorisation activates the historic division of labour between midwives and doctors, and that women's needs for autonomy, choice and continuity of carer are not met.

Lane (138) suggests that obstetricians, midwives and women will benefit from the institutionalisation of a dialogic relationship. This relationship is a partnership, based on Ericson's ideas of 'Generativity'. The dialogic relationship is one that assumes an open discussion among equals and requires a respectful acknowledgement of the skills and world view of the "other". Generativity is the idea that health professionals could transcend narrow professional interests and traditional rivalries in the pursuit of the health and well-being of future generations. In this way, a genuine interdisciplinarity is achieved where the most appropriate care is offered at the most appropriate moment. In Lane's view, the "attainment of an ontological equality within the dialogue cannot be achieved by requiring one party to capitulate to the worldview of the other"... instead it requires the creative enmeshing of technical skills and pastoral skills whether they came from obstetrics, midwifery or both.

The challenge is to get both groups of health professionals to engage at this level of interaction, given the differences in philosophy and power while remembering that gender and gender inequality are pervasive features of hospital culture and central to the negotiation of identities and management structures within the health care system (144) and maternity services in particular (12, 132, 147-149).

2.4 The Partnership Model of the Woman-Midwife Relationship

Guilliland & Pairman explained the woman-midwife relationship as a partnership (150) The Midwifery Partnership model places the woman as the focus of attention, therefore, midwifery care is women centred and midwifery ethics are situated with the woman, which includes her needs, her desires and her experience (10, 126). In this context, woman means childbearing woman. The concept of the childbearing woman includes the baby, because the mother and baby are conceptualised as an indivisible whole: "the needs of one will be the needs of the other" (150, p. 42). The foundational framework of the relationship and therefore the partnership is special because it is based on respect for the expertise of both the woman and the midwife. The woman's body of knowledge is considered to be as important as the clinician's. The woman is respected and valued as the expert on her self and her own embodied experience and history. The midwife recognises that the person best positioned to care for the baby is the woman. Woman

centredness in midwifery, celebrates “the centrality and value of women’s experiences” (Eisentein, 1984 cited in 150). The midwife aims to develop a relationship with the woman that is sensitive and respectful and leads to mutual trust and respect (126, 150). This special partnership is established throughout the woman’s pregnancy as the woman and midwife come to know, understand and trust each other during the antenatal period. The woman is then attended during labour and the postnatal period by a midwife she knows well and who knows her. The partnership model outlined by Guilliland and Pairman (150) is an example of the dialogic relationship articulated by Lane as explained in a previous section (138).

The success of the midwife-woman partnership is dependant upon the integration of a set of foundational premises about the nature of childbearing and a midwife’s role and how those values are applied in practice within the relationship.

These premises are:

- Pregnancy, birth and breastfeeding are normal life events
- Midwives journey with women through their childbearing experience
- The individual woman and her needs are the focus of midwifery care
- Midwifery ethics are based ‘with woman’
- Midwives & women have equal and important bodies of knowledge which they bring to the partnership & relationship
- Trust is built during the ongoing establishment of the relationship

The application of those premises to midwifery practice mean that:

- The woman’s body of knowledge is considered to be as important as the clinician’s.
- Each woman is respected and valued as the expert on her self and her own embodied experience and history
- Informed decision making is a basic human right
- The woman is the person best situated to care for her baby throughout the childbearing process
- A woman’s physiology works best when she has a perception of control over her life and processes

2.5 Attitudes and Values of Midwifery and Medicine

The midwifery partnership model reflects its reliance on a social model of health rather than a medical model (126, 151-153). The social model (74) is based on primary health care (72) and community development principles (73) and is woman-centered (10), with the woman in control. The medical model, on the other hand, makes assumptions about what the patient

needs (21). Whilst midwifery as a profession is more geared to a social model of health, where women are informed, self determining and autonomous, it is important to note that both midwives and doctors can be guilty of making assumptions and indulging in power plays. These behaviours by any health professional can render women powerless in their experience of maternity care (6, 18, 47, 153).

A glimpse into obstetric attitudes and perceptions is given by Pringle's account of her research into the ideas and experiences of one hundred and fifty (150) women doctors in Australia and The United Kingdom (18). Thirteen of these doctors were obstetricians and gynaecologists. One respondent wondered if five years of study are necessary to become an obstetric specialist or whether 'those features of personality which help make a person a good radical surgeon – some degree of aggression, boldness, and to some extent impatience' are those which produce the best obstetrician (p.53). Another respondent, a consultant obstetrician, said "I haven't the faintest idea how to look after women in labour and I can't cope with hours and hours of sitting and pain and being nice to people!" (p.52).

Exemplary midwifery practice on the other hand, is in creating a calm, trusting environment that inspires a sense of normality (154). To create this kind of atmosphere means that midwives, in the words of Powell Kennedy 'do nothing well' (145, 154). Powell Kennedy discovered that midwives present themselves as 'an instrument of care' by the way they construct the environment and are vigilant, attentive and present to the woman in labour. Such watchful waiting is associated with optimal outcomes for women and their babies (155). My own experience and observation is that midwifery care and the midwife's vigilance, attention and behaviour, demeanor and 'presence' to the birthing woman, are highly active processes. In terms of understanding the role of the observer from a quantum physics perspective (156-164), these characteristics of the midwife/observer are very influential in the birthing process.

2.6 Birth Territory Theory

'Birth Territory' is a new theory that gives an explanation of how the environment is related to the way the childbearing woman feels during pregnancy, labour and birth and how her feelings are directly related to how her mind and body functions. In turn, how the mother feels and how her mind and body function are intimately related to the health and wellbeing of the baby, who is part of her body during pregnancy, labour and birth (165). An integral part of the theory has been developed by Kathleen Fahy and Jenny Parratt, two midwives and researchers, who have taken a post-structural perspective and, expanding on ideas from Michel Foucault and key feminist theorists, synthesised Birth Territory theory from empirical data gained from their practice. Birth Territory theory seeks to describe, explain and predict how multiple elements intersect and influence each other in the birth space (166). These elements include all facets of

the physical environment, issues of power and control embodied in the individuals concerned, the woman's physiological and emotional aspects and the outcome of the birthing process. The theory is informed by current research from diverse fields such as psychology, human biology, sociology and midwifery (166). There are two major sub-concepts to Birth Territory theory as initially described by Fahy and Parratt (166). The first is the concept of "Terrain"; the second is "Jurisdiction". Terrain refers to the physical features and geographical area of the discrete birth space, including the furniture and support tools the woman and her support people use for labour and birth. Two forms of terrain are identified. The first is that of "Sanctum", defined as a homely environment which engenders ease and comfort for the woman and provides optimal self expression, thereby facilitating normal birth. The other is that of "Surveillance Room" which indicates a clinical environment designed to facilitate surveillance of the woman and her fetus. This room is for the ease and comfort of the staff and is more likely to inhibit physiological functioning.

The use of power within the room is referred to as "Jurisdiction" (166). Jurisdiction has six inter-related sub-concepts. These sub-concepts are: "integrative power", "disintegrative power", "midwifery guardianship", "midwifery domination"; "genius birth" and "forced birth". Integrative power refers to the way that all forms of power in the birth room are integrated towards some shared higher goal. When integrative power is operational, then the woman emerges from her process feeling supported and good about herself having had a 'genius birth'. Disintegrative power refers to the use of power that is ego based and used to satisfying someone's self-serving goal. The use of disintegrative power disrupts and undermines the woman's sense of integrated self and the woman emerges from her experience feeling diminished and weakened having had what Jenny Parratt has termed a 'forced birth' (167). Midwifery Guardianship refers to guarding the woman and her Birth Territory, nurturing and supporting her sense of emotional, spiritual and physical safety. It is one form of integrative power. Midwifery Guardianship aids the woman's integrative power, so that she is able to labour and birth undisrupted, thus making physiological, instinctive birthing more likely. Midwives who embody midwifery guardianship qualities are doing what Holly Powell Kennedy has referred to as 'doing nothing well' (154). Women emerge triumphant from their experience, regardless of the outcome, having had what Jenny Parratt has termed 'genius birth' (167) when midwifery guardianship is operational. "Midwifery Domination", on the other hand, is usually subtle and is an ego-based, disciplinary use of power. It is one form of disintegrative power and works to keep women docile. Midwifery domination disrupts the labouring process because instead of surrendering to her own inner wisdom, women have to follow the midwife's guidance. This form of disintegrative power is not usually detected until the recipient of domination offers resistance. When midwifery domination is enacted, women emerge from the birthing process with a diminished sense of self, regardless of the outcome, having had a 'forced birth' (167). Table 2.1 demonstrates the concepts and sub-concepts of Birth Territory Theory.

Table 2.1: Birth Territory Theory Concepts and Subconcepts

CONCEPT	SUB-CONCEPT
Terrain Physical features and geographical area of the birth space, including furniture, accessories and functionality	Sanctum Homely environment designed to be beautiful and optimise women's sense of privacy, ease and comfort: includes easy access to bath, shower, toilet; door which is able to be closed; dim lighting; colours; aromas; textures; artwork; homelike furniture; clinical equipment in cupboards, not visible
	Surveillance Room Clinical environment designed to be functional and optimise staff's ability to observe and act upon the woman: includes bright lights; pale walls; adjustable, clinical beds; open door to birth room; obvious clinical tools, such as clock, neonatal resuscitation trolley, cardiotocograph (CTG) and blood pressure machines, intravenous poles and other clinical equipment
Jurisdiction Having the power to do as one wants within the birth environment; power is an ethically neutral energy, essential to living, which enables one to be able to do or obtain what one wants	Integrative Power Integrates all forms of power within the environment to some shared higher goal; refers to use of power by birthing woman, midwife or other person in environment to support integration of birthing woman's mind and body so that she is able to respond spontaneously and expressively to her bodily sensations and intuitions involved in her instinctive birthing process
	Disintegrative Power Is ego centered power than disintegrates other forms of power within the environment and imposes the user's self serving goal; may be used by the birthing woman, the midwife or other person in the environment; this form of power undermines the woman's confidence to be able to feel, trust and respond spontaneously to her bodily sensations and intuitions. In this way the woman's mind-body unity disintegrates and she is separated from her embodied power to birth instinctively.
	Midwifery Guardianship Requires nurturing the woman's sense of self and safety through respecting her attitudes, values and beliefs; controlling who crosses the boundaries of the birth space and promoting and respecting the woman's integrative power by enabling the woman to experience undisturbed labour and birth.
	Midwifery Domination Is a form of disintegrative power that is based on the use of disciplinary power. Is usually subtle and manipulative and not detected until the subject of domination offers resistance. Midwifery domination interferes with the birthing process because it induces the woman to give up her embodied knowledge and power, become docile and follow the midwife's guidance.
	Genius Birth represents the activity of an integrated 'embodied self' using her own power to give birth in the best possible, uniquely individual way for that particular woman at that particular moment of her life.
Outcome How the woman's process is affected by the physical and political aspects of birth territory	Forced Birth refers to birth that is primarily devoid of spontaneity and contrived to fit the pre-determined boundaries of the woman and/or her attendants

3.0 Interactional Factors

The key interactional factors include relationship formation and maintenance, communication, mutual understanding, collaboration and teamwork, (or its' opposite: bullying.)

3.1 Research Related to Nurse-Doctor Interaction

A literature search of the databases Medline, MIDIRS and CINHALL, using key words 'interprofessional collaboration' and 'nurse and/or midwife - doctor interaction/communication' produced more than 15000 articles. Of those 15000 articles, few were specifically related to maternity care service providers. Most of the literature dealing with interprofessional interaction was in the form of theoretical or opinion pieces related to nursing (168). It has been suggested that the interactional approach is important in "understanding the organisation of health care work and relationships between occupational sectors, differences in intra-occupational status and the ways in which context impinges on these issues" (169). There were, however, no in-depth, theoretical accounts of the ways that midwives and doctors interact and how social order is maintained in the face of cultural change. Thus, the present study is meeting a gap in the research literature.

A survey of 551 doctors and 2050 nurses who worked on medical and surgical wards in 15 Norwegian hospitals found that interprofessional communication and cooperation between the two groups were affected by differences in professional cultures (32). Midwives, like nurses, have a very different professional culture to that of doctors. Doctors and midwives have different training, different status, different philosophies and different subtasks in the care of childbearing women. Despite increasing numbers of women going into medicine, doctors and midwives are also different gendered groups. Therefore doctors and midwives have male to female and female to male ways of relating. Mutual understanding and, as a result, communication and collaboration is therefore likely to be more problematic when people who have such wide disparities in perspectives and socialisation are cooperating on different subtasks. Research has demonstrated that ineffective interaction wastes time, endangers patient care, and is almost certainly a principal cause of preventable adverse events in clinical practice (119). It therefore follows that anything that can improve collaboration between doctors and midwives is important for patient safety and workforce satisfaction.

3.2 Interprofessional Collaboration

Interprofessional collaboration, according to Lindeke & Siedkert (31), 'is a complex process that requires intentional knowledge sharing and joint responsibility for patient care'.

3.2.1 Ineffective Collaboration

A systematic review of the literature found that some authors described examples of subver-

sion and/or resistance to collaboration, while others suggested strategies for effective inter-professional collaboration (170). Obstacles to collaboration include stereotypes, gendered thinking (171), expectations, philosophy and perceptions (Pringle 1998), different styles of learning, models of working, regulatory mechanisms (172), role ambiguity, and incongruent expectations (173). When doctors and nurses don't know each other on a personal level and don't have opportunities to develop confidence and trust in each other, they are more likely to revert to stereotyped roles (25). Leonard, Graham and Bonacum (122) found that effective communication is situation or personality dependant. It depends on who is communicating and what else is going on at the time.

Professional groups often claim they work as members of a team. In reality, they usually work as totally different, discrete groups with different cultures and communication styles (174). Interestingly, doctors have been found to be more satisfied than nurses with the level of cooperation between the two professions (175). In a study investigating attitudes towards teamwork in 8 intensive care units in the UK, only 33% of nurses (compared with 73% of physicians) rated their quality of collaboration as high or very high. There was evidence of suboptimal conflict resolution and poor interpersonal communication skills between the two professions. The researchers discovered that nurses found it hard to speak up, disagreements were not appropriately resolved, and when input into decision making was needed, the opinions of the nurses were not well-received (175).

The concept of cooperation may have different meanings for the two professional groups. For example, a Norwegian study found that doctors' idea of cooperation is that nurses 'assist' and carry out their orders without a fuss (32). Doctors have been noted to tolerate more stress and disagreement than other health professionals before they consider they are having a conflict. Krogstad et al. (32) say this can be looked at two ways. It could indicate that doctors are more skillfully coping with the rigors of practice but it could also mean that the physician culture is less aware of what a true collaborative climate is, and therefore cooperation may look less problematic to doctors because they are the traditionally dominant group and consequently, used to getting their own way. Krogstad et al. (32) suggest that the reality is that cooperation does not mean the same thing to the two groups.

3.2.2 The Doctor-Nurse Game

An example of unhealthy interactions between doctors and nurses is what Stein called "the doctor-nurse game" (48, 49). In the doctor-nurse game, the nurse is required to make decisions and contribute ideas whilst appearing passive, so that the ideas seem to have originated in the doctor (37). Shirlee Passau-Buck & Edward Magruder Jones (47) warn that the game is a dangerous one as it demands self deception for the doctor and deters open communication

between professions at the patient's expense. In a study of doctor nurse interactions in a paediatric unit, Bromme and Knückles (174) found that doctors were unaware of nurses' competence regarding prognoses and didn't utilise nurses' knowledge in decision making. These authors suggest that because of their training, tasks and conceptualisations, a doctor's representational system lacks the flexibility needed to benefit from nurse's experiential knowledge. Neither group had a full appreciation or understanding of the other's tasks and perspectives but nurses were less satisfied than doctors about their interprofessional communication and relationships. The nurses, however, had a stronger commitment to achieve mutual understanding than the doctors did (174).

Simpson, James & Knox (153) found that communication and behavioural work patterns involved blurred boundaries between expert US labour nurses and obstetricians during normal labour. They also found that the expert labour nurses reverted to the 'physician-nurse' game when deviations in labour occurred to achieve what they believed was in the patient's best interest instead of "directly communicating and developing a plan of care through the wisdom and experience of two knowledgeable professionals". An Australian study (176) involved interviewing doctors and midwives about their professional communications. The authors found opposing views from each discipline as to what would make good teamwork. Essentially, most doctors are critical of the way midwives behave towards them. Doctors want to feel that their authority is respected by midwives and they want to be included in the care of all women. Midwives are critical of the way doctors behave towards them. Midwives want to feel respected and valued; this includes being trusted by doctors to independently care for women having straightforward pregnancies and births (176).

3.2.3 Bullying

Bullying is a significant workplace issue. The South Australian Working Women's Centre Workplace Bullying Project has estimated that 30-50% of sick leave relates to the effect of bullying (177). Social, structural constraints of institutions, the power relations within those institutions and the political economy combine to tolerate, accept, and perpetuate abuse and allow violence of all kinds to arise from the social context (178).

The medical establishment has been found to act as a powerful agent of social control, enforcing 'socially appropriate' behaviour and perpetuating gendered stereotypes according to its norms and values (179). Paice et al. (180), in their paper on bullying in medical training, provide insight into hospital culture and the role of the medical establishment. Their research showed that most negative behaviours were perpetuated by other doctors in a pecking order of seniority, but that nurses and midwives were an important source of bullying for junior grade doctors. Wong (181), in his reply to Paice et al.'s paper, describes a strictly enforced,

hierarchical communication system in hospitals, in which “the sole reward of progressing in the hierarchy is to be dissociated with the ground level staff”. Wong (2004) describes how in this “hierarchical, punitive system, submissive entourages, obsequious nurses and unholy alliances between “long termers” (nurses and consultant doctors) at the expense of the transients” (doctors in training) is the norm.

3.2.4 Oppressed Group Behaviour

Aggression, bullying and harassment have been found to be endemic in the health sector. One Australian researcher (111) has referred to the health care workplace as a ‘silent hell’ for female health workers. Researchers in the United Kingdom (182) found that there was a deeply entrenched bullying culture in the National Health Service maternity units, adversely affecting both midwives and mothers.

Bullying is associated with oppressed group behaviour (37, 112). Manifestations of subtle forms of self-hatred such as divisiveness, lack of cohesion, lack of participation in professional groups, back-biting, destructive gossiping, fault finding and other forms of violence and contradictory behaviour, characterise oppressed groups. Oppression has been defined as the imposition of the choice of one person or group on that of another (112). It is any situation in which one person or group hinders another’s pursuit of self-affirmation as a responsible person or group (110 p.55).

To have oppression, there has to be a dominant person or group and a subservient person or group. Oppression is the result of the struggle by the dominant group to maintain the status quo and their power base. The concept of power is defined as influence in decision-making, but also involves the ‘fierce emotional pressures’ that can be brought to bear without any overt display of power or ‘open command’ by those in control (183 p.123).

Change generated from those outside the dominant group is perceived as inherently threatening and potentially damaging to their power base and so the dominant group moves to maintain the status quo. It does this by promoting fear of freedom and subservience by using myths, positions of influence and organisational structures (112). In this manner power, technology and ideology combine to produce a ‘reality’ which values certain forms of knowledge and constructs rigidly defined social relations (1). These constructions dictate how various groups will fit into the system and what they will be able to do. Freire (112) explains that oppressed groups internalise the view of themselves held by the oppressor and imitate patterns of oppressive behaviour. According to Freire (112), subordinate groups often seek to adopt the behaviour and characteristics of the dominant group as a way of identifying with them and gaining approval. In this way, oppressed people tend to ‘house the oppressor within’ and contribute to their own

oppression through bullying (112). Parallels can be drawn between Freire's ideas about dominant and oppressed groups and how the medical establishment and nurses and midwives relate, communicate and interact. Learning from these ideas provides insight into how imbalanced power based relationships may be problematic for the people in midwives' and doctors' care.

3.3 Effective Collaboration

A systematic review looking at interventions to promote collaboration between nurses and doctors concluded that increasing collaboration improved outcomes considered important to patients and managers (168). Nurses have been found to avoid communicating with doctors when they perceive it will lead to conflict. But when conflict is embraced as an opportunity to learn and develop and open discussion is valued and encouraged within the workplace, the atmosphere and outcomes are more likely to be positive (184). As Davies (171, 185) suggests, when clinicians truly work together they are more likely to have "real" conversations at work. They will also willingly engage in interactions that initiate and maintain dialogue between professional groups.

Leonard et al. (122) explain that because the barriers to effective communication and mutual understanding between health care professionals are so entrenched it is 'important to embed standardised tools and behaviours into the care process to improve safety in a progressively more complex care environment'. Schmalenberg, Kramer, King & Krugman (186) studied nurse-physician collaboration and discovered that collaboration was 'best viewed as a process consisting of ongoing interactions' and that the amount and longevity of contact is important to positive relationships between the two professions. These researchers also noted that nurses' assessment of the degree of nurse-physician collaboration is more accurately correlated with quality patient outcomes than are those of their medical colleagues.

3.4 Addressing the Health Service Culture

Humans have inbuilt weaknesses; such as a limited ability to multitask, a propensity to get stressed and fatigued and vulnerability to distractions and interruptions. These very real human factors, if there are not processes and protocols to manage them effectively and protect the individuals, can lead to mistakes and errors of judgement. In the health care culture, there has been a tendency for people to hide mistakes and errors of judgement, because of fear of recriminations. Health care organisations are taking lessons from the aviation industry to address the problems caused by these inescapable human factors (122).

Moves to strengthen clinical governance include the development of policies and strategies to improve communication and mutual understanding because as the airline industry has shown such strategies lead to better outcomes and enhanced performance (122). These policies and

strategies include the development of standardised communication processes, care plans and procedures. For example, NSWHealth is implementing a state wide computer based system for monitoring and addressing unexpected adverse incidents during health care provision, called IMS (Incident Monitoring System). Clinicians at all levels of the organisation are responsible for recording any unexpected event on the database system. The incident is investigated at the local level to see if there is anything from an individual, organisational or process/system perspective that could have been done differently at the time to have a different outcome. The patterns of these events are investigated at a state level to see if any change is needed to any process or system. Whilst there is always individual responsibility for professional practice and ethical behaviour, the focus for service quality and improvement is moving towards a system responsibility rather than merely levelling blame at one individual within the system for health care system outcomes that are less than ideal.

As well as putting standardised processes into place, addressing the culture is a vital part of improving safety for the people who access health care services. Scott, Mannion, Davies & Marshall (2003) write that organisational culture management is an integral part of health care reform and when health care cultures emphasise teamwork, group affiliation and coordination, there are improved health outcomes and greater implementation of quality improvement practices.

3.5 The Importance of Leadership

Leaders set the emotional tone of an organization, so it is vital that the leaders have advanced skills in emotional and social intelligence. Research into the watery world of our brain and physiological functioning informs us that emotions are contagious and that we depend upon others for our own emotional stability (187). People transmit signals which are picked up by others unconsciously and these signals can influence their heart rate, hormone levels, immune functions and circadian rhythms. The comforting presence of another in intensive care units, for example, has been shown to lower the patient's blood pressure and fatty acid secretion (187). Our emotional circuits are what is termed an *open loop* system because the system relies on what's happening around us to regulate itself and therefore our perceptions, bodies and experiences. Our nervous systems 'read' each other and respond accordingly, a process called 'mirroring' (187 p.7). When people are in conversation or near each other, their systems become 'entrained' rapidly sharing emotions ranging from joy to fear.

In maternity units, as with any other group of workers, there is a continual interplay of open loop emotional centers, each person's mood adding to and creating the emotional 'flavour' of the workplace environment (187). According to Goleman (187 p.9) the leader's emotional tone and competence is critical because workers watch and listen to the leader and perceive the

leader's emotional response to any situation as the most valid and so model themselves on it. When the emotional tone of an organization is upbeat, positive and encouraging, it brings out the best in people and people are in resonance. When the emotional tone is down, people are in dissonance (187). Both states have profound personal and organizational implications.

4.0 Intra-Personal Factors

4.1 Emotional Needs and Skills

Emotions shape our thinking and are the primary determinants of our choices, behaviours and experiences and affect our health and wellbeing generally (117, 156, 188-192). Three basic emotional needs are common to everyone (40).

These basic emotional needs are:

1. Love needs - to love and be loved - to give and receive caring, affection, warmth and appreciation, support
2. Understanding needs - to understand and be understood
to have a grasp of what is going on
3. Choice needs - to choose and be chosen - to be able to take part in the decisions that affect our lives; to be chosen as someone special because of our own particular gifts or qualities

Heron (40) articulated a clear set of emotional skills which were necessary for optimal personal functioning.

These skills are:

- Awareness – of one's own emotions and their effect on behaviour
- Choice – between control and spontaneity
- Sharing emotions with other people as appropriate
- Releasing emotions cathartically (4 aspects)
 - Controlled letting go – aware of process and choosing time and place to do it
 - Letting go- allowing oneself to let go both emotionally and physically
 - Insights – catching intuitive and creative insights
 - Decision-making – after moving through emotion and intuition, use intellect to consider the learning and make decisions

Emerging understanding from research in disparate disciplines such as neuroscience and psychobiology is demonstrating that emotional skills and their social skill correlates are firmly grounded in a person's neural networks and messenger molecules communication pathways. These skills have their genesis in infancy (156, 193-195).

4.2 Social and Emotional Intelligence

Social and Emotional Intelligence and their competencies are concepts which are being promoted in management circles and business forums as necessary knowledge and skills for surviving in the modern workplace and facilitating good interpersonal relationships (116-118). Goleman (117, 187) and Bar-on & Parker (118) present five factors for emotional and social intelligence and competence. These factors are: self-awareness, self-regulation, motivation, empathy and social skill. While some health service managers have opportunities to attend workshops and programmes exploring these ideas and developing their skills in these areas, most midwives and doctors are not exposed to this information.

The concept of 'emotional competence,' is the ability to manage oneself. Managing oneself has two main aspects. The first aspect is self-awareness, which is having a deep understanding of one's emotions, strengths, weaknesses, values and motives. It involves self-reflection and thoughtfulness. The second aspect involves emotional self-control. It involves optimism, initiative and adaptability. It requires the ability to keep disruptive emotions and impulses under control whilst displaying integrity and trustworthiness (117, 196). Social intelligence and competence determines how we manage relationships (116).

There are two aspects to social intelligence and its associated competencies. The first is social awareness. Social awareness has three aspects. They are 1. empathy, sensing and understanding others' emotions and being actively interested in their concerns; 2. organisational awareness that is, being able to 'read' the politics and currents at the organisational level and service, 3. recognising and meeting other's needs. The second aspect is all about relationship management. These competencies range from inspiring others to team management skills (118). The following adaptation of the table (2.2) by Baron & Parker (118) illustrates a way to think about and utilize these concepts and sub-concepts in the analysis of the doctors and midwives stories of their interactions in the care of birthing women for the purposes of this thesis.

Phil Barker (197), a Professor of Mental Health Nursing, notes that in most fields associated with health care and the social services, there is no assessment strategy to ensure that practitioners possess emotional competence, although practitioners are often stringently assessed for intellectual and practical competence, both as a prerequisite for registration in their practice specialty and to maintain registration. Education and training for effective management of troublesome and difficult feelings of grief, fear and anger is lacking in western culture (40). According to Heron (89) instead of healthy acknowledgement and processing of these uncomfortable feelings, we are taught to suppress and deny them. A constant cycle of repression and denial throughout life generally is said to create 'a system of inhibitions, defensive walls that can end up being like a prison of the mind' (198). Stanislav Grof (199) a transpersonal psychiatrist, has found through his work that the origins of personal distress and the disposition to violence and self-destructive tendencies are rooted in perinatal dynamics and birth circumstances and built upon in childhood and throughout life. Grof (200) considers the perinatal experience a determining and critical force in the development of the emotional and therefore social, orientation of the individual. Current research in developmental neuroscience, epigenetics and psychoneuroendocrinology are validating Grof's observations (201).

Heron (202) describes how unresolved personal distress adversely interferes with professional relationships. According to Heron, when personal distress is not dealt with consciously and constructively, communication is contaminated and maladaptive displacement responses such as 'projections, distortions and degenerative and perverted interventions' can be mixed up with legitimate interventions, and practitioners 'can't tell the difference'. Heron (196) advocates that practitioners must engage in personal growth work or counseling to facilitate healing of unresolved personal distress so that the pitfalls inherent in unconsciously driven defensive behaviours are avoided in practice.

4.3 Biological Basis of Emotional and Social Intelligence and Competence

Daniel Goleman (116, 117) explains the way that thoughts and emotions intertwine and shape our reactions to everyday life, dictating our perceptions of the world and behaviour. In describing brain architecture and the roles of emotion and rationality, Goleman (117) contends that we are modern-day social creatures whose biological templates for emotional life are still grounded in the stone-age necessities for flight, freeze, or fight when faced with perceived danger. Emotion plays the central role in determining what we perceive, experience and do (117). According to the perspective taken by both Goleman (116) and Heron (40) our power and ability in human affairs is a direct result of our feeling nature. Our deepest feelings are meant to guide us in how to live our lives (117). Goleman (116) suggests that the emotional life of an individual underpins their ethical and moral stance, and therefore social behaviour.

Table 2.2: Emotional and Social Competencies

CONCEPT	SUB-CONCEPTS
Awareness of self and others	<p>Awareness of own feelings: The capacity to accurately perceive and label one's own feelings and behaviour</p> <p>Management of own feelings: The capacity to regulate one's feelings</p> <p>Perspective taking: the capacity to accurately perceive the perspectives of others</p> <p>Social norm awareness: The capacity to critically evaluate social, cultural and media messages pertaining to social norms and personal behaviour</p>
Positive Attitudes and Values	<p>Constructive sense of self: Feeling optimistic and empowered in handling everyday challenges</p> <p>Self responsibility: The intention to engage in safe, healthy and ethical behaviours</p> <p>Caring: the intention to be charitable, and compassionate</p>
<i>* indicates additional competencies identified from the data analysis</i>	<p>Respect for others: The intention to accept and appreciate individual and group differences and value the rights of all people. To treat people fairly and justly</p> <p>Seeks understanding; the intention to understand the natural and social world*</p> <p>Appreciation: the intention to express gratitude*</p> <p>Enthusiasm: the intention to fully engage with experiences*</p> <p>Trust: confidence and faith in the ability and integrity of self and/or other*</p>
Optimal cognitive processing*	<p>Problem identification: the capacity to identify situations that require a solution or decision and assess risks, barriers and resources</p> <p>Adaptive goal setting: the capacity to set positive and realistic goals</p> <p>Problem solving: the capacity to develop positive and informed solutions to problems</p>
Communication Skills	<p>Receptive communication: the capacity to attend to others both verbally and nonverbally to receive messages accurately</p> <p>Expressive communication: the capacity to initiate and maintain conversation, express one's thoughts and feelings clearly both verbally and non verbally and demonstrate to other speakers that they have been understood</p>
Social Skills	<p>Cooperation: the capacity to take turns and share within both dyadic and group situations</p> <p>Negotiation: the capacity to resolve conflict peacefully, considering the perspectives and feelings of others</p> <p>Refusal: the capacity to make and follow through with clear "no" statements, to avoid situations in which one might be pressured, and to delay acting in pressure situations until adequately prepared</p> <p>Help seeking: the capacity to identify the need for support and assistance and to access available and appropriate resources</p>

The brain has two memory systems (117). The hippocampus records facts and the amygdala (in concert with parts of the frontal cortex) records and codes emotional memories. As Goleman explains “the hippocampus remembers the facts of the event, the amygdala remembers the emotional flavours that go with the facts”. The more intense the arousal, the more depth and intensity there is in the imprint of the event in the person’s memory. These systems act like neural alarms, useful for animals in the wild, but, as Goleman elaborates, less useful for our modern social world. The amygdala constantly screens our experience and social world, comparing and associating with past events. When threat is perceived, whether real, imagined or triggered by association with memories, the fight, flight, freeze (emergency) response is switched on and stress-related hormones flood the system. The more emotionally charged the memories, the more intense the response to perceived threat (117). With the crisis response, unconscious and outmoded ways of responding to a situation can be activated (117, 203).

The hippocampus is a ‘plastic’ structure and capable of being remodeled by stressful situations (204). Stress related hormones, especially cortisol, are toxic to the cells of the hippocampus, the area of the brain (along with the thalamus and reticular activating system) that is central to consciousness (204). Loss of neurons and dendritic branching in the hippocampus are stress-associated changes. These changes to brain structure are thought to be the reason for alterations in memory and form an important part of post-traumatic stress disorder (PTSD) (205). With severe traumatic episodes, such as child abuse, bullying or combat experience as an adult, there is intense and often repeated triggering of the emergency response and the associated release of stress-related hormones.

Grof (200) explains how babies are imprinted with a view of the world by the hormonal and physical experiences of pregnancy and birth. Oxytocin and endorphins released by birthing women foster feelings of love and attachment, while stress hormones are mediators of the aggressive protective instinct of mothers when birthing in wild, unprotected areas (206). Grof (200) suggests a person who experiences traumatic birth circumstances is hormonally imprinted with a perspective that the world is a potentially dangerous place that requires aggressive responses, whereas babies born in loving, gentle environments are imprinted to experience the world as safe. Evidence demonstrates that early emotional traumas are intimately linked to adverse social behaviours in later life (90, 203, 207-212). In situations where the individual has been subject to deeply traumatic experiences, their brain is conditioned to respond to ordinary stressors as deeply traumatic (203, 205). Some theorists suggest that health care workers may play out their early life experiences in the workplace (200). Emotional and social intelligence and their competencies in our adult lives are forged through our early life experiences. Even though these attributes are not innate and there appear to be ‘windows of opportunity’ when these skills are easily and unconsciously learnt, they can still be developed in later life.

It requires knowledge, awareness and willingness however, to learn these skills in adulthood. These ideas have implications for the workplace and the care of birthing women.

4.4 Defence Mechanisms

John Heron (40) explains that we develop defence mechanisms when our basic emotional needs are not met. Defence mechanisms are unconscious protective strategies which help us avoid feelings of distress and are the reason behind much of our inadequate interpersonal and social functioning.

Defence mechanisms include:

- Rationalisation – judging, blaming
- Projection – attributing one's own faults to other people eg gossip, criticising behind backs
- Reaction formation – overdoing the opposite of the emotion
- Dissociation – distancing from feelings by excessive theorising, analysing, measuring
- Substitution – carrying out activities guaranteed to succeed – focusing on minutiae instead of addressing big issues (which may fail!)
- Repression and denial of own emotions – intrinsic part of each of the previous defense mechanisms – 'water off a duck's back' – 'doesn't bother me at all!'

Unconscious tactics used by individuals, such as splitting, projection, denial, blame and avoidance of change, are supported by the way western health care is organised with its system of checks and rechecks, upwards delegation, active discouragement of staff taking any personal initiative and using their own discretion in clinical decision making (41). Thus the individual and the organisation have been constructed to redistribute conflict and help individual professionals avoid experiencing anxiety, guilt, doubt and uncertainty (41 p.225-6). Problems generated by the use of these conscious and unconscious strategies to repress and deny feelings include impersonal and standardized care and the often violent resistance to any attempts to change the status quo. The defence mechanisms of denial and repression alleviate any sense of responsibility and limit effectiveness of care. Rafael-Leff (41) cautions that caring, satisfaction, and gratitude are lessened where people are treated and behave in depersonalised ways.

In the self-aggrandizing search for money, position and power of corporate life in modern institutions and corporations, where market forces are given precedence over human concerns, Kerpan (213) argues that the human spirit has been denied and repressed. Barbara Shipka (214) recognised the similarity in the expressions of feelings of fear, anxiety, a sense of

isolation, apathy and despair within refugee camps and modern day corporations. Shipka (214 p. 91) labels the phenomenon in modern organisations that finds expression in symptoms of human misery, *spiritual poverty*. An example of the effect of spiritual poverty in our modern health system is described by Jean Robinson (114). Robinson (p. 459) commented on toxicity in the midwifery workplace environment and claims midwives are too busy ‘watching their backs to concentrate on the job they love’. Hostility and back-biting are rampant in midwifery units, warns Robinson, citing the presence of an “organisational emotional virus” within health care institutions, “leaching away morals and ethics”, turning “enthusiasm into cynicism, compliments into complaints and care into malice”. Robinson’s words illustrate the unconscious limiting restrictions described by Heron (40) which, according to Heron, impede and distort human potential within individuals and groups.

Many writers have suggested that group behaviour is restricted by the oppressive norms, values and beliefs that flow into and permeate it from the surrounding hegemonic culture (37, 113, 196, 197, 215, 216). Group behaviour is further distorted by various anxieties of participants and influences from past and present distress flooding the group dynamic, throwing it into a rigid, defensive form (197 p.153). Midwives and doctors within maternity services are two groups whose behaviours are subject to the influences of the hegemonic culture in which they work and interact. Games of one-upmanship and sabotage flourish in these toxic environments, wherein midwives and doctors can play the roles of persecutor, rescuer or victim, finding others who subconsciously or intuitively sense others who play complementary roles (217). Taylor (218) suggests that clinical supervision is essential for stopping these games as the reflective process involved in clinical supervision can bring to midwifery an increase in self awareness and self responsibility which will increase the respect that individuals feel for each other and for individual rights.

4.5 Strategies to Enhance Social and Emotional Intelligence and Competence

Metzner (219) suggests that for integration and wholeness to take place, we need to ask ourselves what is it we most want to hide, what thoughts or impulse do we have that we least want someone to know about? Metzner (p.45) encourages us to face our shadow, to accept the possibility that we might be like whatever it is we don’t like in another. These are important questions for midwives and doctors to ask ourselves if we want to be effective helpers in maternity services. Metzner (219 p.45) acknowledges it takes courage and humility to face our shadow and own our evil aspect. Heron’s idea of what makes an effective helper is “an interaction between inner grace, character and cultural influence” (220 p.11). Helping, says Heron, (220 p. 11) manifests “according to the norms, values and belief systems of the prevailing culture” and when effective is “the wise flow of love from person to person”, the

combination of “concern, empathy, prescience, facilitation and genuineness”. Heron (229 p. 11) maintains that helping is the “spiritual heritage” of human beings.

When the norms, values and belief systems of the maternity services are woman centred, meaning that the services are individualised, personalised and relationship based as Guilliland & Pairman (150) and Kirkham (126) suggest, then midwives’ and doctors’ behaviour at work is more likely to reflect the qualities Heron says makes an effective helper. They are more likely to engage in dialogic relationships, with a ‘creative enmeshing of skills’ as suggested by Lane (2005) because they are working towards a common goal, that is being woman centred.

The human spirit has an inherent drive towards consciousness, explains Carol Frenier (221 p.44), an inbuilt urge to gain an ever-increasing awareness of one’s own existence. Sabina Spencer writes (222 p.239) that the challenge now is to change our mindset and reclaim the aspects of human consciousness and compassion that have been “denied in the service of the scientific model”. According to Donna Strickland (223 p.13), self – aware people know how they feel, how their behaviour affects others and their performance. They have a self-deprecating sense of humour and are honest and self – confident. When we are unaware of something, explains Barbara Fittipaldi (224 p.235) it controls us. The ability to reserve judgment until all the facts are known, the ability to choose one’s mood and control one’s impulses are the characteristics of self regulation. People with high levels of emotional and social intelligence and competence possess an innate drive to achieve that is independent of external rewards. They are passionate about achievement for the sheer joy of doing it. They are creative and energetic and easily take the lead when solutions are required.

As an example of such a leader, Donna Strickland (223 p.113) cited the management initiative of a nursing executive who started regular feedback sessions with her staff, inviting responses to questions such as

What’s working well between us?

What’s not working?

What are the barriers between us?

Strickland (223 p.113) suggests that empathy, the ability to consider another’s feelings while making well reasoned decisions, is the essential first step to creating a trusting, cohesive atmosphere. Empathy, according to Goleman (117 p.104) is the root of ethics and altruism.

5.0 Conclusion

The history of the medical domination of midwifery is replete with examples of power plays and turf wars which will never be the basis for ongoing effective interprofessional collaboration. This history shows that the struggles have been about occupational territory, power, control and money. In spite of rhetoric to the contrary, women and their needs are low on professional agendas, thus woman-centered care is only an ideal that is rarely achieved within current maternity services. I have argued that social and emotional intelligence and their competencies are essential attributes for fully developed interprofessional communication but the literature indicates that these skills are not widespread in either midwifery or medicine. The lack of social and emotional intelligence and competence not only underpins the doctor-nurse and therefore midwife-doctor game, it also gives rise to interprofessional power plays which diminish a woman's power to birth and to mother, with life long consequences for her infant.

However, what good interprofessional collaboration truly looks like is still being investigated. We need more research about how true collaboration between health professionals may be made possible. A major challenge is that the concept of collaboration for doctors tends to mean midwifery cooperation and submission to medical authority. Midwives and nurses, however, view collaboration as meaning equal relationships based on professional recognition and respect with a common goal. For midwifery, that goal is women centered care

There is an absence of empirical evidence on the effects of interventions aimed at achieving teamwork. I conclude that any organisational efforts designed to improve collaboration will fail unless or until we have successful interventions that move towards disbanding professional silos, instituting genuine dialogic relationships between midwives and doctors as well as addressing social and emotional intelligence and competence in both professional groups.

CHAPTER THREE: METHODOLOGY

1.0 Introduction

Qualitative research is a broad approach that seeks answers to how “social experience is created and given meaning” by the participants themselves (225). As my study is designed to explore the way that professional interactions are experienced by midwives and doctors so that a theory can be generated that describes, explains and predicts how various factors inhibit or enhance midwife/doctor interprofessional interaction, it fits within the qualitative genre. This chapter begins by outlining the poststructural feminist philosophical paradigm which underpins this research project. Following the explanation of the philosophical groundings of this research project, this chapter describes and discusses the research design which is an adaptation of Interpretive Interactionism as first proposed by Norman K Denzin (226, 227). Interpretive Interactionism has been updated by Sundin-Huard and Fahy (2007 in press) so that critical and poststructural ideas about subjectivity, truth and power are taken into account at all stages of the research. The final section of the chapter outlines the six steps of Interpretive Interactionism as applied to this feminist, poststructural, qualitative research project. These steps include; ‘Framing the Research Question’ and ‘Critical Analysis of Prior Conceptions of the Phenomena’ of interest: these two steps have been dealt with in chapters 1 and 2 respectively. Step 3 ‘Capturing the Phenomena’ is described here in detail as it involves participant recruitment, selection, data collection and data management. Step 4 ‘Bracketing’ concerns the processes for data analysis. Step 5 ‘Construction’ describes the process of theory construction. Step 6 ‘Contextualisation’ describes how the theory that has emerged by the research process relates to the real world of maternity care practice.

2.0 Methodology

Methodology provides the procedural framework for gaining knowledge about the world (225). A methodological paradigm is a human construction and consists of a basic set of beliefs (225 p. 99). Methodology is a branch of philosophy which is concerned with the foundational assumptions made by scientists in terms of ontology and epistemology (228). Ontology concerns debates about what kind of things can and do exist and involves the “conditions of existence [and] relations of dependency” (228). Epistemology is “the philosophical theory of knowledge—of how we know what we know” (228). These philosophical ‘belief sets’ drive and guide researcher behaviour and understanding (225).

2.1 Poststructural, Feminist Philosophical Foundations of this Study

The philosophical foundations of this study are drawn from post structural and feminist thought about human life, behaviour and experience. Poststructuralism contends that ‘truth’ is subjective and a product of power dynamics and relationships (229-232). Poststructuralist theory recognises that there are many truths and multiple realities (225). From the poststructuralist point of view, power is ethically neutral, fluid and multi directional. Poststructuralism has challenged all theories which fix meanings of sexual and gender differences, arguing there is no such thing as “natural” or a “given” in the world (232). Meanings, from a poststructuralist perspective, are culturally created and ascribed and always changing. Moreover, these “meanings are competing and part of the broader relations of power and have implications for both men and women” (233).

Feminism is both a practical and theoretical undertaking (234). Feminist research seeks to understand the phenomenon under investigation from the woman’s embodied point of view, which includes emotions and feelings as well as intellect (235). This focus is because feminist researchers “see gender as a basic organising principle which profoundly shapes/mediates the concrete conditions of our lives” (232). Feminism, as both theory and action, covers a broad spectrum of thinkers and activists who are committed to changing mainstream society in a way that not only involves freedom from oppression, but also incorporates liberation and equality of opportunity for women, whatever their colour, gender, social status (183, 231, 234-237). Feminisms, the plural used to denote the diversity by Sandra Speedy (238), are, according to Speedy, important political perspectives that aim to gain equalities and autonomies for women by correcting power imbalances in society. These political perspectives have changed society through what is known as the three waves of feminism.

The first wave feminists brought social change primarily through the efforts of the suffragettes, a group of generally privileged white women with socialist leanings who sought equality with men. The feminists of the first wave gained the right for women to vote (231). The second wave of feminism rose out of the counter revolutionary activism of the 1960’s and sought to address race and sex issues of oppression. Emerging ideas about health, stressing self help and prevention of illness, gave birth to books such as the Boston Women’s Health Collective publication, “Our bodies ourselves” (239). A basic tenet of the second wave of feminism was that “women’s bodily integrity and autonomy were seen as essential to liberation” (237). Slogans such as ‘the personal is political’ were coined at this time and second wave feminists focused on ‘consciousness raising’ to help with social change (231).

Contemporary feminism is not single, unified or static” (232). Poststructuralist feminists, however, such as Patti Lather (1991), Judith Butler (1993) and Luce Irigaray (240) embrace

poststructuralist theory which contends that the idea of an integrated 'subject' is a myth. These so called 'third wave' feminists bring the politics of difference into the way we consider our gendered, embodied selves. From this perspective, we are posited as a collection of multi layered sub personalities made up of constantly shifting subject positions (232-234, 237, 241). Our sense of self, what we can think and say is constructed and limited by the subject positions that culture makes available to be enacted (242, 243). Although the various feminisms argue about their various perspectives and criticise each other (244), together they comprise a social change-oriented political movement arising from theory which is grounded in the embodied experiences of women.

I was intrigued by the notion of subject positions because I had become aware over time that I behaved differently supporting a woman having a homebirth than I acted when I was a midwife in a tertiary referral hospital. My style of midwifery also changed depending on who it was that I was interacting with. Having discovered myself acting differently in different locations and with different people, I wanted a way to explore midwife/doctor interactions that took account of our varied 'selves' and the contexts in which we operate. It was important to incorporate an understanding of the power dynamics in human relationships as well as the culturally constructed institutional influences on human behaviour in the method I used to conduct the research.

Dale Spender (235 p.8) has a broad feminist perspective, which fits with this study. Spender suggests 'feminist knowledge is based on the premise that the experience of all human beings is valid and must not be excluded from our understandings'. To include all factors for this research project, both men and women are interviewed. What makes it a feminist study is that the focus is on enhancing outcomes for childbearing women and enhancing the confidence and power of midwives (who are almost exclusively women).

As part of exploring phenomena through our constantly shifting subjectivity, many feminists contend that knowledge and communication requires researchers identifying and sifting through "unacknowledged assumptions, biases and prejudices" (See chapter 1 where my values are made explicit) (233). Poststructuralist feminists assert that we need to come to terms with the contradictory nature of subjectivity, including individual women's 'often hidden complicity with oppression or perpetuation of oppressive practices' (233). This is particularly important for midwives who have been oppressed by medicine for the past century or so (4, 7, 8). A research design that is congruent with feminist post-structural philosophy and incorporates the tensions of multiple truths, issues of power and subjectivity is therefore essential to use when exploring the complexities of midwife/doctor relations.

3.0 Research Design

Interpretive Interactionism as described by Denzin (225, 227) is both a study design and analysis technique (as per page 48). It was chosen because it is a research process that focuses on critical incidents in the interactions of people; particularly when these interactions are related to their experiences of social institutions (245). Interpretive Interactionism takes the interactional process, and the meanings people make of the process, as the focus of research attention (227). Denzin's clear steps in the research process are very helpful for a novice researcher such as myself (see Table 3.2 for a summary of the steps). Deborah Sundin-Huard, a colleague of mine, modified Denzin's Interpretive Interactionism for her End-of-Life Decision-Making study because she argued that there were problems with using Interpretive Interactionism related to its theoretical foundation. Symbolic Interactionism, upon which Denzin based his research design, is a classic modernist, humanist theory which is the very type of theory that poststructural feminists critique (246). Together with her supervisor, Kathleen Fahy, Sundin Huard expanded on the ideas of Denzin (1989). What they did in modifying Interpretive Interactionism (II) was consistent with Denzin's later writing. For instance, he claimed that Interpretive Interactionism needed to adopt "insights from post-structural philosophy, principally work in cultural and feminist studies" (226 p.96). Sundin Huard and Fahy moved Interpretive Interactionism into the critical paradigm and incorporated post-structural and feminist philosophy into its framework (2007 in press: 9). From my reading of the theory and discussing the concepts of Critical Interpretive Interactionism (CII) with both authors, it seemed the perfect research design and analysis tool for my purposes. To remain true to the overtly poststructural feminist positioning of my research project, I have incorporated those words into the Sundin-Huard and Fahy model and for the purpose of my research project, the design and analysis technique I employ is Poststructural Feminist Interpretive Interactionism (PFII).

