

## **Medical and Midwifery Boundaries: Patterns of Formal and Informal Persistence and Change**

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### **Abstract**

The professional boundaries between medical practitioners and midwives have traditionally been characterized as a gendered opposition between medical men and oppressed female midwives. Sociological analysis of the professional boundary suggests that there is increasing subtlety and change in this relationship. This paper, based on interviews with Australian midwives and doctors about their work and their views of each other, provides evidence of complexity in the operation of gender and professional power. Boundaries are managed on the basis of age, seniority, previous experience and philosophy as well as gender and profession. While medical specialists are described as holding traditional patriarchal views senior midwives increasingly demand their respect. Junior doctors and midwives have the potential to form more collegial relationships despite being 'in competition' for patients, but this varies with the philosophical stance of the individuals concerned. Registrars varied in their sympathy towards midwifery claims of autonomy and midwives themselves varied in the way they conceptualized their professional identity. Female medical practitioners are potentially more sympathetic but they are relatively few. The study demonstrates both positive and negative inter-professional interaction and shows that despite differences in power and gender, the possibility of future multidisciplinary cooperation is at least present.

### **Medical and Midwifery Boundaries: Patterns of Formal and Informal Persistence and Change**

Interdisciplinary teamwork and the culture of hospitals is a 'hot topic' in healthcare and discussed frequently in the media (Swan 2005). One area where there is obvious potential for teamwork is in maternity care, despite differences between medicine and midwifery in their knowledge base, their daily practices and their style of relating to patients. The sociology and feminist literature in the critical tradition has analysed this relationship of one of domination and subordination (Willis 1983; Witz 1994) but the opposition between male and female, medicine and midwifery is socially constructed and open to change (Pringle 1998; Treichler 1990). Doctors and midwives can interact in a pragmatic way which contradicts a strict opposition between two models of care (Foley 2003 166; Smeenk and ten Have 2003). This paper provides explores this relationship through an examination of medical/midwifery boundaries as they operate

at a particular hospital. Such detailed examination can challenge a strict dichotomy between technological/natural models of care, suggesting opportunities for and analysing barriers against increased teamwork.

This paper arises from a study of a maternity unit in a rural town in NSW carried out for my PhD thesis (Taylor 2003). My interviews with women who gave birth at the hospital are discussed elsewhere (Taylor 2004a and b), but I also attended the hospital over the course of fourteen months and interviewed two of the four specialist obstetricians (VMOs), four junior doctors who were training either as obstetricians (SRs) or as gaining experience of obstetrics for other purposes (CMOs) and fourteen midwives (MWs), two of whom were unit managers (NUMs). The transcribed interviews and contextual notes were analysed thematically using qualitative analysis software (QSR N4 1997). Although the study was carried out in 1995, the issues it raises are still current in debates within Australia and elsewhere (Reiger 2001; De Vries et al. 2001; Reiger and Taylor 2005)

The rural town hospital was chosen for the study because it did not have a birth centre and so was a good site to examine the extent to which changing ideas about childbirth care were extending to routine and non-metropolitan settings. While the issues of gender and medical dominance persisted to a certain extent especially in relation to the obstetricians, there were signs of generational and gendered change in the relationship between doctors and midwives.

Midwives in the hospital varied in their professional ideologies – some were happy with a conventional and rather subordinate role for midwifery, others aimed for more professional recognition and some were influenced by alternative views of natural childbirth. Reflecting the feminist critique, both alternative and professionalizing midwives described the specialist obstetricians in gendered terms as ‘chauvinist’ and as engaged in a power struggle.

**Table 1**      **Midwives' views of the obstetricians**

June	Some of the obstetricians are still the old school - "I'm the doctor, you'll do as I say".
Nicki	The male obstetricians are fairly traditional and highly, highly chauvinistic, - that makes life difficult at times....They're very young men to be so entrenched ...it's a power struggle between them and the nursing staff in maternity up there, which is very interesting .
Caroline	They're condescending ...and you can almost feel them patting you on the head you know. Or else they'll just be rude to you and, you know, if you don't call them - one of them, particularly, at the right time so he can get there for the delivery, then he can be abusive, you know. "Why did you call me too soon/too late?" For God sake, you know,...the kid doesn't have a watch on and know he's meant to come half-an-hour after I've telephoned you .

According one nurse unit manager, these comments reflects a traditional, patronising attitude to midwifery skills, which she sees as a thing of the past but incorporates the problem of a power imbalance between the younger midwives and the most senior clinicians,

I suppose you were well respected (in the old days) "I'm so glad you're looking after so and so" but it was as long as you didn't have any opinion - just "how many cm is she? And "get me there on time". It seems so long ago.

My girls fight with obstetricians about stupid things, they're not powerful enough to stand up to them over clinical issues. They come to me - that's what they're supposed to do (Margaret NUM 55).

Caroline, draws extensively on a critique of hospital childbirth and finds the interventions of doctors into midwifery care frustrating, because they observe the woman externally and tend to take action instead of relying on the midwives' knowledge.