The way that doctors and midwives relate to each other and whether they relate effectively or not, is heavily influenced by their socialisation as gendered individuals. Their relationships and interactions are also subject to the way in which the health care system is structured and how it functions in the day-to-day world of maternity service provision. PFII allows for both the micro and macro aspects of, as well as the influences on, the midwife/doctor interactions to be examined. Therefore PFII enabled the investigative lens to focus on the health services, the labour ward cultures where the interactions took place and the individuals themselves when considering the interactions. It also allows for etic and emic interpretations of the data, providing a means of capturing both the researcher's and study participants' perspectives of interprofessional interaction as is inherent in poststructural and feminist research. The major theoretical assumptions underpinning CII are presented in column one of Table 3.1 (226, 227). Table 3.1 illustrates the differences and similarities between the major theoretical assumptions underpinning Interpretative (II) and Critical Interpretive Interactionism (CII)

Table 3.1: Theoretical Assumptions Underpinning CII

Symbolic Interactionist premise guiding Interpretive Interactionism	Modification for CII	Application in current study
Human beings are animals who cognitively manipulate symbols and thus create and reproduce culture (247)	Modify to recognise and incorporate the emotional element of human behaviour in data collection and analysis.(248, 249)	Sought participants' reflections on emotions/ feelings during data collection. Recognised impact of emotions upon decision making, interactions and suffering during analysis.
People are autonomous in their actions – able to freely have different responses if they make different meanings of situations (228, 247)	Autonomy implies separateness from individuals and the ability to make decisions in one's own best interests. The subject is socially constructed – the result of interactions and power relations (248) Modify to acknowledge the inherent interconnectedness of all human beings.	Sought participant's reflections on, recollections of interactions with others during decision making. Analysis specifically focused upon degree and quality of interactions and quality of interactions between and interconnectedness of decision-makers and effect on birthing women.
People give meaning to their bodies, their feelings, their situation and their lives as well as to the broader social context in which they live. Although the self is 'multi-layered' the ego is in control thus the self is seen as 'integrated'. (228, 247)	Modify to acknowledge the multiple selves and multiple realities of social and cultural systems: resulting in 'split subjectivities' for the individual and differing prescribed discourses for differing situations and interactions (242, 248, 250)	Analysis examined participants' narratives for varying roles adopted at different stages during their experiences, together with the influences/ constraints responsible for these variations in 'behaviours'.
Focus on common patterns of interaction or common social processes that make explicit the underlying patterns of social life: "... locked into first-order, primary, lived concepts of every day life" (227)	Modify to acknowledge the impact of the macro-social world upon the 'micro-situations' that are the focus of the person's suffering (251-255)	This study examines participants' narratives for the wider influences upon their behaviours as well as the inter and intra-personal; i.e. structural, procedural and policy supports or constraints. Analysis specifically incorporates critical concepts e.g.: race, class, gender, age and power
Emic perspective only in analysis: thus analyses reflect the views of the individuals being studied (227). The implication is that power may not specifically be addressed (256)	Modify to retain the Emic perspective but include Etic perspective. This allows issues of power to be specifically addressed. (255, 257, 258)	Analysis of the participants' narratives included examination of social issues and forces within the health care system which impacted upon decision making experiences (ranging from seniority of health care professional to impact of the 'medical establishment' upon decision making and interaction. Add etic perspective because the researchers are part of the research and have valuable insights to add
Focus on spoken word in analysis (227)	Modify to include what is unsaid, what might have been said (i.e. the gaps and silences in narrative texts). Analysis should also include the 'gaps' in social context that are currently constraining participants acting in their own best interest.	Analysis of narratives examined the spoken interactions between key players. It also identified silences and absences such as missing collegial support between health professionals.

The research design and method reflects the assumptions and processes underpinning CII as described above in Table 3.1 and summarised in Table 3.2 which follows (see also Fahy and Sundin-Huard, 2007 in press). I have re labeled this process “Steps in Creating Poststructural Feminist Interpretive Interactionism” based on Denzin (227) and Sundin Huard & Fahy (246). How these steps were incorporated into this research project is explained in the section following Table 3.2.

Table 3.2: Steps involved in Creating Poststructural Feminist Interpretive Interactionism (PFII) (After Denzin (227) and Sundin Huard & Fahy (246))

1	Framing the research question
2	Deconstruction and critical analysis of assumptions and prior conceptions about midwife/doctor interactions (literature review)
3	Capturing these phenomena in the social world through the study of multiple naturalistic examples of midwife/doctor interactions in the maternity service setting (data collection)
4	Bracketing of these interactions: the reduction of these phenomena into their key elements or features (data analysis)
5	Construction: Interpretation of these key elements more fully through ‘putting together’ a model or single case of the process being studied (data analysis).
6	Contextualisation: The relocation of the proposed model(s) within the social world by contrasting and comparing them with knowledge gained with the deconstructed prior conceptions examined earlier (synthesis).

3.1 Step 1. Framing the research question

Denzin (227) advised that contextual factors such as location, organisational structures and policies need to be considered in framing the question. Further, he contends that the researcher is required to think critically and historically and be able to compare and contrast the phenomena being studied whilst at the same time, examining the factors that are influencing the phenomena. The question, he argues, needs to frame the inquiry to ask ‘how’ rather than ‘why’ questions and this too is reflected in my question. The research question and the factors that I considered when framing it are presented in Chapter 1 and honour Denzin’s guidelines.

My question is: “what factors affect interprofessional interaction in birthing units and how do these interactions impact on birthing outcomes?”

3.2 Step 2. Deconstruction and critical analysis of assumptions and prior conceptions about midwife/doctor interactions (Literature review)

In this step, a review of contemporary literature pertinent to the study topic is undertaken. During this review, previous biases and misconceptions are identified and presented. Theories,

observations and analysis of phenomena under consideration are critically examined as part of the literature review. In this study, the literature review is presented in a way that is consistent with the research question. The evidence is considered from the contextual, interactional and intra personal domains. The related research and theory aspects of these domains are presented within the specific domain (see Chapter 2).

3.3 Step 3. Capturing the Phenomena in the social world through the study of multiple naturalistic examples of midwife/doctor interactions in the maternity service setting (data collection)

Multiple examples of the phenomena under examination are collected or captured in this step. This involved recruiting participants who had multiple experiences of the phenomena of interest (described immediately below). Once participants were available, then in-depth interviews were conducted to capture the phenomena of interest: in this case, interprofessional interactions that relate to the care of birthing women and their outcomes.

3.3.1 Participant Selection and Recruitment

Theoretical and purposive sampling was used to select participants. Theoretical and purposive sampling means the sampling is a way of selecting participants so that the richness and depth in the researcher's understanding of concepts and phenomena is maximised thus enabling theory to be developed (259). In this study, the participants were sampled because they had experience relevant to the research question, that is, they were midwives or doctors working in delivery suites in public hospitals. The participants were selected with awareness of the need to sample diversely in terms of age, gender, class, years of experience etc (see Appendix 6 Table x Midwives' demographics & Appendix 7, Table y Doctors' demographics) which indicates that those who participated were in most ways, similar to midwives and doctors who work in hospital-based maternity settings throughout Australia. This is important because the theory that is generated from this study is potentially transferable to these setting throughout the country (235, 260).

It was anticipated that about 10-14 participants would participate in the study. This number of participants was chosen based on how many we thought may be need to maximise the richness and depth of understanding whilst at the same time being aware of the time and resource limitations of a Masters degree. I planned to continue the process until saturation of the data occurred, i.e. no new information emerged from interviews. In practice I interviewed nine doctors and ten midwives (235, 260). It was easy to recruit midwives to the study. I had recruited ten midwives from four different Australian states and territories in the first six months of the research process and many more offered to be interviewed. It was much more difficult to recruit doctors. Even when doctors had been asked by a co-participant and had

verbally agreed to participate in the study, several did not end up participating because they neglected to fill out their consent forms, were too busy for appointments or changed their minds. In one doctor's case it took over a year to actually do the interview, even though many appointments were made. I did give this doctor the opportunity to withdraw from the study, but she insisted that she was happy to participate. As it was hard to get doctors to participate, I chose to continue to invite her to interview until the interview occurred.

Potential participants were invited to join the study by advertising (Appendix 1) and through presentations by the researcher at team meetings at various locations. I also wrote to an online midwifery list, inviting anyone who was interested to contact either myself as the researcher, or my supervisors, if they were interested in joining the study. In addition, recruitment occurred through the 'snowball' sampling method (225), when participants told others about the study. Once a person indicated their willingness to be involved in the study by contacting the researcher or supervisor (s), a written invitation (Appendix 2), information statement (Appendix 3) and consent form (Appendix 4) was posted or hand delivered to the potential participants' address. If they wished to enroll in the study, potential participants were asked to notify the researcher of their decision within two weeks of receipt of their invitation to participate in the project.

At all times participation, and continued participation, in this research was entirely the participant's choice. Only those people who gave their informed consent were included in the project. The participant's decision about participating in the study or not, did not and would not have disadvantaged the participant in any way. The participant was able to withdraw from the project at any time without giving a reason and without any disadvantage to the participant in withdrawing.

Before the potential participant agreed to participate, they were asked to:

- Contact the researcher or one of the supervisors, if they had any questions.
- Fill out and sign the consent form and return it in the stamped addressed envelope provided or by hand to the researcher.

The participant was then contacted by the researcher to obtain the participant's demographics (Appendix 5 demographics form) and to set a time and venue, at the participant's convenience, for the interview. The demographic information included age, sex, whether they had a partner or children, how long they had worked as a midwife or doctor, how long ago did the interaction they were going to describe happen; what their position of employment was at the time of the interaction and what their employment status is now. The demographic information allowed me to ensure I had a good cross representation of midwifery and medical workforce. The

participant was asked to choose a pseudonym for him or herself and any other people in the stories they were going to tell. The participants were also asked to avoid identifying the particular health facility or state where the interaction occurred.

Interpretive Interactionism is at its best if actual interactions can be observed and then both participants interviewed afterwards. It was not possible from either ethical or logistical considerations to do that and so participants were interviewed and asked to give examples of their interactions related to the research question. Participants were drawn from several states of Australia and their stories involved interactions in both small and large maternity units. The interviews occurred in homes, work venues and on the telephone.

3.3.2 Data Collection: In-depth Interviewing

Guided by poststructural feminist methodology (235), data was collected by semi-structured interviews of participants. With consent from the participants both by written consent and verbal consent at the time of the interview, the interviews were audio taped. During this initial interview, the researcher sought participants' stories of episodes of interprofessional interaction. The participants were asked to relate two stories: one of a positive interaction with a good outcome for the birthing woman; the other story to describe a negative interaction with an impact on a birthing woman. Further and ongoing interaction (via e-mail, telephone or by interview) between the researcher and the interviewees helped the researcher clarify any unclear matter and validate the transcript of the story and the themes. If key phrases or concepts seemed to 'jump out' of the data, participants' reflections on the meaning of these to them both at the time of the event and at the time of the interview, i.e. with the wisdom of hindsight was sought.

Questions that were asked included:

- Now that you have had time to reflect on xxxxxx., could you tell me more about how you feel?
- I am not clear about what happened, could you clarify xxxxx for me?
- Once xxxxx occurred what happened next?

The interviews occurred in locations that suited the participants and the researcher. Telephone interviews made interstate participation viable. Ten people were interviewed on the telephone; eleven people were interviewed face to face; four of these interviews occurred in the participant's place of work and the rest (seven) were conducted in the participants' homes.

The interview process was guided by feminist interviewing practices (235). According to Reinharz (235 p. 42-43) this includes the development of preset questions designed to stimulate a

response in the interviewee; the researcher follows the language and logic of the interviewee, asking further questions to clarify meaning. For this research, the following guidelines/probes were used to elicit participants' contextualised stories and examples of epiphanies concerned with the episode of interaction they are describing:

Think about an example of an episode of interprofessional interaction where interaction went well;

Think about an example of an episode of interprofessional interaction where interaction went poorly;

- What made you choose this example?
- Why do you remember this episode of interaction?
- Why was this episode of interaction important for you?
- Why don't you tell me the whole story?
- Tell me about the place/space/people, who else was there?
- What else was going on around you at this time?
- What led you to believe this was a good/poor episode of interaction?

Data was also derived from the researcher's history, experiences and understanding.

During the course of data collection, field notes, summaries and memo writing (theoretical, thematic, questions to focus later observations or interviews) were used to capture the insights that occurred on the spot and that would be valuable as 'snap shots' of those thoughts (235).

These were part of an audit trail. Records were kept of:

- Process notes,
- Day to day activities;
- Methodological notes;
- Decision-making procedures;
- Materials relating to intentions and reactions: personal notes about motivations, experiences with informants, etc;
- Instrument development information; and
- Revisions of interview questions, etc.
- Notes I made during review of audio tapes and transcripts noting emotional tones and emphasis during story telling

Those instances where I draw upon my own experience are made clear in the text.

3.3.3 Data Management

The tapes were transcribed verbatim. The tapes were all listened to whilst the transcripts were read at the same time. After I had completed the initial 'reading' of a transcript it was returned to the interviewee for comments and/or clarification/editing. All participants were satisfied with the accuracy of the transcripts and only one had any corrections returned. These corrections were minor and related to correcting grammar, not content.

The tapes were listened to again and I made note of emotions noted in the voice (in brackets after the particular comments); inserted three dots for missing words and long pauses and inserted comments regarding other phenomena, such as laughter etc in brackets where these occurred during the interview (235 p. 40).

3.4 Step 4. Data Analysis (Denzin 1989)

Each interview was transcribed in its entirety and the raw data was subjected to the inductive processes involved in deconstruction, construction and reconstruction of the data to produce a coherent core story or narrative. This process involves:

3.4.1 Bracketing

Bracketing involves the decontextualization of the data by reducing it to its 'key concepts'. Bracketing entails 'critically reading' and 'coding' all the data to identify key elements or features that address the research question. It involves reading 'against the grain' to identify discourses, gaps, silences, stresses and ruptures, which interrupt the flow or sequence of the participant's story as well as the implicit contradictions that are embedded within them. As bracketing proceeds, key phrases are identified and, in an ongoing process, these are examined for similarities and differences with phrases taken from earlier stories. During this process, the researcher synthesizes these phrases into more abstract 'key concepts'. In this way the researcher develops key concepts and sub-concepts. This process was lengthy and required many readings of the raw data to ensure conceptualization was truthful.

The final stage of bracketing ends with the creation of new readings that offer a tentative, theoretical explanation of the phenomenon including its major features and a description of how these are influenced by their relationship with their social, historical and political context – with special emphasis on power structures. Once a tentative understanding of the meaning of the key concepts and conceptual links has been made, the researcher enters the final step of theory construction.

After reading and re-reading all the stories multiple times as described previously, I finally focussed on two exemplar stories of negative interactions, one from a midwife and one from

a doctor and two key stories of positive interactions, again one from a medical and one from a midwifery perspective. In some instances the data from a story was superficial and despite the researcher seeking to discover the individual's personal and specific experience, did not provide the depth of description of an interaction necessary for the research. I identified the narratives which were finally chosen for the next two steps in the analysis process as containing the factors involved in confounding and facilitating midwifery-doctor relationships. These factors were confirmed throughout the narratives. Many of the doctors and some midwives talked about heroic or even dramatic instances of midwife-doctor interaction in emergencies or unusual situations as examples of positive interactions. I did not choose these stories to analyse as it is relatively simple to have positive interactions in emergency situations because life and death dramas tend to bring the best out of people. The stories I chose to examine were those stories where the interactions were more subtle and more everyday because they are more indicative of the relationships and culture in the workplace.

The remaining narratives are included at the end of the thesis as The Voices in the appendices. Midwives' stories of negative interactions can be found as appendix 8.1; negative doctor stories are appendix 8.2; midwives' accounts of positive interactions are in appendix 8.3 and the positive doctors stories are appendix 8.4. They are provided here so that the interested reader can verify for themselves that my selection of key narratives and interpretation is accurate.

3.5 Step 5. Construction

During construction, the phenomena are interpreted more fully by re-constituting and re-integrating the concepts and sub-concepts so that a new model is formed. For this research process, there emerged two models, one of a negative interaction and one of a positive interaction which are at work within the context of existing maternity services. Temporal and conceptual connections between concepts and sub-concepts are made by:

- Listing the analytical concepts and sub-concepts underpinning interprofessional interaction;
- Ordering these concepts so that they are linked conceptually and temporally;
- Mapping how these affect and relate to one another;
- Integrating the linked concepts and sub-concepts into two over-arching models that reflect the interpersonal, interactional and contextual processes involved in effective and ineffective interprofessional interactions.

Once a tentative understanding of the process of effective interaction had been developed, then it was rechecked and validated by a number of scholarly midwifery peers who read and commented on my interpretation.

3.6 Step 6. Contextualisation

In the final step of CII the researcher gives further meaning to the analysis by relocating the proposed models of interprofessional interaction constructed during this study into the social world (227 p. 60). In this study, the researcher has therefore re-contextualised the models in chapter six, by showing how interprofessional interactions in the maternity health care setting are shaped by historical, socio-political and cultural structures and discourses.

4.0 Adequacy of the Research

The post structural researcher fully accepts that their work will never represent “the” truth as no single truth is possible in the social world (232). Instead, the post structural researcher seeks each participant’s perspective of their real world, with all its complexities. Poststructural research recognises that the researcher is also a participant. This means that the researcher’s perspective is also considered in the research process so that the real world situation of research concern is more holistically understood (258). *Trustworthiness* is the term used by Kincheloe & McLaren (258) to denote scientific adequacy of qualitative research. Trustworthiness is when the words being read by the reader ‘ring true’, that is feel authentic and the interpretation is close to the actual research data. Denzin (261 p.10) calls this measure *verisimilitude*. Verisimilitude asks the question ‘are the representations in the text consistent with the real?’

The scientific adequacy of this research is verified by its *trustworthiness*, or *verisimilitude*. It is also verified by the adherence to standards identified in feminist research (262). Such standards include a credible representation of the participant’s experiences; a reflexive approach; collaboration with other scholars; naming the concepts as the participants see them; illustration of congruence through recurring themes; coherence of the data with the conclusions and the demonstration of the applicability to the area under study (263, 264) and in the case of this research, contemporary maternity services. Lincoln and Guba (260) argue that the replication of a study which is conducted in a natural setting is particularly subject to the ever-changing nature of society, organisations or culture under investigation. Unique situations cannot be replicated. Nonetheless, clear articulation of the data collection and analysis methods should help ensure the reader that if they choose to conduct a similar study in a similar setting, comparable results would be obtained.

5.0 Ethical Considerations

5.1 Procedures Taken to Protect the Rights of Study Participants

This study was conducted according to the NHMRC’s Guidelines for Human Research. The proposal was presented to the Obstetrics and Gynaecology Management Committee for approval and was also submitted to and approved by the University of Newcastle and Hunter New England Health’s Ethics Committees.

5.2 Risk Protection for Participants

One of the difficulties in conducting research of this nature in a relatively small and close knit community, where the researcher will in most cases be known to study participants and where participants probably know one another and will have worked together in different capacities, is maintaining confidentiality and privacy. Nonetheless, any time participants are being interviewed, observed or otherwise studied; the wellbeing of the individual must be protected. To this end there were several concerns that were addressed for this research project.

First the likelihood that participants can be identified by peers or their employers and therefore embarrassed or ‘punished’ needed to be eliminated. The second concern involves participants being asked to tell a ‘story’ about an episode of interprofessional interaction, which did not enhance positive health outcomes for the women in their care. It is possible that participants will be concerned that these ‘negative stories’ may lead to disciplinary action being taken against them by their employer or used as evidence in litigation. Thirdly the privacy of participants’ responses needs to be guaranteed, especially given that participants will, in the main, be drawn from a relatively small study site in which there may be few practitioners e.g. staff physician or senior registrar or senior midwife. In fact, although this aspect of recruitment was a concern when this study design was submitted for ethical approval, in reality, the participants were drawn from ten different sites in four different states and territories, so these risks were and are significantly reduced.

To remedy these concerns each participant was reassured that as far as possible their identity will not be revealed in any publication or to anyone apart from the researchers. However, despite the researchers’ best efforts to maintain confidentiality, it is quite possible that when reading the final report that clinicians who live in an area where a large number of participants were recruited for example, may be able to determine the identity of study participants. Nonetheless, the interviews were held in a place to suit the participant and the majority of the interviews were held off campus. Identifying data from interview transcripts has been removed and coded. All incidents and stories have been ‘de-identified’. The records identifying codes and the names of study participants are stored separately from the transcripts.

Notes, audio-tapes and computer discs will, according to NHMRC Guidelines, be kept in a locked filing cabinet for five years. After this time computer discs, transcripts, field notes and paper records will be destroyed. On completion of the study the hard drives of the researchers’ computers will be wiped of any interview data. Identifying data has been removed from all transcripts and identity codes are kept in a separate place from the transcripts. No data will be made available to any person(s) other than the researchers and their employees (research assistant) unless specific consent is received from the participant. In the final report participants

are identified by fictional names only and the researcher deleted any potential identifying information.

Finally, participants were informed in writing that they may withdraw from the study at any time without penalty. If any participant had withdrawn from the study, they would have been given the opportunity to request that their data was also withdrawn. Participants were told they had the right not to answer all questions, to stop the audio-tape and have segments of the transcripts deleted if they wished. Participants were given the opportunity to read their transcript and request that quotations from their transcript be removed from the final report and future publications. None of the participants withdrew or withdrew their data from this study.

CHAPTER FOUR: ANALYSIS OF STORIES OF NEGATIVE INTERACTIONS

1.0 Introduction

The purpose of this chapter is to present and analyse two stories illustrating exemplar negative interprofessional interactions in the care of a birthing woman. One story is from a midwife's perspective about her interaction with a medical colleague and the other is from a doctor's perspective about her interaction with a midwife. These stories will provide insight into and help answer the question:

“What factors affect interprofessional interaction in birthing units and how do these interactions impact on birthing outcomes?”

Analysis is guided by concepts from the theories presented in the literature review: Birth Territory Theory (166, 167) (see table 2.1) and Social and Emotional Competencies (116-118) (see table 2.2).

The stories appear as narratives. The midwife's and doctors' actual words are used. The key to understanding the analysis is provided in the box below.

Key to analysis in text

Midwife and doctors words: Arial

Interpretation and description: **Bold Arial**

Summary and Discussion information: Times New Roman

Factors: Times New Roman

Factors (identified within the narrative) which appear to contribute to the negative interaction are displayed in a table format (4.1 and 4.2) at the end of each narrative.

2.0 Virginia

Virginia is a very experienced midwife who at the time of this interaction was working in a large regional unit. According to Virginia, policies were strictly enforced and the culture was very medically driven and hierarchical. The managers of the unit had a history of strongly supporting medical dominance. The interaction occurred with a female, Asian, junior obstetric registrar, I will call Lei, who was on rotation to the country unit from a tertiary referral hospital in a capital city. Virginia was looking after a young woman, Tracey, having her first baby. The woman's husband, Ralph, was with her and she was, according to Virginia, labouring well. It was about 11o'clock in the morning and the woman had been labouring all night. Both

Virginia and the registrar had come on in the morning for the day shift. Neither Virginia, nor Lei knew the woman (woman unknown).

Virginia continues... "Tracey was in the bed, her husband, Ralph was sitting beside her... I was sitting on the other side of the bed, up near her head... the door was open with a curtain across it (no control over privacy)... she was labouring quite adequately from every obstetric parameter. I wasn't in any way concerned about the woman but she was labouring slowly and steadily. There were no obvious complications. Fetal heart was good. She had ruptured membranes. She had already been in the shower and we didn't have baths or anything to use at that point (lack of birthing resources to support normal birth). She got sick of the shower and that was the first time that I had met her so it was a really difficult situation in terms of just trying to get her through (getting woman through to birth normally; midwife committed to normal birth; woman's commitment unknown).

The night midwife had done an internal checking of the cervix at something like 6 o'clock in the morning...the contractions were clearly getting strong **[now]** and she hadn't been in a really strong active labour all night. I'm sure of that...because she was quite fresh...when I came on in the morning, she didn't look to me like somebody who had been labouring strong and hard all night. She just didn't have that look about her.

I had just rechecked her cervix **[at 10.00 am]** and she was 6 centimetres which was the same as she had been at 6 **[am]** or whatever time that previous time was **[in the medical model this indicates no progress and is a time to intervene]**. So we had the compound problem of two different people checking her cervix...there must have been changes because I thought, to be honest I can't remember what the first VE was now ... like what it was in detail but there must have been some change to that VE for me to just think "look I think it's fine..." the other thing that was going through my mind was that, 6 centimetres, somebody else doing a 6 centimetre it's not significant enough. I didn't think that it was significant enough a finding to think that there was any problem (avoiding doctor; shielding woman; keeping woman off the medical radar) **[it is however, a problem from a medical point of view]**. Probably her cervix was feeling thinner or who knows the head probably had descended further but I just can't remember. I just remember when I did the VE thinking "*oh well that's fine*". It feels good and when I was telling Tracey about the findings of the VE **[vaginal examination]** I was being appropriately really positive about it. I thought oh this is good, this is fine.

By 10.30, she was starting to really accelerate, the contractions were getting stronger and she was becoming distressed...and in need of some sort of a change in what we were doing ... and she wanted some other options... she was thinking about have an epidural ... I was just in the process of discussing that with her when the obstetric registrar, Lei came in. Lei had been in the unit on rotation for a couple of months...so she didn't really know the midwives that well **[no relationship between doctor and midwife]**...she just came in wanting to know how come this woman was still in labour basically and why she hadn't had the baby ... she didn't knock...she just came in to the room (invading birth territory; rudeness; lack of normal civility in interacting with people) ... didn't introduce herself (dominating behaviour; rudeness; no etiquette)...and stood at the end of the bed (overbearing body language) and said *is everything going all right here?* (in command of situation)

... She... was looking at me... and said something along the lines of how long has she been 6 centimetres or something (treating woman as object)...the **[midwifery]** manager had obviously told Lei that Tracey was 6 centimetres (midwifery management collusion with medical model). Lei looked somewhat dishevelled and had a certain nervous look about her **[and]** she had a distinct Asian accent which was quite difficult to understand **[English is a second language]** (communication problems) ... I had had quite a few dealings with her and her accent was fine for me but I'm not sure that it was that great for the woman and her partner at the time. I was making a judgement on where Lei was going to go with this conversation just from previous contact with Lei (low interprofessional trust; turf war) and so I said to the woman *would you just excuse us for a moment we just need to go outside for a moment* because I didn't actually want to have that conversation in front of the woman just at that point and said to Lei *could we just go out in the corridor for a moment...*(**use of delaying tactics**).

... I felt anxious...I was saying to myself "oh my god, oh no, she's going to suggest that this woman has a Caesar". That's what I was thinking... I was anxious and I suppose just feeling a bit..... I knew I was completely on my own, put it that way ...I just knew that I would get no support from any of the management in the unit...from any Midwifery Manager (lack of midwifery management support for midwifery practice) ... yes there would be nobody there to support me in negotiating, I guess, with this obstetric registrar...I felt alone and I felt like it was my responsibility to way-lay what I thought was going to happen (focussed on own agenda; perception of being the only one who cares about normal birth).

The generalised way that things happen **[at this particular maternity unit]** were that the obstetric registrars would just ring the obstetricians and say "*I think this woman needs a Caesar*" and the obstetrician would just say "*right I will meet you in theatre*" (gaining 'rubber stamp' from medical hierarchy). Once those decisions were made ... there was an unofficial understanding that, very rarely only if there was a dire emergency, would the obstetrician come in and actually see the woman (medical model). So the midwives were not allowed to have contact directly with the obstetrician unless there was some dire emergency (medical model; access to consultants forbidden; low quality interprofessional relationships).

Lei said "*oh yes, oh yes*". There was no problem. She was happy to come outside... we just went into the corridor which leads up to nowhere. There are three birthing rooms and this corridor just led to a wall at the end. We just walked up there and stood in the corridor...stood facing each other...I was feeling really annoyed and upset ... we walked up and I waited until we were both standing still...she was much taller than me...had to look up at her... I'm sort of used to that because I'm so short...but the feeling that I knew I was completely alone in terms of any sort of backup for what I was about to try to say, I think I felt way more anxious than it was necessary to feel (feelings of anxiety; antagonism; powerlessness).

I felt anxious about the fact that I just thought that this woman was going to get taken unnecessarily for a caesarean section...that there was no reason for it...obstetrically or midwifery there just wasn't any reason for it. But I knew, because I had had dealings with this obstetric registrar before, that there had been a very high number of unnecessary caesarean sections done since she started on her rotation in the unit (low interprofessional trust; low quality interprofessional relationships) ... so I was, I guess, wanting to get in first with my version of what was happening with the woman before she started to say all those things about; you know, that there's a possibility that you might need a caesarean section and all that to the woman (shielding the woman). I was just hoping that we could avoid having to have that conversation with the woman because I just didn't think it was necessary on any level....I was feeling anxious about that...I think that's why I wanted to get outside before we went any further...

...I just said that this woman is a primip and she has actually been labouring quite well and that there was nothing to indicate that there was anything wrong. I felt that she was becoming a little distressed and I felt that we just need to find a way to get through this time and that there was no reason I could see that the labour wouldn't progress normally. The baby was lying in a nice spot. The fetal hearts were good.

The contractions were good. Everything was fine and she had been doing very well up to that point and dah, dah da. So that's where I started and then Lei started in with all the things about, yes but she's been 6 centimetres now for 3 hours (in command; rebuffing midwife's attempts to negotiate; making clinical decisions alone and according to pre-established criteria and timeframes; no negotiations; treating women as object; low interprofessional trust) ... it could have even been 4 hours but there was no suggestion that there was an obstructed labour. I just wasn't at all convinced of that.....her **[Lei's]** manner was a little bit exasperated...she didn't want to hear what I had to say (doctor in command; focussed on own agenda; rebuffing the midwife; acting dominant).

This is where the negativity, for me, came in really strongly. Really, she wasn't interested in anything that I had to say about what was going on...she just kept trying to talk over what I was saying, you know but, but, but (talking over the midwife)... I felt extremely annoyed...extremely insulted...because I just feel that as an experienced midwife, an obstetric registrar should have the respect for me to at least listen to what I'm reporting (both focussed on own agendas; low quality interprofessional relationships).

We didn't resolve our differences. She wasn't satisfied that there wasn't something wrong. So I said "*well, we will go back in and you can just have a look at Tracey*" (use of delaying tactics). Which she **[Lei]** didn't do...she didn't palp her ...she didn't do anything like that. She just sort of stood back, past the end of the bed, and the conversation then unfolded exactly as I thought it would...along the lines of ... that the baby was fine, there was no problem with the baby's heartbeat and all that but your cervix hasn't really opened up any more and we have got concerns (making clinical decisions alone and according to pre-established criteria and timeframes) ... that the labour was going on this long ... and that train of conversation.

We kind of just got to an impasse (both focussed on own agendas) where she was just saying "with this long at 6 centimetres there is likely to be a problem here" and all that sort of thing. I just sort of said "*well I'm just saying that I totally disagree with that!*" I knew I couldn't ... say ring the obstetrician (feelings of powerlessness). I couldn't **[ring the obstetrician]** because they would just listen to her **[Lei]** and we would be meeting them in theatre (feelings of powerlessness).

I was feeling angry ... I was standing on the same side of the bed as where I was sitting previously and I wasn't looking at Tracey. I was looking at the obstetric registrar...just looking at her. I don't know if I was looking angry but I certainly wouldn't have been looking happy. I just sort of listened to what she had to say. It just was so distressing...

the whole thing was just so distressing (midwife focussed on self and own agenda; use of disapproving and hostile body language; no trust).

Tracey was just lying on her side and just going in and out of contraction patterns. So while she was having the contractions obviously she was just involved with that and then when she didn't have the contractions she was just sort of looking at me... she was facing me... the doctor was talking to her back (woman as object) ... her **[Tracey's]** contractions were really quite strong...and close together... her husband was just sitting on a chair on the other side of the bed. He wasn't really that involved...he was looking at her though...at the doctor.

She **[Lei]** said "*so you understand everything that I have said?*"...to which they both just nodded Then she said "*I'm just going to discuss things with the Obstetrician*". Lei went out and rang the obstetrician (gaining rubber stamp from medical hierarchy).

I stayed because I didn't think there was any point in following her. I thought I was better off with Tracey and Ralph. I was trying to make it clear to Tracey and Ralph that everything did seem to be going really, really well. There didn't seem to be any physical problem. There didn't look to me that there was any reason that she wouldn't be able to go on and have the baby. Everything was going beautifully. We could get the pain relief thing sorted out. We could do things here. I was having that conversation while she was out with the obstetrician (treating woman as a pawn in doctor-midwife game; attempting to recruit the woman to her 'side').

Lei came back in and this time when she came back in Tracey actually looked up at her sort of waiting for her to say something. Lei said "*I've spoken to the obstetrician and he thinks that a caesarean section would be the best thing at this point*" (using premature and unnecessary interventions) and I didn't say anything...she stood at the end of the bed and then she said.... "*are you all right with that do you understand why it's necessary?*" and they both just sort of said "yes, yes".

So then Lei looked at me and said "*so can you just organise the bloods and put the catheter in and all that sort of stuff*" (treating woman as object; treating midwife as subordinate) I didn't say anything. I didn't say yes I will, I didn't say anything. I just said nothing, trying to think ... I was back sitting on the chair again, next to Tracey. I looked at her **[Lei]**... I was thinking, I can't trust myself to open my mouth right at this juncture, so I said nothing... I probably had a really dark and angry look on my face (hostile body language). I think I did. I would have, there is no doubt. I'm sure I did.

I turned to Tracey and just said to her “you know you do have to consent to this. You have to give your consent to this”. She just said “yes, no, yes, no I’ve had it... I just want to have the Caesar and dah dah dah dah dah...” Oh I just could have wept! I was so upset. I was angry with the registrar but I was just so upset that I just could have wept. I just sort of said “ok all right if that’s your decision that’s fine. Just give me a few minutes and we just have to go and organise the paperwork” (feelings of grief, powerlessness and anger).

I followed Lei out the door and walked beside her down the corridor and said “*this woman does not need a caesarean section. This is an unnecessary caesarean section*”. Lei wasn’t looking at me ... we were both just walking down the corridor back towards the nurses’ desk. I said “*this is an unnecessary caesarean section and I am going to report it*” ... I just said “*this is so wrong!!*”... she was a bit flustered. She was on the thing now of having to organise herself so she could get down to theatre (rebuffing midwife’s attempt to negotiate). So she was off on that tangent now. So she wasn’t really interested in what I was saying. But I was so angry, I was just so angry... extremely professionally frustrated (feelings of antagonism and powerlessness). I mean to the nth degree. So frustrated...

2.1 Virginia’s Story Discussion

This story is set in a maternity unit with few resources to support women to have a normal birth. The door is left open with a curtain across it, allowing easy access and denying women a sense of privacy and control over who enters their birth territory. The story demonstrates a power struggle between a midwife and a doctor and the tension inherent between someone’s commitment to normal birth and another’s commitment to timeframes and efficiency for labour and birth. Both participants demonstrated an unwavering commitment to their own position and unwillingness to really include the woman and her partner in any of the decision-making. The midwife’s interaction with the woman after the registrar’s involvement appears to me to be more about recruiting the woman to the midwife’s side against the doctor, rather than any real attempt to find out what the woman wanted and to ensure she had the information she needed to make decisions about her process and do what was important to her.

A sense of teamwork and trust may have been engendered between the doctor and the midwife, if Virginia had kept Lei informed from the beginning of her shift. It would have been much better if Lei had heard about Tracey’s dilatation from Virginia. If Virginia had spoken to the registrar herself and engaged in conversation about Tracey’s progress at the beginning of their respective shifts and throughout the morning, and explained her ideas about Tracey’s labour establishing and accelerating, the registrar may have felt more involved and more

likely to believe that Virginia was being open and honest and therefore reliable. Virginia would have been providing the registrar with a role model for interprofessional negotiation and collaboration. Given that the maternity unit was medically dominated and the midwifery management supported a medicalised view of birth, it appears to me that Virginia was avoiding the doctor's involvement in Tracey's care.

Virginia felt unsupported by her midwifery colleagues in her quest to help Tracey have a normal birth and this created a lot of anxiety and distress for her. Virginia appears to feel under siege from the medicalised management of birthing women and feels as though she needs to 'save' Tracey from medical intervention. Virginia also seems to feel self righteous about her role in 'saving' the woman. Although Virginia felt a responsibility to 'waylay' what was in process once the registrar got involved in Tracey's care, she did not take the responsibility of establishing a relationship with the registrar before the event. Virginia's comment about the midwifery managers telling the registrar that Tracey was six centimetres dilated indicated to me that Virginia felt undermined by the managers and that it was not an uncommon event. Virginia would have been wise to engage the registrar and talk to her about her findings and her thinking about the woman's progress before it became a medical 'issue'; being proactive at this point may have avoided the subsequent interaction and its consequence.

The fact that Virginia had previous negative experiences with Lei has several implications; it may be that Virginia was actively avoiding Lei and hoping she wouldn't come into the room and so didn't choose to update the registrar's information about Tracey's labour; Virginia may have sought to 'lie low' and keep 'off the radar', hoping that Lei would have been kept busy with other women in labour; Virginia may have thought that if she went to talk to Lei and update her, that would ensure that Tracey was 'on the radar' with Lei and therefore more at risk of intervention. If however, Virginia had been proactive in seeking to communicate with Lei, Lei's anxiety may have been reduced and she may not have come into the room in such a disruptive manner. My thinking is that Virginia was seeking to avoid the doctor and was attempting to shield the woman from the doctor's gaze by not actively seeking to update the doctor on the woman's progress. From my observation, the action of shielding is usually counter productive because it reduces trust and leads to the doctor pursuing the situation. We midwives often collude with medical dominance and then feel frustrated and victimised because we don't feel like we have a choice when a medical decision is made.

Another important reason why it would have been a good idea for Virginia to be proactive and engage with Lei earlier in the morning and keep her updated on Tracey's progress is that of the language difficulty. I have noted that midwives often act as an interpreter between doctors and birthing women. Midwives generally repeat what the doctor has said to ensure the couple have

heard correctly and understand what the doctor was saying. The midwife tends to simplify medical terminology for the woman and her partner, even when there is not a language issue. To facilitate understanding and comprehension, midwives generally ask questions of both the woman and the doctor to ensure the woman understands what is being communicated. Virginia did not do that in this situation, even though there was an accent problem, on top of the medical terminology problem, because, from my point of view, she was seeking to stop the conversation.

Lei displayed very poor manners in how she entered the room of the birthing woman. In this situation, which had no medical emergency overtones, her behaviour appears almost robotic. Lei seems to have over ridden her innate sensitivity, which no doubt she displays with her family and friends, with the way she entered the birthing room and her subsequent behaviour. She should have knocked on the door, introduced herself and taken the time to sit and observe the process of labour and, in between contractions, whilst sitting at the same level as Tracey, asked Tracey how she felt things were going before she started talking about what was wrong. By addressing Virginia and not engaging the couple, especially the woman, at the beginning of the interaction, and talking to her back about the caesarean section, Lei communicated that the woman is not central to the decision making and indicated that the woman is invisible in the process. Lei should have done her own assessment of the state of labour and Tracey's progress rather than making decisions based on someone else's vaginal examination, especially as she wasn't interested in the rest of Virginia's findings. It seems to me that Lei, being female, relatively inexperienced and new to the unit, was following written and unwritten rules and acting in a proscribed, stereotypical manner and in doing so, lost her normal social way of interacting in this instance. It is hard to know what influence her nationality and accent may have had on the way Lei interacted, but it is reasonable to consider that she would be aware that some people have had difficulty understanding her and that could influence the way she communicates her medical decisions.

Virginia tried to talk to Lei about her concerns on her way to the desk after Tracey was told about the caesarean section but was ignored and rebuffed. Virginia said that Lei was focussed on getting ready for theatre and that was taking precedence for her. It would have been difficult for Lei to change her mind at that stage. It may be much easier for a doctor to ignore a midwife's concerns about intervention in a medically dominated environment than to consider other ideas when the doctor has already taken the medically oriented path before those concerns are raised. It appears to me that Lei had already made the decision about the caesarean section when she was talking to the midwifery managers at the desk before she even came in to Tracey's room the first time.

There are many pressures on obstetric registrars. They have to do the 'right thing' according to medical management and that includes following proscribed standards and timelines. We do not know whether Lei had been chastised or criticised recently for her care of women by the obstetric hierarchy. Registrars have to produce six positive reports from obstetricians each year and that requirement to be seen as 'good' can create a lot of tension which may influence their manner and actions, including their rate of intervention in labour.

The tension between Lei and Virginia would have been immediately noticeable to Tracey. Virginia was being professional in requesting to talk to the registrar out of the room, but the disruption to Tracey's process of labour had already begun with Lei's entry and behaviour in the room. Even though Lei was not interested in Virginia's options on Tracey's labour, what is interesting here is that Lei was prepared to accept Virginia's vaginal examination findings, but not engage in any discussion about the process of labour itself with her. It needs to be noted here that Virginia did not engage the registrar in any discussion about Tracey's labour and progress before the registrar came into the room with the die already cast.

Virginia did not feel as though she could ring the obstetrician directly because of an unofficial embargo on midwives communicating with the consultants. Controlling the way that midwives can access the obstetrician maintains the hierarchical status quo in medically dominated maternity units and leads to a sense of disempowerment and feelings of hopelessness in the midwife. Controlling the midwives access to obstetricians on the other hand, leads to an enormous amount of power and responsibility for the obstetric registrars and allows the obstetricians greater flexibility in their day to day lives. There is a clear understanding that the registrars will carry out the orders and behaviours ordained as necessary by the medical establishment. The lack of collaboration and negotiation evidenced in this scenario is untenable in the modern day climate of quality, evidence based care and clinical governance.

Virginia sought to reassure Tracey and her partner that everything was going well and to seek their agreement and commitment to normal birth after the registrar's visit. This conversation is too late; the disruption and undermining of the process had already occurred with the registrar's behaviour. We do not know exactly what Tracey was thinking before the registrar visited. We do know that Tracey was considering an epidural, which implies that she was not necessarily committed to a normal birth and was apparently open to following medical advice and accepting of intervention. Tracey may well have benefited from the administration of an epidural and a syntocinon infusion to augment her labour before a decision to perform a caesarean section was made. Virginia did not indicate that she had discussed and/or suggested that option to either Tracey or the registrar.

Virginia may have been more effective if this conversation was held earlier in the day when she first came on duty and met Tracey and her husband. It would have been useful if Virginia had established what Tracey's desires were for birth long before the registrar's visit. Virginia could have sought to understand Tracey's ideas about birth and determine how strong her desire to birth normally was instead of making the assumption that Tracey wanted to give birth normally. Even though there is fragmentation of care with shiftwork and taking over the care of someone the midwife doesn't know in the middle of her labour is not ideal, a conversation about the woman's desires and rights together with the unit's protocols is needed at the beginning of every shift.

Given that Virginia had identified that Tracey did not look like someone who had been in strong labour all night, she needed to talk to Tracey and Russell about that and how the doctors would perceive the length of time they had been in the unit. In situations such as Tracey's, the midwife needs to explain to the woman and her support people, how the doctors may behave in response to a seemingly slow labour. The midwife needs to help the woman articulate her needs and make a plan with the couple in line with their wishes and desires. Tracey may have always wanted a caesarean, or been frightened about having a normal birth and so Lei's intervention in this instance may be welcome and Virginia has been upset for no reason other than her desire for Tracey have a normal birth has been thwarted.

2.2 Coda

Virginia continued ... "I rang the Director of Nursing saying "we are just taking another woman down for another unnecessary caesarean section and I just think it's appalling. I just want to express that verbally but I am also going to put an incident report in about it". That's how I coped with it...I wrote my findings that there is no apparent obstruction of labour for this reason and just wrote the clinical findings down. I wrote that I had discussed it with the obstetric registrar on two occasions regarding the necessity for a caesarean section. Wrote that I discussed it with Tracey and her partner Ralph, but that Tracey had consented to the caesarean section...I put an incident report in and she **[Director of Nursing]** approached the Director of Obstetrics and put that complaint to him. He said that there would have to be some sort of written proof that this was the case...that unnecessary caesarean sections were being done. The Director of Nursing got back to me because I was the one that put the incident form in and just said this is going to have to go back to the Obstetrics Committee to get the cases flagged. Those caesareans that the midwives thought were unnecessary caesarean sections and they would be flagged and looked into. Not a single one, including this one, was said to be unnecessary.

I got no support from the Manager of the Unit and very little support from midwife colleagues because it was just too difficult. It was so hard. And there's Tracey, perfectly normal, no typical problems, baby fine and of course fine at birth...with an unnecessary caesarean and scar on her uterus! ...even now I'm telling you this, and I still sort of can't believe it. If I had been faced with that same situation now I think I wouldn't have been so pathetic in not ringing the Obstetrician myself and having it out with him. It was so much a part of that unit that there was to be no direct contact with the Obstetrician that I just kind of got sort of dummied into it in a way. Because that's just how it had always been and that's how it was. I mean there is no way I would ever have allowed that to happen without getting on the phone to the Obstetrician myself...

I know this is really hard to understand but the culture of that unit was so appalling in terms of what midwives were expected to 'do' and to 'be', that it was like every day there was a struggle. I was kind of right at the end of my journey in that unit and I think I was just sort of like punch drunk by then. That I could barely keep my professional balance really and that was the one that did it. That was the last straw. I left. I was punch drunk from the constant emotional battle to try to do my job as a midwife in a unit where that was neither respected nor wanted and the culture of the unit was obstetric nursing not midwifery. So every single day, every single day there would be a situation where I was having to try to explain things to people that didn't really understand and didn't want to know. You were always in a position of having to argue your case, all the time, every day. I had been in the unit years by then and I was tired and exhausted. There just wasn't much fight left in me by then.

2.3 Initial Analysis and Conceptual Integration from Virginia's Story

The following table lists the contextual, personal and interactional factors which were identified in Virginia's story of her negative interaction with a medical colleague. It also depicts my beginning analysis of these factors and how they impact on the way that midwives and doctors interact in the care of birthing women. The concept 'Medical Model of Care' is emerging as significant and has subsumed all the factors which have surfaced about the historical, political, social and physical context within which the interaction took place. Both the midwife and the doctor are focussed on their own agendas and their interaction seems to be about the control of the birthing woman and her process.

Table 4.1: Key Factors from Virginia's Story

Contextual factors		
Factor	Analysis	Emerging Concept
Size of Maternity Unit Model of care Level of medical surveillance Level of medical domination Quality of Interprofessional relationships Access to Consultant Obstetricians Midwife/woman relationship Doctor/woman relationship Midwife's attitude to the doctor Perception of Attitude of Midwifery Managers Policies of unit Interprofessional trust Time of Day Women's access to privacy Resources to support normal birth	Medium regional teaching hospital Strict Medical Model High High Low Forbidden Not known to each other Not known to each other Negative Supportive of medical model, not supportive of midwifery practice Colludes with medical model Rigid, low tolerance for prolonged labour Low Morning shift Limited Limited	Medical Model of Care
Midwife's Personal Factors		
Factor	Analysis	Emerging Concept
Midwifery education Experience Gender Partnered Children Focus of practice Perception of role	Grad Dip Midwifery Senior Female Yes Two Own agenda: Only one who cares about normal birth 'getting women through' normal labour	Avoiding and resisting medical intervention 'Getting women through' normal labour

Doctor's Personal Factors		
Factor	Analysis	Emerging Concept
Obstetric training Experience Gender Partnered Children Ethnicity Accent Focus of practice Perception of role	Registrar Senior Female No No Asian Thick accent Own agenda Compliance with Medical Protocols Intervention	Compliance with Medical Protocols Getting the job done
Midwife's Interactional factors		
Factor	Analysis	Emerging Concept
Lack of normal civility in interaction Feelings of antagonism, anger, anxiety, grief, powerlessness Focussed on avoiding intervention Engaging in a power struggle Shielding the woman from the doctor Avoiding talking to the doctor Using delaying tactics to avoid intervention Attempting to recruit the woman to her 'side' Treating the woman as a pawn in the doctor- midwife power struggle	Passive/Aggressive/Submissive behaviour Passive/Aggressive/Submissive behaviour Actively avoiding intervention Feeling under siege from medical intervention Keeping the woman off the medical radar Engaging in turf war Engaging in turf war Engaging in turf war	Stereotypic roles: Doctor as enemy Midwife as protector Feeling under siege Engaging in Turf War Control over the Woman's Birth
Doctor's interactional factors		
Factor	Analysis	Emerging Concept
Lack of normal civility in interaction Using overbearing body language Rudeness, ignoring and over talking the midwife Acting in Command Invading Birth Territory Making clinical decisions based on pre-established criteria and timeframes Using premature and unnecessary interventions Rebuffing midwife's attempts to communicate Gaining 'rubber stamp' approval from medical hierarchy (consultant) Treating midwife as a subordinate Treating the woman as an object	Dominating behaviour Dominating behaviour Dominating behaviour Dominating behaviour Dominating behaviour Focussing on complying with medical protocols and getting the job done Focussing on complying with medical protocols and getting the job done Dominating behaviour Focussing on complying with medical protocols and getting the job done Dominating behaviour Dominating behaviour	Stereotypic roles: Doctor in Command Midwife as subordinate Dominating behaviour Control over the Woman's Birth

3.0 Belle

Belle is a young married woman with no children who, at the time of this interaction, was working as a junior registrar in a medium sized regional teaching maternity unit. This particular maternity unit has strict protocols about length of labour and duration of inductions. According to Belle, there is a low threshold for doing caesarean sections if there is not adequate progress in labour. The story concerns a woman, known here as Samantha, who, in line with the hospital's protocols, was being induced at ten days post dates. Belle had seen Samantha in the clinic the day before and had organised the induction and her admission to hospital (woman unknown to doctor). Samantha was given prostins, a gel to ripen the cervix, the evening of the clinic visit. The midwife Eve (not her real name), had admitted Samantha to delivery suite (woman unknown to midwife). Belle was on duty for delivery suite the day of Samantha's induction and came into the room to rupture Samantha's membranes. The night resident doctor had inserted an intravenous cannula into Samantha's arm, ready for the administration of a syntocinon infusion.

Samantha was lying on the bed when Belle entered the room.

"... I said hello and re-introduced myself just because I assumed Samantha may have forgotten my name since the previous time I had met her. There wasn't a partner **[Russell]** there at that time. Eve was in the room filling in some paperwork ... she is a very capable midwife and very opinionated in her approach ... This **[incident]** was fairly consistent with previous experience (negative opinion of midwife).

"I ... discussed the plan of the day with Samantha (ignoring midwife; lack of normal civility in interacting with people) and asked if she had anything she wanted to ask or discuss further. I then ruptured Samantha's membranes and just chatted for a few minutes before leaving the room...I chatted with Samantha and Eve to let them know that I would come back in 4 hours time and see how things were going. I then requested that Eve commence a syntocinon infusion as per protocol within an hour (dominating behaviour; treating midwife as subordinate).

Samantha was quite happy with this plan (woman's commitment to normal birth unknown) as we had discussed and agreed upon this plan previously. Eve ... looked annoyed ... that tense sort of "I don't agree with you" look ... was over at the bench attending to the paperwork...her back and shoulder facing toward Samantha and myself ... was slightly rotated so she was speaking and looking over her shoulder ... clearly annoyed that the plan we had created did not agree with her plan (ignoring & rebuffing midwife). Just because she thought it was best for the patient to give her more time before

starting the syntocinon infusion ... Her body language was suggestive of someone not getting their own way when they are used to doing what they want ... (midwife hostile behaviour).

Eve, then stated, in front of the patient that she believed 4 hours would be a more appropriate length of time to wait before commencing syntocinon (midwife seeking to normalise the process of labour). Eve was overtly not keen for the commencement of syntocinon infusion within 4 hours of rupturing the membranes but had verbally agreed to its commencement. It was clear that she disagreed with this decision despite my very reasonable, and standard, argument against waiting (doctor - adherence to strict protocols; both focussed on own agenda).

There was an obvious antagonism between Eve and myself in front of the patient (engaging in power struggle). I believe this created a negative and divided environment that lacked professionalism ... it was an attitude problem ... it was antagonism between medical and midwifery staff ... the midwife involved was very much of the belief that as soon as there was any medical intervention, such as induction, things would go poorly (midwife self righteous belief & behaviour)... I think she had the patient's best interest at heart, we just had two differing lines of thought happening (both doctor and midwife had own agendas) and the poor patient was sitting in the middle (pawn in the doctor –midwife game) ... Samantha's goal was to have a healthy baby and she had no pre-determined expectation. She just wanted to get into labour and have a healthy baby and she believed hospital was the best place to achieve this goal...Samantha was still quite happy with the original plan which was to have the syntocinon commenced within the first hour ...”

This antagonism continued throughout the entire induction. Samantha appeared aware of the friction between Eve and myself in the way she moved her gaze between Eve and myself as if monitoring any tenseness between us (woman treated as object) but remained chatty and focused on the plan for her for her labour. She seemed positive and a little excited but anxious about the day...”

“...**[four hours later]** I knocked on the door, popped my head in and was treated like an intruder ... The whole day felt like I was intruding (midwife avoiding doctor; shielding the woman; keeping woman off the medical radar) ... I normally feel like I'm very much a part of what is happening. I have a responsibility to know what's happening and to be part of the process. This was like I didn't have the right to be part of the process until I was asked and because I wasn't asked, that I was intruding. Eve came to the door

and physically **blocked [emphasised]** the door [**Belle sounds indignant**] (midwife shielding the woman; treating the doctor as an invader of the birth territory).

The look on her face...was hostile. It was a hostile look...as I perceived it said "this is Samantha and my room and you have no place here" (engaging in power struggle; midwife – guarding the door; excluding the doctor; hostile body language) ... Eve said "what do you want?" **[said in stern tones]** ... I said that I would like to review Samantha and see what her progress is...and I had to ask her to allow me in to speak to Samantha. ...I said that it had been 4 hours since we had ruptured Samantha's membranes and I would like to see Samantha and vaginally assess her to see how things were progressing she **[Eve]** stood to the side and ...left the door open and I had to open it further to enter ... She **[Eve]** just stepped away from the door so that I pushed the door open and walked through. I thought,most people are very friendly but this felt like.....less than friendly...not aggressive but an unwelcoming sternness, not a come and join us look ...instead of an open door that says you are welcome it was a closed door around her body not allowing me to look or come in without her permission **[tense voice]**

I then entered the room ... what did I find? No synto! **[louder and annoyed tone]** ... before I moved over towards Samantha, I was told by Eve that Samantha didn't need the syntocinon infusion because she'd been contracting well.

It was fairly obvious by the way that Eve had piped up with this, before I asked, that she was aware of changing the management plan without consulting me ... I asked her why the syntocinon infusion had not been started. She told me that Samantha had established into labour without the syntocinon ... I felt annoyed ... and actively trying not to show annoyance in my face to Samantha because I knew that there was a tense working situation with this particular staff member and I was **actively [emphasised]** trying not to let that show to this patient (doctor annoyed).

Samantha was lying on the bed...you know I can't remember if she had the monitor on....You know I didn't have an issue with the CTG throughout the day so she **must [emphasised]** have had it on...Eve had decided that Samantha was spontaneously labouring and did not require the syntocinon infusion to be commenced! (delaying tactics). Eve had not discussed this decision with me **[annoyed tone]** (avoiding the doctor)

When I entered the delivery room I saw that Samantha was contracting once every 10

minutes and they were only lasting about 10 to 20 seconds per contraction. Samantha clearly was not in labour. She was starting to contract but clearly it was 4 hours later and Eve had carried out the management plan that **she [emphasised]** had decided on despite my requests (avoiding the doctor). I wasn't surprised, but I was disappointed when 4 hours later there was no syntocinon infusion running...It **[the management plan]** was all written in the notes...I thought that because we had discussed it ...twice with the patient and also with Eve, who was not keen for it...and had verbally agreed on it, and especially since it was the usual protocol in this hospital that it would occur (focussed on own agenda; woman treated as pawn in doctor-midwife game).

I wanted to give this woman the best chance to progress adequately and have a normal labour. Clearly withholding syntocinon was not optimising the chances of this... .. She **[Samantha]** thought she was labouring ...They **[Samantha and Eve]** both did... Samantha told me that the pains were coming much more frequently now and they were stronger but they were 1 in 10 and 20 seconds at best. So they were short and sharp and clearly not established labour...I stayed for about 10 minutes monitoring contractions, of which there was only one. I was chatting, mostly to Samantha but including Eve also, during this time about the contractions and how long they had been present and their duration...and then, because her midwife and her decided she was adequately labouring and not requiring synto, I asked Samantha, rather than Eve, because I thought Samantha would be more amenable **[than the midwife]** to the idea of having a vaginal examination to see if she was progressing (playing the patient against the midwife; woman treated as object; ignoring the midwife). I think I did pretty well! Samantha and I still chatted easily, so I figured if I was being tense with her I wouldn't be able to communicate well with her.

I then performed a vaginal examination and there had been no progress made. I presented it to her **[Samantha]** that her contractions were a very positive thing and that she was in the early stages of labour. I stated that her labour was progressing because previously she hadn't been contracting and she was contracting now but that there was no change in her cervix yet. I used a positive and reassuring tone. I told her that it was time to start the syntocinon to make her labour as efficient as possible... Samantha was disappointed because she thought that she would be more dilated. I reassured her that this is often the case and that this was part of the early stages of labour.

Eve looked surprised like she expected her to be much more dilated...She **[Eve]** was behind me, back over near the bench where the paperwork/chart was... Russell,

Samantha's partner, was sitting quietly. He was friendly but not overly chatty. I think he was the quiet supportive type but a positive person in the room...I think she **[Eve]** said something along the lines of that she thought she would be further than that and I said to Samantha that it would be time to start the syntocinon infusion (ignoring midwife)...She **[Samantha]** said yes and seemed quite happy with the plan, but she was less positive toward the labour than earlier because she'd expected to have cervical dilation by this time.

I then asked **again** for syntocinon to be commenced as per protocol ... I said to Eve "let's put up the synton and get it up and running" and she was positive in her reply in saying yes, yes that she would go and do that... but she had agreed to this previously but not started it ... I came out **[of the room]** and spoke to the NUM **[midwifery manager]** at the desk ... I felt compelled to discuss the situation with the NUM as I could not trust that Eve would perform the requested task of commencing the syntocinon (absent interprofessional trust). I had to go to the NUM and ask her for backup (gaining support from midwifery management). This also made the NUM aware of the difficulties I was having. The NUM agreed that the syntocinon should have been commenced hours previously and agreed to make sure it was commenced as soon as possible (lack of midwifery management support for midwife; midwifery management collusion with medical model) ... I knew I was not making an unreasonable request and felt satisfied that the NUM backed my decision. I went off and attended to my other work commitments ... It **[the syntocinon infusion]** was put up but Samantha didn't cope very well with the increase in intensity of the contractions so it was left to a relative low rate (midwife focussed on own agenda).

...it was not increased at the appropriate rate because Samantha was already contracting mildly. So then 4 hours later, the next vaginal examination revealed that there had still been no cervical change. By this stage 8 hours had passed and Samantha was becoming disillusioned with her labour. She then requested an epidural ... I actually heard after it **[the epidural]** had happened but at that particular hospital that's not out of the ordinary ...Eve told me later **[after the epidural was put in]**...She **[Eve]** was always courteous, she was never openly improper about her **[actions]** ... about what she did... she **told [emphasised]** me about the epidural ... I was trying to be nice, but I couldn't **[laughs]**.

Then after the epidural, the syntocinon was increased at an appropriate rate because Samantha's contractions totally went to nothing after the epidural went in...it took a while **[to get the syntocinon infusion running appropriately]** because the epidural

took a while. I wasn't there for most of that because I was covering the rest of the delivery suite and then it was my home time. It was really quite a few hours down the track by this stage so I said goodbye to Samantha and said that I would hand over to the night staff and they came in and introduced themselves. I went home and overnight Samantha's cervix dilated to only about 3cm... four hours after the epidural, Samantha's cervix was reassessed and there had been some change but not as much as expected in the 13 hour period that had elapsed. Due to the induction protocol at this particular hospital it was deemed a failed induction and Samantha went on to have a caesarean section. She delivered a healthy baby.

3.1 Belle's Story Discussion

Belle saw this as a story of a negative interaction because the midwife's anti medical intervention stance, in her view, led to an unnecessary caesarean section. Belle saw the problem as an attitude problem of the midwife's. This story too has all the elements of the dramas and power plays around midwifery and medical relationships. Both the midwife and the doctor are totally grounded in their respective paradigms, belief systems, stereotypes and unconscious behaviours. Neither is actually focused on the woman although both would say they are. Both the doctor and the midwife want their own way and neither are willing or bother to engage in true and honest, open communication with each other. Both the midwife and the doctor are using their personal power in a disintegrative way. Belle made the assumption that Eve would carry out orders because that was the way it was done in this unit, even though she had previous experience to the contrary. Belle feels totally justified in her attitude. Belle is just as opinionated in her position as Eve is in hers. There is no questioning on Belle's part as to whether the induction was warranted in the first place: she offers no insight or counter story to the fact that the induction was scheduled. In Belle's view, the only problem was that the induction didn't happen in the predetermined way. Belle already had a perception of Eve as a person who was difficult to work with and that perception would influence how Belle interacted with her. There is no indication that Belle even said hello to Eve when Belle entered the room or that Belle invited Eve to join the discussion about the day's plan. There is also no indication that Eve felt empowered to join the discussion. This makes Eve invisible and her role in the care of the woman insignificant. Eve's role appears to be to carry out orders as per protocol rather than be an integral part of the decision making team.

Eve has sought to help this woman birth with minimal intervention when the woman had agreed to an induction. Even though we do not know what information Samantha was given and the decision making process about the induction, it is clear that she has agreed to the induction and understood the process to some degree. Eve did not negotiate in any way with Belle, the doctor involved in Samantha's care. The midwife is playing delaying tactics and seeking to keep the

woman off the medical radar. The midwife's also displaying passive aggressive behaviours to get her own way, which is the least amount of medical intervention.

Eve had sought to normalise an abnormal situation. Samantha had come in for an induction which indicates that Samantha is open to medical intervention. The protocols at this institution are clear and closely followed by the doctors; if the woman has not progressed in twelve hours, a caesarean section is performed. The caesarean section was performed on Samantha after 13 hours even though the syntocinon regime had not been followed as per protocol and Samantha's contractions didn't become regular until the epidural had been inserted, and the syntocinon regime followed, four hours before the caesarean was done. According to Belle, Eve believes that medical intervention is bad. Eve was not taking into account the hospital's strict regime and protocol for timeframes in labour in her care of Samantha. Belle, the doctor, acted in a dominant and controlling way and used the 'patient' to get her own way, which is following the protocol of that institution in regards to induction of labour. Belle had previous experiences with Eve and was aware of her resistance to medical intervention. If Belle had been proactive and interested in fostering a collegial relationship instead of predisposed for a problem with Eve's care of Samantha, she could have invited Eve to discuss the induction process outside the room before Belle saw Samantha.

It is interesting that given Belle's prior experiences with Eve, she did not seek to optimise Samantha's chances of having a normal birth by proactively engaging Eve in supporting the induction process. Belle made assumptions about what Eve's plan may have been; Belle did not talk to Eve about her perception of her behaviour or seek clarification about what was bothering her when she recognised that Eve's body language indicated that she was unhappy. Even when the infusion was not started in the allotted timeframe, Belle did not seek to engage Eve in discussion about why she was against starting the syntocinon infusion as requested.

Belle could have highlighted her concerns about Eve's resistance to medical intervention. Belle could have explained her conversations with Samantha in booking the induction. Belle could have worked with Eve to come to some true and agreed plan before going in to Samantha's room to discuss the plan again with Samantha. As Samantha had arrived ready for the induction of labour and had already had an intravenous cannula inserted by the night registrar, it is reasonable to expect that Samantha would have been fully aware of what induction of labour meant at that hospital and what Samantha could anticipate would happen during the process.

The protocols in this unit are very rigid and Eve would have been well aware of the induction protocol; Eve is seeking to protect the woman from medical intervention, however this is not the right time or way to do this. Eve would be better off challenging the strict induction protocol

through evidence based discussion with the key stakeholders at a policy review meeting. To challenge the protocol at the beginning of an induction when the woman was aware of the process she had agreed to, is putting the woman in the middle of a power struggle and turf war. Eve was resistant to medical intervention even after the syntocinon infusion was started. Eve did not increase the syntocinon infusion as per protocol. This is counterproductive when someone is being induced. If Samantha wasn't managing the intensity of the contractions with syntocinon.

Eve would have been wise to discuss self management options with Samantha, which most likely would include the use of an epidural in this circumstance; epidurals can have the benefit of enabling women to manage the rigors of induced labour. Given that Samantha had agreed to induction, it is unlikely that she would have been against an epidural. The use of an epidural when it was clear that she was not coping with induced contractions may have enabled her to have a normal birth.

Belle said that she would not play the patient against the midwife, although she did do that in the way she negotiated with Samantha about a vaginal examination. Belle, in fact, is playing off both the patient and the midwifery hierarchy against the midwife to ensure the midwife does what she, Belle, wants and what the protocol dictates. The relationship between Eve and the doctor is poor and there is little trust between them; they are involved in a battle for control of the woman and her experience and therefore it is understandable that the doctor would not like being told by Eve about Samantha's epidural after the event. If Eve had been interested in fostering a good relationship with the doctor, she could have communicated Samantha's request for an epidural to the doctor and asked the doctor for her input into the situation.

Both midwife and doctor have emerged from this interaction with each other more convinced than ever of their own, and in my view, erroneous position. As Belle said, this experience will have long term and ongoing ripple effects throughout their working relationship. The midwife will continue to put barriers between herself and her medical colleagues, resist medical care and feel victimised in the process, not realising that she is co-creating the situation through her obstructive and counter-productive ideology and manner.

Although the establishment of Samantha's labour was slowed because of the delay in putting up the syntocinon infusion, the tension between the two players, the doctor and the midwife would certainly have interfered with the woman's sense of safety and her hormonal responses to the induction process. Evidence is mounting that women need to feel safe and secure to labour effectively and birth normally as birth related hormones are mediated by the parasympathetic nervous system and disrupted by the sympathetic nervous system's activation (265); the

friction between Eve and Bella would have activated Samantha's sympathetic nervous systems and interrupted the flow of the labour.

Samantha appears unprepared for the rigors of labour, although that too could be a function of the disruption to her process and the fact that she had to emotionally deal with the opposing forces involved in her care. While it is impossible to prove, my impression is the midwife-doctor tension that Samantha experienced in the room, together with the midwife's resistance to medical intervention and resultant poor management of a medical induction and the slavish adherence to rigid protocols in this particular unit, led to this woman having a caesarean section when she did. This story illustrates disintegrative power in operation as both the midwife and the doctor are consumed with their own agendas and the woman is caught helplessly in the middle.

3.2 Coda

Belle continued "... I think if from the outset, we as a staffing team had been united from the beginning, that since there was an appropriate management plan that was agreed upon by all involved, it should have been adhered to. We both had different treatment plans for this lady. I believe there was a definite power struggle present in this scenario and it may have negatively affected the outcome of the patient. I believe that Eve was aiming for the most natural labour possible for this labour but in doing so may have contributed towards the failed induction by not optimising her treatment. I also believe that Samantha considered she was getting the best medical care available to her but I do not believe this was the case. I believe this caesarean section may have been caused by sub-optimal management. If there had been a cohesive **[emphasised]** team environment and a management plan that was adhered to, the outcome may have been very different. The effects of this situation are long-lasting as they will affect this woman throughout her obstetric career.

It **[the situation]** has affected our **[Eve and doctor's relationship]**...in that from that point onwards when I asked for a syntocinon line to be put up early I would speak to the NUM and make sure that she would check. I hate that, *really hate* (emphasised) that having to check up. I really dislike that I had to question Eve's actions and go behind her back to make sure she was doing what she said she was going to do. I don't like that kind of untrusting environment at all. And from that point on, with this particular staff member, when she would close the door and say 'you're not needed in here', I would make a point to..... I wouldn't let her leave me thinking that I wasn't needed in there, because it was my job to know what was happening when I was looking after delivery suite...I found it difficult **[the working relationship with Eve]**.

She was like this with everybody **[the doctors]**.

This was just the way she **[Eve]** was and when you weren't talking work she would be very chatty about all sorts of things...socially, our relationship was fine but in a working situation she just worked differently to the way I was used to working with people **[other midwives]**. It wasn't personal, she didn't just treat me like that, it was everybody really **[laughs]** she behaved in a similar way with all of the doctors...I think we both had a different philosophy. We both were looking out for the woman but my philosophy was that I was viewing things from a medical perspective and if that meant no intervention that was great. But if it meant intervention then I didn't see intervention as a **negative [emphasised]** thing. I saw it as part of the goal of getting a healthy woman with a healthy baby. I believe **her [emphasised]** underlying philosophy was that if it's not natural then it's going wrong and that if you need medical intervention that's a bad thing.

She **[Eve]** was being... quietly aggressive in that she wasn't part of a team and was disrespectful to medical staff **[meaning Belle]**...I certainly won't play the patient against the midwife...I think that's a mistake... that's how it **[this interaction] felt [emphasised]** like that, yes playing the patient against the doctor ...I don't know what one could do differently..... think it's a one off really.....throughout my interactions I have tried new approaches like requesting certain things and discussing it with the patient in front of that midwife so that she would realise that the patient was agreeing with the plan. Certainly involving the NUM was very effective. Eve had great respect for the NUM. If the NUM asked anything she would do it immediately. There just was not a good working environment between this particular midwife and any medical staff. It was more about "I want to do it this way and I don't really care what you want to do". It was about one staff member trying to work individually and not as part of a team with team decisions.

She **[Eve]** probably wasn't **actively [emphasised]** trying to exert power but that's certainly how it felt...I tried not to behave in the Samanthae way..Oh I felt like it...yes of course **[laughs]**. I didn't want to be drawn into the power struggle in front of a patient or use the Samanthae disrespectful tones in retaliation. Basically I just didn't want to behave in a way that I considered unprofessional just because someone else was...I was teeth grinding. I'm sure mine were clenching **[laughs]**...I was feeling cranky..... very disappointing when the woman went for a caesarean delivery because she really thought we had done the best for her but I don't think we did...I talked to Eve about it after...she was confirmed how much she disliked the induction process... her reaction

was that “as soon as doctors intervened things go wrong”.

The comment *infuriated* [emphasised] me...because I let her know that she [Samantha] ended up a caesarean with a failure to progress thinking that she [Eve] would think ...“oh maybe I should have put the synto up quicker and appropriately followed the protocol”. But the attitude was that it just confirmed how much “I hate inductions”. So I thought I’m not going to push that point because she’s never going to change that attitude...I thought that I’m not going to be able to change her so not to try any further. It did make for a difficult working environment though... the underlying philosophy was that the aim was to get to the end point by avoiding medical intervention... to exert power by avoiding medical intervention as much as possible!

3.3 Initial Analysis and Conceptual Integration from Belle’s Story

The following table lists the contextual, personal and interactional factors which were identified in Belle’s story of her negative interaction with a midwifery colleague. It also depicts my beginning analysis and conceptualisation of these factors and how they impact on the way that midwives and doctors interact in the care of birthing women. As with Virginia’s story, the concept ‘Medical Model of Care’ is significant and has subsumed all the factors which have emerged about the contextual and organisational aspects within which the interaction took place. Similarly to Virginia’s narrative, both the doctor and the midwife are focussed on their own agendas and their interaction once again, seems to be about the control of the birthing woman and her process.

Table 4.2: Key Factors from Belle's Story

Contextual factors		
Factor	Analysis	Emerging Concept
Size of Maternity Unit Model of care Level of medical surveillance Level of medical domination Quality of Interprofessional relationships Midwives' Access to Consultant Obstetricians Midwife/woman relationship Doctor/woman relationship Midwife's attitude to the doctor Doctor's attitude to the midwife Doctor's perception of Attitude of Midwifery Managers Policies of unit Interprofessional trust Time of Day Women's access to privacy Resources to support normal birth	Medium regional teaching hospital Strict Medical Model High High Low Not mentioned Not known to each other Not known to each other Negative Negative Supportive of medical model, not supportive of midwifery practice Colludes with medical model Rigid, low tolerance for prolonged labour Low Morning shift Limited Limited	Medical Model of Care
Midwife's Personal Factors		
Factor	Analysis	Emerging Concept
Midwifery education Experience Gender Married Children Focussed on own agenda Focussed on avoiding medical intervention	Grad Dip Midwifery Senior Female Unknown Unknown Feels under siege from medicalised management of birthing woman: needs to save woman from medical intervention; acts self righteous about her position; unsupported by midwifery colleagues	Focussed on avoiding and resisting medical intervention Focussed on 'getting women through' normal labour
Doctor's Personal Factors		
Factor	Analysis	Emerging Concept
Obstetric training Experience Gender Married Children Focussed on own agenda	Registrar Senior Female Yes No Focussed on compliance with Medical Protocols	Focussed on compliance medical protocols and getting the job done

Midwife's Interactional factors		
Factor	Analysis	Emerging Concepts
Lacking normal civility in interaction Hostile body language Demonstrating feelings of antagonism, anger, powerlessness Focussed on resisting medical intervention Sabotaging medical intervention Engaging in a power struggle Treating the doctor like an invader of the birth room Shielding the woman from the doctor Avoiding talking to the doctor Using delaying tactics to avoid intervention Attempting to recruit the woman to her 'side' Treating the woman as a pawn in the doctor-midwife power struggle	Passive/Aggressive/Submissive behaviour Passive/Aggressive/Submissive behaviour Actively avoiding intervention Behaviour indicates that midwife is feeling under siege from medical domination and intervention; Engaging in turf war Keeping the woman off the medical radar Engaging in turf war Engaging in turf war Engaging in turf war	Stereotypic roles: Doctor as enemy Midwife as protector Feeling under siege Engaging in Turf War Control over the Woman's Birth
Doctor's interactional factors		
Factor	Analysis	Emerging Concepts
Using overbearing body language Lacking normal civility in interaction Ignoring and not including the midwife Acting in Command Demanding entry to birth territory Making clinical decisions based on pre-established criteria and timeframes Using premature and unnecessary intervention Rebuffing midwife's attempts to negotiate Gaining support from midwifery hierarchy Treating midwife as a subordinate Treating the woman as an object	Dominating behaviour Dominating behaviour Dominating behaviour Dominating behaviour Dominating behaviour Focussing on complying with medical protocols and getting the job done Focussing on complying with medical protocols and getting the job done Dominating behaviour Focussing on complying with medical protocols and getting the job done Dominating behaviour Dominating behaviour	Stereotypic roles: Doctor in Command Midwife as subordinate Control over the Woman's Birth

CHAPTER FIVE: ANALYSIS OF STORIES OF POSITIVE INTERACTIONS

1.0 Introduction

The purpose of this chapter is to present and analyse two stories illustrating exemplar positive interprofessional interactions in the care of a birthing woman. The first story is from a midwife's perspective about her interaction with a medical colleague and the second is from a doctor's perspective about his interaction with a midwife. Each story is followed by a table which contains a beginning analysis to provide insight into and help answer the question:

“What factors affect interprofessional interaction in birthing units and how do these interactions impact on birthing outcomes?”

Analysis is guided by concepts from the theories presented in the literature review: Birth Territory Theory (166, 167) (see table 2.1) and Social and Emotional Competencies (116-118) (see table 2.2). The stories appear as narratives. The midwife's and doctors' actual words are used. The key to understanding the analysis is provided in the box below.

Key to analysis in text

Midwife and doctors words: Arial

Interpretation and description: **Bold Arial**

Summary and Discussion information: Times New Roman

Factors: Times New Roman

Factors (identified within the narrative) which appear to contribute to the negative interaction are displayed in a table format (5.1 and 5.2) at the end of each narrative.

2.0 Sarah

Sarah has been a midwife for three years. She is married and is the mother of three girls. Sarah relates the story of a junior registrar, Jack, at his first waterbirth as her example of a positive interaction with a doctor. This incident takes place just after the night duty staff arrived on duty in an urban maternity unit. According to Sarah, the maternity unit has very strong midwifery leadership and is very women centred. The midwives and doctors enjoy good, trusting interprofessional relationships. This unit caters for a large and diverse ethnic population, although this situation involved Alison, a Caucasian woman. Alison had given birth at the same unit two years previously.

Sarah, who was on evening shift and about to go home, said “I recognised her face as soon as she arrived”. Alison had a waterbirth the first time and wanted the same again. This information was written in her notes. As it was handover time, there were extra staff members in the unit. It just so happened that the three midwives who were on duty when Alison had her previous baby were in the unit when Alison arrived in labour. Sarah went into the room to run the bath for Alison as the other midwives organised her admission (midwifery autonomy; woman’s choices central to care; resources available to support normal birth). All ideas of going home evaporated for Sarah as she was keen to be involved again with Alison’s care and the birth of her baby.

The midwifery manager, Jasmine, was very experienced with waterbirths. She was talking with Jack, the registrar at the desk when Alison arrived in strong labour. Alison was being pushed in a wheelchair by her mother, Sandra, accompanied by her two year old, Ellie Rose. Jack told Jasmine that he would like to observe a water birth (supportive of woman’s choice and interested in learning). When Alison was settled in the bath, Sarah explained the situation and asked her if Jack could observe her birth (welcoming of registrar; collaborative practice; woman’s choices central to care; inclusive of doctor). Alison said that was ‘fine’ by her.

Sarah explains that ‘Alison was contracting beautifully and sounded like she was progressing well...she got into the bath and Jack came in...he was very quiet, you didn’t even notice he was in there (respect; trust). He just made eye contact with the midwives and smiled and then walked back out (unobtrusive; focussed on woman’s needs and choices) ... I thought...he will come in a bit closer to when the baby is being born... we three midwives that were there two years earlier just thought it was wonderful, we just thought it was all beautiful (enthusiastic; grateful) ... Alison was in the bath quite happy and when it came time to birth the baby, Jack came in, stood back, way back at the door and just rechecked that it was ok that he was there (good manners; polite; unassuming; collaborative and cooperative body language). Jasmine, the senior midwife came in as well and she stood with Jack to reassure him and to support him (engaging with the doctor; trust, kindness, respect; collaborative behaviour)

As they were waiting for the baby to be born, Jasmine the senior midwife said to Jack “now when the baby is born it could possibly come out not really screaming because often water birth babies are very calm ... so I don’t want you to be worried or concerned or anything and sometimes they are a different colour but don’t be concerned about that either”. This was a quiet conversation but we were all very close together so we could hear the conversation and he was very quiet ... the dialogue was almost non-existent apart from Jasmine very quietly talking to Jack ... Jack just had a lovely smile

on his face...we could see that... and he was very quiet...this registrar is a lovely registrar, highly skilled, very gentle man, very nice (appreciative) and he was there and just the way he had approached and come into the room was very midwife like...he stood there quietly, he stood there very happily and then let this process take place (trusting and respectful) ... when I say he let it take place we just all let it take place. We all let it take place, it all just happened.

Alison birthed beautifully but fairly slowly...we **[midwives]** were there by her side, by the bath and we really didn't do very much...Jack was lovely, and you didn't even really notice his presence (calm and respectful). It was the first water birth he had ever seen (willing to learn) ... Everybody was happy, everybody was smiling, and it was all very joyous, as it should be (enthusiastic).

Then the interesting thing, after the birth he came out to the desk and he said *"I'm really beginning to understand this letting go of control"*. He said *"it was so powerful, this 'I have to let go of control'"*, while he was standing there at the birth he had to say to himself, "I have to let go of control here" (insightful reflection). You wouldn't have known because he was very quiet, but this was his comment afterwards to all of us. *"It's really apparent to me how you have to absolutely let go of control and it is the woman that controls her birthing experience"*.

We all went "ah ha, that's it you've got it!" So we thought it was wonderful because hooray he's got it. He's got it, that's it. That's what it's all about...it all happened very, very quickly ... my respect for him grew and I would imagine that it was the same with the rest of the midwives in the unit as well...it was something he wasn't comfortable with...it was foreign to him but he was the one to say at the end *"you know I understand that 'giving away the control'"*...he acknowledged that that was very difficult ... he understood that he was there as an observer to something very precious...he thanked the birthing woman for allowing him to be there (demonstrating gratitude and kindness).

2.1 Discussion

Sarah saw this story as a positive interaction because Jack, the registrar didn't intervene, didn't tell them what to do and was willing to learn. Sarah could have excluded the registrar and instead, saw it as an opportunity for growth and development for the registrar. The registrar could have easily either ignored the fact that the woman was going to have a waterbirth, or gone out of his way to disrupt the plan for waterbirth. Instead, the registrar had a beautiful experience and discovered that he had to let go of control, that it was the woman who controlled

her experience. The registrar demonstrated his ability to be curious and reflect on his own feelings and sense of being out of control in that situation; he is having to ‘be’ not ‘do’ and that is causing internal conflict; his ability to observe himself and self regulate is high; he is also demonstrating trust in the midwives expertise in this unfamiliar, to him, situation. The registrar, by his behaviour, was exhibiting a sense of awe in the wonder of birth, rather than a need to control it. He could have been overtly frightened and interfered in the process by talking to the woman or the midwives loudly. He could also have rushed in to resuscitate the baby if he was anxious that the baby could be compromised by being born through the water. His actions and body language reassured the midwives that his presence was a positive one. Sarah paid the registrar the highest compliment when she said that he was ‘midwife like’; she is saying that he acted respectfully and supported the process.

The birthing woman was happy to provide the registrar with a beautiful experience. Here is a story of midwives, who, while supporting the woman in her choices, incorporated the registrar into a beautiful learning experience; the senior midwife, ‘midwifed’ the registrar through the birth and therefore provided an opportunity to build relationships and extend knowledge. A waterbirth can be a very confronting experience for someone who is medically trained and the fact that the senior midwife supported the registrar through this experience demonstrates openness, trust, respect, kindness and a collaborative, caring orientation on the part of the midwifery manager. Sarah said the midwives ‘didn’t do very much’ but being mindfully being alert, attentive and waiting, also known as ‘doing nothing well’ is considered a high level midwifery skill. It is the recognition that birth is normal and women have the innate ability to do it themselves. This approach to care of birthing women can be perplexing to someone who is used to being in control of the birthing process, so it was good that Jasmine was able to talk the registrar through the experience. The registrar was able to see skilled midwifery in action and experience the raw beauty of a birthing woman in her power within a facilitating and optimal environment.

2.2 Initial Analysis and Conceptual Integration from Sarah’s Story

The following table lists the contextual, personal and interactional factors which were identified in Sarah’s story of her positive interaction with a medical colleague. It also depicts my beginning analysis of these factors and how they impact on the way that midwives and doctors interact in the care of birthing women. This is a transitional step towards the production of ‘A Theory Of Interprofessional, Integrative Power’. The concept ‘*Women Centred Model of Care*’ is significant and has subsumed all the factors which have emerged about the historical, political, social and physical context within which the interaction took place.

Both the midwife and the doctor are focussed on ‘*supporting the woman’s choices*’ whilst

providing an opportunity for the doctor to experience a waterbirth. The midwife displays the following behaviours during this interaction: autonomy of practice; normal civility in interacting; smiling, eye contact, nodding, collaborative approach, welcoming and facilitating the doctor's presence in the room, enthusiasm, respect, kindness, appreciative and women centred care. The doctor displays behaviours such as; normal civility in interacting; checking his presence was acceptable; smiling; nodding; eye contact; collaborative approach; willingness to learn; actively seeking new experiences; treating midwife as an equal; respecting women's choices; entering the birth room in a respectful and non disturbing manner; insightful reflection; gratitude; kindness. The midwifery manager too, displays positive behaviours and attitudes. These midwives and doctor demonstrate what Lane (138) has referred to as a 'dialogic' relationship. This is a relationship which assumes an open discussion among equals and requires a respectful acknowledgement of the skills and world view of the "other". The phrase "**collaborative behaviour**" is used to denote these behaviours by both the midwife, (including the senior midwife) and the doctor. The woman is treated as an autonomous human being and receives '**women centred care**'. The midwife and doctor's interaction seems to be about supporting the birthing woman's process and her sense of control as he learns.

Table 5.1: Key Factors from Sarah's Story

Contextual factors		
Factor	Analysis	Emerging Concept
Size of Maternity Unit Model of care Level of medical surveillance Level of medical domination Quality of Interprofessional relationships Access to Consultant Obstetricians Midwife/woman relationship Doctor/woman relationship Perception of Attitude of Midwifery Managers Policies of unit Interprofessional trust Time of Day Women's access to privacy Resources to support normal birth	Medium city teaching hospital Women Centred Model Low Low High Not Relevant Previous Birth Not known to each other Supportive of Women Centred Care Guidelines for Practice High Night Duty Handover time High High	Women Centred Model of Care
Midwife's Personal Factors		
Factor	Analysis	Emerging Concept
Midwifery education Experience Gender Partnered Children Focus of practice	Grad Dip Midwifery Senior Female Yes Three Supporting woman's choices	Supporting woman's choices
Doctor's Personal Factors		
Factor	Analysis	Emerging Concept
Obstetric training Experience Gender Partnered Children Focus of practice	Registrar Senior Male Unknown Unknown Supporting woman's choices	Supporting woman's choices
Midwife's Interactional factors		
Factor	Analysis	Emerging Concept
Normal civility in interaction Expressed Feelings Attitude to other health professional Behaviour during interaction Perception of role	Present Positive Positive Collaborative Behaviour Women centred care	Collaborative behaviour Midwifery Autonomy Women centred care
Doctor's interactional factors		
Factor	Analysis	Emerging Concept
Normal civility in interaction Expressed Feelings Attitude to other health professional Behaviour during interaction Perception of role	Present Positive Positive Collaborative behaviour Women Centred Care	Collaborative Behaviour Women Centred Care

3.0 Jason

Jason is married and has two young children. This interaction takes place in a birthing centre which was attached to a large teaching hospital in a capital city. The midwives in the birthing centre are autonomous and the whole maternity unit is women centred. The doctors and midwives have good interprofessional relationships and like each other. Jason was a registrar working in the delivery suite. It was late in the evening and he was asked by the birth centre midwife to help with rupturing the membranes of a woman who was postdates and wanted to be induced. The midwife was having trouble doing the procedure (collaborative and respectful, trusting interprofessional relationship).

Jason described how he "... went over there to introduce myself to the lady and her husband (civility in interaction). This was their first time that they had been in that particular birthing unit; their previous delivery had been in the labour ward where problems, difficult births, intervention or voluntary processes go on. So after introducing myself and making sure everything was appropriate. I managed to break the waters without too much difficulty and I excused myself because I wasn't needed any more.

Well the rest of the night went on; normally I don't have much more interaction with the women. I was actually having a quiet night that night. I was asleep and my pager went off and it was the birthing unit. I went over there, actually I rang up first and there was no answer, which usually means that there tends to be a mega problem so I thought I had better go over there. So I went across there and as I walked in the door I could hear three women all in active labour and I thought, 'what is going on?' I managed to find the midwife and she said would I mind looking after this lady that I had seen earlier and "just help her along for a bit while I do deliveries here and then I will come back later on ..." (interprofessional cooperation, collaboration and role blurring).

My first thought was that it was nice that she asked me (interprofessional respect and trust). It's not common for a medical registrar to be involved when things are normal, so I felt quite honoured that she called me instead of calling one of the midwives from the labour ward ...she already had one of the other midwives over from the normal labour ward ... helping the other lady...the other labour ward was probably a little bit busier **[than Jason was]**...also I think I had a little bit of rapport with this particular midwife already ...she knew that I was somebody who supported them in their endeavours" (perspective that midwives are professional equals; interprofessional respect and trust).

Jason found the couple distressed. After talking to the couple and helping them calm

down; Jason asked them if they wanted to know how far they were (woman's choices central to care) and after gaining consent, performed a vaginal examination. The woman was on her hands and knees on the mat on the floor resources available to support normal birth); her cervix had an anterior lip which Jason pushed away and the baby was born with the next contraction.

Jason continued ... "I thought so we've had the baby and I've got no equipment. Except for a pair of gloves but I didn't have any of the delivery equipment there. So I thought 'OK I'd better find that!' (doctor flexible). The baby was obviously fine and didn't require any intervention at all so I went and found everything I needed. It was a very normal **[homelike, not clinical]** environment, there was a chest of drawers in the corner there, and it looked like a normal chest of drawers, so I found the delivery pack and Dad cut the cord (supportive and inclusive). She didn't want to have any... well, I didn't even bother asking her about syntocinon (supportive of woman's choices) ... the placenta came out properly by itself with a little bit of cord traction. She probably lost about 50mls of blood.

So the baby was fine, Dad was much happier, Mum was much happier. I checked the placenta to make sure it was all fine and then I said to her 'what do you want to do now?' and said to her did she want to have a shower? She said 'yes that would be quite nice' so I wrapped the baby up and gave Dad a cuddle and she got up and had a shower. While Dad was cuddling the baby I was ferreting through her bag to find all her clothes to get dressed in. I got her towels and then I thought the bed is a bit of a mess so I had better clean that up. So I cleaned up the bed and put some clean sheets on it, it was just a normal double bed (cooperative and egalitarian). Then she got dressed and she was sitting in the chair and I said did she want a hand breast feeding ...and she said 'yes I might do that'. So I got the baby positioned and put the baby on the breast.....then I made her and her husband a cup of tea and then in walks the midwife.

She says 'how are you going in here?' and then she sees the Mum dressed with the baby breastfeeding with the room cleaned up and the husband and wife drinking a cup of tea and she said 'OK, you are now an official honorary midwife!' **[laughs]**.

... I've had lots of experiences like that but you know I felt that it was good from the point of view that the midwife asked me to be involved. I had already had a relationship with the patient from before and they felt confident with me and I came in and assisted with a normal delivery and there was no fuss about it...I also think that

normal birth is the domain of the midwives ... I was being invited into it (invited into birth territory; crossing domains). Not that I was thinking that at the time but afterwards I felt very privileged that I was. I felt good that she did feel confident to ask me and she knew that I was supportive ... I just consider the whole thing a big team work, the doctors and the nurses and especially the midwives working together. I'm of the opinion, the doctors, the midwives, the cleaners, everybody, is an important part of the team. I just don't stand on ceremony about 'you know I'm a doctor and I only do these things' and I like to think that maybe the midwives view this principle and also think that we **[doctors]** can be involved in some of the more normal things as well.

3.1 Discussion

This is a beautiful story of cooperation, interprofessional respect and kindness. Jason believes this is a story of a good interaction because the midwife trusted him enough to call on him for help in the birth centre and to leave him looking after a birthing woman and her partner. The midwife obviously felt comfortable about calling Jason to help her because he respects midwifery and midwives. The midwife demonstrated that she feels she can rely upon Jason to work appropriately with birthing women. The midwife leaves Jason to his own devices in the birth centre with the couple, displaying a trust in his clinical ability and behaviour. Jason goes above and beyond what constitutes 'normal' medical care and provides ongoing practical and emotional support to the birthing couple in a flexible and innovative way. When the midwife returns to the room and sees what Jason has in fact done, the midwife pays Jason the highest compliment by saying he is an official honorary midwife. The midwife is saying that he acted respectfully and supported the woman's birthing process in the best way possible. Jason's ability to cooperate, be flexible and blur roles (crossing domains) means that he had the joy of assisting in a normal, natural birth and providing the couple and their baby with a wonderful, honouring experience. Jason also was able to reinforce his already good relationship with the midwife. Jason likes being involved in normal birth and so was more than happy to be involved and help the midwife. He hoped that his actions would positively dispose the midwives to letting doctors be more involved in normal birth, something that in this unit, is the domain of the midwives (crossing domains).

3.2 Initial Analysis and Conceptual Integration from Jason's Story

The following table lists the contextual, personal and interactional factors which were identified in Jason's story of his positive interaction with a midwifery colleague. It also depicts my beginning analysis of these factors and how they impact on the way that midwives and doctors interact in the care of birthing women. This, as in the analysis of Sarah's story, is a transitional step towards the production of 'A Theory Of Interprofessional, Integrative Power'. The concept '*Women Centred Model of Care*' is significant as it is in Sarah's story and has

similarly subsumed all the factors which have emerged about the historical, political, social and physical context within which the interaction took place.

Both the midwife and the doctor are focussed on '*supporting the woman's choices*' whilst managing a busy time in the birth centre. The midwife displays the following behaviours during this interaction: autonomy of practice; normal civility in interacting; smiling, collaborative approach, welcoming and facilitating the doctor's presence in the room, enthusiasm and women centred care. The doctor displays behaviours such as; normal civility in interacting; collaborative approach; willingness to help; treating midwife as an equal; respecting women's choices; entering the birth room in a respectful and non disturbing manner; insightful reflection; gratitude; kindness. These practitioners, like the practitioners in Sarah's story, demonstrate the dialogic relationship with its respect of the skills and world views of the other. The phrase "*collaborative behaviour*" is used to denote these behaviours by both the midwife and the doctor. Again, in this story, the woman is treated as an autonomous human being and receives '*women centred care*'. The midwife and doctor's interaction seems to be about supporting the birthing woman's process and her sense of control as Jason steps into the midwife's role to help out.

Table 5.2: Key Factors from Jason's Story

Contextual factors		
Factor	Analysis	Emerging Concept
Size of Maternity Unit Model of care Level of medical surveillance Level of medical domination Quality of Interprofessional relationships Access to Consultant Obstetricians Midwife/woman relationship Doctor/woman relationship Perception of Attitude of Midwifery Managers Policies of unit Interprofessional trust Time of Day Women's access to privacy Resources to support normal birth	Medium city teaching hospital Women Centred Model Low Low High Not Relevant Unknown Not known to each other Supportive of Women Centred Care Guidelines for Practice High Night Duty High High	Women Centred Model of Care
Midwife's Personal Factors		
Factor	Analysis	Emerging Concept
Midwifery education Experience Gender Partnered Children Focus of practice	Grad Dip Midwifery Senior Female Yes Three Supporting woman's choices	Supportive of woman's choices
Doctor's Personal Factors		
Factor	Analysis	Emerging Concept
Obstetric training Experience Gender Partnered Children Focus of practice	Registrar Senior Male Unknown Unknown Supporting woman's choices	Supportive of woman's choices
Midwife's Interactional factors		
Factor	Analysis	Emerging Concept
Normal civility in interaction Expressed Feelings Attitude to other health professional Behaviour during interaction Perception of role	Present Positive Positive Collaborative Behaviour Women centred care	Collaborative behaviour Midwifery Autonomy Women centred care
Doctor's interactional factors		
Factor	Analysis	Emerging Concept
Normal civility in interaction Expressed Feelings Attitude to other health professional Behaviour during interaction Perception of role	Present Positive Positive Collaborative behaviour Women Centred Care	Collaborative Behaviour Women Centred Care

CHAPTER SIX: CONSTRUCTION AND CONTEXTUALISATION

1.0 Introduction

In this chapter I complete the theorising process as outlined in Chapter 3, Methodology. These final steps include construction; which involves the interpretation of the key elements more fully by constructing two theoretical models of midwife-doctor interactions. One model depicts the factors involved in the negative interactions; the other demonstrates the factors identified in the positive interactions. The final step is contextualisation, in which the proposed models are relocated within the social world by contrasting and comparing them with knowledge gained from the introductory chapter to this thesis and the literature review. The process of analysis so far, has been demonstrated in chapters 4 and 5 which showed the organisational, personal and interactional factors that are operating in positive and negative interactions (see chapter 4 tables 4.1, 4.2 for the negative factors; and chapter 5 tables 5.1, 5.2 for the positive factors).

Theories of Social and Emotional Intelligence and their competencies (see table 4.3 for details), coupled with Birth Territory theory have been used as a lens to understand and predict how the birth environment, as described by the midwives and doctors, is impacting on them and their social and emotional intelligence as demonstrated in their interprofessional interactions. As discussed in Chapter 2 in this thesis, Birth Territory and Midwifery Guardianship Theory (266) provides a way of describing and explaining how the birth environment impacts upon birthing women. The concept of Birth Territory encompasses the structural, termed 'terrain' and political, termed 'jurisdiction' aspects of environment: See table 2.1 for definitions.

2.0 A Theory of Interprofessional Integrative Power

I, and others, have written about integrative power as part of the Theory of Birth Territory (266). Integrative power integrates all forms of power within the environment towards a shared higher goal, in this case; genius birth. A genius birth (267) is defined as one where the woman uses her own power to give birth in the best possible, uniquely individual way for that particular woman at that particular moment of her life. A genius birth may or may not involve interventions. A forced birth, by comparison, is one that is primarily devoid of spontaneity and contrived to fit the pre-determined boundaries of the woman and/or her attendants (267). Thus, by this definition a forced birth can include a 'normal birth' that the woman is forced to have even if it was not wise (267). Using integrative power promotes mind-body integration for the woman. When the woman needs to make decisions about her care options then the use of 'integrative power' harnesses the power of all participants in the birth environment so that all power is focussed on the woman's enhanced mind-body integration and consequently, on her self-expression and confidence in being the one who is making the ultimate choice about

what happens. Importantly, the use of ‘integrative power’ supports the woman to feel good about her self even if the birth outcome is not as she had wished.