God, why did you offer them [pain relief] - they were doing alright. So that's very frustrating. You don't want anybody else to interfere. You're managing this woman, you can see that she's coping well, the baby's coping well - just leave things alone. But they're doctors and they can't... they just can't separate the pregnant woman from that 'sick person' thing; all people in hospital are sick, and ... and we must stop the pain, we must make it better for them. So they want to do all these things which go against the natural flow of it, you know (Caroline MW).

Caroline might be expected to find the doctors 'interfering' because of her commitment to low intervention, but even Rose who is more conventional gets annoyed.

When they do a VE (vaginal examination) “just to see how you’re going” when we’ve done one five minutes before. If it’s only to assess progress why do they do it? If we’re good enough to care for them they should trust our judgement. It’s an indignity for the women too. One day I’ll get the guts to say, at the moment I just seethe (Rose MW).

However, individual senior midwives were able to exert some authority, because of their position, their personality and the length of time they had been in the job.

As for the medical staff, I think I enjoy respect of the men who work here. I’ve had to work hard for that. I don’t know if it’s them changing or me - I couldn’t possibly say (Margaret, Nurse Unit Manager (NUM)).

and she also notes a co-operative relationship with younger doctors

Younger doctors are better with midwives. The midwives are less tolerant of arrogance from them (Margaret, Nurse Unit Manager (NUM)).

The increased confidence of senior midwives and their willingness to back up their junior colleagues obviously impacts on the potential for genuine cooperation between medical and midwifery staff, while overshadowed by some entrenched traditional attitudes by specialist obstetricians.

The traditional critique of gendered attitudes amongst doctors also has to be modified in the light of the increased number of female medical trainees who are also laying claim to the role of women’s health advocates (Pringle). In this study, the female CMO has a cooperative relationship with the midwives and argues against a dichotomy between medical and midwifery care

Doctors equal intervention, midwives clinic equals natural birth, that’s the perception but it doesn’t always follow. Some obstetricians will deliver in all sorts of positions. It’s gone the wrong way and we have to fight to bring it back. It’s possible to make a big difference - to encourage them [women] to be in charge. I think it’s different for women doctors – people perceive that a female obstetrician will intervene less (Michelle CMO).

The midwives in turn find her easy to get on with. They are more likely to go to her than a male doctor because she does not ‘interfere’ without asking. She also behaves more like a midwife sometimes up to the point of doing strictly nursing work

Michelle’s a dream...She’ll give a pan if it’s necessary. (Peggy MW).

The midwife with the most commitment to ‘natural birth’ balances gender and professional training as factors and concludes that women doctors are probably preferable, but there are too few of them.

I think women doctors are possibly better, but even then I think just because they've gone through the training - because they wanted to be a doctor, they wanted to help the sick - men or women - you know, they do want to take the pain away and make it all better. But I think women are better because - especially if they had children themselves - they know what to expect. They know that the woman looks as if she's falling to bits, but "I looked like that when I had a baby and I was alright" sort of thing, so - But there aren't many female obstetricians ... (Caroline MW).

In terms of generational change there was some advocacy for teamwork even amongst junior doctors who held conservative views about the increased role of midwives.

I think it [Active Birth] should be encouraged as long as there's continued team work - there's a tendency at the Teaching Hospital for the midwives to see the Birth Centre as their domain and they keep the doctors away from public patients - they're subtly kept away... In most cases nothing happens but things can get left - the midwives might not be as alert to changes in CTG [heart beat]- they tend to miss failure to progress, it could be eight hours before you pick it up...The midwives tend not to do PV's [vaginal examinations] so often. It is bad for the juniors - they are supposed to see so many normal labours but it's often a case of "oops, we forgot to call the doctor in time" (Robert SR).

Robert rather traditionally attributes problem to the midwives who do not carry out procedures or interpret data competently and who maintain a territorial attitude to their patients, but other juniors attributed problems to the quality of the medical/midwifery relationship. Stephen, a progressive Senior Registrar expresses his concern in a more sympathetic way

The midwives are very well educated - very motivated, so they provide good education for the patients. The down-side is that they are very anti-interventionist which is OK because the clients are too, by and large, but it can get them into trouble. I have seen cases where they have waited too long with disastrous outcomes, they are potentially doing harm. That's experience of course, but also stubbornness - I've seen very experienced midwives involved in disastrous outcomes because they just wouldn't say 'I need some help'. It depends on the nursing medical relationship. It's not good at present at Town - there's a lot of tension (Stephen SR).

Michelle who is viewed very positively by midwives, feels that the relationship at Town hospital is constructive, despite the structural tension over who is going to manage and who will deliver normal babies.

...you have a better relationship with the midwives here. It's difficult for residents and midwives to get on well. Some groups of midwives are less likely to want me to get involved, though it's more likely that they'll ask me than some male residents. Because of the title you're expected to waltz

in and interfere, but if I'm not asked I don't interfere, I don't examine her or touch her (Michelle CMO).