Using concepts from the theories which guided analysis, together with conceptual integration of the key factors and concepts gained from data analysis, A Theory of Interprofessional Integrative Power has been developed. Each concept in the theory is conceptualised on a continuum with a positive aspect of the concept at one end and a negative aspect at the other. For example: the birth territory can, metaphorically, be considered as either a ‘round table’ or an ‘occupied territory’. Although there is only a single theory, I present it in two tables to make explicit how each concept is affecting the interaction and outcome, either positive or negative. Table 6.1 demonstrates the theory which explains the process of negative interprofessional interactions and their outcomes, whilst table 6.3 illustrates the process of positive interprofessional interactions and their outcomes. Following the table for each aspect of A Theory Of Interprofessional Integrative Power, a flowchart model table 6.2 and 6.4 are presented to summarise the theory.

3.0 Background to Analysis and Conceptual Integration

In examining the factors which emerged from the data, there were some factors which did not seem important in the final analysis. ‘Time of day’ and ‘size of unit’, for example, as contextual and organisational factors, seem to have no impact on the quality of these particular interpersonal interactions and so have been removed from further analysis. However it is possible that they may be important. A large quantitative study would demonstrate whether these factors do have an impact or not. Similarly whether the midwives and doctors are married or have children does not seem to impact upon their interactions in these stories. One aspect worthy of attention is the gender of the doctors involved in the stories. In both the negative stories, the doctors were female; in the positive stories, the doctors were male. It is beyond the scope of this project to come to any conclusions, however, it is interesting to muse on this phenomenon and what it may mean in obstetric training and the identification of this factor in the data provides an indicator for important future research.

It was difficult to identify what influence that the length of time professionals knew each other or knew the woman at the centre of the interaction had on the interaction itself and so these factors were discarded in this analysis. This was interesting given that Baggs (25) had found that when doctors and nurses don’t know each other on a personal level and don’t have opportunities to develop confidence and trust in each other, they are more likely to revert to stereotyped roles. The midwives and doctors in the negative stories both had a negative perception of the other whether they knew each other for any length of time or not. They certainly acted in stereotyped roles in their interactions with each other and with the woman,

so I wondered if Bagg's findings were more to do with the contextual and organisational culture of the intensive care units he studied, as it was in these stories, than it was to do with the development of personal relationships between doctors and nurses. This is another aspect which would be useful to investigate in future research. It is also important to mention here that the current obstetric and health service management obsession with risk, risk management (35) and the spectre of litigation provide a cultural context that did not demonstrate itself in this research project. These factors could be underpinning and influencing the doctors' responses in the negative scenarios, even if it was in an unconscious way. This is another area which is ripe for investigation.

The policies of the maternity unit together with the ease of midwives access to consultants are factors which have been subsumed under the broader concept of 'Model of Care'. For the negative stories, the model of care has been termed 'Medical Model of Care'. In this model, policies were found to be rigidly adhered to and midwives have no direct access to obstetric consultants. In some medically dominated units, such as the one that Virginia described, access to obstetric consultants is actively forbidden. Doering (1) explained how power, technology and ideology combine to produce a 'reality' which constructs rigidly defined social relations such as found in these stories of negative interactions. It can be seen how myths, positions of influence and organisational structures promote fear of freedom and subservience (112). Willis (8) has written extensively on medical dominance and has explained how it is a structural feature of the subordination of other health care practitioners.

The way that midwifery managers in Virginia's and Belle's stories collude with the medicalised care of birthing women is also subsumed into the 'Medical Model of Care' concept. Freire (112) and Foucault (45) provide insight into the behaviour of the midwifery managers in these stories. According to Freire, subordinate groups often seek to adopt the behaviour and characteristics of the dominant group as a way of identifying with them and gaining approval. Freire suggests this is how oppressed people tend to 'house the oppressor within' and contribute to their own oppression through bullying. Foucault (45) explains the way that patriarchal management structures designate the observer role to members of the oppressed group to keep order and maintain control of the population being observed. Freire (112 p.114) argues that these representatives are part of a divide and conquer strategy by the dominating group, because the favoured ones brought from the rank and file to keep order, actually tend to represent the oppressor, not their comrades. The concept, 'Model of Care' for the purpose of this thesis, also denotes whether there are resources, such as baths to assist women to have normal births and whether women have control over their privacy. In the medical model, as found in these stories, because the organisational structures are geared towards the comfort and convenience of the dominating group (45, 112), there is a lack of such control and resources for birthing

women, as they are on the lowest rung of the patriarchal hierarchy (268).

In the stories of positive interactions however, the policies of the maternity units are used to guide practice, rather than dictate care. These units provide resources such as baths to support normal birth. Access to consultants was not an issue in either of these stories and was initially thought to be irrelevant. It is perhaps more likely that consultants were not mentioned because the organisational culture was very supportive of women centred care, and the medical establishment as a patriarchal, controlling entity has no relevance. The characteristics of the model of care that emerged from the positive stories have been subsumed under the broader concept of 'Women Centred Model of Care'

Contextual and organisational factors are seen as the pre-conditions that set up the framework and social milieu within which any interprofessional interaction is possible. When comparing my initial conceptualisation with the theories of Emotional and Social Intelligence and their competencies, I recognised that some of my concepts are equivalent to and contained sub-concepts of existing concepts that were developed by Bar-On and Parker (118). For instance, I have categorised 'own agenda focussed' a concept which occurs in the stories of negative interactions, as an absence of Bar-On and Parker's first competency 'Awareness of Self and Other' which has four sub-concepts. Two sub-concepts relate to the self; firstly, 'Self Awareness' - which means "a non-reactive, non-judgemental attention to inner states" (117) (p.47) and 'Managing one's own feelings', both of which are inhibited if one is totally focussed on one's own agenda. The other two sub-concepts relate to 'other' awareness. These are 'Perspective Taking' and 'Social Norm Awareness', which is, according to Bar-On and Parker, the capacity to critically evaluate social, cultural and media messages pertaining to social norms and personal behaviour (118). This ability is also disabled when one is totally focussed on one's own agenda as in the stories of negative interactions. Conversely, these aspects are enhanced when one is considering and supportive of the needs and choices of another, as the practitioners are in the stories of positive interactions.

4.0 A Theory of Interprofessional Integrative Power (Negative)

In the following discussion, I explore the ideas and concepts which emerged from the analysis of the stories of negative interactions. New concepts are presented and outlined. In the literature it was identified that the medical establishment acts as a powerful agent of social control, enforcing 'socially appropriate' behaviour and perpetuating gendered stereotypes according to its norms and values (179). The stories of negative inter-professional interactions give a perception of the medical establishment acting as an agent of social control, dictating the behaviour of the health practitioners in the stories. This concept has been named 'Medical Establishment acts as an Overarching Dictatorship Style Government'. The medical establishment in these stories

is considered to represent the 'patriarchy', a group of faceless, nameless, male doctors who are outside the hospital. This fantasised group is imagined to be surveilling and potentially judging and punishing individuals who do not follow conservative obstetric practice. According to Foucault (45), patriarchy ensures its survival by constructing knowledge that fits with its own ideology and setting up systems of surveillance that ensures the rules of patriarchal ideology are followed. The way that the Medical Establishment functions in these stories of negative midwife-doctor interactions is a perfect match for Foucault's interpretation. Foucault (45) described how dominant groups set rules and social structures that tend to restrict the autonomy of subordinates and allow those at the top to view all aspects easily. Restricting autonomy is oppressive (110, 112), and leads to all kinds of negative consequences for midwives, doctors and childbearing women. The literature demonstrates that keeping doctors and midwives separate in a punitive, hierarchical system, leads to stereotyped, submissive, obsequious behaviours, 'unholy alliances' and progressive dissociation between health care practitioners (25, 181). It also results in suboptimal conflict resolution, poor interpersonal communication skills, unresolved disagreements and the opinions of nurses and midwives are not well received (175).

In the Medical Model of Care as depicted in these stories, the medical profession takes on the role of 'Officers in the Medical Army' who ensure the Medical Establishment's rules are enforced and followed. The doctors in these stories acted as 'Junior officers in the Medical Army' and their behaviour is at times, almost robotic, focussed on their role of 'obeying the rules' and 'getting the job done'. Birth Territory appears in these stories as an 'Occupied Territory' subjected to surveillance and military-like control of all the activities within the territory. The way that Birth Territory functions in these stories as an Occupied Territory is a new concept relating to Power.

Foucault (45, 230) likened the 'bird's eye view' of patriarchal management to the use of the Panopticon, a tall tower, situated in the middle of prisons where prisoners of war were held. The tower ensured large numbers of people could be observed by the few. Observers (non commissioned officers-NCOs) were drawn from the ranks of the imprisoned community and, in the absence of leaders, keep control. The NCOs were more abusive and cruel than the leaders. According to Foucault (45), this coercive surveillance and control strategy is found in most western institutions, including hospitals. In the stories about negative interactions between midwives and doctors, the midwifery managers can be seen to function as NCO's in the Medical Army. This concept appears in the model as 'Midwifery managers as NCO's in Medical Army).

The midwives in these stories reminded me of 'Covert Resistance Fighters' whose focus is

‘avoiding medical intervention’ and ‘getting women through’ labour to birth normally and have been named accordingly. Iacono (184) described how nurses have been found to avoid communicating with doctors when they perceive it will lead to conflict. The midwives in these stories also used avoidance as a tactic in their care of birthing women. Whilst the midwives used avoidance, the doctors used dominance. Both avoiding and dominating behaviours convey a problem with the expression of the whole range of social and emotional skills intelligence and their competencies (see table 2.3 for details). In the ‘Medical Model of Care’ as demonstrated in these stories and depicted in this table, the registrars ‘win’ control of the woman’s birth and she is subjected to a ‘Forced Birth’.

The following table displays these factors and concepts from analysis of the negative interactions as ‘A Theory of Inter-Professional Integrative Power - Negative’ to illustrate what inhibits inter-professional interaction in the care of birthing women. The table reads from left to right. The factor from the data is in column one; the degree, size or intensity of the factor is in column two. The third column denotes the relationship of the factor to the first level of theory development and the last column contains the final concept of my theory. There are five aspects to the table: the contextual/organisational and the personal and the interactional for both the midwives and the doctors in these stories of negative interprofessional interaction

Table 6.1: A Theory of Interprofessional Integrative Power (Negative)

ORGANISATIONAL AND CONTEXTUAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Medical Model of Care	Strict adherence	High levels of surveillance Midwives are unable to practice autonomously Focus on compliance with protocols and job completion Encourages use of disintegrative power.	Medical Establishment acts as Overarching Dictatorship Style Government Terrain: Surveillance Jurisdiction: Medical Domination Disables Midwifery Guardianship by midwives and doctors Forced Birth more likely
		Encourages turf war and power struggles	Birth Territory becomes an Occupied Territory
		Doctors, midwives and birthing women assigned and take on stereotypic roles	Encourages stereotypic roles: Obstetrician/s as General/s in Medical Army Registrars and Resident Doctors as Junior Officers in Medical Army Midwifery Managers as Non Commissioned Officers (NCO's) Midwives as Troops or Covert Resistance Fighters Birthing women are patients who should be submissive
		Destroys the ability of midwives and doctors to exercise social and emotional intelligence	Emotional Competence: Low Social Competence: Low
		Absence of resources to support normal birth	Promotes Forced Birth
MIDWIVES' PERSONAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Midwifery Education Graduate Diploma Midwifery	Medium	Was a nurse before becoming a midwife; may affect way socialised	Jurisdiction may be compromised
Experience: Senior	Medium	Long socialisation in the medically dominated system	Jurisdiction may be compromised
Gender	Female	Stereotypically women are more likely to be submissive	Jurisdiction may be compromised
Avoiding and resisting medical intervention	High	Decreases Emotional and Social Intelligence *	Supports 'Midwife as Covert Resistance Fighter' stereotype Emotional and Social Competency may be compromised

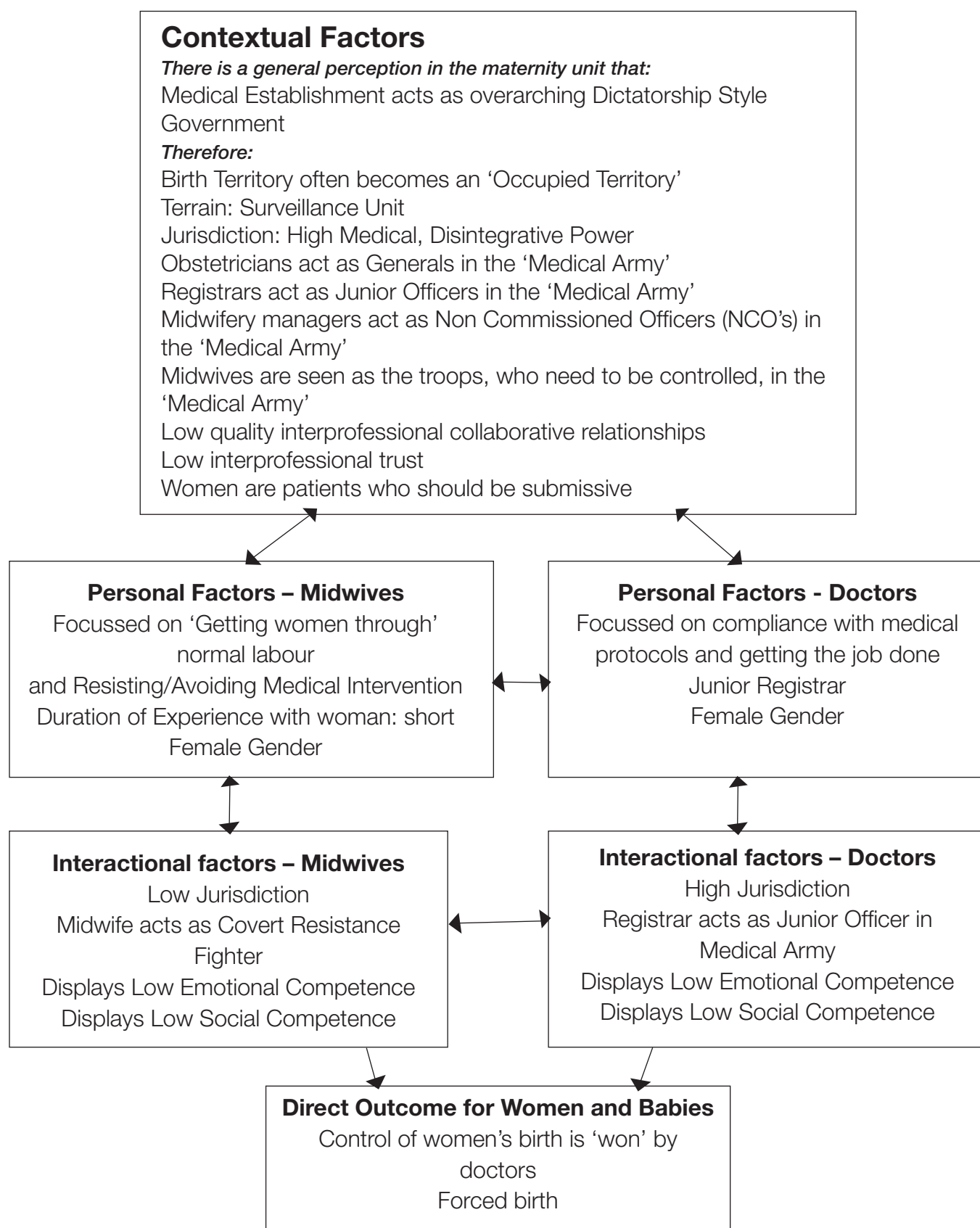
DOCTORS' PERSONAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate Theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Obstetric Training: Registrar	Medium	Training conducted under Medical Model	Potential for disintegrative power: medium
Experience: Junior	Medium	More likely to adhere to rules and follow orders from superiors	Potential for disintegrative power: medium
Gender: Female	Low	Stereotypically women are more likely to be submissive	Potential for disintegrative power: medium
Complying with medical protocols and getting the job done	High	Decreases Emotional and Social Intelligence*	Supports 'Junior Officer in Medical Army' stereotype Emotional and Social Competency may be compromised
MIDWIVES' INTERACTIONAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate Theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Passive/Aggressive/Submissive behaviour	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Creates Occupied Territory Jurisdiction: Low Midwife as Covert Resistance Fighter: High Emotional Competence: Low Social Competence: Low Promotes Forced Birth
Feeling under Siege	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Occupied Territory: High Jurisdiction: Low Midwife as Covert Resistance Fighter: High Emotional Competence: Low Social Competence: Low Promotes Forced Birth
Engaging in a Turf war	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Occupied Territory: High Jurisdiction: Low Midwife as Covert Resistance Fighter: High Emotional Competence: Low Social Competence: Low Promotes Forced Birth
Women as object	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Occupied Territory: High Jurisdiction: Low Midwife as Covert Resistance Fighter: High Emotional Competence: Low Social Competence: Low Promotes Forced Birth
Controlling women's birth	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Occupied Territory: High Jurisdiction: Low Midwife as Covert Resistance Fighter: High Emotional Competence: Low Social Competence: Low Control over woman's birth 'lost' by midwife Forced Birth: High

* less likely to be self aware, less able to take another's perspective; less likely to have positive attitudes and values etc (see Chapter 2 for Emotional and Social Competencies in more detail)

DOCTORS' INTERACTIONAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate Theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Dominating/Robotic behaviour.	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Creates the Occupied Territory Jurisdiction: High Junior Officer in Medical Army: High Emotional Competence: Low Social Competence: Low Promotes Forced Birth
Acting in Command	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Creates the Occupied Territory Jurisdiction: High Junior Officer in Medical Army: High Midwives as 'troops': High Emotional Competence: Low Social Competence: Low Promotes Forced Birth
Treating Midwife as Subordinate	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Occupied Territory: High Jurisdiction: High Junior Officer in Medical Army: High Midwives as 'troops': High Emotional Competence: Low Social Competence: Low Promotes Forced Birth
Treating Woman as Object	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Occupied Territory: High Jurisdiction: High Junior Officer in Medical Army: High Midwives as 'troops': High Emotional Competence: Low Social Competence: Low Promotes Forced Birth
Controlling women's birth	High	Emotional Intelligence: Low Social Intelligence: Low Disintegrative power: High	Occupied Territory: High Jurisdiction: High Junior Officer in Medical Army: High Midwife as Troops: High Emotional Competence: Low Social Competence: Low Control over woman's birth 'won' by registrar Forced Birth: High

Table 6.2: Model of Interprofessional Integrative Power (Negative)

The following flow chart provides a model of negative interprofessional interactions. It includes the organisational, personal and interactional factors which contribute to the negative interaction and demonstrates the effect on the birthing woman. In this model, interprofessional power is disintegrative.



5.0 A Theory of Interprofessional Integrative Power (Positive)

In the stories of positive interactions (those that went well and facilitated a genius birth for the woman) we note the egalitarian, trusting, respectful behaviour of all the midwifery and medical participants in working with women. This behaviour is consistent with the manner in which people come together around a table in a way that creates integrative power to focus on a common goal. The common goal in these instances of midwifery and medical interaction was to support the woman and her choices through her birthing process; *i.e.* Genius Birth. Therefore I have added a new concept that relates to Power and have named the way the Birth Territory functions in these stories as '***The Round Table***'. Not surprisingly, once the power in the birth territory is shared in this 'round table' way then the knowledge/power of the medical establishment seems to have no relevance in these stories.

A comprehensive report from the Institute of Medicine, *To Err Is Human: Building a Safer Health System* in 2001, highlighted the need to create environments that support safe passage for patients. A systematic review looking at interventions to promote collaboration between nurses and doctors concluded that increasing collaboration improved outcomes considered important to patients and managers (170). The creation of The Round Table in birthing units enables a safe environment, where clinicians truly work together and are more likely to have "real" conversations at work. They will also willingly engage in interactions that initiate and maintain dialogue between professional groups (184). The Round Table environment is one in which the importance of every health care practitioner's role and contribution to health service delivery is recognised and valued by health care providers. In such an environment, each health care practitioner can freely use his or her skills, expertise and clinical judgment when planning and providing health care to patients (269). The benefits for childbearing women are obvious from these stories.

The behaviour of the midwifery and medical participants in these stories of positive interactions needed to be depicted in a satisfactory way and initially I discarded the Birth Territory concept of 'midwifery guardian' thinking it too practitioner specific. I decided to call their behaviour 'Birth Guardianship' because the midwives and doctors in these stories were similar in their attitudes and behaviour during their interactions. Both were equally woman focussed and protective of her birth territory. When Jack, the doctor, had the goal of attending his first water birth, he, like the others in these stories was focussed on supporting the woman in her process and her choices as well as his own learning needs.

As I read and reread the stories, the words 'with woman' continued to come up for me. I was aware that in the past, doctors were known as man-midwives when they first started practicing obstetrics. William Smellie, for example, was known as the 'father of midwifery'

and called himself a Professor of Midwifery (270). Both the doctors in these positive stories were regarded as being ‘midwife-like’, meaning they acted ‘with woman’ and were respectful of the woman’s choices and protective of the birth territory. In consultation with others involved in the development of Birth Territory Theory, I thought the concept of midwifery guardianship could mean someone who was ‘with woman’, ‘supportive of women’s choices’ and ‘protective of the birth territory’ as these practitioners in these stories were. Therefore the roles and behaviour of the midwives and doctors in these stories of positive interactions are conceptualised as **‘Midwifery Guardianship’**. The concept of ‘midwifery guardian’ from Birth Territory theory needs to be understood as applying to anyone who takes a ‘with-woman approach to birth’. These factors and their concepts are shown in the table below. The table is read in the same way as the previous table.

Table 6.3: A Theory of Interprofessional Integrative Power (Positive)

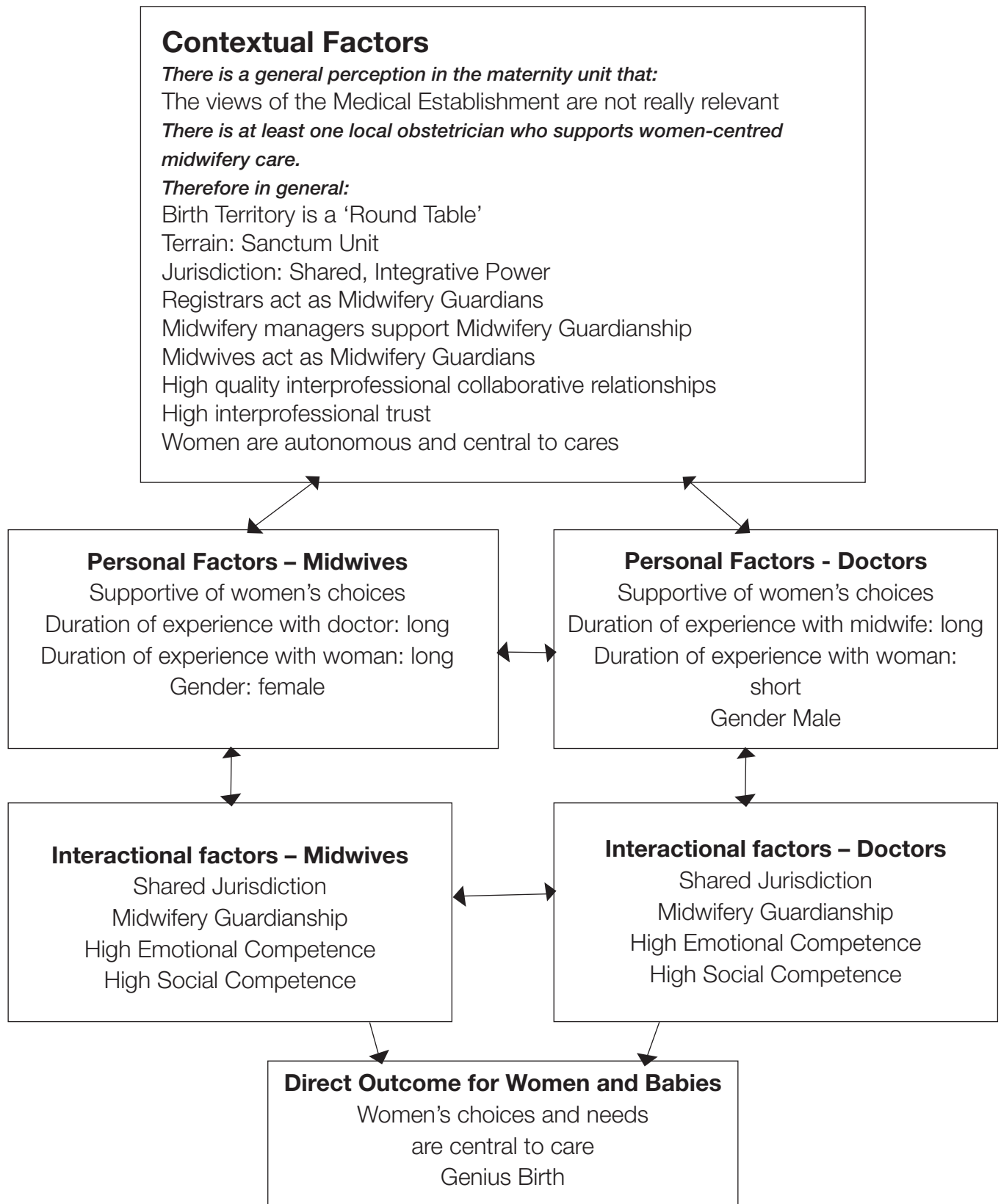
ORGANISATIONAL AND CONTEXTUAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Women centred Model of Care	High	Low levels of surveillance Midwives practice autonomously Focus on woman and her experience Enables use of Integrative Power	Terrain: Sanctum Jurisdiction: Shared The Round Table Enables Midwifery Guardianship by midwives and doctors Enables Genius Birth
		Midwives and doctors work, learn and socialise together	Enables Midwifery Guardianship Enables Genius Birth
		Enhances ability of midwives and doctors to exercise social and emotional intelligence	Emotional Competence: High Social Competence: High
		Women's rights and choices are respected Presence of resources to support normal birth	Enables Genius Birth
MIDWIVES' PERSONAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Midwifery Education Graduate Diploma Midwifery	Medium	Was a nurse before becoming a midwife; may affect way socialised	Jurisdiction may be compromised
Experience: Senior	Medium	Long socialisation in the medically dominated system	Jurisdiction may be compromised
Gender	Female	Stereotypically women are more likely to be submissive	Jurisdiction may be compromised
Supportive of woman's choices	High	Increases Emotional and Social Intelligence *	Enhances Emotional Competence and Social Competence Supports Midwifery Guardianship Supports Genius Birth

DOCTORS' PERSONAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate Theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Obstetric Training: Registrar	Low	Training conducted under Medical Model	Potential for disintegrative power: medium
Experience: Junior	Low	More likely to adhere to rules and follow orders from superiors	Potential for disintegrative power: medium
Gender: Male	Low	Stereotypically men are more likely to be dominant	Potential for disintegrative power: medium
Supportive of woman's choices	High	Increases Emotional and Social Intelligence *	Enhances Emotional and Social Competence Supports Midwifery Guardianship Supports Genius Birth
MIDWIVES' INTERACTIONAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate Theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Demonstrating collaborative behaviour	High	Emotional Intelligence: High Social Intelligence: High Integrative Power: High	Promotes The Round Table Jurisdiction: Shared Midwifery Guardianship: High Emotional Competence: High Social Competence: High Genius Birth: High
Providing women centred care	High	Emotional Intelligence: High Social Intelligence: High Integrative Power: High	The Round Table: High Jurisdiction: Shared Midwifery Guardianship: High Emotional Competence: High Social Competence: High Genius Birth: High
DOCTORS' INTERACTIONAL FACTORS			
Factor identified in data	Degree, size or intensity of factor	Relationship of factor to Sub-Ordinate Theoretical Concepts	Relationship of sub-ordinate theoretical concepts to Super-Ordinate Theoretical Concepts
Demonstrating collaborative behaviour	High	Emotional Intelligence: High Social Intelligence: High Integrative Power: High	Creates the Round Table Jurisdiction: Shared Midwifery Guardianship: High Emotional Competence: High Social Competence: High Promotes Genius Birth
Providing women centred care	High	Emotional Intelligence: High Social Intelligence: High Integrative Power: High	The Round Table: High Jurisdiction: Shared Midwifery Guardianship: High Emotional Competence: High Social Competence: High Genius Birth: High

* more likely to be self aware, be able to take another's perspective; have positive attitudes and values etc (see Chapter 2 for Emotional and Social Competencies in more detail)

Table 6.4: Model of Interprofessional Integrative Power (Positive)

The following flow chart provides a model of positive interprofessional interactions. It includes the organisational, personal and interactional factors which contribute to the positive interaction and demonstrates the effect on the birthing woman. In this model, interprofessional power is integrative.



5.0 CONCLUSION

In this chapter I present a Theory of Interprofessional Integrative Power which I have developed by drawing together the factors identified from the data. The Theory can be used to describe, explain and change how power operates in Birth Territory for the ultimate benefit of birthing women. I have developed two inter-related models which depict the two poles of the use of power in professional interactions; one positive and one negative. I have provided a flow chart of the models for easy identification of the elements of the theory and how they related to each other. I have demonstrated how the literature supports this *Theory of Interprofessional Integrative Power*. In summary, the theory of interprofessional integrative power leads to the following conclusions.

When a strict medical model of care is used as the framework for maternity services, then midwives and doctors, irrespective of their usual levels of emotional and social intelligence and competence, assume stereotypical competitive roles. Under these circumstances, birth territory becomes an ‘occupied territory’; interprofessional power is used in a disintegrative manner; women are subjected to pressure to conform to a rigid set of rules and they end up with a ‘forced birth’. In addition, neither midwife nor doctor feels good about themselves or the interaction.

In contrast, when a maternity unit has a women centred model of care and managers create a ‘round table’ birth territory, in these circumstances midwives and doctors are expected and supported to and interact in collaborative ways which means they continue to develop their emotional and social and social intelligence and competencies. In a round table birth territory, interprofessional power is used in an integrative manner and both midwives and doctors are much more likely to act as ‘midwifery guardians’. The outcome is that women are supported in their choices and are able to have a genius birth (267). In addition, both the midwife and the doctor feel good about themselves and the interaction.

CHAPTER SEVEN: CONCLUSION

1.0 Introduction and Thesis

This research sought to discover ‘what factors affect interprofessional interaction in birthing units and how do these interactions impact on birthing outcomes? In the literature review and results chapters I demonstrate that the link between poor communications and adverse events in maternity services has been well known for a long time and yet no real change in how midwives and doctors relate to each other has occurred. This may be because organisations think the issues have to do with personalities and are therefore somehow not the responsibility of managers and clinical leaders. On the contrary, my thesis is that organisational factors are more important than the personalities of the individuals involved in the interactions because organisational factors frame, direct and limit what discourses and therefore behaviours, are possible.

Strategies which focus on improving relationships, such as workshops/policies etc promoting teamwork, between health professionals have some immediate benefits for some of the participants of these programmes and so are worthwhile. In my opinion, these strategies alone, as good as they are, are not enough to change the culture and so are doomed to failure in the long run unless the culture is changed along with the implementation of these strategies. The problem is the underlying structure of health service delivery which gives preference and privilege to one group over another and the enormous power imbalance this system of preferential treatment creates. As the history of maternity services demonstrates, the enormous power imbalance inherent in modern maternity care creates tensions, underhanded practices, over inflated personalities and unsatisfied women. It also produces avoidable adverse outcomes for women and babies.

This study demonstrates that when there is a woman centred approach to service delivery, then team work, collaboration, good interprofessional relationships and optimal outcomes for mother and baby are more likely to occur. A woman centered approach in maternity care means that the care is individualised. The woman is regarded as an autonomous being who is the expert on herself and the person best situated to care for her baby. The woman has the right to be self determining and have control over what happens to her. She has the right to be fully involved in decision making about her care. In this model of care, the midwife and doctor establish a partnership with the woman to meet her needs within the context of her childbearing experience.

2.0 Recommendations

There are five domains of midwifery which benefit from this study. The domains are outlined below and recommendations for each domain are given.

2.1 Midwifery and Organisational Administration

The theory generated by this study provides a compelling rationale for moving to an individualised, woman centred approach to maternity service provision. The theory illustrates the need to remove the silos of professional separateness and dismantle the medicalised, hierarchical approach to maternity care. The means of achieving a woman centred approach to maternity care and a 'round table' culture are provided below.

2.2 Recommendations for Midwifery and Organisational Administration include:

Leaders in maternity services to create and maintain a culture and setting which has integrated the following practices and principles into the processes and structure of the birth territory:

- The adoption of a woman centred approach to care
- Provide choice of birthplace for women; home, birth centre, traditional birth rooms
- One to one care for midwives to care for no more than 40 women a year so that individualised focus can be maintained
- Provide homelike environments in hospital facilities for birthing women where women's privacy is respected and protected
- Treat birth room the same as room of conception
- If seeking entry to a birthing women's room, must knock and wait to be invited in (true emergencies are excluded of course)
- Admission to birth rooms by staff members must only be sought when women have genuine need
- Demonstrate that the woman and her baby are valued by ensuring the woman has the information she needs and the opportunities to make informed choices about her care.
- Demonstrate that women are regarded as competent, autonomous beings who have the right to be self determining and whose rights and choices are respected and central to the care provided
- Provide the resources to support normal birth in each birthing room
- Minimise the use of technological surveillance of birthing women
- Encourage a flexible approach to protocols/guidelines to allow for individualised care of birthing women
- Encourage use of integrative power whereby midwives, doctors and women together discuss options of care

- The deconstruction of professional silos
- Midwifery and medical staff are considered as a single team as evidenced by:
 - Shared staff tea room
 - Shared case conferences
 - Multi professional learning sessions
 - Shared social occasions
- Systemic use of integrative power whereby midwives, doctors and women together discuss options of care
- Clear policies designed to promote respectful, effective communications between clinicians
- A range of strategies that can be used when individual clinicians violate policies designed to promote effective communication
- Midwives, women and doctors on working parties together to develop policies etc.
- Promoting and providing opportunities for staff to learn and develop emotional and social competency
- Provision of a range of options of care for childbearing women, including midwifery models of care

2.3 Midwifery Practice

This study provides insight into ways to improve collaboration between midwives and doctors and increase the coordination of care for birthing women, thus reducing the potential for clinical error.

2.3.1 Recommendations for Midwifery Practice include:

- That midwives learn about and take a partnership approach to women's care
- That midwives seek to ensure the focus of their care is the woman; her needs and desires
- That midwives learn and incorporate emotional and social skills and competencies into their midwifery work with colleagues

2.4 Midwifery Education

This study provides a blueprint for acceptable interprofessional behaviour and important emotional, social and communication skills that can be taught to doctors and midwives so they know how to relate to each other better.

2.4.1 Recommendations for Midwifery Education include:

- Providing a women centred curriculum
- Incorporating Birth Territory Theory into the midwifery curriculum
- Incorporating the Theory of Interprofessional Integrative Power into the curriculum

- Incorporating emotional and social intelligence theory into the learning process and providing opportunities for students to practice the skills and develop the competencies in these domains of midwifery practice
- These recommendations have application to medical training too.

2.5 Midwifery Research

This study is only a beginning of a research agenda which could be expanded to incorporate similar research in multistate and multicentre sites, together with a combination of quantifiable as well as qualitative data to determine if the conclusions can be applied to a broad population of midwives and doctors. A large quantitative study could closely examine the contextual factors that did not appear relevant, or whose relevance was difficult to interpret in this study such as time of day and size of maternity unit, gender of doctor, length of relationship between doctor and midwife etc and see what effect those aspects have on a larger scale than what was possible in this small project. The risk averse nature of modern maternity care would be good to investigate because although that did not emerge as an identifiable factor in this study, it is a reality of modern day professional practice. It would be very valuable to know what doctors and midwives experiences are in relation to that contextual factor and how that impacts upon midwife-doctor relationships. The interview schedule could also be refined to fit an expanded and more in depth study.

In thinking about the difficulties I had in recruiting doctors to my study, it would be useful to study doctors' attitudes to midwifery research. Even doctors who are supportive of midwifery work and actually participated in this research project did not recruit other doctors to my study. There are many aspects about the midwifery-doctor relationship which are worthy of investigation. As I read and reread the stories of the negative and positive interactions I wanted to investigate aspects like what doctors think of midwifery management; what doctors and midwives think would improve relationships etc. Other areas are what midwives and doctors think collaboration means and what women centred care means. I feel sure that as people read the stories, many research projects will suggest themselves to the readers. I found myself fascinated by the body language of midwives and doctors as related by the participants and thought that it would be very important and useful to design and conduct a research project that could look at that aspect of midwifery-medical relationships. Interpretive Interactionism is at its best if actual interactions can be observed and then both participants interviewed afterwards. It was not possible from either ethical or logistical considerations to do that in this study, but it is an exciting opportunity for research in the future.

2.6 Midwifery Theory

This research has drawn upon and strengthened birth territory and midwifery guardianship

theory. I have developed new theory about power and how power is used in the workplace. The study can also contribute to social theory in particular to health service organisation theory.

3.0 Limitations of the study

Whilst this study is useful in that it combines original findings with a rigorous literature review, the limitations of such a small study were recognised from the beginning. It is clear from this study that further work needs to be done. Further work could involve research conducted in multistate and multicentre sites, together with a combination of quantifiable as well as qualitative data to determine if the conclusions can be applied to a broad population of midwives and doctors. The interview schedule could also be refined to fit an expanded and more in depth study.

4.0 In conclusion

The history of the medical domination of midwifery is replete with examples of power plays and turf wars which will never be the basis for ongoing effective interprofessional collaboration. This history shows that the struggles have been about occupational territory, power, control and money. In spite of rhetoric to the contrary, women and their needs are low on professional agendas, thus woman-centered care is only an ideal that is rarely achieved within current maternity services. I have argued that social and emotional intelligence and their competencies are essential attributes for fully developed interprofessional communication but the literature indicates that these skills are not widespread in either midwifery or medicine. The lack of social and emotional intelligence and competence not only underpins the doctor-nurse and therefore midwife-doctor game, it also gives rise to interprofessional power plays which diminish a woman's power to birth and to mother, with life long consequences for her infant.

However, what effective interprofessional collaboration truly looks like is still being investigated. There is an absence of empirical evidence on the effects of interventions aimed at achieving teamwork although this study provides some information; we need more research about how true collaboration between health professionals may be made possible. A major challenge is that the concept of collaboration for doctors tends to mean midwifery cooperation and submission to medical authority. Midwives and nurses, however, view collaboration as meaning equal relationships based on professional recognition and respect with a common goal. For midwifery, that goal is women centered care. I conclude that any organisational efforts designed to improve collaboration and outcomes of maternity care will fail unless or until we have a women centred approach to care provision coupled with successful interventions that move towards disbanding professional silos, instituting genuine dialogic relationships between midwives and doctors as well as addressing social and emotional intelligence and competence in both professional groups.

REFERENCES

1. Doering L. Nurse-physician collaboration: At the crossroads of danger and opportunity. *Critical Care Medicine* 1999;27(9):2066-2067.
2. Donchin Y, Gopher D, Olin M, et al. A look into the nature and causes of human errors in the intensive care unit. *Critical Care Medicine* 1995;23:294-300.
3. Douglas N, Fahy K, Robinson J. Final Report of the Inquiry into Obstetric and Gynaecological Services at King Edward Memorial Hospital 1990-2000", (Five volumes), Western Australian Government. Inquiry into Obstetric and Gynaecological Services at King Edward Memorial Hospital Western Australia State Law Publishing. 2001.
4. Fahy K. An Australian history of the subordination of midwifery. *Women and Birth* 2007;20(1):25-29.
5. Hastie C. Midwifery: Women, History and Politics. *Birth Issues* 2006;15(1):11-17.
6. Wicks D. Doctors and Nurses at Work: Rethinking Professional Boundaries. Buckingham: Open University Press; 1998.
7. Wicks D. How History Contains the Present and the Future In: Hunter Valley Midwives Association Conference. Newcastle, NSW; 1989.
8. Willis E. Medical dominance: the division of labour in Australian Health Care. Sydney: Allen and Unwin; 1983.
9. Flook C. Women-centred antenatal care *Nursing Times* 1992;88(9):62-63.
10. Thompson F. Midwives and Mothers: the Ethical Journey. London: Elsevier; 2004.
11. Buhagiar T. Eyeing off the patients is not on. *Australian Doctor Weekly* 1992;6.
12. Cochrane S. Midwives, nurses and doctors: Interprofessional relationships. In: Murphy Black T, editor. *Issues in Midwifery*. New York: Churchill Livingstone; 1995. p. 253-273.
13. Kitzinger J, Green JM, Coupland V. Labour relations: midwives and doctors on the labour ward. In: Garcia J, Kilpatrick R, Richards M, editors. *The politics of maternity care: services for childbearing women in twentieth century Britain*. Oxford: Oxford University Press; 1990.
14. Robinson S. Caring for childbearing women: the inter-relationship between midwifery and medical responsibilities. In: Robinson S, Thompson A, editors. *Midwives research and childbirth*. London: Chapman & Hall; 1986.
15. Marland H, editor. *The art of midwifery: early modern midwives in Europe* London: Routledge; 1993.
16. Blais R, Lambert J, Malheaux B. What accounts for physician opinions about midwifery in Canada? *Journal of Nurse-Midwifery* 1999;44(4):399-407.
17. Miller S, King T, Lurie P. Certified nurse-midwife and physician collaborative practice.

- Piloting a survey on the Internet. *Journal of Nurse-Midwifery* 1997;42(4):308-315.
18. Pringle R. *Sex and Medicine: gender, power and authority in the medical profession* Cambridge: Cambridge University Press; 1998.
 19. Mackin P, Sinclair M. Labour ward midwives perceptions of stress. *Journal of Advanced Nursing* 1998;27(986-991).
 20. Peter E. Ethical conflicts or political problems in intrapartum nursing care? *Birth* 2000;27(1):46-48.
 21. Cahill H. Male appropriation and medicalisation of childbirth: an historical analysis *Journal of Advanced Nursing* 2001;33(3):334-342.
 22. Quinlivan J, Thompson C, Black K, al e. Medical and midwifery students: how do they view their respective roles on the labour ward? . *Australian and New Zealand Journal of Obstetrics and Gynaecology* 2002;42(4):401-406.
 23. Hughes D, Deery R, Lovatt A. A critical ethnographic approach to facilitating cultural shift in midwifery *Midwifery* 2002;18(1):43-52.
 24. Cresswell A. *Battlefield Birth. The Weekend Australian* 2005;Sect. 20.
 25. Baggs JG. Intensive care unit use and collaboration between nurses and physicians. *Heart Lung* 1989;18:332-338.
 26. Haertsch M. *Safe Staffing and Patient Safety: Literature Review*. Canberra: The Australian Council for Quality and Safety in Health Care; 2003.
 27. MCHRC. *Confidential Enquiry into Stillbirths and Deaths in infancy Annual Report*. London: Department of Health UK.; 1998 1 January - 31 December 1996. Report No.: Fourth.
 28. Consortium MaCH. *Confidential Enquiry into Stillbirths and Deaths in infancy Annual Report*. London: Department of Health UK.; 1998 1 January - 31 December 1996. Report No.: Fourth.
 29. HCCC. *Investigative Report into Adverse Outcomes at Macarthur and South Western Health Services*. Sydney: Health Care Complaints Commission; 2003.
 30. Nückles M, Bromme R. Knowing what others know: A study on interprofessional communication between nurses and medical doctors. *Klinische Padiatrie* 1998;210:291-296.
 31. Lindeke L, Sieckert A. Nurse-Physician workplace collaboration. *Online Journal of Issues in Nursing* 2005;10(1).
 32. Krogstad U, Hosfoss D, Hjortdahl P. Doctor and nurse perception of interprofessional co-operation in hospitals *International Journal of Quality Health Care* 2004;16:491-497.
 33. Donnison J. *Midwives and medical men: A history of interpersonal rivalries and women's rights*. New York: Schocken Books; 1977.
 34. Glass LK, Brand KP. *The Progress of Women and Nursing, Parallel or Divergent?* Armidale CAE Handbook 1985.

35. Murphy-Lawless J. *Reading Birth and Death: A History of Obstetric Thinking*. Cork: Cork University Press; 1998.
36. Donnison J. *Midwives and Medical Men: A history of the struggle for the control of childbirth*. London: Historical Publications; 1988.
37. Roberts SJ. Oppressed group behaviour. Implications for nursing. *Advances in Nursing Science* 1983;21-30.
38. Hunt S, Symonds A. *The Social Meaning of Midwifery*. London: Macmillan Press Ltd; 1995.
39. Muff J, editor. *Socialisation, sexism and stereotyping, women's issues in Nursing*, CV Moseby Co. London. London: CV Moseby Co; 1982.
40. Heron J. *The Facilitator's Handbook*. London: Kogan Page Ltd; 1989.
41. Raphael-Leff J. *Psychological Processes of Childbearing*. London: Chapman and Hall; 1991.
42. Furler E. *Women and Health, Radical Prevention*. *New Doctor* 1985.
43. Scutt J. *The Incredible woman; power and sexual politics*: Artemis Publishing; 1997.
44. Scutt J. *The Incredible Woman: Power and Sexual Politics* Melbourne: Artemis Publishing Pty Ltd; 1997.
45. Foucault M. *Discipline and Punishment*. London: Penguin; 1977.
46. Meredith L. The Doctor Nurse Game: Sexual Politics in Health Care. *New Doctor* 1985;30-31.
47. Passau-Buck S, Magruder Jones E. Omnipotent, Omniscient Paternalism. *Revolution: The Journal of Nurse Empowerment* 1997(Winter):18-71.
48. Stein L, Watts DT, Howell T. The doctor-nurse game revisited. *New England Journal of Medicine* 1990;322:546-549.
49. Stein L. The Doctor-Nurse Game. *The American Journal of Nursing* 1968;68(1):101-105.
50. Radcliffe M. Doctors and nurses: new game same result. *British Medical Journal* 2000;320:1085.
51. Brodie P. *The invisibility of midwifery - will developing professional capital make a difference?* [PhD]. Sydney: University of Technology, Sydney; 2003.
52. Adamson B, Kenny D, Wilson-Barnett J. The impact of perceived medical dominance on the workplace satisfaction of Australian and British nurses. *Journal of Advanced Nursing* 1995;21:172-183.
53. Adcock W, Bayliss U, Butler SM, Hayes P, Woolston H, Sparrow P. *With Courage and Devotion, A history of Midwifery in NSW*. Marrickville: Southwood City Press Pty Ltd; 1984.
54. Kenny A, Duckett S. A Question of Place: Medical Power in Rural Australia *Social Science & Medicine* 2004;58(6):1059-1073.

55. Abbott T. More support for GP obstetricians in rural areas. In: Aging DoHa, editor.: The Australian Government; 2007.
56. Woollard L. Closure of Muswellbrook Maternity Unit Averted:Team Approach to Maternity Care to Continue. Muswellbrook: Rural Doctors Association (NSW) Inc; 2006 Wednesday 18 October.
57. Editor. Mums lobby for birthing options. Manning River Times 2005 Wednesday 22 June;Sect. 1.
58. AIHW. Australia's Mothers and Babies 1999. Canberra: Australian Institute of Health and Welfare; 2001.
59. Maternity Coalition, Australian Society of Independent Midwives, Community Midwifery WA Inc. National Maternity Action Plan: Maternity Coalition; 2002 September.
60. The Jacobs Institute of Women's Health. Models of Collaborative Practice: Preparing for Maternity Care in the 21st Century. Women's Health Issues 1997;7(5):279-288.
61. Health Department of Western Australia. Enhanced Role of the Midwife Project. Perth: Government of Western Australia; 2001.
62. NSWHealth. The NSW Framework for Maternity Services. In: NSW Department of Health, Better Health Publications; 2000.
63. Shearman R. Final Report of the Ministerial Task Force on Obstetric Services In NSW: The Shearman Report. In: NSW Department of Health S, editor.: State Health Publication 1989.
64. NHMRC. Options for Effective Care in Childbirth. In: Department of Community Health: Australian Government Printing Service; 1996.
65. Victorian Department of Health. Having a baby in Victoria: Ministerial Review of Birthing Services in Victoria. Melbourne: Victorian Department of Health; 1990.
66. Commonwealth Department of Community Health and Aged Care. Rocking the Cradle: Report of the Senate Community Affairs References Committee Inquiry into Childbirth Procedures, . Australian Government Printing Services, Canberra; 1999.
67. WHO. Care in normal birth: a practical guide. Geneva: Maternal and Newborn Health/ Safe Motherhood Unit, Family and Reproductive Health, WHO.; 1996.
68. Tucker JS, Hall MH, Howie PW, Reid ME, Barbour RS, du Florey C, et al. Should Obstetricians see women with normal pregnancies? A multicentre randomised trial of routine antenatal care by general practitioners and midwives compared with shared care led by obstetricians. British Medical Journal 1996;312:554-559.
69. Campbell R, Mcfarlane A. Where to be born? The debate and the evidence. (Second ed.) London: National Perinatal Epidemiology Unit; 1994.
70. Department of Health Expert Maternity Group. Changing Childbirth (Cumberledge Report). London: Department of Health HMSO; 1993.

71. WHO. Report on appropriate technology for birth. Geneva: World Health Organisation; 1995.
72. WHO. Declaration of Alma-Ata. In: International Conference on Primary Health Care; 1978 6-12 September; Alma-Ata: World Health Organisation; 1978.
73. WHO. Ottawa Charter for Health Promotion. In: First International Conference on Health Promotion; 1986 21st November; Ottawa: World Health Organisation; 1986.
74. Walsh D, Newburn M. Towards a social model of childbirth Parts 1 and 2. *British Journal of Midwifery* 2002;10:476-481.
75. Hodnett ED. Continuity of caregivers during pregnancy and childbirth Oxford: Cochrane Review; 2004.
76. Walsh D. Improving Maternity Services: Small is beautiful - lessons from a birth centre. Oxford: Radcliffe Publishing Ltd; 2007.
77. Roberts C, Tracy S, Peat B. Rates for obstetric intervention among private and public patients in Australia: population based descriptive study. *British Medical Journal* 2000;321:137-141.
78. Tracy S, Tracy M. Costing the cascade: estimating the costs of increased intervention in childbirth using population data. *British Journal of Obstetrics and Gynaecology* 2003;110:717-224.
79. Hartley H. The system of alignments challenging physician professional dominance: an elaborated theory of countervailing powers. *Sociology of Health & Illness* 2002;24(2):178.
80. Australian Health Ministers. Emerging/Priority Health Workforce Issues (Attachment D). St Kilda, Melbourne: Inaugural National Health Workforce Strategic Forum; 2007 3rd May.
81. Rowley M, Hensley M, Brinsmead M, Wlodarczyk J. Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. *Medical Journal of Australia* 1995;163(95):289-293.
82. Turnbull D, Holmes A, Shields N, Cheyne H, Twaddle S, Harper-Gilmour W, et al. Randomised controlled trial of efficacy of midwife-managed care. *The Lancet* 1996;348(9022):213-221.
83. Oakley D, Murtland T, Mayes F, Hayashi R, Peterson B, Rorie C, et al. Processes of Care: Comparisons of Certified Nurse Midwives and Obstetricians. *Journal of Nurse Midwifery* 1996;40(5):399-409.
84. Downe S, editor. *Normal Childbirth: evidence and debate*. Edinburgh: Churchill Livingstone; 2004.
85. Sandall J, Davies J, Warwick C. *Evaluation of the Albany Midwifery Practice: Final Report*. London: Florence Nightingale School of Nursing and Midwifery; 2001 March.

86. Lepori B, Foureur M, Hastie C. Mindbodyspirit architecture: Creating birth space. In: Fahy K, Foureur M, Hastie C, editors. *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research*. Oxford: Elsevier Science; 2008. p. 95-112.
87. Odent M. *The Scientification of Love*. London: Free Association Books; 1999.
88. Prescott JW. *The Origins of Love and Violence: An Overview*. In; 2002.
89. Jacobson B, Bygdeman M. Obstetric Care and proneness of offspring to suicide as adults: case-control study. *British Medical Journal* 1998;317:1346-1349.
90. Jacobson B, Eklund G, Hamberger L, Linnarsson D, Sedvall G, Veverius M. Perinatal origin of adult self destructive behaviour. *Acta Psychiatrica Scandinavia* 1987;76(4):364-371.
91. Jacobson B, Nyberg K, Eklund G, Bygdeman M, Rydberg U. Obstetric pain medication and eventual adult amphetamine addiction in offspring. *Acta Obstetrica et Gynecologica Scandinavica* 1988;67:677-682.
92. Jacobson B, Nyberg K, Gronbladh L, Ekland G, Bydeman M, Rydberg U. Opiate addiction in adult offspring through possible imprinting after obstetric treatment. *British Medical Journal* 1990;301:1067-1070.
93. Raine A, Brennan P, Mednick SA. Interaction between birth complications and early maternal rejection in predisposing individuals to adult violence; specificity to serious, early-onset violence. *American Journal of Psychiatry* 1997;154:1265-1271.
94. Lipton BH. Nature, Nurture and Human Development. In; 2005. p. 1-9.
95. Saunders TA, Lobel M, Veloso C, Meyer B. Prenatal maternal stress is associated with delivery analgesia and unplanned caesareans. In: *Journal of Psychosomatic Obstetrics*; 2006. p. 1-6.
96. Tops M, van Peer JM, Korf J, Wijers AA, Tucker DM. Anxiety, cortisol, and attachment predict plasma oxytocin. *Psychophysiology* 2007;44: 444-449.
97. Uvnas-Moberg K, Arn I, Magnusson D. The Psychobiology of Emotion: The Role of the Oxytocinergic System. *International Journal of Behavioral Medicine* 2005;12: 59-65.
98. Wadhwa PD. Psychoneuroendocrine processes in human pregnancy influence fetal development and health. *Psychoneuroendocrinology* 2005;30(8):724-743.
99. Weertha Cd, Buitelaar JK. Physiological stress reactivity in human pregnancy—a review *Neuroscience & Biobehavioral Reviews* 2005;29(2):295-312.
100. Kinnear A. Maternity - Public Homebirth Services. In: *Partnerships Primary Health and Community: NSWHealth*; 2006.
101. NSWHealth. Maternity - Public Homebirth Services. In: *Partnerships PHaC*, editor.: NSW Department of Health; 2006.
102. Della P. Homebirth Policy and Guidelines for Management of Risk Factors. In:

- Principal Nursing Advisors Office: WA Department of Health; 2001.
103. South Australian Health Department. Policy for Planned Birth at Home in South Australia. In: Primary Health Care Co-ordination: Government of South Australia; 2007.
 104. Leboyer F. Birth without Violence. London: Wildwood House Ltd; 1975.
 105. Gaskin IM. Spiritual Midwifery. Summertown Tennessee: Book Publishing Company; 1975.
 106. Arms S. Immaculate Deception: A new look at Women and Childbirth in America. Boston: Houghton Mifflin Company; 1975.
 107. Hastie C. Dying for the Cause. ACMI Journal 1996;9(1):28-30.
 108. Hastie C. Midwives eat their young, don't they? Birth Issues 1995.
 109. Hastie C. Exploring horizontal violence. MIDIRS Midwifery Digest 2006;16(1):25-30.
 110. Hedin B. A Case Study of Oppressed Group Behaviour in Nurses. IMAGE: Journal of Nursing Scholarship 1986;18(2):53-57.
 111. Hockley C. Silent Hell: Workplace violence and bullying. Norwood, SA: Peacock Publications; 2002.
 112. Freire P. Pedagogy of the Oppressed. Great Britain: Sheed & Weed; 1972.
 113. Roberts SJ. Oppressed group behaviour: implications for nursing. Revolution the Journal of Nurse Empowerment 1994:29-35.
 114. Robinson J. Are you in the Soup? The toxicology of institutions. British Journal of Midwifery 1998;6(7):459.
 115. Berne E. What do you say after you say Hello? 7th ed. Beverly Hills: Transworld Publishers; 1983.
 116. Goleman D. Social Intelligence: The New Science of Human Relationships. London: Hutchinson; 2006.
 117. Goleman D. Emotional Intelligence. Bloomsbury: Great Britain; 1996.
 118. Bar-On R, Parker JDA, editors. The Handbook of Emotional Intelligence: Theory Development, Assessment and Application at Home, School, and in the Workplace. San Francisco: Jossey-Bass Inc; 2000.
 119. Gosbee J. Communication among health professionals. British Medical Journal 1998;316:642.
 120. Australian Health Ministers' Advisory Council. The Final report of the Taskforce on Quality in Australian Health Care. Canberra: Australian Health Ministers' Advisory Council; 1996.
 121. Health Care Complaints Commission (HCCC). Investigation Report: Campbelltown and Camden Hospitals Macarthur Health Service. Sydney: Health Care Complaints Commission; 2003 December.

122. Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care* 2004;13(suppl_1):i85-i90.
123. Fahy K, Foureur M, Hastie C, editors. *Birth Territory and Midwifery Guardianship*. London: Elsevier; 2007.
124. Editor. Obstetricians banned from Labour wards. *NASOG News* 1995:3.
125. Editor. Independent Midwifery. *NASOG News* 1995:5.
126. Kirkam M, editor. *The midwife-mother relationship*. Basingstokes: Palgrave Macmillan; 2000.
127. Kirkham M. Professionalisation Past and Present: With women or with the powers that be? . In: Kroll D, editor. *Midwifery Care for the future: Meeting the Challenge* London: Bailliere-Tindall.; 1996. p. 164-201.
128. Weaver EW, Clark KF, Vernon B. Obstetricians and midwives modus vivendi for current times. *Medical Journal of Australia* 2005;182(9):436-437.
129. Baldwin L, Hutchinson H, Rosenblatt R. Professional relationships between midwives and physicians: collaboration or conflict? *American Journal of Public Health* 1992;82(2):262-264.
130. Bathgate W, Ryan M, Hall M. Divided views among health professionals on place of birth. *British Journal of Midwifery* 1995;3(11):583-586.
131. Callaghan H. Factors affecting the practice of hospital midwives and independent midwives. In: 3rd National Midwifery Research Forum; 1994; Melbourne; 1994.
132. DeVries R, Barroso R. Midwives among the machines: Recreating midwifery in the late 20th Century, eds, . In: Marland H, Rafferty A, editors. *What is to be done with the midwife? Midwife debates, 1890 - 1990*. London: Routledge; 1996.
133. Murphy Black T. Comfortable men, uncomfortable women. In: Murphy Black T, editor. *Issues in Midwifery*. New York: Churchill Livingstone, 1996. p. 275-297.
134. Sleutel M, Schultz S, Wyble K. Nurses Views of Factors That Help and Hinder Their Intrapartum Care. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 2007;36: 203-211.
135. Stewart M, editor. *Pregnancy, Birth and Maternity Care*. Edinburgh: Books for Midwives; 2004.
136. Coombs M. Power and conflict in intensive care clinical decision making. *Intensive and Critical Care Nursing* 2003;19:125-135.
137. Dodson L, Piatelli D, Schmalzbauer L. Researching inequality through Interpretive Collaborations: Shifting power and the unspoken contract. *Qualitative Inquiry* 2007;13(6):821-843.
138. Lane K. Beyond the Silo Effect: The Challenges of Collaboration. In: 27th Congress of the ICM. Brisbane: ICM; 2005.

139. Wyndam D. Women and Health Services, Catalysts for change. *New Doctor* 1980(May).
140. Koutroulis G. The Orifice revisited: women in gynaecological texts", *Community Health Studies*, Vol. xiv, No. 1. *Community Health Studies* 1990;xix(1).
141. Whelan C. Quality Audit of Fourth Year Medical Students Experience in Delivery Suite. In: *unter New England Health*; 2007. p. 5.
142. Green J, Kitzinger J, Coupland V. The division of labour. Implications of medical staffing structures for midwives and doctors on the labour ward. Cambridge: University of Cambridge: Child Care and Development Group; 1986.
143. Snelgrove S, Hughes D. Interprofessional relations between doctors and nurses: perspectives from South Wales *Journal of Advanced Nursing* 2000;3(7):661-667.
144. Halford S, Leonard P. *Negotiating Gendered Identities and Work: Place, space and time*. First ed. London: Palgrave Macmillan; 2006.
145. Pollard K. Searching for autonomy. *Midwifery* 2003;19(2):113-124.
146. Walker J, Hall S, Thomas M. The experience of labour: a perspective from those receiving care in a midwife-led unit *Midwifery* 1995;11(3):120-129
147. Kirkham M, Stapleton H, Thomas G. Checking not listening: how midwives cope *British Journal of Midwifery* 2002;10(7):447-450.
148. Kirkam M. Midwives and Information-giving during labour. In: Robinson S, Thompson A, editors. *Midwives, research, childbirth*. London: Chapman & Hall; 1989.
149. Deery R, Kirkham MJ. Moving from hierarchy to collaboration. *The Practising Midwife* 2000;3:25-28.
150. Guilliland K, Pairman S. *The midwifery partnership: a model for practice*. Wellington, N.Z.: Victoria University of Wellington; 1995.
151. Reime B, Klein M, C, Kelly A, Duxbury N, Saxell L, Liston R, et al. Do maternity care provider groups have different attitudes towards birth? *British Journal of Obstetrics and Gynaecology* 2004;111:1388-1393.
152. Rosenblatt RA, Dobie SA, Hart LG, Schneeweiss R, Gould D, Raine TR, et al. Interspecialty differences in the obstetric care of low-risk women. *Am J Public Health* 1997;87(3):344-351.
153. Simpson KR, James DC, Knox GE. Nurse-Physician Communication During Labor and Birth: Implications for Patient Safety. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 2006;35(4):547-556.
154. Powell Kennedy H. A model of exemplary midwifery practice: results of a Delphi study. *Journal of Midwifery and Women's Health* 2000;45(1):4-19.
155. Powell Kennedy H. The Midwife as an "Instrument" of Care. *American Journal of Public Health* 2002;92(11):1759-1760.
156. Rossi EL. *The Psychobiology of Gene Expression*. First ed. London: WW Norton &

- Company; 2002.
157. Davies P. *The Cosmic Blueprint*. Third ed. Radnor: Templeton Foundation Press; 2004.
 158. Braud W. Distant mental influence of rate of hemolysis of human red blood cells. *Journal of the American Society for Psychical Research* 1990;84(1):1-24.
 159. Atmanspacher H. Deviations from physical randomness due to human agent intention? *Chaos, Solutions and Fractals* 1999;10(6):935-952.
 160. Becker ROS, G. . *The Body Electric*. New York: William Morrow &Company Ltd; 1985.
 161. Hunt V. *Infinite Mind: Science of the Human Vibrations of Consciousness*. Malibu: Malibu Publishing Co.; 1996.
 162. McTaggart L. *The Field*. Second ed. New York: Harper Collins; 2003.
 163. Morris JS, Frith CD, Perrett DI, Rowland D, Young AW, Calder AJ, et al. A differential neural response in the human amygdala to fearful and happy facial expressions. *Nature* 1996;383(812-815).
 164. Righard L, Alade MO. Effect of delivery room routines on success of first breast-feed. *Lancet* 1990;3(336):1105-1107.
 165. Fahy K, Foureur M, Hastie C, editors. *Birth Territory and Midwifery Guardianship*. London: Elsevier Science; 2008.
 166. Fahy K, Parratt JA. *Birth Territory: A theory for midwifery practice*. *Women and Birth* 2006;19(2):45-50.
 167. Parratt JA. Territories of the Self and Spiritual Practices during Childbirth. In: Fahy K, Foureur M, Hastie C, editors. *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research*. First ed. London: Elsevier Science; 2008 in print.
 168. Zwarenstein M, Reeves S. What's so great about collaboration? (Editorial). *British Medical Journal* 2000;320:1022-1023.
 169. Griffiths L. Making connections: studies of the social organisation of health care. *Sociology of Health and Illness* 2003;5(Silver Anniversary Issue):155-171.
 170. Zwarenstein M, Bryant W, editors. *Interventions to improve collaboration between nurses and doctors (Cochrane Review)*. Oxford: Cochrane Library; 2003.
 171. Davies C. Getting health professionals to work together. *British Medical Journal* 2000;320:1021-1022.
 172. Doyal L, Cameron A. Reshaping the NHS workforce. *British Medical Journal* 2000;320:1023-1024.
 173. Hojat M, Fields S, Rattner S, Griffiths M, Cohen M, Plumb I. Attitudes toward physician-nurse alliance: Comparisons of medical and nursing students. *Academic Medicine* 1997;72:10.
 174. Bromme R, Nückles M. *Perspective-Taking Between Medical Doctors and Nurses*:

- A Study on Multiple Representations of Different Experts with Common Tasks. In: Van Someren M, Reimann P, Boshuizen E, De Jong T, editors. Learning with multiple representations. Oxford: Elsevier; 1998. p. 175-196.
175. Thomas E, Sexton JB, Helmreich RL. Discrepant attitudes about teamwork among critical care nurses and physicians. *Critical Care Medicine* 2003;31(3):956-959.
 176. Reiger K. Domination or mutual recognition?: Professional subjectivity in midwifery and obstetrics. *Social Theory and Health* 2007; in press.
 177. The Working Women's Centre of South Australia. Workplace bullying project. Adelaide, SA: Workcover and SA Health Commission Health Promotion Unit; 1997.
 178. Varcoe C. Theorizing oppression: implications for nursing research on violence against women. *Canadian Journal of Nursing Research* 1996;28(1):61-78.
 179. Nettleton S. *The Sociology of Health and Illness*. Cambridge: Polity; 1995.
 180. Paice E, Aitken M, Houghton A, Firth-Cozens J. Bullying among doctors in training: cross sectional questionnaire survey. *British Medical Journal* 2004;329(7467):658-659.
 181. Wong K. Medical culture perpetuates bullying. *British Medical Journal* 2004.
 182. Hadikin R, O'Driscoll M. *The Bullying Culture*. Oxford: Books for Midwives; 2000.
 183. Connell RW. *Gender and Power*. UK: Polity Press; 1987.
 184. Iacono M. Conflict, communication, and collaboration: Improving interactions between nurses and physicians. *Journal of PeriAnesthesia Nursing* 2003;18(1):42-46.
 185. Davies C. Doctors and nurses: Changing family values. *British Medical Journal* 1999;319:463-446.
 186. Schmalenberg C, Kramer M, King C, Krugman M, Lund C, Poduska D, et al. Excellence Through Evidence: Securing Collegial/Collaborative Nurse-Physician Relationships, Part 1. *Journal of Nursing Administration* 2005;35(10):450-458.
 187. Goleman D. *The New Leaders: Transforming the Art of Leadership into the Science of Results*. London: Little, Brown; 2002.
 188. Damasio A. *Descartes' Error: Emotion, Reason and the Human Brain*. New York: Grosset/Putnam; 1994.
 189. Csikszentmihalyi M. *Flow: The Psychology of Optimal Experience*. New York: Harper and Row; 1990.
 190. Pert C. *Molecules of Emotion: The Science behind Mind-Body Medicine*. New York: Scribner; 1997.
 191. Lipton B. *The Biology of Belief*. Santa Rosa: Mountain of Love/Elite Books; 2005.
 192. LeDoux J. *The Emotional Brain*. London: Weidenfeld & Nicolson; 1998.
 193. Perry B, Pollard R, Blakely T, William L, Vigilante D. Childhood Trauma, the Neurobiology of Adaption and use dependant development of the brain: How states become traits. *Infant Mental Health Journal* 1995;16(4):271-291.
 194. Panksepp J. The long-term psychobiological consequences of infant emotions:

- Prescriptions for the 21st Century. *Infant Mental Health Journal* 2001;22(1):132-173.
195. Pierrehumbert B, Miljkovitch R, Blancherel B, Halfon O, Ansermet F. Attachment and temperament in early childhood; implications for later behaviour problems. *Infant and Child Development* 2000;9(1):17-32.
 196. Heron J. *The Complete Facilitator's Handbook*. London: Kogan Page; 1999.
 197. Barker P. Emotional competence in professional communication. *Journal of Psychiatric and Mental Health Nursing* 1999;6:153-159.
 198. Metzner R. On Getting to Know One's Inner Enemy: Transformational Perspectives on the Conflict of Good and Evil *ReVision* 1985;8(1).
 199. Grof S. Planetary Survival and Consciousness Evolution: Psychological Roots of Human Violence and Greed. . *Journal of Primal Psychology* 1996;2(1):3-36.
 200. Grof S. Planetary Survival and Consciousness Evolution: Psychological Roots of Human Violence and Greed. . *Journal of Primal Psychology* 1996;2(1):3-26.
 201. Hastie C. The spiritual and emotional territory of the unborn and newborn baby. In: Fahy K, Foureur M, Hastie C, editors. *Birth Territory and Midwifery Guardianship: Practice, Research and Education*. Edinburgh: Elsevier; 2008 in print.
 202. Heron J. *The Complete Facilitator's Handbook* London: Kogan Page; 1999.
 203. DeMause L. Restaging Prenatal and Birth Traumas In War and Social Violence. *The Journal of Psychohistory*. 1995;23(4):344-392.
 204. McEwan B. The Weathering Hypothesis of Aging - Part 3. In: *Cyberounds*; 1998.
 205. Bremner J. The lasting effects of Psychological trauma on Memory and the Hippocampus. *Cyberounds* 1999.
 206. Moberg KU. *The Oxytocin Factor*. Cambridge: Da Capo Press; 2003.
 207. Bale TL. Stress sensitivity and the development of affective disorders. *Hormones and Behavior* 2006;50(4):529-533.
 208. Buitelaar JK, Huizinka AC, Mulderb EJ, Medinab PGRd, Visserb GHA. Prenatal stress and cognitive development and temperament in infants *Neurobiology of Aging* 2003;24: Supplement 1(1):S53-60.
 209. Davis EP, Snidman N, Wadhwa PD, Glynn LM, Schetter CD, Sandman CA. Prenatal Maternal Anxiety and Depression Predict Negative Behavioral Reactivity in Infancy. *Infancy* 2004;6: 319-331.
 210. de Kloet ER, Siburg R, Helmerhorst FM, Schmidt M. Stress, genes and the mechanism of programming the brain for later life. *neuroscience & Biobehavioral Reviews* 2005;29(2):271-281.
 211. Huizink AC, Mulder EJH, Buitelaar JK. Prenatal Stress and Risk for Psychopathology: Specific Effects or Induction of General Susceptibility? *Psychological Bulletin* 2004;130(1):115-142.
 212. O'Connor TG, Ben-Shlomo Y, Heron J, Golding J, Adams D, Glover V. Prenatal

- Anxiety Predicts Individual Differences in Cortisol in Pre-Adolescent Children. *Biological Psychiatry* 2005;58(3):211-217.
213. Kerpan M. Balance: The ultimate hope of the 21st Century. In: Barradine P, editor. *When the Canary Stops Singing*. San Francisco: Berrett-Koehler; 1993. p. 73-88.
 214. Shipka B. Corporate poverty, Lessons from refugee camps. In: Barradine P, editor. *When the Canary Stops Singing*. Sydney: Berrett-Kohler Publishers; 1993.
 215. Clare J. A challenge to the rhetoric of emancipation: recreating a professional culture. *Journal of Advanced Nursing* 1993;18:1033-1038.
 216. Ashley J. *Power in Structured Misogyny*. New York: Aspen Systems Corporation; 1980.
 217. Whitehouse D. Games of One-Upmanship and Sabotage. *Nursing Management* 1991;22(6):46-50.
 218. Taylor M. An ex midwife's Reflections on Supervision from a Psychotherapeutic Viewpoint. In: Kirkham M, editor. *Supervision of Midwives*. Cheshire: Books for Midwives Press; 1996.
 219. Metzner R. On Getting to Know One's Inner Enemy: Transformational Perspectives on the Conflict of Good and Evil. *ReVision* 1985;8(1).
 220. Heron J. *Helping the Client: A creative practical guide*. London: Sage Publications; 1990.
 221. Frenier C. Love at Work. In: Barradine P, editor. *When the Canary Stops Singing*. San Francisco: Berrett-Kohler Publishers; 1993.
 222. Spencer S. Seven Keys to Conscious Leadership. In: Barradine P, editor. *When the Canary Stops Singing*. San Francisco: Berrett-Kohler Publishers; 1993.
 223. Strickland D. Emotional Intelligence. *Journal of Nurse Administration* 2000;30(3).
 224. Fittipaldi B. New Listening: Key to Organisational Transformation. In: Barradine P, editor. *When the Canary Stops Singing*. San Francisco: Berrett-Kohler Publishers; 1993.
 225. Denzin NK, Lincoln YS. *Handbook of Qualitative Research*. London: Sage; 1994.
 226. Denzin NK. *Symbolic Interactionism and Cultural Studies: the Politics of Interpretation*. Cambridge UK: Basil Blackwell; 1992.
 227. Denzin NK. *Interpretive Interactionism*. London: Sage Publications; 1989.
 228. Scott J, Marshall G. *A Dictionary of Sociology*. In. Oxford: Oxford University Press; 2005.
 229. Lather P. Feminist perspectives on empowering research methodologies. In: Holland J, Blair M, Sheldon S, editors. Lather, P. 1995, "Feminist perspectives on empowering research methodologies", in Holland, J., Blair M. & Sheldon. S. (eds) *Debates and Issues in Feminist Research and Pedagogy*, The Open University, Bridgend. Bridgend: The Open University; 1995.

230. Gordon C, editor. Foucault, Michel. Power/Knowledge: Selected Interviews & Other Writings 1972-1977. New York: Pantheon Books; 1980.
231. Fahy K, Harrison K. Feminist and Postmodern Approaches to Qualitative Research. In: Tenenbaum G, Driscoll M, editors. Research Methods in the Sports Sciences: Quantitative and Qualitative Approaches. Aachen, Germany: Meyer and Meyer Sport; 2005.
232. Lather P. Getting smart: Feminist research and pedagogy within the postmodern. New York: outledge; 1991.
233. Weedon C. Feminism, theory and the politics of difference. Oxford: Blackwell Publishers; 1999.
234. Stone L, editor. The Education Feminisim Reader. New York: Routledge; 1994.
235. Reinhartz S, editor. Feminist Methods in Social Research. New York: Oxford University Press; 1992.
236. Saunders K, Evans R, editors. Gender Relations in Australia: Domination and Negotiation. Marrickville: Harcourt Brace Jovanovich Group (Australia) Pty Ltd; 1992.
237. Bell D, Klein R, editors. Radically Speaking: Feminism reclaimed. North Melbourne: Spinifex Press; 1996.
238. Speedy S. Nursing and feminisms: a glance backwards, a gaze forwards. Nursing Inquiry 1997;4:217-218.
239. Collective BWsH. Our Bodies. Ourselves. New York: Simon and Schuster; 1973.
240. Irigaray L. This Sex Which Is Not One. New York: Connell University Press; 1985.
241. Weiler K. Freire and a Feminist Pedagogy of Difference. In: Holland J, Blair M, Sheldon S, editors. Debates and Issues in Feminist Research and Pedagogy. Adelaide: The Open University; 1995.
242. Butler J. Bodies that matter: the discursive limits of "sex". New York Routledge; 1993.
243. Sundin-Huard D. Subject positions theory - its application to understanding collaboration (and confrontation) in critical care. Journal of Advanced Nursing 2001;34: 376-382.
244. Longino H, Hammond E. Conflicts and tensions in the Feminist study of gender and science. In: Holland J, Blair M, Sheldon S, editors. Debates and Issues in Feminist Research and Pedagogy. Adelaide: The Open University; 1995.
245. Denzin N. Ethnography; 1992.
246. Sundin-Huard D, Fahy K. Critical, Post-structural, Interpretive Interactionism: An update on Denzin's Methodology. Nurse Researcher 2007;In press.
247. Blumer H. Symbolic Interactionism: Perspective and Method. Berkeley: University of California Press; 1986.

248. Johnson P. *Feminism as Radical Humanism*. St Leonards: Allen & Unwin; 1994.
249. Fahy K. Postmodern feminist emancipatory research: Is it an oxymoron? *Nursing Inquiry* 1997;4(1):27-33.
250. Smart B. *Postmodernity*. London: Routledge; 1993.
251. Agger B. *Critical Social Theories*. Boulder: Westview Press; 1998.
252. Habermas J. *The Theory of Communicative Action: Lifeworld & Systems: A Critique of Functionalist Reason*. Cambridge: Polity Press; 1987.
253. Ray LJ. *Rethinking Critical Theory: Emancipation in th age of global social movements*. London: Sage; 1993.
254. Stevens P. A critical reconceptualisation of environment in nursing: Implications for methodology. *Advanced Nursing Science* 1989;11(4):56-68.
255. Taylor B. *Qualitative Critical Methodologies*. In: Roberts K, Taylor B, editors. *Nursing Research Processes*. 2nd ed. Southbank: Nelson Thompson Learning; 2002. p. 546.
256. Stryker S. *Symbolic interactionism: a social structural version*. Menlo Park, California: Benjamin/Cummings; 1980.
257. Fleming VEM, Moloney JA. Critical social theory as a grounded process. *International Journal of Nursing Practice* 1996;2:118-121.
258. Kincheloe JL, McLaren P. *Rethinking Critical Theory and Qualitative Research*. In: Denzin NK, Lincoln YS, editors. *Handbook of Qualitative Research*. 2nd ed. Thousand Oaks: Sage; 2000. p. 279-312.
259. Glaser B, Strauss AL, 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Chicago, . *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Company; 1967.
260. Lincoln YS, Guba E. *Paradigmatic Controversies, Contradictions and Emerging Confluences*. In: Denzin NK, Lincoln YS, editors. *Handbook of Qualitative Research*. 2nd ed. California: Sage; 2000. p. 163-188.
261. Denzin NK. *Interpretive Ethnography*. Thousand Oaks: Sage; 1997.
262. Hall J, Stevens P. Rigor in feminist research. *Advances in Nursing Science* 1991.
263. Morse J, Barrett M, Mayan M, Olson K, Spiers J. Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1 (2), 1-19. *International Journal of Qualitative Methods* 2002;1(2):1-19.
264. Fahy K. Quality and Significance of Australian Midwifery Research. *Australian Midwifery Journal* 2005;18(1):8-15.
265. Foureur M. Creating birth space to enable undisturbed birth. In: Fahy K, Foureur M, Hastie C, editors. *Birth Territory and Midwifery Guardianship: A Theory for Midwifery Practice, Research and Education*. London: Elsevier; 2008 (in print).
266. Fahy K, Foureur M, Hastie C, editors. *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research*. Oxford: Elsevier Science; 2008 in

print.

267. Parratt JA. Feeling like a genius: women's changing embodied self during childbearing. Newcastle: The University of Newcastle; 2008.
268. Reynolds GJ. Hospitals: Our patriarchal institutions. *Revolution - The Journal of Nurse Empowerment* 1995(Spring):58-62.
269. Yeager S. Interdisciplinary Collaboration: The Heart and Soul of Health Care. *Strategies from Industry Leaders in Critical Care* 2005;17(2):143-148.
270. Smellie W. A set of anatomical tables with explanations and an abridgment of the practice of midwifery. Edinburgh: Charles Elliott; 1785.



The UNIVERSITY
of NEWCASTLE
AUSTRALIA

Research invitation For Midwives and doctors Working with birthing women

Would you like to help us find better ways to collaborate?

What works well between us? What doesn't work?

What would work better?

We want your stories and opinions!

Ring Carolyn for more information on Ph 02 43893919 or mobile 0428112786

Or email her at: heartlgc@bigpond.net.au

Research Conducted by Ms Carolyn Hastie; RM, RN, Master Student

Supervised by Professor Kathleen Fahy

***“Good interprofessional collaboration has been linked
to improved outcomes for women and babies”***

*Donchin, Gopher, Olin et al, 1995; Gosbee, 1998, KEMH Inquiry, 2001, HCCC, 2003;
Australian Health Minister's Advisory Council, 1996; Bhasale, Miller & Reid, 1998;
Haertsch, 2003:25

Appendix 2

Carolyn Hastie RM, RN, IBCLC, Grad Dip PHC
Dip Teach, FACM
Midwifery Manager, Belmont Birthing Service NSW
Telephone 4923 2291 and 0428 112 786
Fax: 02 43886819
Email: Carolyn.Hastie@hnehealth.nsw.gov.au

Professor Kathleen Fahy Head of School
School of Nursing and Midwifery, Faculty of
Health, University of Newcastle, CALLAGHAN
NSW 2308. Telephone (02) 4921 5966
Fax: (02) 4921 6981
Email: Kathleen.Fahy@newcastle.edu.au

Date

Hello,

Thank you for considering participating in my research project.

I've attached an information statement, which outlines the research project and what is required of participants.

When you have read this and clarified any queries, please contact either my supervisors or myself if you want any further information. When you have decided you wish to participate, please fill out and return the consent form to me at the address on the consent form. Once we receive your consent form, I will ring you to make an appointment for the interview.

Once again, thank you for considering becoming part of the study seeking to provide a model to enhance inter-professional collaboration and maternity service outcomes across Australia.

I look forward to hearing from you.

Sincerely,

Carolyn Hastie



Information Statement for the Research Project:
Inter-professional interaction in maternity services

(date)

Research Team:

- Professor Kathleen Fahy, Professor of Midwifery and Head School of Nursing and Midwifery, The University of Newcastle.
- Associate Professor Kerreen Reiger, Sociology Program, School of Social Sciences, La Trobe University, Victoria.
- Dr Andrew Bisits, Staff Specialist, Department of Obstetrics and Gynaecology, John Hunter Hospital, Newcastle.
- Carolyn Hastie, Masters Student, School of Nursing and Midwifery, The University of Newcastle.

Carolyn Hastie is doing this study as required for the Masters of Midwifery by Research with the University of Newcastle. Her supervisor is Professor Kathleen Fahy.

Thank you for your interest in this research project. This information sheet is a formal invitation to you. It contains information about what will be involved if you decide to participate.

Why is the research being done?

Doctors and midwives work alongside one another, each striving to achieve the goals: the provision of high quality, safe and satisfying maternity care. Even though the two groups have common aims, anecdotal and experiential evidence reveals an uneasy working relationship tainted by power struggles and turf wars. The literature illustrates a long history of rivalry and lack of collegiality between doctors and midwives with women caught in the middle or “left out”.

This research aims to discover what individual, contextual and interactional factors enhance or inhibit effective inter-professional interaction in maternity care.

The objectives of the study are to identify and develop:

1. Two contextualised models of professional interaction between doctors and midwives that demonstrate situations and processes which enhance or hinder in professional interaction between doctors and midwives;
2. Draft guidelines for promoting optimal inter-professional collaboration in the maternity units.

Who can participate in the research?

Midwives and doctors who work in Australian maternity units and who are willing to engage in active self-reflection and self-disclosure about episodes of care in which they were involved.

What would you be asked to do?

If you agree to participate, you will be asked to:

- Participate in an interview. Interview length will vary but will last no more than one and a half hours. The researcher will be available for a total of two hours to answer any questions you may have. Interviews will be in private, at a venue and time of your choice. The interview will focus on stories you can tell about positive and negative interaction between doctors and midwives
- Be available for on-going interaction (via e-mail, telephone or by interview) to help clarify any unclear matters and to validate the researcher's understanding or interpretations of the data, to seek new information and meanings (60 minutes).
- You will be given an opportunity to check and correct the interview transcript. These will be sent a few weeks after the interview. Carolyn Hastie will then write about your experiences using your own words from the interview. This will be organised like stories. You will be given the opportunity to check and correct these stories. The amount of time you will need to put into this research should be considered now. It should form part of your decision about whether you will participate or not.
- You will also be given an opportunity to comment on the whole study toward the end of the research. The amount of time, if any, you spend on this will be up to you.

What are the risks and benefits of participating?

The risk is that a researcher could divulge confidential information that is humiliating to somebody who is mentioned/discussed in a participant's story/stories. The student researcher may be known to some of the potential study participants and may share a collegial rapport with some of the potential study participants. The stories will not be discussed with anyone, nor written up until they are completely de-identified and permission to do so has been given by each of the relevant participants.

Participation in this study will present no threat to your physical welfare. Uncomfortable feelings of distress over the recall of events that were examples of poor communication and interaction are possible risks of participation. If you do become distressed, you are encouraged to contact the Hunter Health Employee Assistance Program on 4921 2811 or your local hospital programme.

The opportunity to discuss positive experiences and interactions with colleagues and your feelings surrounding this situation is an expected benefit of participation. Your participation and contribution will lead to the creation of valuable guidelines for collaborative practice and improvement of working conditions and maternal care.

How will your privacy be protected?

Your privacy and confidentiality will be respected through the following steps:

- You will be invited to choose a pseudonym for yourself and others. Within written records and computer files all names, including those of health care providers and other non-essential information, will be altered.
- The interviews will be audio taped, if you agree to participate, but you can turn the tape off at any time. You can ask for the tape to be edited or erased. You will be given a copy of the transcript to review and edit. You will be

discouraged from mentioning people's real names during the audio-recorded interviews.

- Audio-tapes will be stored in a locked cabinet in the researcher's home for short periods whilst under analysis and stored securely at the School of Nursing and Midwifery until analysis is complete. Either Carolyn Hastie or an audio typist familiar with the process of confidentiality will transcribe these tapes. He/she will be asked to sign a Promise of Confidentiality. You have the right to decide to withhold sections of the transcript from the study.
- On completion of the study all computer files will be transferred to and stored on a compact disc. This will be stored with the paper records and audio-tapes in a locked cabinet in the School of Nursing and Midwifery at the University of Newcastle for a period of five years. Only the researchers and authorised administrative staff will have access to this data. All names, addresses and consent forms will be secured and separated from records.

How will the information collected be used?

The data will be presented in a research report by Carolyn Hastie. Results from this study will also be presented at conferences and published in scientific journals. In these reports individual participants will only be identified by their pseudonym. Every effort will be made to disguise any information in this study that could possibly identify you, your family and any health care providers. Sections of the study will be withheld from publication if there are any details that, despite being disguised, are still identifying. With your permission, the completely de-identified 'core stories' of positive and negative interactions may be used in related research.

What choice do you have?

At all times participation, and continued participation, in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Your decision about participating will not disadvantage you in any way.

You may withdraw from the project at any time without giving a reason and without any disadvantage to you and your material will not be used. If you decide to withdraw from the study, you have the option of withdrawing all data relating to you.

What do you need to do to participate?

- If you would like to participate please fill out and sign the attached consent form and return it in the stamped addressed envelope provided, or by hand.
- You will then be contacted by Carolyn Hastie to set a time and venue, at your convenience, for the interview.

Further information

Further information is available from:

Carolyn Hastie
John Hunter Hospital
Locked Bag No 1
Newcastle Mail Exchange 2300
49214462 (w)
43893919 (H)
0418 428 430 mobile
page 49213000 ask for 5528
Carolyn.Hastie@hunter.health.nsw.gov.au

Kathleen Fahy
School of Nursing & Midwifery,
The University of Newcastle,
Callaghan, NSW 2308
02 492 15966
email: Kathleen.Fahy@newcastle.edu.au

Thank you for considering this invitation,

Yours sincerely,

Kathleen Fahy
Head of School
Nursing and Midwifery

Carolyn Hastie
Masters Student
Nursing and Midwifery

Complaints about this research

This project has been reviewed and approved by the Hunter Area Research Ethics Committee, Reference Number 04/04/07/3, and the University of Newcastle's Human Research Ethics Committee,

Approval No. H-857-0704

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2304. Telephone 02-049216333, email Human-Ethics@newcastle.edu.au .

Or

Dr Nicole Gerrand, Professional Officer, Hunter Area Research Ethics Committee, Hunter Health, Locked Bag No 1, New Lambton, 2305. Phone 4921 4950 or 4921 4943, email Nicole.gerrand@hunter.health.nsw.gov.au



Professor Kathleen Fahy
Head of School
School of Nursing and Midwifery
Faculty of Health,
University of Newcastle
University Drive, CALLAGHAN, NSW 2308
Phone: (02) 4921 5966 Fax: (02) 4921 6981
Email: Kathleen.Fahy@newcastle.edu.au

Consent Form for the Research Project:
Inter-professional interaction in maternity services
(Date)

Research Team:

- Carolyn Hastie, Masters student, School of Nursing and Midwifery, The University of Newcastle.
- Professor Kathleen Fahy, Professor of Midwifery and Head School of Nursing and Midwifery, The University of Newcastle.
- Dr Andrew Bisits, Staff Specialist, Department of Obstetrics and Gynaecology, John Hunter Hospital, Newcastle.
- Associate Professor Kerreen Reiger, Sociology Program, School of Social Sciences, La Trobe University, Victoria.

I agree to participate in the above research project and give my consent freely. I understand that the project will be conducted as described in the Information Statement. I have kept a copy of the Information Statement.

I understand I can withdraw from the project at any time. I do not have to give any reason for withdrawing.

I consent to

- participating in an interview.
- checking and correcting material from the interviews some weeks after each interview.
- Being reinterviewed if necessary to clarify some data

I understand that:

- my personal information will remain confidential to the researchers.
- the interviews will be audio-taped but that I can turn off the recording at any time. I will be able to review the interview transcripts and edit or delete my contribution.

I have had the opportunity to have my questions answered to my satisfaction.

Name (please print):.....

Signature: Date:.....

Address:.....

.....Postcode:Phone (H):Phone (W).....

Email address.....

Please return to Carolyn Hastie via email, post or fax as per email, thanks.

Appendix 5

Demographics

Name.....Pseudonym.....

Age.....Gender.....

Postal address.....

Phone.....

Email address:

Profession.....

Where educated

Length of experience now.....

How many maternity units have you worked in?

Partnered/single.....

Children.....ages.....

Ethnicity.....

English as second language.....

Do you have one positive and one negative story about doctor/midwife interaction and the effect on labouring women?.....

Are stories about birth?.....

How long ago did the incidences happen

1. negative..... 2. positive.....

Length of experience as midwife/doctor at time of incident

1. negative.....2. positive

Any other comments?

.....

.....

Demographics of Research Participants – Midwives

Assumed Name	Partnered	Sex	Age	Children	No of Mat units	English as second language	Time since incident		Employment position at time of incident		Years of experience now
							Neg	Pos	Neg	Pos	
Amber	Yes	Female	34	Yes -1	5	No	2 yrs	5 yrs	Midwife	Caseload Midwife	7 years
Dana	Yes	Female	30	Yes – 2		No	2/12	3 /12	Midwife	Caseload Midwife	1 yr 4/12
Betty	Yes	Female	51	No	6	No	2/12	2/12	Midwife Manager	Midwife Manager	26yrs
Jacky	Yes	Female	NK	Yes - 1	4	No	1/12	2 /12	Midwife	Caseload Midwife	16 yrs
Virginia	Yes	Female	46	Yes – 2	8	No	5 yrs	6/12	Midwife	Midwife	20 yrs
Toni	Yes	Female	43	No	10	No	2 yrs	3 yrs	Midwife	Midwife	20 yrs
Kitty	Yes	Female	55	Yes – 2	7	No	2 yrs	1 yr	Midwife	Midwife	31 yrs
Roberta	Yes	Female	30	Yes – 2	9	No	1 yr	18 /12	Midwife	Midwife	3 yrs
Sarah	Yes	Female	30	Yes – 3	1	No	6/12	3/12	Midwife	Midwife	3 yrs
Gemma	Yes	Female	46	Yes – 2	5	No	3 yrs	3 yrs	Caseload Midwife	Caseload Midwife	18 yrs

* /12 = months

Appendix 7

Demographics of Research Participants – Doctors

Assumed Name	Partnered	Sex	Age	Children	No of Mat units	English as second language	Time since incident		Position at time of incident		Years of experience now
							Neg	Pos	Neg	Pos	
Gary	Yes	Male	50 yrs	Yes - 2	6	No	10yrs	3 yrs	Registrar	Consultant	23 years
Helen	No	Female	37 yrs	No	10	No	8yrs	2 yrs	Junior Resident	Senior Registrar	10 years
Jason	Yes	Male	39 yrs	Yes - 2	5	No	3 yrs	3 yrs	Senior Resident	Senior Resident	5 years
Belle	Yes	Female	36 Yrs	No	4	No	1 yr	2 yrs	Junior Registrar	Second yr Registrar	7 years
Lucy	No	Female	33 yrs	No	3	No	1 yr	1 yr	Junior Registrar	Junior Registrar	6 yrs
Jacinta	No	Female	28 yrs	No	4	No	1 yr	2 yrs	Senior Resident	Junior resident	4 yrs
Richard	Yes	Male	47 yrs	Yes 3	6	No	6/12	5/12	Professor	Professor	24 yrs
Marie	No	Female	39 yrs	No	3	Yes	6/12	3/12	Senior Resident	Senior Resident	10 yrs 3 yrs obs
DJ	Yes	Male	47 yrs	Yes 6	5	No	2 yrs	2 yrs	Junior Registrar	Junior Registrar	5 yrs obs

* /12 = months

THE VOICES

Doctors' stories of Negative Interactions

Jason

Jason is a senior registrar and a father of two. He works in a large city teaching hospital. At the time of the interaction he was a new registrar. He was called in to the birthing room to look at a CTG. He is unable to remember why the woman's baby was being monitored, as the woman was healthy and the pregnancy was normal. The CTG was normal. As it turned out, the woman recognised Jason because he had been involved in her antenatal care through the clinic.

Jason continues... "This was a pure fluke... she went into spontaneous labour and I just happened to be rostered onto the labour ward at that time. The particular midwife that was assigned to her care was somebody who had a lot of experience in midwifery care and was very much - a midwife delivers baby normally and doctors get involved when there is a problem - sort of person. She basically wouldn't normally have asked me to be involved but the CTG needed reviewing for some reason and so I came into the room and the woman was going "oh *hello* how are you going!" The lady in labour started talking to me.

The CTG was fine and she was reassured and then the lady in labour said to me "can you deliver my baby now that you're here?" and she said this in front of the midwife.

At this point in my career I was very keen to try and get as many normal deliveries in as I could because as I said before registrars don't get too many normal deliveries despite the fact that its part of our training and we have to do about 100 in our first four years. You know in a hospital that has a midwifery teaching program as well, for a registrar to do a normal delivery is unheard of. So of course I was very interested in doing that and I said yes... you know I suppose, at that point in my career I was so focused on trying to do as many normal deliveries as I could, I was probably in my second year of training and I had probably done about 8 normal deliveries. I had done 150 caesarean sections and 8 normal deliveries which seemed a totally distorted balance and this was a great opportunity and plus I knew the lady from beforehand. So it was like all this great continuity situation which made me feel, you know it was something that I craved, so I was thinking great fantastic I'm going to get to do a normal delivery on someone that I know, its all very good.

And then this midwife, when we walked outside, just crushed me... the midwife then,

this being on the other side of the door let rip at me about how dare I take away a normal delivery from her ...she said angrily "how dare you say yes to a normal delivery, it's not appropriate for you to be taking this away from me!"

I said "but the lady did ask me if I would do it, it's not like I'm going against her wishes." She said that " a normal delivery is the domain of the midwives!" and I said "well this lady I have known a lot longer than you have I have been there for all of her antenatal visits and I want to do it, even though its completely normal."

I think just her sort of ranting and raving, it's just not supposed to happen. I think she was still very professional but she was just sighing and making sort of sarcastic comments to me like, "you're the doctor" and "whatever you say" and that sort of thing...sort of passively aggressively.....I wasn't expecting that response at all. I was....shocked so the whole rest of the time in labour I'm on tenterhooks feeling if I bugger this up I'm... ..., so you know I felt I wasn't able to enjoy it as much myself and firstly I think the patient was aware of that because of the body language and such.

I suppose the other thing that they **[midwives]** are worried about is that a doctor is going to come in and stuff the labour up. He's going to want to do something that is going to be seen as negative or wrong and so when a patient warms up to the doctor she's worried...worried about me offering some sort of intervention that was inappropriate and you know take away her control of the situation... I knew that she was this way inclined, to try and avoid medical intervention. I try and avoid medical intervention but I think that she just thinks that if a doctor is coming in the room it's an intervention.

I wished I wasn't in the situation was how I felt, but being stubborn I carried on because I knew that I wanted to do this. In retrospect I should not have done it. For all the grief it caused the midwife and all the grief I had to go through over the next few days, you know, the problems that I caused etc. I found the whole thing to be a little excessive so at the time I was getting very uncomfortable. I wasn't really focussing on the lady I was focussing on how to pacify this midwife...I think the patient became acutely aware of the awkwardness of the situation but anyway she stuck to her guns and I stuck to my guns and basically the midwife wasn't there much at all during her final few hours of labour.

Actually my shift ended and she was just sort of getting going, so I stayed back When

she finally delivered when she attempted to feed the baby and do all the things that they sort of do in the labour ward and basically, despite the fact that my shift had ended and I was well and truly past my going home time, the midwife insisted that I clean up the room completely, shower the lady, do everything. She made it very clear that I would be expected to do that because I was doing the delivery – I therefore need to do everything... it left a bit of a bad taste in my mouth. I guess I could have walked away after the delivery – but I knew that I needed to do this.