**Table 2            Scope for Midwifery decision making according to doctors.**

Robert SR	Well, its not really their decision, they can say what they think -especially about pain relief, "she isn't coping or she's coping quite well" In this unit the midwives do ARM, scout clips, take blood, give anti-biotics and some of them can cannulate. Other units are beginning to do suturing - at the Teaching Hospital they can do a course in repairing 1st degree tears, but only 1st degree, not any others.
Michelle CMO	The seniors will tell you – she needs ... The juniors will say what do you think? If it's a junior resident they'll say "We did an ARM and she's going well..." The midwives do all the top-ups [of epidural anaesthesia] - they taught me how to do them - no midwives were accredited to do it - so we were in this situation that they taught me how to do it so that I could authorise them to do it. I suppose if they've done the course, I'd be happy to teach them to suture; if they've done the episiotomy, they should be able to fix them up - and minor tears.

Robert's conservative response is that midwives are not allowed to make decisions, although they can follow protocols and make suggestions. The scope of midwifery practice may be expanding elsewhere, but only to a small degree and the traditional hierarchy between the two occupations is preserved. Michelle is very much more cordial towards midwifery decision making and accepts the realities of life in the maternity unit. She distinguishes the senior midwives, who will tell junior staff what needs to be done from the junior midwives who will ask for an opinion. She acknowledges that if the doctor is very junior, the midwives will take action and tell the doctor afterwards. Michelle points out the paradox that the midwives taught her to top up epidurals so that she could authorise them to do it and she is willing to teach midwives who are qualified how to suture [stitch tears]. She is uncertain whether all midwives want to expand their scope of practice though because she knows midwives from other settings who say they are too busy to take on medical work, saying "We've got more sense".

The midwives at this rural hospital reflect the uneven pace of change but with a desire to be recognized for the responsibilities they are capable of taking. Rose's account of

conventional midwifery work stresses responsibility without taking on the whole of a woman's care.

We have more responsibility here. In some places you can't even do a VE (vaginal examination) without a doctor's OK. It's a huge responsibility, but the staff are capable of it. If you wonder "Am I overstepping the mark?" you go to one of your peers and get a second opinion, some support and input. It's backup in case someone questions you. If someone's labouring away and there are no complications we let them know that they're there. Ring the doctor and they come in for the delivery. You ring and then arrange the care. Pain relief is liaised with the doctors (Rose MW).

And many midwives at Town believe that they already have higher level skills than at other places, but are not sufficiently recognised for their professionalism.

We provide a high standard of care and have more clinical expertise than the Teaching Hospital. Midwives here rupture membranes and put on scalp clips. Our clinical skills are much greater - there you have to compete with students, residents, med. students. It gives us a better feel about our work. Margaret and I write the protocols. I've had registrars say, when I've offered to do something "Oh, can you do that?" Sometimes I feel frustrated; midwives need more recognition for their professionalism. A junior doctor is going to be educated by the midwives, not by the medical staff - but when they leave they won't realise that most of what they know has been taught by the midwives (Stephanie NUM).

At least one of the junior doctors I interviewed was aware of the role of midwives in their education and I also found that midwives and junior doctors had combined to promote continuity of care for public patients against the wishes of the specialist obstetricians.

Feminist and sociological literature on hospital childbirth has conventionally drawn a dichotomous picture of male medical dominance and female subordination. The advocacy of homebirth and independent midwifery as the optimal 'feminist' and liberated form of childbirth has tended to marginalise the practitioners and patients who practice and experience mainstream care. The critique has been in circulation for thirty years and has had varying degrees of influence. The results of this study reflect the complexity of the contemporary organisation of maternity care in which there are patterns of persistence but also signs of change.

Traditional, gendered authoritarian attitudes amongst obstetricians persist and while obstetricians hold a great deal of formal power they are challenged by senior midwives who will not accept the attitudes which were pervasive in the past. Senior midwives also have the opportunity to promote increased responsibility amongst their colleagues. Amongst some midwives the acceptance of midwifery as a subordinate role persists but even amongst the most conservative there is impatience about lack of respect for their skills and a belief that they can and do take on increased responsibility. Professionalising and alternative midwives draw on critiques of hospital childbirth and medical dominance to reflect on their experiences, and while they are not always in a position to challenge decisions directly, they can make alliances and use their authority with younger doctors. On the part of the junior doctors, I found a similar diversity with even the conventional juniors referring to team work as a desirable goal. More sympathetic junior doctors sought a cooperative relationship with midwives and blamed problems on a lack of relationship rather than a deficit in their midwifery colleagues. Finally, the gendered aspect of the critique of hospital childbirth has to be modified in the light of the increased number of female medical practitioners. The example of one such doctor in this study shows the extent to which cordial, cooperative and non-conflictual interprofessional relationships are possible.

A close study of a single mainstream maternity unit illustrates the intensity of the personal and working relationships between doctors and midwives. Hostile and patriarchal behaviour emerge as anachronistic and bullying under this lense. Small changes in attitudes and behaviour, in the willingness to admit the need for help (on both sides) and to promote the interests of the patient have the potential to lead to desirable change in women's experience of maternity care. While power is still held and exercised by obstetricians and administrators, there is at least the potential for new generations of midwives and junior doctors to effect transformative change.

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