The next day I was hauled over the coals by the NUM of the labour ward for taking away a normal delivery and it was quite a negative experience from my point of view despite the fact that I got a good result and the lady was very happy that I was there. I actually get on really well with her (the NUM) – she totally understands me and where I am coming from – it's just that she will defend her staff to the end and that's why she was mad at me.

In retrospect if I had my time again with all the things that I know now I would have just let the midwives do it because that would have been easier but at that time I was craving the continuity of care and I took the opportunity to actually enjoy that for a moment and the labouring woman was responding well to me and she had a normal delivery. But I think the circumstances would have been more favourable to her because she was very aware, even after the labour, post partum a few days later on the post natal ward, and she was obviously very aware of the talking about how the midwife was not very happy with it. I thought that was very unfortunate because she had a normal delivery and it could have been so much more of a positive experience if that situation hadn't arisen. It was a negative outcome in that she was aware of an awkward interaction and I think it took the focus off her and put the focus on us. She still pushed the baby out and she still did everything normally but I think that she was a little bit more aware of that situation.

Maybe I'm being selfish because I felt it was negative from my point of view and it didn't involve labour that ended up with a caesarean section unnecessarily and it didn't involve unnecessary intervention but I felt that it wasn't an ideal situation for the lady in labour... she felt responsible for that because she was the one who asked ...a few days later she said she was aware that she caused a ruckus by asking and she said "sorry did I cause problems by asking for you" and I said no, no, not at all – completely lying. She was kind of making comments about how the midwife's attitude towards the whole situation changed after she had asked that and hoped that the midwife wasn't upset with her.

Helen

Helen is single and in her late thirties. At the time of the negative interaction, Helen was a junior registrar in a large, busy maternity unit, rostered to work on the delivery suite. The maternity unit overall, had 'pretty good relationships' between doctors and midwives. Helen was feeling overwhelmed and having difficulties feeling confident during the first few months of her training. She felt anxious being responsible for labouring women instead of being a resident where the registrar was responsible. She was told during an assessment that she was perceived by some of the Consultant Obstetricians as being overly anxious. The midwifery manager was a 'fairly forthright person' and Helen found it difficult to get along with her.

As Helen explained "...the relationship with the manager was senior to junior in the sense that it was a little bit like private to drill sergeant. It wasn't like mother to young child it was drill sergeant to private. It was not nasty but she told me what to do..."

Helen was urgently called to a room in which a woman was labouring. Helen knew that the woman was a non English speaking primigravida who was labouring spontaneously at term. The woman had ruptured membranes, was 2 or 3 cms dilated and had just had an epidural inserted as she was distressed by the labour. Helen also knew that a junior midwife was caring for the woman and the Midwifery manager was supervising her.

"...after the epidural was inserted there was a fetal bradycardia on the CTG for 5 minutes. I was called at about the 3 minute mark...I raced in to find the Midwifery Manager doing a vaginal examination saying *she's only 5 cm I've called for a Code 1 Caesar*. I said that we can turn her on her side, we can stop the epidural and she said *no we need to go and we're getting the trolley...* I said I don't want to do it and she said *she's not going to deliver this baby; we need to get the Caesar*. I said it's my call and I'm not making that. She said *I've already called the Caesar and I'm calling the Consultant*. I think that she made a decision which, was I believe was a valid one, that this baby was unlikely to come out and with the slightest stress was having a deceleration. She made her decision and wanted to make the call as to the woman needing a caesarean that she was wanting to take charge of this woman and tell the inexperienced junior what to do.... I felt powerless... and pressured... but also that I was trying to advocate for the woman and not being listened to.

In fact the difficulty for this woman was, while I suspect it was a posterior position ... I suspect that she may not have delivered vaginally eventually, for her having a Code 1 Caesar...crashing down to theatre with me trying to explain

in English to a woman who didn't really speak English as her first language that we had to do a caesarean straight away!and where ... I know that I didn't believe that it needed to be a Code 1 caesarean because the fetal heart rate was recovering well by the time we had practically finished this conversation about whether or not we were doing a Caesar.

... I quietly asked her to come outside to talk about it the problem was that she wouldn't leave the room. She was getting the woman onto the trolley. She wouldn't leave the room for me to have a conversation with her. With what conversation we had, especially in a language that the woman didn't speak, had to be in the room in front of the woman. I was saying I don't think we need to do this so urgently it's recovering. She said *but she's only 5 cm she'll need to go down*. The partner was a non English speaking, sorry that's not true he spoke a little English because I obtained the bare bones consent of yes I will have a caesarean by him. He was standing there almost impassive in the sense of just that standing, frightened, I don't want to move approach.

I felt that there wasn't an advocate for the woman in the room. I was trying to advocate but I was being turned down. The junior midwife wasn't advocating for the woman. The husband was in too difficult of a position; that is not knowing enough about the situation to be able to advocate. The woman didn't have any English and wasn't able to advocate for herself. The Midwifery Manager was arguing a management which in my opinion wasn't advocacy. The interaction had difficulty because we weren't both listening to each other and trying to come up with the best plan for the woman. There was one person making that plan. There was no negotiation and there was no space for negotiation in that what was the perceived urgency of the Midwifery Manager...we couldn't have a conversation out of the room.

I felt very much that I had been bullied into the decision but also that the woman had been bullied into the decision and frightened about what was going on ... The junior midwife was essentially powerless as well. The Midwifery Manager ran the show... maybe what could have been a – *well looks like the baby is having a little bit of a complain about things but seems to have recovered well, its early on in the labour but we will keep a close eye and if there's any suggestion that baby is distressed or worried in the future that we might do a caesarean*. I could have had the interpreter up and had that conversation in a less pressured time environment.

The Consultant met me in theatre but wasn't very receptive and I didn't know whether

to speak to her about what I felt. I did speak a little and said that I thought that I had been pressured into it but I didn't ever hear whether they **[midwifery manager and consultant]** had had a conversation about that later. We were talking more about "well now we're here we better do the Caesar...let me see how you do a Caesar". Rather than talking about the emotions of feeling pressured and should we cancel the plan for a Caesar.

The baby was fine and I spoke to Mum with an interpreter afterwards and she was OK. I still felt at that time that I didn't get a chance ever to express my views fully about this woman. Because I was junior and because the Midwifery Manager was so senior I let myself make a decision that, still in hindsight I think yes it would have probably ended up with a caesarean, but that she was forced to have too urgent a caesarean section. There was no definite fetal distress. There was fetal bradycardia with an explainable cause of just having had an epidural. We gave fluids and the fetal heart rate came up.

I have been wondering about it since. Whether I felt that I was feeling my pride was injured because I was the doctor and I was supposed to make the call for the operation it wasn't the mere midwife whose duty was that because she wasn't going to do the operation but I don't think it was that. At least I hope it wasn't entirely that. It was that I felt that the woman was frightened into an urgent caesarean and although I agree that with the size of the baby, the position of the baby and so forth, that she was likely to end up with a caesarean section but we just made her do it too early... too frighteningly.

I did eventually have a conversation with her about it but she dismissed the conversation with – "she would have needed a Caesar anyway and that was my call". I said technically it wasn't because although yes I think she was going to end up needing a Caesar, as the registrar it's my call in conjunction with my consultant to make the decision for a caesarean. She said "I've been working here a long time you know and that was what she was going to end up with". I said yes but..... then it didn't continue any further. We didn't get a chance to sit down and have a conversation in any detail. It was a standing up one, I didn't get time to sit down. I was too nervous and too unassertive to insist on it or try and get an advocate.

It left me feeling much less confident ...in fact it increased my nervousness and lack of confidence. It also impaired my ability to interact with senior midwives a little. Because although there were many excellent senior midwives I got along with very

well there was always that – but the most senior one I’m scared of – underlying feeling. I was always quite nervous about interacting with that Midwifery Manager. When I came back a couple of years later after a country rotation things were different because I was much more confident but initially...for the rest of that year it was still that – she’s going to be second guessing me, she’s going to overrule me...

I’m still angry...still wishing that I had been able to manage it better because if I had assertively walked out of the room and called my boss and said I am not calling theatre. I don’t care if the Midwifery Manager has called theatre and got the trolley and got the woman on the trolley but I’m not going ahead with it and made it her call. Then at least I would have passed the responsibility up the correct chain of command. But if I had done that and had the Consultant said “no you’re wrong we do need to do a crash Caesar”, then how difficult would it have been for me to have continued working in that unit where I had flatly refused to do what the very experienced Midwifery Manager had said. Because this particular Consultant that I was working with had actually said to me on my very first day as a very junior resident – think very hard about why you want to disagree with a senior midwife, she may occasionally be wrong but she is less likely to be wrong than you will...which is actually pretty good advice for a day one resident but it’s maybe not so appropriate for a registrar because its different responsibilities.

...it distresses me in other interactions where I see a doctor dictating to the midwife – oh we’ve got to do this. You can tell that the midwife truly doesn’t think that is the appropriate thing for her woman as the advocate for the woman she is looking after in labour. The system certainly favours doctors in that as a general rule doctor disagreeing with midwife or nurse about the management of a patient, usually the doctor will win. If such an awful thing can be described as a win/lose. But there wasn’t negotiation in that position. I’ve still been wondering whether it was a hurt pride thing but still looking back on it, looking at that CTG, because I photocopied it, looking back on that CTG later on I still don’t think that she needed to have a going now, no time to think about it, caesarean.”

Lucy

Lucy is single and a senior registrar. She was working in a rural teaching hospital which had about 1,000 births a year when the situation she talks about occurred. She was working with competent midwives she trusted and whose company she enjoyed. Lucy spent a lot of time at the desk in the delivery suite, sitting and talking with the midwives when she wasn’t actively doing anything medical. The midwives would come and tell her what was happening in the

rooms.

Lucy said she... "lets the midwives to do what they were good at, which is caring for women in labour. I don't try and take over."

Lucy continues... "this woman was having her first labour. She came in with spontaneous labour and laboured well throughout the day. Recently her sister-in-law had had a term still birth so there was a lot of emotion involved with the family at the time. The midwife who looked after her through the day shift was communicating with me frequently. I had gone in and met the woman and it was all very good. Then the shift changed and a different set of midwives came on.

The new shift midwives went down to the room where the woman was. She was getting in the bath at that stage for some pain relief. Which was fine. Everything was normal. We had a CTG that monitored within the bath via a clip ... it was on because she had had some variable decelerations earlier in the day. The midwife came out to the Delivery Suite desk where I always am ...I was ...sitting down because I was waiting for the next shift to come on. At the end of the shift if you are not actively working somewhere you tend to sit down. She ...came out of the room and up the corridor. She stopped at the desk and she said "just letting you know..." and told me that "she's pushing down there it won't be long"...

I had assessed the woman about two hours before that and she was 8 centimetres so it was reasonable that she would be fully and pushing. So it was consistent with what I thought... I assumed that she had assessed **[done a vaginal examination]** the woman and that the woman was fully dilated and the woman was pushing. I guess it would have been quite reasonable not to do one at that stage just for obstetric management but I just assumed from what they said, when they said that she was pushing down there that she was fully and she was pushing....there are midwives that we trust and there are midwives that we don't. These ones I trust... that was just as I was about to hand over and so that was the information that I passed onto the next doctor and the information that I passed onto the Consultant. I then went home.

When Lucy came on duty the next morning, she was greeted by a very upset doctor. Approximately two hours after Lucy left, the baby was stillborn. The midwives hadn't been able to find the fetal heart for 15 – 20 minutes before the baby was born. The scalp clip had fallen off and the midwives had tried to find the heart rate to no avail, using a Doppler, a hand held ultrasound machine which transmits an electronic sound representing the fetal heart rate.

The midwives thought that the fetal heart was behind the woman's pubic bone and that is why they couldn't get the heart rate. They didn't inform the on call doctor when they couldn't find the heart rate. They didn't call the doctor until they were trying to resuscitate the baby. The doctor had been in the after hours flat asleep when he was called to delivery suite.

Midwifery and medical shifts change over differs by an hour. The night duty midwives had gone home. They had the next night off because they were 'too upset to work'.

Lucy continued: "...the day midwives were down in the rooms or in the tea room or somewhere. They weren't at the desk. They were somewhere doing midwife jobs...I don't know what they were doing...secret midwives business! I spoke to the day midwives probably about ten minutes later...at the desk at delivery suite...they came to the desk just because that's where all their stuff is as well. It's the place where we all met...the midwives on through the day were the ones who had cared for the woman... they were also quite upset and they filled me in on the story ...the first midwife was particularly upset because she had been the one that was on when the decelerations had first appeared earlier in the day. She said to me *this would never have happened if you had caesared the woman when the first deceleration was there...* a very unusual midwifery attitude...but the woman has her own personal reasons for saying that... she has had an adverse event in her family. She has had a baby that was born with disabilities...so she was clouded by her own personal emotion plus the fact that she had cared for the woman all day the previous day...

I was very upset. Because it wasn't my fault...I said *but there was no reason to the Consultant had reviewed the trace at that stage as well*. She was in the hospital at the time. I said *we did everything that we should have and there was no indication to caesar back then*. She said *yeah well that's what you think* and then she left. I knew that she was upset. I knew the reason why she said it but it still upset me because I felt that I was being blamed for something that had occurred when I had left a normal woman in normal labour, at the end of a normal labour...then something happened a couple of hours later when I wasn't there and the other doctor wasn't there and suddenly it was being perceived as my fault.

She blamed me because I was here...it was wrong. I shouldn't have been blamed ...I felt upset. I was already upset for the woman and now I felt that I was being inappropriately blamed for something...she needed someone to lash out at and she picked me. I talked it over with someone who I am very close with. A midwife in a completely different health service, completely anonymously... part of my support

system. I have since spoken to the midwife plenty of times and she is fine. All is forgiven. She said to me *I didn't mean anything personal* ...it was good that she could come and say that sort of thing ... spontaneously...it would have either been later that day or the following day...within a short time. I have a fairly good working relationship with the midwives in general... the other doctor was tired and he was upset. He went home. I don't know what his debriefing systems are. Certainly he wasn't part of the debriefing while I was here but we were on opposite shifts...I know he is still working and he is still fine...

.... it hasn't so much altered the relationship with the midwives...I guess it has altered my perception of... the more senior of the two midwives...if she was to come out and tell me that again, I probably would want to make sure.....the woman wasn't fully dilated when they spoke to me, they hadn't assessed her. So this had made me a little bit more cautious and a little bit less trusting...I guess it just reinforced the need for me to make sure that I don't just listen to what everyone says; that I actually go and check in, not so much examine them all but check in with the women. Keep my finger on the pulse a little bit more.....the way that they had communicated that to me indicated that they did know and that they had already done that and that was where things were. The fetal heart was lost and the baby was stillborn and the family of course were devastated. As were the midwives and as was I because I had cared for her all day and as were all the doctors involved..... it wasn't just communication with me, it wouldn't have made a difference which doctor was on because they still wouldn't have communicated that information. There was not so much negative or nasty or angry communication, there was miscommunication. It led to the medical staff not being concerned about the patient because the information we got was that it was all OK. It led to a patient's experience being absolutely devastating and it led to us, in counselling the patient, what could we say. We didn't know what was going on. That is no consolation to a woman who has just lost a baby. So it was a very negative outcome for everyone”.

Marie

Marie is unmarried and is an overseas trained doctor from South America and English is her second language. She is a third year obstetric registrar working in a small urban maternity unit which has about 1,000 deliveries a year. In her example of a negative interaction, Marie explains she was working alone with a very good, experienced midwife. The woman had given birth, but was continuing to bleed after she gave birth to her placenta.

Marie explained “...so I do the old fashioned, check the uterus, check the cervix. ...I

did what I was taught to do what I supposed to do and was quite confident on that. She said to me, “no that’s alright give her another medication”. I wasn’t keen to give medication. The woman was trickling. I think in different ways. It’s good to think in different ways. We both have eyes and think different things. It’s not good to be thinking the same way...she said give the woman medication. I think at this stage it’s much better tocheck the cervix, maybe the cervix is ...torn. She wasn’t happy...I knew because of the way that she looked at me...like maybe “she doesn’t know what she is saying”... You know when a person looks at you and she doesn’t like what you say? So she said “No Marie”

... but I’m going to call the consultant and I know that she is going to ask me... if I checked everything...so I checked things. There was a tear in the cervix. It was very difficult to know that there was a tear and if you don’t check you don’t know. So I said “look this is that **[tear in the cervix]**”. The midwife said.... “No, but this is not causing the bleeding!”... I said “Yes it is...I need to stitch it up. If not, we don’t know if it is causing the bleeding or not”. She wasn’t happy at all.

I called the consultant after I did the suture and the bleeding had stopped. So naturally I was right but she wasn’t happy. She told me “OK let’s check again. The bleeding seems to have stopped.” She was right maybe in what she was telling me but I think I was right ...she said that in front of the patient...if I have a difference of opinion with the midwife I prefer to be outside... because that means respect to the patient...not in the presence of the patient, checking obs. So we did it that way.

Then I said “look we will have a chat later on when it’s time for a coffee, you know, in the night when you have more time to have a talk”. I told her before she says everything – “look I respect your experience but you should listen to me as well”...“So if two brains work it is much better. So maybe you are right because you have more experience and you have more age than me and I do respect that but you should listen to me as well”. She was open minded and I think because first we fixed the problem and the talking at that time, not later on because then you can think medical things without other issues in the way. So we have a talk at the table with a coffee...I prefer to address the issue straight away and I feel when something is not on the board and worked very well...it leads to problems...so then we fix the problem and I need to talk...but we need to fix between each other... so both together we had no problem and I had a good week...I’m a straight forward person. I prefer to work as a team I don’t know how to work alone. So you must know me but I should know you.

So I prefer to, I don't know the English expression but, try to clean all the difference and so we must be very clear when we talk about what we think. The thing is most of the time they go "oh you come from overseas" so they don't know how much experience I have had...I say look we will work as a team, we need to think together. What do you think? ... Most of the time if a midwife tells me "Marie I'm not happy", I trust on her hands and what she says. It's the way I work. I don't know if it's right or wrong but I trust on the hands and the eyes of the midwife. I have big picture by midwife so I know how the midwife thinks and most of the time they are very clear person. They listen to you in the night. What you think, what are your fears. What are you worried about. Maybe your boss is out at the moment and she is going to see the woman with you.

So most of the time I need to work at the relationship. For me this is very important...I like to work with the more experienced midwife; we don't have any problems because we don't need to speak. We look at each other and we know now we have to do it. Most of the time this happen with a new trainee, they are maybe scared and that is normal because I was scared when I was a resident. You don't know what to do, where to run and who to ask and all this stuff. But with the more experience no problem at all. We look at each other and we know when the problem is. For me it is very important that the decision comes from the group, not from my experience, because maybe I am going to be a little moment with the patient but the midwife was all the time with the woman in labour. This is the way that I am used to working".

DJ

DJ is a male junior registrar working at a large rural unit. He is married and has six children. At this particular unit, DJ said "the midwives manage things themselves if they can and they tend to call the doctor when there's a problem". DJ was called to the birthing unit about 1am because a midwife was concerned about a CTG. The woman in labour was having her third baby.

DJ described how he walked up to the desk, the "midwife was standing behind the desk saying quite forcefully that "this baby is having decelerations and you have to do something now!"

DJ continued.... "the midwife was anxious and stressed and looked grumpy. She was frowning, looking very serious, leaning and looking like she had decided on what course of action needed to be taken...it was a very confrontational approach initially.... she said ... " Dr xxxx **[the consultant]** wouldn't tolerate this he would be taking her up

to theatre!' I said well hang on, you have just called me. I put my hand up and said hang on, let me assess this situation. Let me have a look at the partogram, tell me about the woman, what's happening, and asked her what sort of assessments she had done etc...

I felt defensive, because right from the outset I felt pressured to make a decision without even having the opportunity to look at the facts and assess the situation...I said well lets have a look at everything and lets make an assessment and I will call a specialist if I feel that it's necessary. It was her third baby and the other two births had been normal. I also knew that the consultant that was on was fairly pro-intervention... if I had rung that's what would be happening. I mentioned to the midwife that I wanted to wait a bit longer and see how things went and after I had made my assessment. I sat at the desk...read the patients notes...looked at the CTG **[this unit has central monitoring and the CTG trace is able to be viewed at the desk]**...the midwife was standing over my shoulder looking down. I felt intimidated...obviously what she was trying to communicate to me, or what I felt she was, was hurry up, don't muck around. She obviously felt that this was somewhat of an emergency situation.

[the midwife] ... followed me out afterwards. I was feeling pressured...and angry... she hovered while I wrote in the notes and called the specialist. I was thinking when I ring this specialist... I know what was going to happen...I know that they are going to want to do a caesarean section...the midwife would have spoken to the specialist herself ...would have bypassed me if I hadn't have done so myself...she would have gone over my head to the specialist ... the midwife had a long relationship with the specialist...I did actually suggest doing a pH but then I was advised at this particular unit that that wasn't done, so that course of action wasn't available.

My gut feeling was to leave things alone and let the woman continue on with her labour and monitor the situation and I did suggest that to the specialist...the specialist said no let's just do the caesarean section. She **[the midwife]** wasn't saying very much, but her body language and constant presence as she was hovering over me with her arms folded...was intimidating...afterwards she was smiling ... had a smug, superior look on her face. I felt frustrated, I felt angry, I felt a little bit cheated in the whole process. A little bit invalidated, that my input wasn't really heard, wasn't really valued by the midwife or the specialist...

I felt a little like I was the junior person in this situation and to some extent being intimidated into making a decision that I didn't really feel good about ... I felt very

much like I was trod over the top of by the midwife and by the specialist. I tend to find that I don't like to have interactions with that midwife and I try to avoid interactions with her as a result of that. However, that's not always possible. There certainly is an undercurrent there. The relationship isn't a smooth one, it isn't a very collegial relationship...she tends to like to get her way so it becomes an ego battle, a battle of wills...I don't feel very valued by that particular midwife There does tend to be a bristling of our personalities when we work together...what's best for mother and baby isn't necessary what's best for our egos...it ended up with an unnecessary operation ...which also affects the woman's reproductive future ...

Gary

Gary is married with two children. He is a staff specialist obstetrician. He works in a busy, tertiary referral maternity unit. The delivery suite manages 3,500 births a year. Gary's example of a negative interaction with a midwife revolves around the care of a woman having a breech birth. Gary first saw the woman when she was 38-39 weeks pregnant. Gary explored all the options with the woman and her partner. The couple decided they wanted a normal birth with their breech baby.

"...she and her partner were very down to earth people and ...she went post dates and the breech was fairly high and we decided to induce her during the day.....the labour was slow to get going and I can remember at the time I was very tired because I had been working hard.....by the evening the labour had started and there was progress with cervical dilatation and the breech was descending.

I had a very good registrar on over night who was paying attention to the progressthe midwife on was a very capable midwife ... fairly matter of fact, more on the abrupt side.....she was a midwife I had never quite got on with and never quite understoodshe was always wanting to get on with things, get things done... I would resent that because I feel that you just need a little bit more time so that you can attend to all the important details of a woman's care and then proceed on... that was the sort of professional relationship at that time and it had been like that for about eight years.....it was probably at 2am....we were outside the room which was fortunate and it was just myself and the midwife and ... the registrar discussing the woman's progress in labour, which was slow.

The midwife said "*don't you think it's time for a caesarean*" there was eye contact ...she was looking very directly at me...not in a threatening wayher manner was very measured ... she was talking fairly civilly and expressing an opinion....my stance

at the time was a very weary one.....I had to make a fair bit of effort to acknowledge her ... I wasn't making maximum use of the fact that she was more awake than I was... I was letting past interactions weigh in on my reception of what she was saying...my fatigued response was *"no I think we should keep on going I think things will be OK."*

Now my response to that was a combination of a fatigued response and a response that was saying *"well you're not going to tell me what to do"* – we need to give labour a good go and we will proceed...there was antagonism ... and it was probably more from my side... reacting to that cut and dried mentality or what I perceive as a cut and dried mentality...she accepted that reluctantly and the woman did proceed ...the fact that I was fatigued and really by the time we did the delivery it was the middle of the night and I don't think at the time in the state where I was really capable of a more discriminating reception of what people were saying.....

I recall at the time that her mode of telling me "shouldn't we be doing a caesarean" was in fact not very confronting at all....but there had been a few negative interactions in the past which I think were playing on my mind at the time. Again I think, reflecting on those, that didn't allow me to really listen to what she was saying.... the registrar didn't say anything ...I can't really put my finger on what was going on there. She was very cooperative and supportive...I had a good working relationship with the registrar. She knew what I was like and I don't think she had any huge problem with my approach at the time...this particular midwife had a fairly abrupt, matter of fact approach to things...and she expressed an opinion which was clearly right...it's just that I was not in the position to receive that for its full value because I had other things clouding my ability to receive that information.

I think that had a significant impact on the outcome....the cervical dilatation proceeded to fully and the woman started pushing but then there was significant fetal heart rate deceleration and we were in a situation where the breech was starting to be on view but there was very significant deceleration and I attempted to do a breech extraction because I didn't think there was enough time to get them down to theatre. With some difficulty we delivered the baby but the baby was unresuscitatable which, even despite the abnormal trace, I was a little bit surprised at. That's the long and the short of it and the baby was stillborn...so if you ask me how it should have happened, I should have actually been aware that I was tired.

I should have put past interactions aside and realised that this woman actually was far more awake and perceptive than I was at the time and I didn't listen.....the day

aftershe said to me *"Gary, you're a very good obstetrician"*. I think I was still so upset at the time I couldn't actually..... I thanked her for that but..... at the time it didn't have a huge impact on me but it has had a longstanding impact on me....I just think it was quite an amazing comment.....that's why I say the fact that she was able to say that, in terms of the negative interaction, I think that was more my problem than hers.....just being aware of how different people's tendencies are and ways of doing things that I just realised that it doesn't matter how wrong you think someone is, it usually means that there's something about them that you don't understand in the majority of cases.....it's usually when you think you are extremely right and you're indignant about the way that someone has done something...I have just realised, in a quiet moment, not that they're totally wrong it's just that there is something about the way they are doing things differentlyyou are actually seeing something that you don't normally see but they do see".

Jacinta

Jacinta is a new first year obstetric registrar. She is single, young and has no children. Jacinta is working in a tertiary referral unit which has about 3,500 births a year.

"...I'm certainly intimidated by some midwives. I think that's something that a lot of doctors would say and in turn a lot of midwives would say again... I think it's the manner in which you are initially thrown into a situation with a person. I think with midwives and doctors especially I think there is quite a lot of "our club and your club" and I think coming to a new place especially, because the doctors tend to rotate quite a bit – I think that takes a while. It is building a relationship ... I think I'm pretty good at communicating and getting along with people but I do see it with other people. You see where it may be a bit more of an uphill struggle for them to.... I guess it's the same on both sides. It's gaining the person's trust. It's gaining...you know...if the midwife is feeling confident that you can do your job as a doctor and if the doctor is feeling confident that the midwife can do their job... the intimidation gets less with familiarity and once again working in situations where they see how you react and they think – 'hang on a sec maybe she is ok, maybe she does know what she's doing'.

I can remember one night shift collecting a blood sample, putting a cannula in and just collecting a group and save, because that was what I had been taught...when you put a cannula in you should collect blood for a group and save...it was outside the room... and this one particular midwife making me feel particularly small because I had done that..... saying – 'we don't do that here; it's a waste of resources. You should just throw it out and you shouldn't do that' – you know that sort of thing and it was also

in the tone of voice as well... that sort of *what are you doing you silly person* kind of *That maybe how you do it where you come from but that's not how we do it here*....I just felt that I had to prove something next time...We get along well now... it's always in the back of my mind if something has previously happened but we get along well now and I'm comfortable working with her...I'll always remember the incident ...I wouldn't hold it against her. You have to move past it... but I took the bloods and walked out and said to the midwife at the desk "I need to get away for a couple of minutes"...I just walked to pathology down the other end of the building and took a few deep breaths and came back and got over it...I do like debriefing as well. I think that's a really important way of dealing with... **[negative interactions]** I debriefed with my Registrar at the time. Just said this happened... It's such a small incident though, that's why it's so silly...but the small things can lead to breakdowns....it could potentially build up yes...if you couldn't move on from that.

Richard

Richard is married with two older children. He is a senior staff obstetrician with primary responsibility for the education of the medical students. Richard talks about an experience which he had to deal with from the student's point of view. Richard said the problems in terms of the attitude towards medical students were from a minority of midwifery staff, but nonetheless were very challenging and can have far reaching consequences.

"...we had a situation recently where we had two students who had been looking after helping one of the senior midwives to look after a woman in labour. It was unusual that there were two students in the room, neither of whom had suggested it themselves but there were very few other ladies in labour that day. One of the students had known the woman beforehand because she was following her as her baby and the family case study and the woman had been asked whether she would mind if a second student was present during the delivery, which she had agreed to. She had asked the second student if she would mind holding her video camera and filming as the father held the baby up as she didn't have any other hands to do that. It certainly had not been her **[the student's]** suggestion to do so.

When the baby was birthing a second midwife had been asked to attend in the normal way, to help the principal midwife and without making any enquiries as to the whys and wherefores of the situation, forcibly ejected one of the medical students from the room. The medical student found that upsetting. I can imagine the patient, the woman herself, found it perplexing because she was fulfilling a role at the request of the family in terms of recording this event for them...I wasn't present in the room but

I had to speak to the students involved who were upset. They were anxious that they might have done something wrong and didn't understand why they had been, why one of them had been manhandled out of the room...they initially approached the other midwife who had been with them and then they also spoke to one of the other consultants...

Another specific situation that has occurred on more than one occasion, which does have perhaps a more direct impact on patient care, is the situation in which a student doctor has been assigned to follow a particular patient during the process of labour and has been there for the entire shift, maybe eight hours or longer...a handover occurs, a new midwife takes over care of the woman, prior to or at the time of second stage and particularly if that handover occurs at a time in which there is a student midwife handover, the medical student is removed from the room and the trainee position as it were is given to the student midwife who comes on. Clearly that is not good from the point of view of continuity as far as the woman is concerned. It's not the medical student wanting to leave...it's them being told they can't stay and being replaced by a student midwife. It's not good for training and it's certainly not good for continuity of care...its happened two or three times in the last six months...I always follow those sort of incidences up with the person who is the lead midwife for delivery suite...and sometimes with whoever was involved in the incident.

...obviously I'm disappointed on a number of levels when that happens, I mean firstly it offends my natural sense of justice, when a student has invested a lot of time and effort and established a relationship with a patient that they should then be displaced for the needs of another trainee of another group. Secondly I feel that it undermines whatever efforts we are putting in to educate our medical students to have a positive attitude towards midwives because it sort of reinforces the stereotype that they are being badly treated by midwives and they carry that onto their own professional practice.

They [**medical students**] don't feel part of the team, they obviously feel very frustrated and angry about it and understandably so and they don't understand why it's necessary. So that requires a degree of debriefing from me for the medical students concerned and further I feel obliged to try and prevent that happening again in the future by addressing it. Not just with one individual concerned but also with the whole collective attitude. I mean clearly one has to establish the exact facts of the situation for any given scenario. Obviously there are sometimes reasons why students shouldn't be allowed to stay. There are degrees in which I think midwives have a responsibility to

act as patient advocates, as we all do, but to recognise that women sometimes will give consent to have a student present when they don't really want them to because they have been pressured into accepting that. Maybe in that situation the midwife has a role in protecting the woman from being over exposed to too many people in the room and that can be relatives as well as students and other staff.

It would be a big step to say that any professional group would have the right to decline or give consent for anything on behalf of their patients or on behalf of a woman in labour. So I guess my main thing, the thing that was worrying me most about it is the way in which it perpetuates barriers between doctors and midwives. I mean you cannot understand how important the delivery suite experience is for undergraduates...it's an enormously powerful experience for these ... young adults. More than any other single week I think in their five years of medical school, they remember it and they tend either to come away with hugely positive or hugely negative experiences, not just because of problems with communication or relationships with people, obviously lots of other things can happen in that week."

THE VOICES

Midwives' stories of Negative Interactions

Sarah

Sarah had been a midwife for two years at the time of this interaction. Sarah is married to Fred and has three children. She works in a busy urban maternity unit in a capital Australian city with a multicultural clientele. The maternity unit is a teaching unit and has about 2000 births a year. At the time of the interaction, Sarah was on afternoon shift, looking after an Arabic woman having her third baby who was being induced.

Sarah explained ... "the baby was coping beautifully, everything was beautiful and I had just followed this woman around wherever she wanted to be, in the shower, in the bath, wherever she wanted to be...the whole time that I was looking after this woman we spent a long time talking and I spent a long time developing some sort of trusting relationship. When I say a long time it was just during her labour...

There was not much going on in the unit at the time and the registrar on duty wanted to know what was happening. Sarah said that it was around 8.30 or 9 o'clock at night, when there is a changeover of registrars... he wanted the baby born before shift change. Sarah had worked with this doctor a few times before and thought he was a 'tell you – the mother and the midwife both - what to do sort of person'.

Sarah said "...he likes to tell everybody...very directly... I think lack of experience perhaps...he likes to cover an insecurity by directing all of the traffic...he came into the room and wanted to know what she was at etc... and I said that she was labouring beautifully etc and he said "*well what was the examination*" and I said I hadn't done that but things are going along fine. So anyway he wanted an examination ... he wanted continuous monitoring ...the policy wasn't for continuous monitoring, we don't have a continuous monitoring policy with an induction..... ...

...so I examined her and ...the doctor went out while I examined her...so while she was on the bed for the examination I put the monitor on and she just had an anterior bit of cervix left. She was very tired and transitional and wanted to have her baby and I had said it will be very soon ...she said "*I just want to have this baby, what can I do, what can I do*" and I said "*well let's get back out of the bed*". She was on her back and I said "*babies don't like that let's get out of the bed and stand up and perhaps try leaning over the bed*". So we propped the bed right up, put pillows on it and she was leaning over the bed, leaning forward and I thought well that might fix that anterior

cervix and more importantly she was comfortable in that position...so then the doctor came in to see what was happening and I said *"well it's fabulous, it's fabulous, it's just an anterior bit of cervix"*. *"Oh"* was his words, *"oh there's still something left there"* ... I actually thought that that was very good and I had behaved as though it was a very good event and he sort of had behaved as though that was a negative result...

I said to her that perhaps lean forward now and that will help that last bit of cervix melt away and the doctor said *"No, no...that will make it worse, it will put too much pressure on the cervix it will make it worse"*.....his suggestion was to get back on the bed...he said the position she was in, standing up there leaning forward onto the bed, would make the cervix worse, that anterior lip would be worse. She would be better on her back taking pressure off the cervix. I said very quietly *"or perhaps it might make it go away"* ...I felt undermined as a midwife as soon as the doctor had suggested something that perhaps what we were doing wouldn't work... the doctor was standing on the other side of the bed...looking at her, I was next to her, she was leaning over the bed and she was looking into the pillows, not looking at him and ... luckily not listening to him..... I felt that had just completely really destroyed the idea of standing etc...however to the woman I asked very, very quietly, right next to her ear, standing next to her..."*what would you like to do, what position do you want to be in to birth this baby and how do you want to labour and birth this baby?"* and she said *"I'm not moving and I'm happy exactly where I'm standing"*.

The registrar was still in the room at that time and he walked out, not happy...I said to the woman *"well that's very good, you do what your body is telling you to do, you've got messages happening there and you just listen and birth your baby"*. That's pretty much what she did, just standing there birthing the baby...I felt that the dialogue that took place was probably distracting for her but to her credit she maintained this focus on her. But for myself I just felt undermined. I use that word, undermined bearing in mind that I had spent hours, hours and hours with this woman and I thought he can just walk in here and in once sentence say that's not right.

We weren't on the same wavelength, we weren't on the same side on the best way to approach the care of this woman and I think his idea and my idea were so completely different that he really did try to pull rank in that room. He really did try to say, not suggest something perhaps might be better but no, what we were doing was wrong, it wasn't going to work, it was going to make it worse... ...that created conflict in the room between the doctor and the midwife. It was almost humiliating...well I say almost humiliating because I hadn't met this woman before but I had tried very hard to

develop a relationship with her throughout her labour... one that would be trusting... one that I would give her what she needed, when she needed it and that I would just be with her and supporting her. So I felt.....humiliating is a bit too strong a word but for me it was dreadful because I knew ... that what the woman was doing and she was following her body, was right. I was quite happy to be with her. I felt that it was a negative experience because the doctor just said that it's not only not going to work but its going to make it worse.

I came out to tell the midwives at the desk and they had wondered why the huffing and puffing at the desk was taking place...he just wasn't happy...there was no dialogue it was just body language...they said something very reassuring to me... oh no that's exactly right, let's just continue on and that's what to do. Fortunately she had a beautiful birth. She had a beautiful standing delivery.

Amber

Amber was working as a caseload midwife in a birth centre in a major teaching hospital at the time of the interaction she is relating. The woman the story revolves around was having her third baby. The woman was fully dilated but had no urge to push and was finding labour too painful and wanted an epidural. Amber moved the woman to the delivery suite for an epidural. The delivery suite was 'hideously busy' and the delivery suite staff didn't come in at all. After an hour Amber had to go out and ask for assistance. Some time later a third year registrar came in. He rushed in and very quickly inserted a cannula in the woman's hand, measured and felt her uterus and did a vaginal examination.

Amber continued: ... "it was sort of this wave that went through and we were all standing there a bit stunned really about what was going on. At that point she wanted an epidural and so to have an epidural you need a cannula anyway so it wasn't something that we were fighting. She wanted pain relief. We came in for pain relief and what we got was hell...as he measured her belly... he said things like "this baby is really big you should have had it 2 ½ hours ago...the baby is OP [**occipito posterior position, associated with longer labours and more difficult births**] you will need to have a caesarean". She was absolutely hysterical and I was saying "no, the baby is not OP. I am absolutely positive that the baby is not OP... it's just a bit stuck and she would like to have an epidural." He insisted ... "No the baby is OP and I will go and organise a caesarean"... he treated that woman badly from the outset and never listened to her!

The mother was very distraught having had two normal births before and she said "can

I have an epidural, can I have an epidural?" He said "yes we will do an epidural before the caesarean" and she said "fine do whatever you like just give me an epidural". She said to me later that in the back of head she was thinking just give me the epidural and when I calm down then we will sort this caesarean thing out.

So he went out of the room and to organise the caesarean and again no staff came to assist us. So she said "well that's it!" and pulled the monitoring that we had put on the baby off and sort of said "I can't be in this position any more!" which was on her back. She flipped over onto her hands and knees and she lifted her knee up at a backward angle as I was putting on some TED stockings...as she did that I could see head. I don't know whether that movement of just rolling over onto her hands and knees and moving her hip out at a funny angle something did all that it needed...but the head was on view so we all got very, very excited about the head being on view. I said to her "you're doing a great job because the baby is almost here".

The doctor arrived, barging in through the door with a trolley and said "she needs to get off her hands and knees and get onto this trolley". I said "oh the head's on view", really excited. He said "oh so what, you need to move her off that bed and get her onto this trolley and she can't stay in that position." I looked at him absolutely stunned and said "the baby is about to be born". He just left the trolley where it was and went back out of the room and within minutes a beautiful big healthy baby was born.

He walked back into the room and threw a bag of fluid loaded with 40 units at me and said "hang that up will you" and I actually stunned myself and I still think "how did I say that?" but I looked at him and said "OP my arse!" ...I was standing there holding a brand new baby! ... and the woman sat up and went YEAH! There was this whole room of this absolute kind of unbelievable energy of us going – stick it! The minute it came out of my mouth and the minute it had this echoing yeah, yeah round the room, I went "oh shit, what have I done" ...he just turned on his heel and walked straight out of the room and I sort of went "oh what have I done, what have I done!" ... the baby was out, the placenta came out beautifully and we sort of hung up the bag of fluids and I ...gave her a cuddle and took a few photos and then said to her "just let me see if I can go and sort that out". I left the room just thinking "oh shit!"

I went to him and I said "Donald, I'm really sorry I don't know where that came from". I said "nine months of knowing this woman and the energy of this labour and the exhaustion and the disbelief that she could possibly need a caesarean" – I was sort of blurting out all this stuff "I'm sorry". He just said "you came in there asking for my

assistance and I gave you my assistance and that's what I get!" He just went on and on and on and I was thinking in one breath "OK I probably deserve this" and in the other I thought "no I don't!" I think he was very cross that he was wrong...humiliated. It wasn't a conscious decision to humiliate him...it was just something that just came out of my mouth and I'm not sure where it came from ...he was really cross that he was wrong ... to see that the baby had been born and that he was wrong from the outset and then that I humiliated him and rubbed it in his nose didn't help! It was really, really awful. For the woman it left us instead of celebrating the birth of her baby she had her midwife in tears. Although we had come to delivery suite for assistance we hadn't ever seen a midwife, only the doctor demanding that she have a caesarean!!!

But my relationship with that registrar was for ever and probably now still...very strained because he insists that he was offering us valid help and I humiliated him in front of a woman. Whenever I was working in the Birth Unit, if I ever needed to transfer or ask opinion or anything I was always anxious that I would get this registrar. He treated the women that I cared for badly because it was me...so it impacted well beyond that one birth... into birth after birth after birth for probably another year until I left that hospital.

The energy was fantastic but it certainly impacted that woman, we talked about it lots and lots....she was very angry with the hospital and very angry with that particular doctor. In the end I saw him months and months later and said "look it certainly wasn't appropriate professional behaviour and I apologise for that but this is the circumstances surrounding that and can we just get on professionally now and move past that kind of stuff?" He accepted that but he certainly treated women that I cared for badly ever since... having known him before that incident and knowing him after, he certainly had a definite change of attitude. I don't know whether that was just towards me. He wasn't always the nicest bloke anyway; to women, but after that he was definitely worse. I mean I made the assumption and I could be wrong but he had definitely changed... that relationship will always be, if I ever get him anywhere it will be screwed...I tried to avoid him really and didn't have much to do with him.

Gemma

Gemma is partnered and has two children. She is a very experienced midwife who works in a caseload group attached to a busy, tertiary referral city hospital maternity unit. The birthing suite has a birth centre side and a more traditional delivery room side. The midwives in the caseload practice mainly work in the birth centre. The group looks after women who are designated either high or low risk. The woman, Elizabeth, is having her second baby. Her first baby was

stillborn, delivered by emergency caesarean following a car accident. This pregnancy has been a totally normal pregnancy and Elizabeth wanted to birth normally with this baby. Susan, Elizabeth's primary midwife, was on days off, so Gemma, who had met Elizabeth during her pregnancy, was on call. Elizabeth's sister Nancy, was also a midwife. Nancy had her babies through the caseload programme and was Elizabeth's support person. A student midwife Judy, was also involved in Elizabeth's care. Elizabeth wanted to use the bath in labour and the bath was in the birth centre. Women having vaginal births after caesarean section (VBACs) in this maternity unit were not continuously monitored with a CTG machine. The women usually had an admission CTG then intermittent fetal monitoring during the labour. There was, however, no written guideline.

When Elizabeth was admitted late one evening, Gemma rang the registrar to let him know that Elizabeth had been admitted, was labouring well and was a VBAC.

Gemma explained ... "she came in spontaneous labour and she was labouring really beautifully...I had done the admission CTG and was monitoring intermittently....she was getting close to second stage and everything was fine...fetal heart was great and everything was fine...everyone was very happy and she was doing really well...then the registrar came along, he happened to be in delivery suite for somebody else and I came out of the room and he asked how she was going. I said that everything was great, she is progressing very well. I had done a vaginal examination at some point early on and I said she's this much, things are moving along, fetal hearts are fine and she's in the bath. I think at that point he was OK but then he went away and came back, not specifically for me but for other things because he was in the hospital on call.

Although I was keeping the Team Leaders and the midwives up to date, there was miscommunication there between what the Team Leader thought I was doing and what she told him and what was actually happening. That's when he started to get a bit more toey...I hadn't had any busy shifts with him before or any big problems but I suppose I was aware that he was on the more intervention side...he knocked on the door and asked for me to come out...that's enough in a sense that he is not waiting for an update he was coming looking for information...he just seemed to have a slightly more assertive pose...kind of leaning forward and asking his questions fairly intensely... he was actually a little bit shy...I had learned through experience with him before that sometimes when he came across as a bit abrupt it probably wasn't really that so much it was more that his shyness was perhaps what was apparent.

...he was increasingly...not aggressive that's too strong a word but a bit more forceful in his questions and his pressuring of trying to direct the labour more in what he wanted...I felt, probably intimidated is probably too strong a word, but I felt imposed upon. I felt some frustration and I guess then I began to worry because I know then that I am starting to head into that territory of kind of juggling the different needs. I've got the woman's needs on one hand and I've got his needs on the other and it's often a difficult path to tread. So that's quite a tense situation I find ...tense because you know that you are probably not going to be able to reconcile those two needs. Because this woman is labouring beautifully in the bath and she doesn't want to get out and he wants her to get out and have a CTG...that was his concern and the other concern was that he thought I hadn't done any VE's ...

...to me it came down to a lack of trust that I actually knew what was going on...it's that thing that if you don't do a vaginal examination you can't know where a woman is up to in labour. So he was thinking that I hadn't done one for a long time so then he was worried that maybe the labour was going to go on longer than he would have thought was safe with a VBAC ...even though it hadn't been a really long time ...he felt that we were excluding him, that he didn't know what was going on and that he was concerned about the woman being in the bath because she was a VBAC...even though I had been going out throughout the labour ...and talking to the team leader and keeping her posted with how she was progressing and saying that everything was fine and that the fetal heart checks had all been good...he just kind of got more and more toey ... he was pacing outside the door...and felt that weren't keeping him up to date enough and it reached the point where he was really insisting that she get out of the bath and that she have a CTG...

...initially we stayed in the bath but then when he came back the second time I said *the doctor is quite concerned that we haven't done a trace for a while, what do you think?* ...we talked about it with her sister and she didn't mind getting out of the bath at that point...she got out of the bath and we put the monitor on for a while...there was then a bit of discussion between her and the student was also asking can she go back in the bath...at that point I was actually feeling quite pressured by the doctor... at that point I wasn't sure just how much he might want to interfere...so it's like buying time... a bit of a trade-off... so I said *let's leave the monitor on for a little bit longer...* then I think she started pushing and in the end decided to stay out of the bath.

...I did feel kind of distressed I suppose because I could see she **[the student]** was trying to work out what was going on and I didn't really have an opportunity to talk

to her about the kind of layers of what was happening. I was still conscious of trying for this woman to have a good birthing experience. ...I felt really strongly that I just wanted to do my absolute best to try and give her a really positive experience after her previous experience which had been so tragic. I just felt that she was doing so well it was such a shame to disrupt the flow of her labour just because of somebody else's anxiety when I was confident that the baby was fine. Her sister was very supportive. She wasn't in any way criticising what I was doing or anything like that...it's difficult. I did find that difficult... I suppose there are lots of layers. There's the doctor's anxiety about VBAC and there's all the different opinions about whether VBAC women should have continuous monitoring. What is the real risk of rupture? How long should somebody labour? How long should second stage be? I guess the other things about did I feel OK about her getting back in the bath and was she maybe going to have the baby in the bath. Was that going to be OK? I suppose just the things about her, because she had had a previous stillbirth.

With the first baby the baby was actually alive when they came into the hospital following the car accident and they were doing a trace and then it just went very non reassuring and they rushed her off for a caesar but the baby died. So obviously I was trying to juggle that wanting her to have a positive experience but obviously knowing that I need to be really sure that this baby is OK. That kind of pressure of thinking that maybe the doctor is right. Maybe I should keep the monitor on and all that kind of stuff as well...she certainly seemed to be managing the labour really well. She certainly wasn't outwardly expressing any concerns about that. Her sister was certainly feeling that she was fine...her husband, when we first walked in the room, when we first arrived, that was the first time he had been back into the delivery suite since the last baby and he just immediately started weeping...it was so difficult...that sort of past experience. He hadn't been back there. So that was the start of the labour in delivery suite.

She was actually really centred and focused on the labour and seemed fine...very positive...it was a bit of a trade off...that was partly why I thought well this is what he wants...I mean it's always a bit of a gamble because obviously if there is the tiniest blip on there well then you've got to keep the bloody thing on longer. But yes I was certainly thinking that this will keep him happy, this will buy us a bit more time and hopefully by then she will be well and truly pushing and it will all be academic. She will have a baby and we won't need to worry anymore...he felt that I was excluding him and that I wasn't keeping him up to date enough...through the whole process really. I think he just felt that he wasn't involved enough or something...I wasn't that fussed

really in some ways because I find him not the most women centred practitioner... eventually we did do that...she actually just stayed in the bathroom and stayed out of the bath for the birth. She had a lovely normal birth and everything was absolutely fine with her and the baby.

I suppose it was just an example where I felt kind of powerless in a sense that I had to kind of defer to that hierarchical medical system and I felt frustrated that I had been communicating well with this doctor and particularly with the team leader, the midwife that was on. The delivery suite midwives can actually undermine our role as well because we work in a different area. There is a bit of difficulty sometimes between the midwives and sometimes it seems like those midwives in delivery suite almost work against what we are doing and kind of side with the doctors. They were probably the main feelings that I had.

...he was under the impression that I hadn't done a VE for quite a long time. I had actually done one so he misunderstood where things were going and that was part of his concern. He actually made a complaint about me and we had a meeting with the Professor of Obstetrics and my Co-ordinator which was quite useful actually because the Professor is quite supportive of our program. My co-ordinator is very strong and stood up for the care that I had given and also for our program. I felt pretty comfortable with the care that I had given and I also knew that I had kept people up to date so I didn't feel that concerned about him complaining.

In a way it was kind of good to get together and have a chat because I suppose too often we have these experiences and then we just all complain to each other but we never actually try and do something about it. When we actually sat down with the notes and went through it sort of step by step when the registrar said you didn't do a VE for so many hours, the professor had the partogram and he said well hang on a minute there's a VE here and there's one here so what do you mean? So that was quite good and we clarified things a bit more.

He was obviously genuinely worried about the woman and thought that he couldn't impose himself and I think that made him more anxious so then he came across a bit more forcefully than he might otherwise. Part of what he was arguing was that women just don't know. She should have had the monitor on more because she didn't understand the risks. What we were trying to say was that the women on our program are really well informed and they have done their reading and they are actually making informed decisions about that stuff. He doesn't have to take all the

responsibility. That's a big thing for us...they seem to feel like they have to take all the responsibility for women...however, since the complaint was made I am more wary and more cautious around him.

Betty

Betty is partnered and has no children. She is the manager of a birthing unit in a tertiary referral hospital in a large Australian city. She had a practice development approach and midwives were taking more authority, taking more decision making and responsibility in the care of women experiencing normal labour and birth. The culture of the unit was very much evidence based and respectful of both doctors and midwives. It was 8pm and Betty was supporting a young midwife in her care of a couple having their first baby. The consultant on for the day was what Betty called 'traditional patriarch' who was close to retiring. The woman was in second stage in the shower with the new graduate midwife and the woman's husband near by. The consultant has the reputation of giving women epidurals in early labour, doing episiotomies and assisted deliveries, usually forceps 'lift out' in early second stage. Betty and the new graduate midwife had talked about the fact that because he was the consultant on duty, they may have him coming in wanting to do something to make the birth happen quickly. They had decided that if he came in, Betty would ask him to talk outside and the other midwife would stay, focused on the woman.

Betty continues ... "he came in ... I was in the bathroom and he came in. So I stepped out hoping to push him out and he stepped into the doorway so that left me on the outside... in his big boisterous voice, said *how are you going* and she looked at the midwife and said *OK I think*. I said a few positive words and tapped him on the shoulder and said *can we talk outside?* ... he just kind of looked over his shoulder at me and I pointed to the door and said – come here, come here...He said something to the woman like "*we'll have to see how you're going*" and said "*if it's not out in 10 minutes I'm going to pull it out*".

I asked him if we could talk about that outside and left the woman with the new grad midwife. and then walked out... he followed me out because I was kind of ushering him out... the other midwife was staying totally focused on the woman [**as they planned**]... we went out to the desk and standing at the desk leaning over the counter...and looking at each other sideways... he folded his arms and basically said that he was in charge and said *I've got to get down to private within the hour.*"

I felt angry because he was going to interfere with a normal birth and angry because I didn't want that to happen to the woman and I thought it was completely inappropriate...

he had other priorities... I felt pressured but determined I guess. I thought he might have gone away for a bit longer. I said to him *"why don't you go down to the private and do what you have to do?"* and he said *"that's going to take me 40 minutes"* ... I said... *we will be OK, we've got the registrar here* ...he was worried about the registrar being inexperienced, which he was. So he was covering his bases... so I asked him to give us another half an hour and he begrudgingly did that and went away...

I felt very challenged when I went back into the room...determined on the one hand to try and protect the space for the woman but knowing that I didn't know whether I was going to be able physically restrict him from coming back in, well I knew that I couldn't... She **[the woman]** said who was that, because he didn't introduce himself...I said he's the consultant obstetrician on for the evening and she asked what did he want and I just told her he was checking how things were going.

I left it at that... her partner was holding her... he was kind of losing it by then. He was tired and just not really saying much at all...he didn't see the doctor ... because he was kind of behind the woman holding her in the shower...they were very focused. We had the lights down and they were very into each other... it was less than 30 minutes... about 5 contractions probably when he (the consultant) came back..... when he came back in we were out of the shower and in the room and she was sort of standing, not quite squatting, sort of standing, not quite all fours but sort of slumped over one end of the bed and pushing when she felt like it to bring the baby down in kind of a semi squat position. She had her husband on one side and the midwife on the other...she had a big T-shirt on...he came in the door.....came in without knocking as he always does. *"How are we going?"* he says.... he came right in and shut the door.

"How are we going?" he says and I kind of pushed him back into one corner so we could talk...I didn't physically push him. I said *going quite well* ... I thought she had made reasonable progress. Not spectacular but adequate and he said something like *I think its time we got it out* and I said *can we talk outside* – because he's not capable of whispering.

We went back outside...I took him outside and said *no the baby is not out yet, as you can see, again I believe that she is progressing adequately*. He said *"what do you mean adequately?"* I said *well enough and I think that she will have the baby in the next half an hour to 45 minutes* and he said that wasn't acceptable...again we stood next to the counter of the workstation there and I said *I think she's fine and I do think*

she will push the baby out in the next 30 or 40 minutes and he said *I haven't got that sort of time*. I said *the fetal heart is fine* and he said *she's been fully for 2 hours* and I said *but she's only been pushing for an hour* and he said *I don't care!*we were standing front on by then.

He was standing there, he had his arms folded and I can't remember if I had my arms folded or not.... He is taller and bigger than me...I stepped back far enough so I didn't feel like he was towering over me... I was feeling threatened because he was going to take over what I was doing and take over my practice really...I felt backed into a corner...I felt like I had to negotiate hard and yet I knew I wasn't going to get anywhere with him... it's his track record...it's a classic...the fact that that woman didn't have an epidural – he didn't like that either ...he was frustrated...he was talking fast and wanting to get on with it and I was kind of slowing him down...he was just agitated... he was kind of “*come on get on with it and get it out...*”

... the nervous registrar was pretending not to listen and keep her head down and keep out of the firing line. I asked him if he would go away, could he find something to do for another 20 minutes and he said no that he thought it was time to get that baby out. I disagreed and he said *well it's not your call*. I felt angry. I was the manager of the unit after all so I felt it could have been my call for a normal birth...he was determined to do it...I asked him for 10 more minutes and went in and kept going thinking that I could fob him off again when he came in...I had been there for 13 hours by this time so I was tired. So I felt a mixture of anger and frustration as well. Not with the woman, I was happy to stay another 2 or 3 hours to get the baby out. But it was also busy and so I didn't have, not that it would have made any difference, but I wasn't surrounded by other midwives who could sort of share the battle...the other midwives ...were all in with other women. It was the reason that I was still there at 8 o'clock at night...I wanted to see it through with this woman and this midwife...that's why I was hanging in there...I was possibly a bit vulnerable because I was tired but I did ask myself later would it have been any different if it had been 10 o'clock in the morning and with him it probably wouldn't have. Except that he wouldn't have been pursuing around time as much because he had something else to do...

He spun on his heels and he said *come on*. I said *well what are you going to do?* He said *I'm going to deliver the baby* and I said *how?* He said *with a ventouse* and I said *I really don't think she needs it*. He said *we've had our discussion and this is what I'm going to do*. I said *can I go in first and explain to the woman what you are going to do* and he said *no you can come with me*.

So off we went. He went into the room. I went with him. She was in the middle of a contraction and he started talking and I put my hand up and said his first name and said *can we just wait until the end of the contraction because she won't be able to hear you*. So we waited. It was quite a good, big contraction... she was standing and groaning and pushing...she had her back to him and her head down and her hair all over her face. So when the contraction finished I said her name and I said *Dr Bloggs is here and wants to explain what he thinks should be happening...* what he thinks should happen now...she kind of opened her eyes and looked at me and I pointed to the doctor and said *Dr Bloggs wants to tell you what he thinks is going on*. Something like that.

So he said to her *I think you're very tired. I think its time we gave you a hand to get the baby out and I think you've done your best*. ...I was feeling really angry because how would he know he hasn't been there...I was looking right at him because I couldn't bear to look at the woman...she was looking at him in a sort of "out of it" sort of way... he (the husband) was looking at him (the doctor) and then I looked at the husband and he raised his eyebrows. You know looking for my opinion. I said to the fellow *do you have any questions? If there are things that you want to ask you should ask them*. He said something like *will it hurt her?* This old guy uses a pudendal and he said *no, no we'll give her a little bit of anaesthetic down there*. She looked at her partner and said *what do you think?* He said *its up to you babe*. She looked at me and said *what do you think?* I said *I think you're making good progress*. She said *well how much longer?* I said *well it's hard to know*. Then he cut across me and said *I think you've done all that you can do so I think its time we just got on with it so let's get moving*.

The new graduate midwife was looking out the window. I remember looking at her and she was kind of half holding the woman and kind of half looking out the window in disbelief I suppose. Which it was because we talked about it later...so then he (the doctor) started asking for equipment and we had to put her back up on the bed. We set up, I remember tipping the bed right up and getting a bean bag and having her really upright so she could keep pushing and he told me to take the bean bag out and lower the bed more... I felt angry and dismissed. You know like my contribution was not required.

We set things up as slowly as we could. I said to the other midwife *you keep working with Sally and doing what you're doing and Sally you keep pushing while we set things up*. I was hoping he would go out of the room but he didn't... it all happened

very quickly then... he did explain what he was doing... with my encouragement. He drew it [**local anaesthetic for the pudendal block**] up and I said *now Sally, doctor will explain what he is doing he's just getting things ready and then he'll explain*. So he did and it was a reasonable explanation. Basically he came in and insisted on doing a ventouse and cutting an episiotomy. The woman was tired and agreeable and consented, as they do, but the next day of course she was really pissed off..... the baby came out easily really. I think it was like two pulls on the ventouse... with an episiotomy. It was awful, I felt sick.

Jacky

Jacky has a partner and one child and is a very experienced midwife who is working in a caseload programme in a busy teaching hospital maternity unit. The unit has a high risk side, the normal delivery suite and a low risk side, which is a birth centre. The birth centre has baths and homelike furniture. The caseload midwives mainly work in the birth centre. If a woman requires an induction for postdates, the midwives insert the prostaglandin the evening before in the birth centre. They also care for women with syntocinon infusions in the birth centre. Susan was having an induction for post dates. There are no assessments, like CTG's or scans, the women are just automatically booked for induction 10 days post dates. It was Susan's first baby. Jacky had inserted prostaglandins the previous afternoon to start the induction for Susan. Jacky left for the night, with the understanding that the core staff would assess Susan during the night, do another CTG monitor trace and insert another dose of prostaglandins if labour had not established in the meantime. Jacky was to return in the morning to continue the next stage of the induction of labour if she hadn't been rung to come in during the night.

Jacky said that when she arrived the next morning ... "they hadn't put the second lot of gels in ... the CTG wasn't good during the night....but nobody explained that to Susan or Kevin, her partner. Somebody just arrived and put an intravenous cannula in her arm and she said *what's that for* and they just said she needed extra fluid. Nobody explained about the CTG or anything to her...I was just standing in the room and talking to them and she had the CTG on at that time and we were just talking about the CTG and what had happened overnight...nobody had rung me overnight and I walked in and there was Susan with a cannula...she had had fluid running. The empty bag was there...they had taken the CTG off overnight...they hadn't left it on all night.....

I'm not exactly sure how long it was off, but they decided to turn it off overnight..... and put it back on early in the morning...the night staff have gone home by that time because the new staff start at about 7 in the morning...so they wouldn't have known much...when I went in the room, Susan was semi sitting on the bed and the

husband was there sitting on her left hand side on the couch... I was standing beside the CTG on Susan's right...I was uncertain what was going on...I was trying to work out what exactly had happened overnight and how she was feeling about what was happening....trying to pre-empt what the doctors might decide to do... I was talking to her about what might be happening... the CTG had ... a few small decelerations on it...they would have been called like, I guess shallow.

Susan wasn't necessarily contracting well or anything like that so they were just happening independent of contractions...you would have to call them variable but I don't think they were cord related they were just happening...the variability was ok, it was about 5 – 10 ... knowing the woman and knowing that she was a non-smoker, healthy young woman with an uncomplicated pregnancy I wasn't overly concerned. But two unusual things had happened during her pregnancy. Twice during antenatal checks, just on a routine antenatal check the baby had been having a bradycardia down to sort of 80 beats lasting 1 to 2 minutes. The first time I just sent her straight to have a CTG which turned out to be absolutely normal no problems and they sent her home. The second time it resolved fairly quickly so we just pushed on. That was, I guess in the back of my mind but everything else was absolutely normal. There was nothing else to report...it was an absolutely normal pregnancy...

The doctor, Karen, walked in, unannounced, didn't knock, walked around the bed and put her back to Kevin, the husband, she didn't acknowledge him and spoke directly to Susan. I was standing next to Susan, next to the CTG machine...Karen glanced at me, then looked back at Susan and said "We're going for a section"... the doctor just comes into the room, walked around the other side of the bed and said "OK we're going for a section"...no explanation, no nothing... the doctor has come out from a handover, where they have a meeting, a changeover in the morning... I just looked shocked for a while and then I tried, I guess to prepare her...Karen...walked out and got the paperwork ready to get it signed up and consented and all that sort of stuff... then we started preparing her for section...then Susan was up in surgery probably within about 20 to 30 minutes after that...it's shocking about the speed at which it happened... because usually once they said that you were going for a caesarean at this particular hospital, they organise it.

They [**doctors**] have a code ... a caesarean code and that means that the orderly will be there within about 10 minutes...they come and everything gets organised and everybody is ready within about 10 to 15 minutes...we still had to put the catheter and everything in on the ward...Karen came back in and got the consent and explained

the risks...I was telling Kevin, her partner what was happening...

Susan told me later she was terrified...she didn't say anything at the time..... I was shocked but I know that they had discussed it with the consultant and I know that the decision has already been made and It's one of those instances where you feel like you don't have any input basically...you don't have any input into those decisions. They go away into this room to have their handover and come out with the decisionsthat's the way it is!

That's the medical structure. They go off and have their handover and the decisions for any woman, you know about whether she has forceps or whether she goes for a caesarean is made usually by someone who never sees that woman. It's made by a consultant who is off site or not even in the area!...or the consultant may be in the meeting room but they never come in to see the woman or even look at the trace I don't think. The decision was made. They probably took some of the trace into the meeting and the decision was made and the decision comes out. That's how it happens.

The decisions are handed down basically...I think it's a lot of the reason why, you know, that even in midwifery models of care that we don't have a huge impact on the caesarean rates or anything like that because we aren't involved in the decision making. If they come into the room and start to discuss it with the woman you've got a chance to maybe negotiate with the registrar or whoever it is but often the decisions just come from somewhere else and are not made in the room. The registrar comes in and carries them out.....you hope that it's a collaborative world but its not...

At the hospital that we work at the birthing area is divided into a low risk side and a high risk side and women have to go in and be sorted like sheep into one or the other. There's nothing in between you're either high risk or low risk...she started off in the low side and when I came in the morning that's when I knew something was wrong because they had shifted her to the other side...they have a birthing centre side where they have a little symbol called a smiley face that they put up when it's a low risk woman and that means that doctor's aren't meant to come into that room. They were having problems with doctors just walking into the birthing centre rooms and starting to do things. So they developed this smiley face that you put next to the woman's name and that means that she is low risk and she should be under the midwives care and unless you are asked you don't go in there as a sign to the doctors. So if everything stays there that's fine but as soon as you cross the line over

to the high risk side, then doctors can walk in at any time...the CTG's are linked to the computer at the desk so they know absolutely what is going on in the room. If you haven't got a scalp clip on they can tell from the desk.

They are watching the CTG and if the woman has a vomit and there is a dip they will come into the room and see what that is about...they knock, but they just enter. It's like knock means yes. As one woman put it...just because you knock doesn't mean yes that you can come in...the birthing centre term is probably very loose...they do use some inductions over that side including syntocinon and things like that in the low side so it gets a bit grey about whose are whose **[which women are midwife care and which women are medical care]** really... I was very frustrated with the way they treated Susan, but its common and it's been happening for years and we have little input into the care. Would they listen anyway? You don't get to speak to the person that makes the decisions it just happens.

You feel awful for the woman about what has happened to her. That nobody has explained it to her. Nobody has explained the CTG and then you know that you have to deal with that afterwards because we have continuity with our women and we see them afterwards. We debrief about the birth and everything and you know that you will have to explain why. It puts you in a very awkward position to have to do that...I had cared for this woman throughout her pregnancy...she was ten days overdue.... it was a normal healthy pregnancy. The baby was fine when it was born of course. You have to explain the doctor's actions basically and try and make sense of why someone would just walk into the room and say something like that.

Roberta

Roberta is a direct entry midwife who did her bachelor's degree in New Zealand. She is married with two small children. Roberta was working in a large regional maternity unit which did not have good relationships between doctors and midwives. Roberta came in for the afternoon shift and was allocated the care of Zoe, a woman who was having her first baby and had been admitted for a post dates induction even though she was only one day post dates. No one knew why Zoe was being induced because the baby was growing well, Zoe was healthy and the baby's head was engaged. To begin the induction, Zoe had a synthetic hormone, Prostin, inserted vaginally in the morning to soften and ripen the cervix.

Zoe had seen her obstetrician, George, throughout the pregnancy and had not attended any antenatal classes. Although she had read a lot, Roberta thought she was poorly prepared for labour. While the midwives were in handover, George, the doctor came in to assess Zoe. He

ruptured her membranes, put the CTG on and left without telling anyone what he had done.

Roberta explained.... “there was no consultation with the midwife that that was what he was going to do, he just did it and then we came in after we had handed over to see how Zoe was... there was prolonged bradycardia, that’s how the whole negative thing started with the doctor...there was no communication about what his plans were and/ or why he had done that... he just put the CTG on her and walked out the door ...we tried all the normal things – positioning...tried turning her on her side and giving her oxygen which you know doesn’t do anything anyway, changed position, stand her up and all of that...still prolonged bradycardia so I did a VE to exclude cord prolapse and that was fine.

In the meantime George, the doctor didn’t have his mobile phone with him or any way of contacting him so there was a mad run around the hospital trying to locate him which finally they did after 15 minutes, by which time the fetal heart had returned to normal. Meanwhile the midwives were trying to explain to Zoe and her partner, Luke, what had possibly happened and maybe it was just the baby being distressed because it didn’t like that happening to it in a kind of..... not to undermine what the doctor had done, even though we didn’t agree with it, but trying to keep her informed. Within about 8 minutes the fetal heart had come back to the baseline, it was reactive, it was variable, there were accelerations and the baby seemed to be fine.

...George decided to come in and do another vaginal examination, even though I had just done one 10 minutes before. He found the same thing. Found she was making great progress, even though she was still 2-3cms dilated. Anyway, he was trying to be positive about her progress. Actually he was misinforming her to encourage her. Do you know what I mean? Like trying to say she was doing really well even though she wasn’t in labour and she wasn’t doing anything rather than actually giving her proper information about herself or her baby. Then he decided he would like to do a fetal scalp sample, a pH so I was really unhappy about that. There was no discussion with Zoe as to why, so I tried explaining to her why but really it was really hard to explain why when you didn’t agree with it. So then he did a fetal scalp sample and of course the pH was fine. We took the CTG off and Zoe just mobilised and he went away again.

Then there was lots of discussion because Zoe was really anxious. She was upset and crying. Luke, her husband was really worried, saying “*maybe the baby needs to be delivered now, maybe she should*”..... before George left he put in her mind that

if she hasn't had the baby by a certain time then she will need a caesarean section. So I discussed with Zoe that really she wasn't in labour yet, this wasn't labour..... whilst trying not to undermine what progress she had made...

When the doctor came back two hours later he examined her and she was still the same again so he decided that he would put up syntocinon to stimulate her labour. Then for the next two hours he proceeded to maybe give her 2 or 3 vaginal examinations in that period of time, without any consultation as to why she needed them...and kind of putting her down in a way to make her feel like she was special or something like – *“you're doing really well, you're making great progress but if this baby is not born soon, you're going to get tired aren't you, you're going to get tired...and you'll need a caesar”*.

I felt horrified that someone could physically do something to someone without their consent or explaining anything to them and as a midwife I felt that it was my obligation to support and empower the woman and it was really hard to do that because it didn't support what was happening to her. But in a way I questioned it verbally so that Zoe could hear ...but George didn't ever answer why he was doing it or he told me that he was very experienced and we need to assess the progress, meanwhile making some kind of face at me to shut up.....like raising his eyebrows and looking at me with big wide eyes telling me *“because SISTER”*. He would call me sister even though I told him to call me my name, Roberta. *“Because SISTER, we NEED to make sure that the mother and the baby are OK, because even though she's done VERY well, she might need a CAESAREAN”*....meaning don't question what I'm doing and don't ask anything.

Well I didn't shut up because I thought that my job is to empower Zoe and to be her support and if I don't say anything I don't care it's only my job..... but at the same time I didn't want it to have a negative impact on Zoe or Luke, because George and I weren't interacting in a positive way. I didn't want it to negatively affect Zoe but I wanted them to be aware that there was an alternative to that...it's hard to do that.

So the whole communication was negative there wasn't anything really positive about how she was doing or yes she could do it or there would be no harm for her to wait until the morning or having something to help her sleep and get things going tomorrow, even though the baby was fine and she was fine.

So in that period of time he then decided that he would like to do another fetal scalp

pH and that's when I said *"I really don't think that's necessary because the baby is fine, we can see its reactive and babies that have got a reassuring CTG are not distressed and there was no meconium staining"*.

George disagreed with me and the other thing that made me anxious as a midwife was that there was no documentation of what he had done during those three hours since the prolonged bradycardia. So I had documented everything in Zoe's notes and he really took offence to that and started scribbling in the notes and telling me that I couldn't do that and said he wanted to talk to me outside the room. I mean things like scribbling on people's notes and stuff! I mean it's against the law for a start but it was just pathetic...crossing out notes I had written because he didn't like what I had written about his practice! I informed him that hasn't he ever had a woman who has come back in two years time and said *how many vaginal examinations did I have in labour?* or *why did I have five?* and there's nothing documented. Because I have had women come back and say *why have I don't this to them or that to them or why did someone do that* and we have gone through the note and tried to find out the reason. I said that to him and I said that was my reason for documenting what he had done whilst I was in the room because there was no documentation and you should keep contemporaneous records.

I asked him if he can he remember at the end of the night if he did two VE's or 10.... you don't, you're tired...but he's that was very much that I shouldn't be doing that, I'm just the midwife, and how *dare* I document anything that I'm not doing. Well I don't see it like that because Zoe will come back to the midwife clinic and see her midwife and then we have to go through the notes...and why shouldn't they, it's information about themselves and their body and why is he hiding it? If he's hiding it he knows it's not right so don't do it. **[laughs]** I'm not playing these stupid games. I have women who come back and say stuff like that. The computer asks how many VE's did they have in labour, if it's written down, then I can count and put it in the computer correctly.

George shouted at me in a loud angry voice, telling me *'he's a very experienced practitioner* and I said *"well so am I"*. ...I asked him not to speak to me like that and then he refused to leave the room at all....I think he was worried what the midwife was going to do when he's not there. I don't know why he stayed. It was more to make a point that he's got the power. He sat in a rocking chair with his legs up, asleep. So then I told him that if he wanted to be there then he needed to be providing her labour care because I wasn't going to stay there.

I couldn't see the point of her primary carer, the doctor, being in there if he wasn't providing any continuous care. I didn't see the purpose of him sitting there in a rocking chair or watching television or then in half an hour doing another vaginal examination. That was not of any benefit to Zoe. He was being like a piece of furniture...I didn't see what my role was. To sit there and watch the CTG or to detach her from the CTG so she could go to the loo or to take her blood pressure. There wasn't a role for me to provide support. I think the relationship that I had with Zoe or the rapport with her and her husband was gradually getting destroyed by each time I would say something with him saying something negative about it. For example *"would you like to get up and have a walk around"* - because for some reason the CTG had been put back on when I had gone out of the room, for no apparent reason but then him saying *"no, no, we need to make sure the baby is OK"*. ...the policy in the unit was that once we had a reassuring CTG then that indicates that the baby is fine and that she can actually come off and be allowed to walk around and labour... it doesn't empower the woman it empowers the midwife to let her off the CTG! **[laughs]**. But even if that's the policy still he told me that what his practice is, that's not what he does. It's like defensive practice. He's doing everything in case something might happen. He feels like if he did something it was better than nothing and that he feels that's how a court will look at it. So everything I did to try and support her to have a vaginal birth or to support her labouring was undermined by something he would say.

So then I didn't see that I had a role because there was nothing else. I mean sit there with the woman and not making any communication, even when it was needed...I felt I couldn't support the woman while he was there undermining everything I did or snoring in the chair so in the end the negative impact for the woman was that I left the room and didn't provide her with midwifery care anymore because he said that's fine he's going to be there. Even though the other midwives said things like *"god this man is a pig"* they were not really supportive, they said to me *"you should just give up"* and *"don't come and sit out here or you'll get in trouble"*.... in a court of law as well....how do you support women? ... if things are continually happening that you don't agree with, that you let them happen, that's not my role.

My role is to prevent that happening and so if you're there and you can't change it, do you know what..... if I'm not there well then I'm not, you know....but that's not why I wasn't there, I couldn't stand to be in the room anymore. I didn't feel that I could be in the room and support Zoe and just agree with whatever was going on even if it made the situation more positive because I felt if I didn't say something I wasn't doing something for that woman. It was like I was agreeing with it. I couldn't be in there and

not say anything because that would be like I'm agreeing and thinking it's ok. So it was easier to be not there at all.

Zoe told me later that she refused to get on the bed she stayed standing and had a lovely standing birth, I presume, because there was stuff all over the floor. ...I heard the baby crying and I thought everything is fine and soon he will call me to come and tidy up this mess or something but he didn't. After about 20 minutes I wandered down and there was a pink screaming baby boy on the resuscitaire with the husband holding the "ambu" bag of oxygen over the baby.

...part of me felt really angry that someone would dare to communicate with me like that and the other part of me felt like a failure for Zoe. I felt really upset and distressed... more angry. But still I felt confident. I kind of wondered how I could have made it any better if I had stayed in the room would it have been better or it wouldn't it have... I don't really know. But I wasn't being responsible for looking after her when there was not really a role for me...even though maybe she didn't feel that she had failed I felt like I had failed her in providing midwifery care that was positive or effective. I felt like I didn't empower or I didn't have the opportunity to interact with her in a way that was positive. Like the outcome, even though it was physically positive, she had a live baby and she was fine but..... that was another thing – the perineum did not need suturing, there was no tear but he still sutured it. That is common. You can guarantee he will suture a perineum even if it doesn't need it ... because that way he makes it like he did something for that woman. So that is just terrible, it's horrific.

Luke, her husband did ask me lots of questions later about why was something happening or why did she have so many examination or why did I say I don't think you should have this done and the doctor said you should. So I did try to explain to him a bit but its hard not to undermine other health professional, who you want to rely on when something isn't normal but that's what they are there for, when really you think their care has been absolutely terrible. I think the effect for Zoe during the whole process she felt, from what she said to me she kind of had a struggle in her own mind because she thought she felt confident with what the doctor was saying because the doctor knew everything, in her mind but at the same time she didn't' feel comfortable with being so out of control and not having any information.

For Luke, her husband who was really like the onlooker, it was quite the same for him. He thought he could trust the doctor looking after his wife but something didn't sit quite right. He couldn't understand why things were happening and there wasn't a

real reason...the husband was definitely easier to talk to because he could see what was going on in the room, like the interaction between myself and the doctor and her. He was much more questioning than she was. But I don't want to undermine other colleagues, even though their practice is atrocious, because it doesn't achieve anything.. So I didn't lie to them and make up some reason why she had so many vaginal examinations or why he did fetal scalp tests. I didn't do that to support the doctor's practice because I didn't think it was right myself but it's hard to make Zoe feel positive about an experience that was really negative.

I didn't feel like I could confront him again because it was just such a horrible situation. Straight after the event you always feel too emotionally involved with the woman or whatever to address it and then afterwards you just think you can't be bothered because they're not going to change,

Dana

Dana is a young woman, married with two young children. She is in her second year of midwifery practice. She is employed as a caseload midwife in a busy, regional hospital which has about 3000 births a year. Usually, core staff midwives have little to do with the women who are having one to one care with the caseload midwives. On the occasion that Dana is talking about as a negative interaction. Dana was called in for a woman who had ruptured her membranes at 36 weeks. The incident occurred at about 10pm when Dana had been up since 6am and had a full day at work. Dana was exhausted. The woman, Jillian was very anxious and demanding. She required a lot of support. The registrar, Shelley, was not very experienced. One of the core staff midwives in delivery suite had done the woman's initial assessment and said she wasn't in labour because the CTG wasn't picking up any contractions and the midwife couldn't palpate any contractions. The woman had ruptured her membranes, but the core staff thought that, because the woman had diarrhoea a few days previously, that the pain she was experiencing was only 'gastro'. When the woman wanted pain relief, the doctors wouldn't agree to an epidural and would only allow her to have an injection of Pethedine because they didn't believe the woman was in labour.

Dana continued ... "when I actually went out there to the corridor to speak to the doctors I said I know she is 36 weeks but I really believe that she is in labour. They were still reluctant to do a vaginal examination to see if she was actually in labour. I mean I had the benefit that I knew her and I could tell by the way that she was behaving. I knew she was in established labour but the doctors wouldn't commit to it. They just weren't interested. They believed the hospital midwives saying this woman, Jillian, is anxious, she's panicky and rah, rah, carry on. She's a nurse...and no she's not

in labour she's a nurse and she's just an anxious girl"...the doctor, Shelley I have worked with her before... she is inexperienced and I think that she gets bullied by the midwives at the hospital as well... because you can tell...sometimes the midwives will have a word to me about well you didn't do this or you didn't do that; not that I bite back but I just sort of say well it's not the end of the world sort of get over it but a lot nicer than that and you can sort of see Shelley looking in horror and sort of giggling afterwards. I have just seen the way that the midwives speak to the doctors and the registrars and the RMO's and they treat them badly....just bossy...that sounds like a terribly juvenile word but they are just bossy...they are bossy midwives...

...I just said to Shelley, "*look, she is in labour*". I can't really palp these contractions, because I couldn't, but I said Jillian is displaying everything that indicates that she is in labour...she has just vomited...she is feeling pressure. I know, because I knew Jillian antenatally and you know the change in women when they are in labour. I could just tell, I just knew. I said she's in labour can we do something because she really wants to have an epidural, she is in pain. It was her first baby. I was conscious about that...I thought we could be here for ever...I told them that she is begging for an epidural, some pain relief and we need to give her something... Shelley didn't go and see Jillian. She just said "*no if we do a vaginal examination then we commit that she is in labour and no we are not doing that*"...I felt angry. I thought how am I going to go in and tell this poor girl that she has been denied an epidural. I felt like I was going in and lying to the woman which essentially I probably was...I didn't really say anything. I said "*well we will just see how you go for the next hour. Why don't you try the gas or you know get back in the shower*" and that sort of stuff...

Jillian progressed as if she was in labour. She progressed really well...beautifully... she had vomited and I thought oh she's doing all this transitional behaviour.....like she had vomited she was on the toilet, off the toilet and she was supported by her partner, John and her mum...I rang the bell and said that she was pushing. I rang the bell because on the delivery suite side we are supposed to ring the bell when they are pushing to have another midwife come in to aid with whatever, suction or whatever needs to be done. Just an extra set of hands...I hadn't seen Shelley, the doctor again but I had seen the midwives...because Jillian was making a lot of noise so they were sort of sticking their heads in and out...they just appear. You turn around and there is someone there...They morph. They morph in and out... they say "*what's going on in here, what's happening*" That's when I said I need to see what is happening. Then the midwife went back out and came back in and said "*OK examine her*"....she must have gone and spoken to whoever. I don't know if she spoke to the doctor or if she

spoke to the team leader, I don't know...or just another midwife...all I know is that I then examined her...

Jillian was 8 centimetres dilated...then I said *"you're 8 centimetres, this baby is going to be born...you've done so well!"* just all that encouragement, you know... *"You're nearly there most of the hard work is over"...* *"No, you're not going to get your epidural but it won't be long before baby is here"...* Shelley, the doctor didn't actually come in until she was pushing...the next interaction I had with Shelley was when Jillian was pushing... I came out of the room and said well she is pushing now... then another midwife came in.....there were external signs of dilatation, anal pouting and all that sort of stuff so I knew that she was ready. By this time I was not coaching her, directing her to push but encouraging her with the pain to push and all that sort of stuff.

Then Shelley came in and wanted me to do directed pushing with her. Which I thought well she hasn't really had a go of pushing by herself yet so I'm don't really think that we need to do that and baby was fine...Jillian was on the bed at that stage....she was back on the bed...that was her choice.....she just stayed on there because that's where I had done the examination... I had put the bed up and she just stayed there and didn't want to get off... I was just doing intermittent monitoring because she wasn't in labour according to the doctor...so the hospital midwife would have had to report that she was pushing...then Shelley, the doctor appeared...morphed in... ... Shelley told me off...I got in trouble because I didn't have the CTG on...hands in the pockets no introduction or anything like that... the first thing she says is *"Why isn't she on the monitor?"*... at that stage Jillian was on the bed and I was sitting on the end of the bed... John, her partner was with her and her mum was with her so she was wonderfully supported...Shelley stood next to me at the end of the bed looking straight at her bits...she walks in and has gloves on so everyone should know who she is...I had been monitoring the baby and I didn't actually at that stage care what she said...

I thought this is a labouring woman and didn't actually make the connection that she was 36 weeks and probably wasn't aware of the protocol that she should have been whacked on the monitor as soon as we realised that she was 8 centimetres... apparently I should have had the CTG on because she is prem! That's what the doctor said. I was monitoring 5 minutely, 5 or 10 minutely the heart rate anyway ...the fetal heart was fantastic...and so I put the CTG on and it didn't really work properly anyway so that was OK...Shelley was still there, then she disappeared....then she

came back...Jillian was...pushing, she couldn't pant through it any more.....the head was there...then when it was time for her to push they all got panicky and didn't want her pushing. It was her first baby so you know she wasn't the most effective pusher in the world. They were panicking over cerebral haemorrhage because the baby was only 36 weeks. Fetal heart was fantastic....I reckon her whole second stage was like 40 minutes or something like that ...it was really, really, for a first time mum it was really good progress..... I don't care if a woman makes noise or if she holds her breath. To me it's whatever works best for her....Jillian's baby was fine...

When Jillian was actively pushing, Shelley, the doctor came in and over-rode when I was saying ... She said *"ok you need to take a big deep breath, put your chin to your chest and push down and don't make a noise"*... she spoke over me.... I felt pretty crappy... thinking well don't you waltz in here at the last minute, especially when you didn't believe that she was in labour! Now you still have to take all the control away from her of what she wants to do...when she was progressing beautifully...there was just no indication to intervene the way the doctor was intervening...especially when she didn't want to do anything about it in the first place...sometimes you can't bite your tongue and you will say something...but I just think that the girl...I felt there was another time and place to do that. I didn't feel that now was the time for me to get all bossy like that... Shelley was there for probably 2 or 3 contractions and then said *"I want you to cut an episiotomy if she hasn't made any progress in the next 2 contractions"*....the head was on view but I think it was too early to cut an episiotomy... I just looked at her and said *"why?"*. She said *"because she's pushing and we don't want the baby to get a cerebral haemorrhage"*. I said *"well she has only really been actively pushing for 15 to 20 minutes and I don't think that we need one"*. Shelley said *"yes but intracranial haemorrhaging so cut an episiotomy"*... I said *"well I'm not doing it. I'm not cutting her. I don't think we need to cut her"*.

The doctor said *"fine I will go and get someone who will!"* and left the room. She came back with a another hospital midwife...to cut the episiotomy because I refused to.. .. I was probably encouraging Jillian to push too much then to get the baby out before Shelley came back and cut her.....I felt terrible because Jillian was being violated, was about to be violated. I felt terrible for her...absolutely, yes...Jillian was beautiful...Shelley, the doctor came in with the other midwife and then Shelley left the midwife to it ...

Shelley didn't want to cut the episiotomy, she wanted someone else to cut it ...and it was just me and the other midwife. The other midwife said *"the doctor wants an*

episiotomy cut". I said *"I'm not doing it"*. She said *"if you haven't done one before I will walk you through it"*. I said *"no I'm not doing it she doesn't need one"*...I was also thinking that I hadn't had a lot of experience with premature births and maybe the doctor was right about this... then I asked the other midwife when was the last time that she had cut an episiotomy and she said about three years ago. I thought yeah there you go. So she cut the episiotomy...she did cut it. ... she's actually one of the better midwives that's actually a little bit more supportive of us in the hospital so I just think she was just doing what she was told to do. I don't believe she felt that Jillian needed to have the episiotomy but she just did it anyway...the head didn't come out straight away. Then Jillian tore some more... ..then the baby was born...when I looked around Shelley was in the room all of a sudden with a medical student... and the paediatrician...so this poor girl was cut and then still didn't birth the baby straight away and then birthed her and tore more and needed lots and lots of stitches...so she had an episiotomy and a third degree tear...

I put the baby up onto Jillian's chest and the paediatrician was sort of waiting for me to cut the cord so that she could take the baby away. The baby came out pink and crying and beautiful. It was a lovely size 3 kilo 36 weeker...the baby had to go to the nursery...I got in trouble because I didn't get it there within the hour. I was trying to get Jillian to breastfeed and all sorts of things and I got into trouble because keeping the baby with the mother was anti-protocol; the baby should be in the nursery within the hour. I hadn't done its weight or anything...the baby was fine!

This was obviously Shelley's first experience in obstetrics...I just feel that she was practising defensive obstetrics. I think she panicked when it was a 36 weeker that she didn't believe was in labour and wanted to cover her tracks if something went wrong...I feel sick for the poor girl. I feel terrible for her. Jillian didn't need to be **[cut]** and every time I see her postnatally she was "ouch", you know she sits down and she's still sore. Everything is healing really well but she is still sore. I just think it's terrible..."

Kitty

Kitty is partnered and is the mother of two teenage girls. It was four o'clock in the morning when Kitty, who is a very experienced midwife, was working in the birth centre of a busy, tertiary referral hospital. Kitty was caring for a woman, Joan, who was a new immigrant from South African, having her first baby. The woman was a private patient and the consultant on call has a reputation for inducing women at 38 weeks and telling them they are overdue. Kitty says he is more of a surgeon than an obstetrician as he does a caesarean section with little

provocation. The woman and her baby were being monitored by continuous cardiotocograph (CTG) as part of the standing orders for the private obstetrician. Kitty said there was no clinical indication for the continuous monitoring of the baby and described the woman, Joan as a tall, fit and healthy, statuesque young woman.

Kitty explained ... "Each private obstetrician has personal preference cards and they are their guidelines and we have to obey them... he was the specialist on call for this woman ... it's just the luck of the draw isn't it?"

Well she has this deceleration and ...I felt pissed off because I knew then, that as soon as soon as she was on the radar, we were off to theatre...I just knew it! ... I fairly knew what would be happening, even if I didn't somebody else would tell me what would be happening..."*oh well you'll be going to theatre Kitty...I'll do your notes for you*"... it means I'm going to theatre...she'll be going to theatre.....I rang him and I said there has been one isolated deceleration with quite a quick recovery...I'm just ringing you to let you know... you couch it and try to make it sound like it means... yes I've been looking at the CTG and I've noticed the deceleration and I'm actually letting someone know about it but there is no real cause for concern...we will monitor her...we will continue...we will keep her continuously monitored and it's fine now..... he said on the phone "*we'll go to caesar then*" without seeing her!

.....I felt a bit disappointed for Joan really. I thought you go into theatre on this! on one decel!...an isolated deceleration that could just – you know clinically it's not an issue ...you wouldn't bother saying anything with this one ...because...he just caesars a lot of women...that's his practice and what would be the point in even trying to advocate for someone?....I wouldn't bother...it's just a waste of energy that I don't have, it's a fait au compli at that stage ...You feel quite sad really...I didn't have that much time to think about it but you kind of do... you have the woman all ready...you explain...the doctor will be coming into have a look at you and your baby and have a look at the CTG...the baby is fine .. you try and say the baby is great, it's a tiny way of trying to explain that the baby's heart rate is going down a bit here – but sometimes that happens when the baby has the cord in its hand and it gives it a little squeeze and that's all it can be sometimes... you have to reassure them because she was frightened and I didn't know her and she was from another country...so culturally she would have been terrified.....having her first baby....she would have been even more fearful then she had one isolated deceleration on the CTG...the rest of the CTG and before that it had been perfect and after that it was good, really reassuring except for one deceleration and we went to theatre on that!

They think the doctor knows best and they are relieved...someone is going to do something it's four o'clock in the morning...we're all treading water then... everybody is trying to be safe...it's a fait accompli...it's disappointing but you know what? You know you just feel what else can I do? That's it ...I've done this, he's coming in, we'll be going to theatrehe came in...and walked past...doesn't stop for breath...walks past...goes to the room...doesn't knock...I don't think I've ever seen him knock...and then we're into it...he had a look at the CTG and said, standing at the foot of the bed, looking at the woman *"right we'll go to theatre"*...it was a normal trace!...

I thought..."*oh...just let's get on with it then*"...he said *"let's go to theatre, your baby's not obviously very well and..."* all this worrisome stuff *and* even more terrifying *"because your baby is not doing very well here and we have to get it out"*.....she not only had a caesar that was unnecessary she also had a general anaesthetic...that was probably unnecessary as well but at four o'clock in the morning as somebody remarked to me, it was the safest way...because that anaesthetist is more au fait with general anaesthesia... I felt very sad for her...it might have been the safest thing to do at four o'clock in the morning with someone who is sleep deprived...yes...it was the quickest, it was expedient and it was safest, can't be buggarising around with somebody's back at four in the morning when you've not had any sleep all day...the baby had great APGARs and was absolutely fine of course!"

THE VOICES

Doctors' stories of Positive Interactions

Helen

Helen, at the time of this interaction, was a junior consultant working the evening shift in a busy, tertiary referral hospital. The woman the story revolves around had a significant past history of abdominal surgery. Helen had seen the woman extensively during her pregnancy and she knew that if the woman needed a caesarean section, she would need to involve the colorectal surgeons as the woman had many adhesions and it would be a very difficult operation. Helen was nervously 'hanging around, watching' her labouring, anxious that she may have to make a decision to do a caesarean section.

Helen explains ... "but in fact the midwife was with her doing an excellent job encouraging this woman. The woman laboured really well and despite **[being short]**– I keep talking about short woman as though are fat – but this woman was not very tall at all with a tall husband that was fat. I was nervous that she was not going to get this baby out ...but she laboured really well and got to fully dilated and I started relaxing and thinking – oh good, that's lovely, I won't need to be doing a caesarean section... the midwife who was an experienced and very competent midwife would be more than capable of doing the delivery...just before handover she was fully dilated and then the husband said *and I'm going to deliver my own baby.*

All of a sudden the situation changed from one of what I had thought was a resolving distress about whether she would need a caesarean section to one of 'oh dear we've got a security issue here!' He was saying *everyone get out of the room I'm going to deliver my baby...* both of us **[Helen and the midwife]** had a little chat with him and he was a very possessive man we suspect there may have been an element of domestic violence but certainly there was that emotional control of – 'you do what I say, this is what I'm doing'. He didn't become violent but he said that he didn't trust us to look after the baby, he had to deliver the baby. We said 'but you're not a qualified midwife or obstetrician, you can't deliver the baby by yourself. You can be there and touch the baby when the baby is born...' He's saying *I'm a First Aider and you're getting out of the room and I'm delivering my baby.*

So at that point the midwife and I moved to a corner of the room and spoke very quietly and agreed that I would go out of the room, leaving the door open, with the midwife between the door and the husband. I then went out and spoke to the Midwifery Manager and we called security up and spoke to the night Midwifery Manager and the

midwife who had now been allocated to this woman, because the handover was just about to occur. I had never actually got along with the night midwife who was again a very experienced midwife...she took charge of the situation beautifully.

She **[the night duty midwife]** went in, we made sure that everyone that went in was wearing a duress alarm. So she went in with me and we were both wearing alarms and we made sure that the midwife who was in the room came out and got a duress alarm. Then she went back in and we had discussions with him and he was still saying that he was going to deliver his baby and didn't trust us with his kid and what if we did something wrong. I was finding it very difficult. The woman was pushing and the head was on view and he was saying you've got to get out of the room. He was a great big tall man but he wasn't actually being violent towards us he was just saying I'm doing it, I'm staying here and I'm delivering. The night midwife managed to...discuss calmly with him and they came up with the best compromise which was that they both put gloves on and just like pretending that he was a medical student, she delivered the baby with his gloved hands over hers. I found that just the way that she managed to diffuse a potentially very unpleasant situation, while advocating for the woman that she was going to get the best care, which was a qualified clinician delivering the baby.

She was also able to keep the situation under control so we didn't have a freak out or the husband being ejected from the room or being forcibly carried away by security or anything like that. We just had her calmly diffusing the situation now that he, as a very possessive, I don't think protective, I think domineering was the right word, man that he was able to be kept safe and the situation was kept as safe for the woman as possible. They also had made sure that there were always two midwives in that room from that moment on. They were both wearing duress alarms and security sat at the desk until the baby was delivered, the placenta was delivered and everything was sorted out and the husband came out and went home.

I had always found that she... I had thought that she was a – get the baby out, get her tidied up – I had always thought of her as a cleanliness freak. Just get it done. It was a very procedural sort of thing I hadn't thought of her as an advocate and I hadn't thought of her skills. But just the way that she listened and said we will be able to sort this out. When we spoke about it the next morning, because being on overnight I came in overnight as well for another thing, and she said 'yes what you said to him helped'... she said that she was able to then discuss with him about that. I was feeling, as the Consultant, I was supposed to be taking charge and I didn't know how to deal with

this. It wasn't an obstetric dilemma. The woman was about to have a normal birth. It was a management dilemma and I was just so grateful that she was able to take charge and reassure me and keep the woman safe...that we have a senior midwife able to take charge and yet do it by negotiation and in a way that kept the woman safe and feeling that she was going to have this normal birth and everything was OK in the room ...she spoke to me outside the room because the husband was getting so difficult and so then after that I would go to the doorway because we always made sure that the midwife in the room had eye contact with somebody outside because there were always two midwives in the room. The husband knew that I was coming to the door but then we would have a brief conversation outside the room...I felt very grateful and pleasantly surprised that this night shift midwife who I had always found that I didn't have much in common with, had been such a good advocate for the woman and kept the situation under control...she was able to take charge while keeping everyone in the loop and keeping everyone feeling that it was safe and it was all going to end well...this situation where the partner suddenly became distressed and with a potential for violence, I just didn't know how to deal with that and she managed it and let me know that she was going to keep everyone safe...I had much more respect for her as a person **[after that incident]**. Because of the seniority I had respected her as a clinician but I had more respect for her as a person and realised that she was not just one of those invisible group of permanent night shift people. My vice has always been that people who do permanent night shift must be a little odd never to see daylight.

Lucy

In this story, Lucy is a junior registrar working in a regional maternity unit. She is on duty for the day in the delivery suite. In this unit, the obstetrician in charge of the unit makes all the policies whether people agree with them or not. The caesarean section rate is very high and there is a very low tolerance for deviations from normal.

Lucy explains that this positive interaction with a midwife, Janet ... "is a good one because, interestingly, it happened in a hospital that I can't stand...a hospital where most of the midwives drive me nuts...they have got weird attitudes there".

The woman was being induced because she was having a 'big' baby. Her previous baby had been well over nine pounds and had shoulder dystocia, which is a difficulty with birthing the shoulders. The woman had her membranes ruptured by the night staff. Lucy, the registrar and Janet, the midwife, were day staff. Janet, the midwife had palpated the woman and felt clinically that this was a very large baby.

Lucy continued.... "She had come out to me and she sat down and spoke to me at the desk. Yes that's where I do all my work...all good obstetrics at the desk [laughs]... Janet outlined to me the woman's history and the reason for the induction. She said to me *I'm worried that this is a very big baby*. She said *I would like you to come and meet her and I would like you to be at the desk when she is delivering*. She said to me very clearly that she was concerned shoulder dystocia would happen again and she said *I don't necessarily want you in there but I would like you around*. So she made it very clear to me what she was worried about, what the woman's problems were and what she needed off me, which was really good. I felt that that was a very appropriate thing to do. I felt good that she had told me that so I didn't get any nasty surprises when I got an emergency call later in the day for something like a dystocia. I thought it was good that she wasn't saying *oh you're going to have to do a caesar* because at that particular hospital that's the usual course of action. So I felt that the midwife was being sensible. I just felt that she was being very organised and the woman was in good hands.

I went down and met the woman. I said *hi, I'm the registrar and I will be looking after you today*. I palpated her and I agreed. She was a decent sized woman. She had birthed a big baby before....so the head was well down... well engaged... and I felt that she had a good chance of getting the baby out. I was also confident in my management of shoulder dystocia. Janet said if the baby is not coming easily these are the sort of things that we will be doing...so she had prepared the woman well as well. I was writing in the notes over at the side. The notes are kept in the rooms there and I was writing in the notes when she was talking about it...it was good. It's good to let women know what might happen so you are not suddenly folding them in half without them knowing what the hell you are doing. It makes it a little bit less scary. So good communication between the midwife and her patient...Then I went off.

The woman got to full dilatation and a reasonable time appropriate for a multi, when she was fully and started pushing the midwife requested her second midwife to call me. I was paged, given the message very clearly that the woman in room 6 was delivering. I knew who she was and could I come to the desk. So I did. At the appropriate time the emergency buzzer sounded, the head was stuck. We went in. We both knew exactly what I was there for. She was lying on the bed semi reclined. We laid her down flat when it became obvious the head wasn't moving. She was already aware that we were going to push her knees up against her ears. She had been told this beforehand. We managed shoulder dystocia according to the ALSO

[Advanced Life Support in Obstetrics] protocol which both of us knew; with minimal verbal communication because we each knew the steps to go through. We had both used the same protocol for treating it. The way ALSO is designed you know to be ready with the next step. So it was very smooth when I took over because she said *I need you to deliver*. It was not her sort of standing there pulling on the head and me saying *look get out of the way I've got to deliver this baby*. Her saying we've done this.....she just said I need you to take over and I did...very organised and very calm.

We required extensive manoeuvres and the baby's arm was actually fractured during the procedure. I heard it, the midwife heard it and the woman heard it. But the baby came out, was alive and well, had good APGAR's and the mother didn't get a tear. The baby was 4.9 kilos. He was huge. The paediatrician came and checked him out and it was all fine. The next day I went and spoke to the woman on the ward, mainly because of the fracture. The woman handed me the baby and said *give him a big cuddle*. She said *thankyou, thankyou for everything you did. Thankyou for the way you managed it. I know he has got a broken arm but he is alive*. She was really, really positive about the whole thing. She took what was, I mean a broken arm in a baby is a fairly nasty event; she took that well. It was such a calm situation that could have been a nightmare. It was because the midwife was organised. Janet and I had liaised with each other. We had liaised with the woman and it was all really smooth. The woman was pleased, we were pleased and the baby did well. When something like that has happened, it's important to see the people afterwards when it's all a bit calmer...to have a chance to talk through it. In any delivery where there has been some sort of difficulty or some sort of distress, I will often say to the woman, especially if we have had to go to caesar or something, I say to her before we go in *I will come and talk to you in more detail about this afterwards as well*. Try to. It helps them next time. Helps reduce traumatic birth experiences if we have talked about it beforehand.

Janet was also so happy to have had a good outcome. We sat down at the desk and we talked about it afterwards. She just said *thanks for being here. It was well managed. I'm glad I got you*. I said *I'm glad you did too*. It was all that very much positive, well done...probably a little bit unusual to congratulate someone when they did something well for that particular hospital, they tend to focus more on criticism of the bad rather than praise for the good...but that's not the midwives, that's the medical staff. It is about knowing the midwife and as you work with them you just pick up which ones make extremely good judgements, which ones are very good with the patients and which ones are not quite as good..."

Marie

Marie is an overseas trained doctor who is an obstetrician in her own country. English is her second language. Now in Australia, Marie is working as a senior resident in a regional hospital at the time of this interaction. The interaction with the midwife involves the care of a large woman who was labouring. Continuous monitoring was in progress and the midwife was having difficulty monitoring the baby's heart beat because of the woman's size. Marie was asked to put a scalp clip on to the baby's head to make monitoring the heart beat easier.

Marie explains ... "and the midwife told me 'OK Marie try and put the fetal scalp on'. OK no problem. The woman was a big woman...but a membrane **[to be]** broken, no problem ...so I turn to her husband and asked him to press the buzzer, triple buzz **[an emergency signal]** ... I was kneeling on the bed ... the midwives **[were all]** at morning tea ...it was morning tea time...everybody jumped in ...they check the patient buzzer system alert and says Room 2 so everyone was running ... **[the midwives were saying]** "What's going on, what she has done?"...the midwife recognise that without knowing because I need to put the fetal scalp because it was very difficult, big woman and like that it was the cord...

[When they all came running in, Marie said] but look I have a cord? One of the midwives told me... "Marie don't move" ...no problem... then it was pick up ready to leave, go to theatre and everyone was on their way...everyone was excellent and then I talk to them 'thank you very much' because I work as a team and everyone was coordinated on the way and mother was happy and the baby was perfect. I was so happy that day that everyone had done a little and both of them **[the mother and the baby]** were very happy **[healthy]**. So for me it was very positive.

DJ

DJ is a male junior registrar working at a large rural unit. At this particular unit the midwives have responsibility for caring for the women in labour and birth and they call the doctor when there's a problem. DJ was called to the birthing unit about 10pm because a midwife was concerned about a CTG. The woman in labour was having her first baby.

DJ explains "the midwife was at the desk, on the other side and she greeted me by name and said 'hi, thanks for coming'... she was very polite...her body language suggested that she was anxious and concerned ...she wasn't smiling...this particular midwife had **[very little]** experience and probably didn't feel quite confident in her decision making...she brought up the image **[of the cardiotocograph trace; in this unit there is central monitoring and so the trace can be viewed at the central**

desk] on the computer screen, I walked around the other side and ...she explained her concerns and pointed out the areas she was concerned about ...we talked through the CTG and I remember saying that there is good variability here, the baseline rate's quite good and yes there's decelerations here but they are mirror image decelerations and I asked how long it has been since she done an assessment...was this baby's head being compressed during the birthing process or was it possible that the cord was being compressed or did it really represent that the baby was in distress. I asked her other questions. She answered my questions as best as she could...and then I said to her we need to make a full assessment. I asked her when was the woman last examined, how has her progress been, all of the usual sorts of things we need to do when we are making a proper assessment in this situation, so I reviewed the notes. I remember thinking that this is a reasonable concern she's got every reason for me to come and have a look and I felt valued and I felt that she really did want my opinion. I felt that she was genuinely concerned. I felt like we were colleagues together trying to work out the best outcome for the mother and baby. Although we were both concerned I didn't feel the angst or the pressure...I felt that she actually valued my opinion and wanted my opinion and wanted me to be in the decision making process...I didn't feel that I was being pressured to make a particular decision. We were making a decision together and it felt very much that we were team players and working together...I felt valued by that particular midwife, I valued her input...there wasn't this clash of wills or clash of egos. Both of us genuinely wanted what was best for mother and baby and we working together for that purpose and it was very much that sort of atmosphere as opposed to being intimidated or being pressured into making a decision that I may not have necessarily wanted to have to make...I felt supported by the midwife in making my decision.

I felt reasonably relaxed and I felt more relaxed as I gathered more information, I felt that we had time to allow this woman to continue to labour and have a normal vaginal delivery which is what she wanted and what her partner wanted. As I gathered more information at the desk and had a discussion with the midwife and had asked her some questions and then we made a joint decision to go and see the woman. It was understood that I would go and see the woman. I think the midwife expected me to go and see the woman to do the examination **[vaginal examination]** because one hadn't been done for a period of time and that we needed to gather information to try and make the right decision and she was very supportive with that. I think that she expected me to do that, it was the next step in this situation it would have been remiss of me to have not taken the next step". We went in together and I was introduced by the midwife and the midwife explained to the woman and to her husband that why I had

been called. The couple didn't seem unduly anxious and they seemed to appreciate me being there. At the time I was thinking that they were a lovely couple, they were very nice people. The whole atmosphere, even though there was an element of concern, was a fairly calm environment.

I did the assessment [**vaginal examination**] and I explained to the couple that we would go out and discuss the assessment and I would come back and I would explain what we would do next. We did the assessment, we went out and sat at the desk and review all the information we had, how dilated the woman was and the position of the baby, whether there was meconium, review the trace which we discussed together.

DJ continues "We reviewed the notes and the CTG together...she was agreeing with me in a lot of cases or saying well what about this, we were both having equal input discussing what might happen and what might be the next step...we have a good working relationship, we communicate well, we tend to trust each other decisions to a great extent... I respect her. I think she also respects me as well and we both respect each in that we know our limitations as well. I appreciated that she called me to be in that decision making process, she felt uncertain and asked for my advice and I actually respect that as well. I know sometimes midwives have been given hard times by doctors if the doctor's feel the trace had been perfectly fine and had been woken up unnecessarily...we sat there discussed the case, formulated a plan and that plan involved allowing more time and allowing the mother to birth more naturally without unnecessary intervention...we went in together and told the woman what was happening... explained that the way things were going that the labour was progressing well and that, in support of the midwife, that she had quite reasonable concerns because of the trace and at times the traces were difficult to interpret to make the correct decision and I felt that the way the labour was progressing that we had some more time and that if things didn't continue to go well then I would be straight back down and we would take whatever steps were necessary I think both the woman and her partner felt satisfied by that...and as it turned out the woman went on and delivered within half an hour to an hour later and there were absolutely no problems...mother and baby and father were all delightedly happy at the end of the birthing experience... we [**the midwife and DJ**] felt good about it because no intervention was required and that everybody seemed very happy. The energy in the room was very positive and very loving and I think that we both felt very good to be a part of it, to participate and share in that and to some extent facilitate that. The baby was healthy and the woman was intact! We were both smiling at that stage.

Gary

Gary is a father of two and a staff specialist obstetrician with over twenty three years experience. He has worked in the same tertiary referral hospital for most of that time. He is well known for supporting women in their choices. The story involves a woman who chose to birth her third baby normally after two caesarean section births.

Gary said ... "her sister-in-law was a midwife here and she said that she would support her in labour ... I actually felt very good about her being the midwife for this woman because the woman herself had great confidence in her sister-in-law as a midwife... this woman needed consistency amongst her carers and I don't think she could have got better consistency **[than with both Gary and her sister in law as her caregivers]**. We went through the usual processes of counselling highlighting the issues of safety regarding uterine rupture and being set up to deal with that if it happened, a slightly higher incidence with two previous caesarean sections...then also talking about why and the positive side of vaginal delivery if it was attempted. I can remember her husband being very anxious at the time. The woman herself was clearly delighted at the possibility of being able to attempt a vaginal delivery.

Closer to the time of delivery things were teetering in that the husband was becoming more anxious and then it was discovered that the baby was a little bit growth restricted and there was some compromised Dopplers. I can remember thinking to myself at the time that this is probably a sign that the baby will come a little bit early and I sense that's a good thing because you've got a smaller baby and possibly less pressure on the scar. In fact my feeling was right and 24 hours later on a Saturday night, when I was pretty tired in that I had had the Saturday off **[Gary had been busy doing family things and so hadn't had much rest]** and I was just about to go to bed, I was rung up to say that this woman was in labour and things seemed to be going well.

Her midwife sister-in-law was someone I've always got on well with. This is a person who expresses her opinion readily but with me it has always been in a respectful way and I've always been able to receive it like that... I remember going up there and visiting and the room just felt good ...I knocked on the door and as soon as I opened the door, I could see and feel that everything was OK...they looked at me and smiled... everything was set up. The atmosphere was made good by the sense of trust she felt in what I had said up till then...the presence of the midwife she knew was crucial...essentially it was a three way thing, if you could call it that...we didn't have to say anything, you just knew that the labour was happening.

She **[the woman]** could feel that I felt comfortable with everything...the monitoring was there and it was all normal. There was not that unhealthy obsession with the monitoring it was all on the fact that this was happening, good. I could see that the partner was a little bit more relaxed because finally it was happening... it was so positive he just got drawn into it...I knew that the midwife would be looking after this woman with the best attention to all the important details so I could just sort of sit back and watch that and listen to everything ...she **[the midwife]** knew me fairly well and always knew my intentions in the situation but always knew that if she disagreed with something she could say that...there was a significant trust there... even if there was a disagreement and I don't know if I might have said something that she disagreed with she would have accepted that and vice versa as well.

So the upshot of it was that about 2 hours later there were some very significant decelerations towards the end but by that time she was fully dilated. I decided to put on a vacuum extractor after discussing it with the woman and it was a very easy vacuum delivery of a smaller baby. Everything was OK and this woman was just ecstatic...the key points of the good interaction were firstly planning for the delivery in that I knew that this midwife would be around for the delivery. So even prior to the delivery I was aware that a positive space was likely to happen. That was because I knew the particular midwife and I also, because I had a good idea of the anxieties that were influencing the woman herself, I was very aware of the anxieties of the husband. I was aware of all the necessary data prior to the delivery so when she came into labour all of that just unfolded in the right way and we used that to everyone's advantage...I was very tired, but the fact that this had been discussed with the midwife that was caring for her beforehand just made it more manageable.

Jacinta

According to Jacinta, she is by nature 'very cautious'. Jacinta's caution means that she likes to be in control and therefore is more likely to intervene in a woman's labour than not to intervene. Jacinta told me that 'we (doctors) are trained to worry'. At the time of this interaction, Jacinta was a new first year obstetric resident working in a rural hospital which has about 1000 births a year. She was working with a male midwife.

Jacinta said ... he ... "was very helpful with just teaching me basic, normal delivery skills. He took a lot of time to actually teach me those things. I guess in terms of that, he was very encouraging towards me and fostering my knowledge. I found that very encouraging. There were a couple of births that I was involved in with him and I found that a really positive experience for my learning and I know the women were very

happy as well at the end.

Jacinta continued... "there was a birth where we were listening to the fetal heart and I was getting anxious because they **[heart sounds]** were going very low and he sort of held back saying *no you don't need to do anything, you don't need to do anything* and then I didn't do anything and the baby came out and it was a good experience all round obviously.

Jacinta explained... it was the woman's first baby, she was in second stage, on the bed on her back, pushing... I was delivering, I was the accoucher and he **[the male midwife]** was on the other side **[of the bed]**. The **[baby's]** head was just coming but it was slow...it was crowning but it was very slow...the heart rate was going down to 60...she had the CTG on ...the heart rate was going back to normal after contractions and pushing...but being relatively new I was getting quite anxious...I know I go bright red and get a big rash so that was probably number one sign **[of me being anxious]** ... I put a suggestion out 'do you think we should do an episiotomy? Do you think we should...and he was very experienced and obviously **[knew what he was doing and that the baby was in good condition]**.....he was saying 'no leave it for the moment'

..... we argued...the woman is probably sitting there thinking 'oh what's happening!' ...I remember that I was very confident having him there and I felt supported but at the same time you feel scared and wanting to do something and your heart rate is up through the roofknowing that he's got a lot of years of experience...from talking to other people and finding out...plus other births I have been involved with him ...I was reassured that I could see how well he cared for other women and so I was able to bring that to this delivery...also his body language and his mannerism...he was very calm throughout the whole experience ... he was relaxed, he's not looking stressed... not tensing up...he was certainly not anxious about the situation ... because I do get stressed and anxious, having that calm and relaxed other person there is a very good thing...I find that very helpful... knowing them before and having a bit of an idea about their experience ... trusting their judgement based on what you have seen before... I am particularly reassured in a stressful situation by knowing that I have an experienced midwife there...

Richard

Richard is senior consultant staff specialist obstetrician whose primary responsibility is the teaching of medical students. In this story of a positive interaction with a midwife, Richard was

the consultant on for the day in a busy, tertiary referral hospital when the midwife approached him about a woman she had admitted whose baby she suspected, from her admission assessment, was an intra uterine fetal death. The midwife asked Richard to see the woman. Richard said there were two aspects about the subsequent interactions with this midwife that were positive. The first was the way the midwife supported the woman through a difficult process of diagnosis of fetal death. The second was the way the midwife told Richard that she appreciated what he did for that woman.

Richard explains how the midwife... “came and sat with me while I talked through the diagnosis and the implications and management with this woman.we confirmed the diagnosis on ultrasound scan and had a discussion about the possible causes and what the management would be...it was firstly, extremely good in the way she supported the woman during the conversation that we were having ... by being present, holding her hand, sort of getting me to clarify, you know sort of checking that she was happy, that she was understanding what I wasthen after I had gone off to make arrangements...she stayed behind and talked to the woman and went over things again with her and stayed with her and supported her during the subsequent birthing process.

.... unfortunately I have had these sorts of conversations many times over the years with different women but at the end of that process this midwife, who had obviously, as is usually the case, found this a difficult experience and ...helped manage it very well.....she still had the time to come to me as a senior consultant the following day ...we were... standing in the corridor and say *“listen I just wanted to tell you that I thought the way that you handled that consultation and dealing with that woman was really good and it was really helpful in terms of her coming to terms with that”*....so getting that kind of support and that kind of feedback is, I find, a very, very powerful experience ... I felt..... well, very encouraged ...nice to hear positive feedback always...

I think in such a difficult situation you appreciate it moreobviously it's possible to give sort of facile, ingratiating, meaningless feedback but when it's heartfelt and obviously genuine it's going to leave you with a more positive attitude towards that individual ...although to be honest I think it probably, in my case, just reinforces my own sort of general attitude towards midwives and all the other professional groups involved...it reinforces a sense that what I am doing is working within a team, a multidisciplinary team, with good inter professional relationships.

... if I say its because its relatively unusual to get positive feedback from a different professional group then that will kind of undermine what I've said about the good relationships in the unit but it still..... when you're a consultant, particularly the more senior you get, I guess it can be quite difficult sometimes for other people, particularly in a more junior role within a different professional group, to give you negative or positive feedback. So in that way it sort of stands out a bit more and I guess it's because it's one of the things that I would like to think that I can do well for patients and its nice to have it appreciated when I do do it well. Also I guess because it came from a midwife who I had come across before was obviously, well she wasn't that junior, was obviously quite professional and competent and therefore her respect and her opinion meant something to me".

Belle

At the time of this positive interaction, Belle was a second year registrar. It was late on an evening shift, which meant that there were 'no bosses in the hospital' and as Belle says 'there is no one senior **[doctor]** that you can immediately rely on'. Belle was the only registrar on and was covering delivery suite. She was called to a room by a triple buzz **[a triple buzz means emergency and everyone who can goes to the room]**. As Belle entered the room, two midwives entered the room with her. The woman, Danielle, was on her back on the bed, the baby's head was born; the woman's partner was on the right side, 'red faced, almost collapsing' and he had "one of those screams that tear your heart out"; her mother was holding her left leg; Dee, a very senior midwife, was between the woman's legs and another midwife was writing notes on a 'scrappy piece of paper'. Belle instantly recognised that she had been called to a shoulder.

Belle continues ... "I knew this midwife **[Dee]** and always had a positive relationship with her...and could trust her...with anything...my heart **sank** when I entered the room and saw it was her ...because I thought this is someone that I would trust in any situation and if she can't get that baby out then I'm going to have a very difficult time getting it out ...it was scary...but I knew there wasn't anybody else. We had the most senior people in the room, there was a boss to call in but if we required that it would be 20 minutes time. I figured just do the best you can...Dee quietly told me the pertinent points- how long the head had been born (2 ¾ minutes), what manoeuvres she had done, that she was unable to tip the anterior or posterior shoulder of the baby - very succinctly, very pleasantly while I was putting my gloves on. She introduced me to Danielle ... there was no more yelling in the room **[Danielle's partner had stopped yelling]**, there was no messing about. Dee stood back and allowed me to take up the position she had formerly been in between Danielle's legs.

Dee stood right beside me and she didn't move the entire time. She was my support person and I appreciated that. She knew that she had been a midwife for 15 to 20 years and I had been doing this for a short time - this was my second year as a Registrar. We both knew there was no boss to help us. The other midwives, one took over the timekeeping and she stood near the trolley and she called out and got someone to call for the paediatric doctors, there were two of them, and they came.....The first thing I did was speak to Danielle because I figured that the most important person in the room was her... I told her who I was and what I was going to do. She knew what the problem was that we needed to get this baby out and I told her that I needed her help. She was incredibly cooperative, she just knew what she had to do and she did it. She pushed when I asked. She moved when I asked and she had had an epidural and she was an incredible woman...I did the manoeuvres again as quickly as I could.

I could not get this baby out with Danielle in her current position. I couldn't tip either shoulder, well not adequately to try to deliver the baby. I said to Dee that I thought we needed to get Danielle on all fours. Danielle was not a very big lady but she wasn't a tiny lady either so it was a big ask. Dee, almost military fashion, repositioned everybody, told everybody where to be, where to stand and what to do. Within 20 seconds we had this lady up and over and on all fours. Danielle did a lot of the repositioning herself. We involved her Mum also. She was holding Danielle on one side, 2 midwives on another side. Dee was still beside me but had one hand supporting under Danielle's hip. The husband, well we made him sit down, he was only just hanging in there because he could see what was happening. When we had Danielle on all fours I actively did the manoeuvres again and I still struggled. I told Danielle that I might need to break one of the bones in baby's shoulder. As I was actively trying to fracture the clavicle, Dee asked if there was anything she could do to help and I had no answers. Dee instinctively pressed down on Danielle's sacrum. She pressed firmly downwards to flatten her sacrum with one hand and held her up with the other hand. This movement altered the shape of her pelvis enough for me to deliver the posterior shoulder - much to my excitement and relief because I then knew I could deliver this baby.

The first thing we did when the baby was delivered was to place the baby onto Danielle's back so she could feel the baby because she wasn't going to get to hold her at the delivery. We rapidly attached clamps, cut the cord and handed the baby to the paediatric team. Immediately after this we all congratulated Danielle and then congratulated ourselves. We then all got quite teary **[laughs]** and emotional - I'm even getting teary now **[laughs]**.

I was so sweaty because of the acute stressfulness of the situation. Danielle was fantastic. We then moved her onto her back. It became apparent that her vaginal bleeding was very heavy and she appeared to be going to have a post-partum haemorrhage from all of the manipulation of her uterus. We rapidly commenced an infusion of Hartmanns containing 40 units of syntocinon that someone had previously anticipated we might need. It was already there, they had drawn it up in anticipation - so very efficient.

The baby girl was neurologically intact with no fractures and Danielle amazingly had an intact perineum!! Throughout Danielle's hospital stay, all of us involved independently chatted with her about the delivery and congratulated her for her incredible efforts. Danielle and her family clearly appreciated everybody's concern, compassion and involvement regarding a very traumatising but ultimately positive event.

I firmly believe that if we had not had such a cohesive working team with everyone contributing and supporting one another that there would have been a different outcome. Still now, on occasion when I see Dee we still chat about this scenario because it was a significant event for all of us, it was such a big deal. We were all very teary. It is one of my scariest but favourite moments...I came out of that room absolutely covered in sweat and exhausted. We were all **exhausted [emphasised]**. I think it was acutely emotionally draining rather than physically...

...We had one single goal and that was to look after the lady, keep the baby alive and deliver it in the best condition we could. There wasn't any "who's in charge" and "who do you listen to it"we were task focussed....it was – this is our goal and we were aiming for it... no different philosophies... not at all. It was simple - we needed to work together and if we wanted this to be a positive outcome we needed to work well together...I **really [emphasised]** appreciated that she **[Dee]** was very much there for me in that situation. She didn't have to be standing next to me and it was physically **harder [emphasised]** for her to be standing where she did, leaning to hold the lady. I really appreciated that she was helping me to the best that she could...if she **[Dee]** asked me for **anything [emphasised]** I would do it if at all possible. Coffee, anything, anytime, anywhere **[laughs]**

...From my perspective it felt like the underlying philosophy was to work together as a team to achieve a healthy baby and healthy woman ...definitely an "us" approach. There was no 'me' about it, it was "we" trying to help the lady ...it was all about getting

the job done...

...it's so traumatic talking about the shoulder dystocia, it's surprisingly emotional talking about the shoulder dystocia. Just thinking about it brings tears to my eyes, certainly not in a bad way, it's a proud and accomplished emotion. A satisfying feeling that things turned out really well and I got the privilege of being involved...the beauty of team work...it was just nice that the first thing everybody did was congratulate the patient, the family and ourselves. I thought was really lovely... there was an abundance of respect. We all respected each other. We were all courteous, efficient, polite and respected that we all had a unique but critical role to play. There was no rudeness, no power-plays. There was no trying to put down anybody, there was just respect that everybody was doing their best.

THE VOICES

MIDWIVES' STORIES OF POSITIVE INTERACTIONS

Amber

Amber is an experienced midwife who, at the time of the interaction, had been a midwife for a year and was working in a little country hospital with an eight bed maternity unit, with two birth rooms. The hospital and maternity unit was run by General Practitioners (GP's). There were twelve midwives on staff and as Amber did the antenatal classes as well as worked full time as a midwife, she got to know the women very well. One of the women, Matilda, Amber met through the antenatal classes was someone who wanted to have a normal birth after a caesarean section [VBAC}. Amber had given Matilda 'lots of information' and had many discussions with her about her dreams and desires. Around term, Matilda was admitted because there was a question about whether she had ruptured membranes or not. Matilda stayed a few nights and during that time, Amber and Matilda 'talked about lots of stuff' to do with birthing her baby and Matilda felt really confident about her ability to give birth normally. She was eventually discharged to await events because it was determined her membranes were still intact. A few days later, Matilda rang saying she was bleeding. Amber was on duty and took the call. She asked Matilda to come in, did a full assessment and decided that the bleeding was actually a 'show'. Amber rang the GP, Max, to inform him of her assessment.

Amber said ... "I let Max, the GP know and he was fine with that and he had wanted Matilda to come into hospital in really early labour and stay there. I was able to negotiate with him that the best place for her was to actually go back home and be at home and labour there and spend her time at home. What Max wanted to do was to put in a cannula. So we put in a cannula and she went home again. Max was quite fine with my assessment. I wasn't actually on when Matilda had her baby but she did come back in and have a beautiful VBAC with that GP there and no excessive monitoring. Just the normal intermittent monitoring and all of the things that we had negotiated during her pregnancy with the information that I had been able to give her during the antenatal classes ...I know it sounds like a really simple story but the reason that it highlighted and made a difference to me was because I think I had probably been working at the hospital for about a year and that was the first point that I had been recognised as a midwife with knowledge. Every other time, in that first year after graduating, they sort of listened to what I said but did what they wanted to do anyway...so for me I guess it was a turning point. It gave me encouragement to know that I actually do know stuff and if I present it in the right way people will listen... that was the first point where I had actually been able to negotiate with this man using the knowledge that I had and have Max respect those decisions. To have the woman

able to stand on her own feet to give her the knowledge to be able to say these are the decisions that I Matilda want to make as well. I think the difference was that by that stage Max trusted me ... having known me and seen me and seen the way I practice for a year and having the faith that I actually knew what I was talking about...I knew this woman so I knew Matilda's capabilities and I knew what she really, really wanted and I was able to convey that to this GP. Although Max was her GP, he didn't know her on the same level that I did. He didn't know those wants and desires and wishes as well as I did. So I was able to convey them to him and he respected that I think and that's what made the difference. Had I not known these keys previously it might not have been the same outcome... in a small unit you actually see each other much more. There is no sort of intermediate levels of people, you are actually all working on the same thing.

Gemma

Gemma has had thirty years experience as a midwife and at the time of this positive interaction with Dr Susan Wright, a medical colleague, was working in a caseload practice. Laura, the woman at the centre of the story, had shared care for her pregnancy and birth with Susan, a specialist obstetrician. Gemma is not keen on shared care because even though, as in this case, the doctor may be supportive of the midwifery programme, she is 'still an obstetrician'. Laura was a primigravida at term and was taking a long time to establish in labour.

Gemma continues ... "so Laura was doing the typical primigravida, pre early labour stuff and had sat about for most of the night. I went and saw her at home early in the morning, about breakfast time and was thinking, partly I suppose because she was with a specialist, I was thinking that Susan won't want to let her hang around, she will definitely want her to come in and augment the labour. I was thinking maybe that is a good idea because Laura has already been doing this most of the night and she's probably getting a bit tired... because I was maybe trying to second guess the specialist and thinking 'well that's what they will want anyway'.

Maybe that was the main thing... you are always kind of juggling that thing of 'you don't want to intervene' but then if in the end the labour takes so long the woman is really exhausted then you're not doing her any favours either. Maybe I just didn't listen enough to Laura to really see what she wanted ...So I rang Susan and said *this is the story and this is what she is doing shall we come into the hospital and augment her labour?* Susan actually said *oh, no I don't think she needs to do that just yet. Things sound pretty normal and it's her first baby. If she's not too tired...* which she wasn't so, in fact, she stayed at home much longer and she did eventually have some

syntocinon, but not until much later in the day and she had a lovely normal birth.

I suppose the thing for me was that it kind of took me back a bit because we actually joked about it because it was like the midwife wants to intervene and the specialist is saying hold off. I guess it was a good learning experience for me...firstly don't try and second guess the specialist. Just because she was an obstetrician she wasn't necessarily going to want to rush in with intervention. Susan was more willing than me to give the woman more time and the benefit of the doubt to try and establish and labour without augmentation. That just reinforced that thing that so long as the mother and the baby are OK it's OK to let the labour unfold and see how it does go...I felt good in a sense that it was like that's great we are not going to move in now and augment the labour because there is always that potential of a cascade.

I suppose I felt a little bit, it kind of pulled me up a little bit; I thought '*oh I should be thinking that too, why did I rush in and think that we should augment already?*' I should have been thinking more about the woman. But it was good...it's always a little bit of a dilemma when you are doing one to one care, obviously you get to know the women reasonably well and obviously they have come to the program wanting that midwifery care...but ... there's a bit of a tension and a potential kind of conflict..... when a woman goes to a private obstetrician as well...it's like they are kind of hedging their bets. So then I don't feel that maybe we are not going to be working completely as a team because there is always this other added factor of the specialist and what they think...

Betty

Betty is the manager of a maternity service in a major city tertiary referral teaching hospital. This maternity service has about 2,400 births per year. Betty said the culture of the maternity service is women friendly and supportive of midwifery overall but varying depending on who was present at any given time. The positive interaction with a medical practitioner involved a woman, Angela who came in to the birth unit in strong labour and who progressed rapidly. Angela was 36 weeks pregnant with her second baby and Betty, who welcomed and admitted the woman because all the other midwives were busy, quickly identified on palpation that the woman's baby was in the breech position. Angela was keen to birth normally and Betty noted she was labouring rapidly. Betty informed the registrar, Pamela, of the situation and continued to care for the woman, which included a vaginal examination, confirming Betty's assessment of both the baby's presentation and fast approaching birth. Betty organised the room for the birth.

Betty continued ... "so I went out and talked fast to the registrar, Pamela and quickly convinced her that this was a very suitable vaginal birth for a breech. Pamela is a very nice female registrar – knowing that the protocol was to offer caesareans, appeared in the room with an ultrasound machine. I said *no, no, no* and pushed her back outside gently and took the machine with me. I said *no I've done a vaginal examination, it is breech*. Pamela said *but I have to confirm*. I said *you have to take my word for it, it's breech. You could do a vaginal examination but the woman doesn't really need a second one and I'm asking you to take my word for it so why don't you get on the phone and ring the consultant and tell them what's going on?*. So she did that. The consultant, Robert, said that the registrar needed to go and offer the woman a caesar and that he was on his way because it sounded like the baby was going to be born anyway. I quickly gave Pamela the spiel on what to say and I had worked with her before and she trusted me so she went in and presented Angela with the options.

Angela was really fully dilated and ready to give birth by then and I chipped in that the consultant was on his way and that the consultant had delivered lots of breech births and if we kept going like we were going we would have the baby quite quickly...I felt brave ...I felt I had to be courageous because I was sticking my neck out but I knew – as much as you ever know – but I felt very strongly that it would be OK because ... in this situation it was just a perfect breech...an opportunity for a breech...because it was a second baby, it was a bit smaller, it was well down and it was cracking on fast. If we could get everything in place it was potentially going to be really, really good. So I was driven by my clinical assessment of the situation. I felt very confident that I knew what I was talking about ...the consultant arrived and we basically talked very positively about this woman and this baby and it was all looking good.

Robert insisted on the woman being up on the bed. We had talked about upright positions. So that was one negative aspect that Robert wanted her on the bed, in fact he adjusted the bed so that she was in the sitting stirrups. But we managed to arrange the bed so that she was quite comfortable and she was almost upright, sort of sitting. Angela had a beautiful breech baby about 40 minutes later with an intact perineum and it was all gorgeous. We had a student midwife and the registrar and a medical student, with Angela's permission. We had the lights down low and it was gorgeous. Beautiful...Pamela had really good communication skills. She was a great listener. She was only a 3rd year but she already understood woman centred care and she respected midwives. She was a fairly kind of balanced individual. She was, you know, healthy and normal. Not caught up in her own importance or ego...we'd had a couple of other experiences. She said that she had learned lots from me. .. I just

sort of looked her in the eye and said *you need to trust me on this. I realise that it's your responsibility as well but I think that we can share this responsibility.* She was tentative but she was on for it ...

Robert and I had a very good rapport. I had worked with him setting up the new model at the community clinic. He trusted me. We didn't always agree but we could debate and argue the evidence. We had a good relationship...we knew each other. We worked as a team. We recognised each other's skills. I didn't have a need to get in there and catch the baby. He needed to demonstrate a beautiful breech birth to the registrar and he made the registrar have hands on and do it. So it turned into a teaching opportunity for him. So he got what he needed to get from his role and responsibility. I was able to be a midwife and facilitate the woman's journey. I was able to help Angela get what she wanted. There was lots of trust. We trusted the woman and the doctor and midwife trusted each other...it was about the relationship but it was also about the individuals, their values and wants...a world view, a philosophy, a belief in women, a belief in midwives, a flexibility and a lack of desire to control...time of day probably played a part...it was morning and everyone was fresh...but to a lesser degree with those individuals... I remember thinking, given the uniqueness of the event, and notwithstanding the need to maintain Angela's privacy, I knew it was going to be wonderful and I wanted more people to see what was possible. It was one that you wished you could film, you know. I remember thinking 'well the rest are all too busy anyway'... about a year later I chatted to that registrar again and Pamela said that she had never seen a breech since...I felt happy and satisfied. I felt valued. I felt respected. I suppose I felt quite powerful ... brave... I knew this baby was going to just pop out any minute...so I had the clinical signs on my side...the clinical certainty... the woman was really happy ...

Jackie

Jackie has been a midwife for 16 years and works in a continuity of care model in a busy tertiary referral hospital. Jackie told me that the relationships between doctors and midwives are not usually that good in this unit. The doctors make all the decisions. The story of a positive interaction with a doctor, Erik, involved the care of a woman, Lucinda, who was being induced for high blood pressure at term. Lucina was in second stage and had been pushing for some time.

Jackie explained ... "she had tried pushing and we had got to the point where she had had enough ...I went to the desk and explained what was happening...said I think she's had enough now... and we asked Erik to come“you hear rumours about

people before you meet them and I had heard people say that he was really good ... he personally knows some people that I work with and they tell me that he is a nice person ... thorough, good at explanations and supportive of my role. I have heard him say that the midwives made a good call in consulting with the doctors and things like that ...helps us know we are on the right track... helps us to know that we are doing the right thing... it feels safer when he is on duty ...he is someone you can talk to

Although Jackie had only had brief interactions with this doctor previously, she knew him from his reputation and her experiences, although brief had been positive.

Jackie continued "...he assessed her then explained what he found and what he had to do...then we did the ventouse ... I was happy about that ...because we had arrived at that decision in the room ... it was a joint decision..."the birth was a difficult ventouse delivery but the registrar was excellent! Erik explained everything to Lucinda as he went along and was just fantastic at explaining and wasn't in a panic. There was no rush... he included me in the discussions... He explained everything to Lucinda. If it had been somebody who didn't explain things... others that just rush in the room and rush out again...the birth experience for her would have been horrific because she had ongoing pain from that birth and lots of issues about how it happened and everything, but this registrar, Erik ... just explained everything and was lovely. It made it so much better for her...we were working as a team. It was so much better to work as a team. He would say "when you're ready..." and all this sort of thing and we worked as a team... we were all part of a team, the woman, her partner, the doctor and the midwife I was talking to Lucinda afterwards and she was in pain for days ...but I was able to tell her that he did a fantastic job and she said he was really lovely and he came to see her afterwards...to see how she was going...so Erik actually visited her personally in the post natal ward...she was really pleased about that...

Roberta

Roberta is a direct entry midwife from the United Kingdom. Roberta was looking after Naomi, a woman who was having her second baby. Roberta knew Naomi well because she had provided her antenatal care through the hospital clinic. Naomi's previous birth was traumatic for her and Roberta thought that Naomi was carrying a large baby, but Roberta was not worried about the size of the baby. At the time of this positive interaction with Judith, a female doctor, she was working in the birth unit of a medium sized regional hospital which had 1500 births per year. In this unit, it is the policy that the midwives inform the doctors on duty about the women they are looking after.

Roberta doesn't agree with that policy as she feels that ... "it's our role to monitor the normal and if it's not the normal then it's our role to inform the doctor about what's going on ... one doctor told me that it was his role and that if I let anything happen to that woman and he didn't know about it then he would be in trouble. He would be the one to stand in court. I said that "no you wouldn't because you wouldn't know anything about that woman. It was my responsibility to tell you and if I choose not to and the outcome is negative then I will stand up, I will be the one standing up saying why I did or didn't do something, it's not you". But they don't see it like that, they are scared. It's drilled into them that that is what they are responsible for and they must go to the labour ward to find out everything about the woman so that they can have control over everything. But that's not how I see their role and...it isn't their role".

Roberta returned to the story about interaction with Judith when caring for Naomi, the woman having her second baby "...she was a female doctor, which I think does make a difference, and she was genuinely interested in how Naomi was progressing in labour and whether I thought it was a big baby and what the ultrasounds during her pregnancy said. I suppose the difference was that she asked me what did I think rather than just to tell her the facts ... she asked me what did I think the baby was going to do or how was she doing and she wanted to meet the woman. Judith wanted to come in the room when Naomi was labouring...I told her not to come in and I will go and ask Naomi what she wants, if she wants to see your face or not. Naomi chose that she did want to see her face...it wasn't what I thought she needed but Naomi felt positive that she had met a doctor who she may need later...we were more on equal terms, Judith was genuinely interested in how Naomi was progressing and what I thought she would do, she didn't actually want to intervene. She wanted to make the woman feel comfortable and if she needed her later then she knew her face and the woman was quite comfortable with that. That's all she did. But there was a big risk. Because, I mean when you get to know them, you worry as soon as they step in the room what they might say. It's one thing to just see their face but if they start saying "*if you need an epidural just tell your midwife*" or anything like that.

So I was really sure with this doctor that she wouldn't say anything about pain relief or she didn't really see that was her role. It really was to say - *this is my name and really nice to meet you*...I knew the doctor quite well but I think at the same time she felt a bit put off by the fact that I was asking her what she was going to say before she went in the room...because it's not normal...I don't find midwives here in Australia very questioning...so the doctor felt possibly threatened a bit by the fact that I wanted to know what she was going to ask Naomi or say to her when she popped her head in to

say hello... she didn't directly answer my question. She wanted to know why I wanted to know that and so there was a discussion around why I wanted to know that. I said *because often people go in and say this, this and this and I don't want you to do that she's really doing fine. If you want to pop in and put your head in so she knows your face, that's fine but please don't be doing anything else.* I know Naomi, I know how her mind works and what we have achieved during her pregnancy and I didn't want it all ruined by some small comment ... I felt positive for me that someone would listen to what I was saying but I kind of felt like I wish I didn't have to do that, that it would be obvious...I find that for myself, a bit of a challenge because you don't want to put people offside...you want to be working in a great relationship with everyone..

Virginia

At the time of this interaction, Virginia, a very experienced midwife, was working in a low risk birthing unit in a rural hospital. GP obstetricians were the primary care givers for childbearing women. There were no residents and no registrars. Virginia had just come on for a night shift. She walked in to the birth room, where a young woman, Jodie, was in labour, having her first baby. Jodie was very close to having her baby and was beginning to have expulsive contractions. Jodie was kneeling on a mat on the floor, leaning over a bean bag. The GP obstetrician, Stan was sitting on the bed, the afternoon shift midwife, Annie, was kneeling down with Jodie and Jodie's husband, Mick, was supporting her on the other side of the bean bag.

Virginia relates how the midwife, Annie ... "looked up at me with a really anxious look on her face. I could see that she was extremely anxious ...Annie said *"I think she's transitional I don't think it's very far off but she's got mec lic.. there's a bit of mec lic and her blood pressure is quite high...I think it was about 150 on 100"*...I just said to Jodie *"I'm just going to recheck your blood pressure to see what it's doing"*. I did that and it was still high. The mec lic ...wasn't fresh it looked to me like old mec lic and I think she was over the 40 week mark. I wasn't really worried about the mec lic but the blood pressure I asked Stan, the doctor, did Jodie have blood pressure problems in her pregnancy, because I didn't know this woman. He said that her blood pressure was always OK, in this low voice. She just continued to contract and we just continued to support her. The other midwife, Annie, opted to stay. Annie indicated to me to be the 'accoucher' so that when the baby was born she could just go home. So that was fine and we were just down there on the mat supporting Jodie. She continued to contract more expulsively for about 45 minutes..."

Virginia and Annie took turns in listening to the fetal heart 'almost continuously' and

they were 'perfect'.

Then into about an hour I thought that the baby was coming. I looked up at Stan the doctor and he didn't make any verbal communication with me. He just looked at me, perfectly calm, he just looked at me ...he was sort of meeting my eyes. He was making eye contact with me and what he was saying with his eyes was that it was all good, all good. I was communicating to him yes it was all good. Just with our eyes. I had had dealings with him before so I knew he trusted me and he wasn't in any way there to tell me what to do. He was there to backup if need be and that's the role he took. Fantastic...He was just sitting on his hands. He didn't really do anything. That was the thing. That was the beautiful thing. At one point Stan left the room while we were still there with Jodie. I wondered where he had gone so I just poked my head out the door to see where he had gone because Annie the other midwife was still with Jodie. He was out with the neonatal manual on the resuscitaire, just reading what he needed to do in the case of an emergency. Just reading up on the ET tube sizes and stuff like that and I thought that was priceless ...I went back in. He came back in and sat on the bed again. Jodie birthed the baby and it was beautiful. Stan just sat there and said how lovely it was...it was so positive...it was so positive because he allowed us to do our thing. He completely trusted us. If we had said to him I think we need to do something about this blood pressure he would have but we didn't ... I felt perfectly comfortable with him. I didn't want any input from him in that birthing room ...I just felt fantastic. I felt like this was heaven on earth. It was just trust. I felt respected and I felt like it was the best possible way things could have happened for Jodie and Mick ... she was focused in what she was doing...Stan was perfectly happy to just sit there and let us do our thing. I was perfectly happy that everything was fine. I wasn't worried about that blood pressure at all and it would have been better had he not taken the blood pressure when she was in transition I thought. But it was taken so that was it. There was no problem. Her blood pressure settled back to normal, back to what was normal for her about an hour after the birth. She had no bleed. It was beautiful and they were ecstatic".

Dana

Dana is 30 years old, has two children and has been registered as a midwife for over a year, after a 3 year BMid University programme. Dana is working in a community midwife programme based at a large and busy urban hospital. This particular unit has centralised monitoring. When a woman's labour is being monitored by cardiotocograph, the trace is relayed to a central monitor at the main desk. In this unit, Dana thinks that midwives bully junior doctors, but the doctors make all the decisions. On the day of the positive interaction that was the subject

of this interview, Dana said she had enjoyed a good night's sleep and was refreshed when she came on duty to take over the care of Tulip, a Vietnamese woman having her first baby. Dana said she felt confident looking after Tulip, as she was a healthy woman, labouring at term. The doctor involved in the interaction was a senior registrar, Dan, who Dana hadn't met before. Tulip had been labouring overnight and because the progress of her labour was slow, her labour was being augmented with an intravenous syntocinon infusion and she had an epidural anaesthetic for pain relief. Dana had called an interpreter to help ensure there was informed decision making about those interventions before they occurred, as neither Tulip, nor her husband, Wang, spoke English.

Dana explained ... "we started having some decelerations and they started as normal dips that went up and recovered very quickly and then they started being quite prolonged decelerations. Because Tulip was hooked up to the monitor out at the midwives station the doctor had been informed. The doctor came in and morphed into the room, so to speak and I just sort of said *hello I'm Dana the Community Midwife and this is Tulip and her husband Wang*. Then he sort of went *oh yeah hi my name is Dan*, and said who he was, but he didn't look at any of us, not at me, Tulip or Wang. He had a quick look at the CTG...and had a feel of her belly and sort of looked at her notes and how much progress she was making which was slow. She wasn't really making much progress...eventually what the doctor decided was; she wasn't making progress, she had been labouring forever and surprise, surprise he wanted to take her for a section. He began to tell her about the section and all that sort of stuff and all the risk involved. He said what he had to say and I just said to the woman "He said do you understand?"... and she said "uh huh". Then I said to her "*OK could you tell me what you understand is happening to you?*" She just looked at me and said "*no I don't know*". I looked at him and he said "*well, that's not really informed consent is it?*" and I said "*no*". He said "*OK, I will go and get a translator in.*" He was really good after that. He went and got a translator in and helped explain everything to her. I think he had picked up a normal robotic spiel about caesareans and the risk and women understand what's going on and realised that he hadn't made it clear to this woman and made restitution to fix it. I think that was a good positive outcome because then she did have informed consent for what she was up for and the risks and stuff like that... at least she knew what she was going in for. She knew the risks of what was happening as opposed to her having limited English and not actually understanding... because I made, not an example, but I made it very clear to him that she does not understand ... I made it very clear to him that "*no she doesn't actually understand you need to do better than that... you can speak as slowly as you want to but they still don't understand...*" The baby was born with good Apgars, so everything worked out

well. I was glad that she understood what was happening.

Kitty

Kitty has thirty years experience as a midwife and is working in the birth unit of a busy, regional, tertiary referral hospital. Kitty came on night duty at 9pm and took over the care of Renae, who was having her first baby. Renae had an epidural inserted some hours previously and it wasn't working well. She was due for a vaginal examination to check her progress at 11pm. Renae was hot with perspiration, "distressed and disheveled, long hair all over the place, and clutching the vomit bowl and vomiting". In Kitty's words, Renae had 'lost it... was completely overwhelmed'. She wanted to be 'as pain free as possible'. Kitty assessed Renae's situation quickly and recognised she needed medication to stop the vomiting and medication to alleviate pain.

The hub of the activity in the delivery suite is the main desk which is in the middle of the unit.

"I knew Joseph, the registrar was down there at the desk so I didn't have to page him and I wanted him to see to Renae's problems. I went to the desk...I got some Maxalon and went to see Joseph and told him... I need some Maxalon...he just scribbled that down. He said "right what's she doing?" ...I said "well she is vomiting and the epidural is not working....."

The evening shift midwife had been trying to get the anaesthetist to come to see Renae to rectify the problems with the epidural anaesthetic...Joseph suggested some morphine intravenously for Renae for short term relief of her distress. Kitty got both the antiemetic and the analgesia out of the cupboard and drew it up, ready to administer.

Kitty continued "...I didn't even say come and see her, we just set off both together and walked towards the room and it was a fair little hike round the corner and Joseph walks very fast...I'm walking down the corridor and I'm looking up at him and I'm talking and he's looking at me and he's talking as well... in a interested and collegial way where you feel that you are sharing the responsibility ...it's not all him...it's not like **his** woman...this woman needs us and needs our expertise now ... we were quite intensely talking from the desk to the room and ... and we both just stopped together ...it would have been an interesting video and we stopped ... I stopped and then he just had to stop... and stood and we were talking ... like eyeball to eyeball... not confronting ...

I said to him “but what do you think Joseph? You’ve been looking after her all day and I’ve just come on and this is what I’ve found...she’s due for the 11 o’clock VE ... I want to know what she is before then and I would like you to do it now before you go off ... I’m just coming in here and you’ve done the last VE and you would be the best person to assess the change” ... he said yes he would ... I didn’t need to push the issue with him...there’s understanding there...you just know that things will get done by Joseph and done in a way that’s acceptable to you and the women ...we got to outside the room and ...we finished the discussion, we had formulated the plan, we knew what we wanted to do... I gave Renae the morphine and the maxalon which fixed her symptoms. Joseph examined Renae and found that she was fully dilated. Renae was thrilled and pushed the baby out a couple of hours later. The baby had good Apgars and Renae was very grateful. I got a lovely thankyou card from Renae which said that I had “saved her life!”