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
<table>
<thead>
<tr>
<th>Chapter Four: Analysis of Stories of Negative Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Introduction</td>
</tr>
<tr>
<td>2.0 Virginia</td>
</tr>
<tr>
<td>2.1 Discussion</td>
</tr>
<tr>
<td>2.2 Coda</td>
</tr>
<tr>
<td>2.3 Initial Analysis and Conceptual Integration from Virginia’s Story</td>
</tr>
<tr>
<td>3.0 Belle</td>
</tr>
<tr>
<td>3.1 Discussion</td>
</tr>
<tr>
<td>3.2 Coda</td>
</tr>
<tr>
<td>3.3 Initial Analysis and Conceptual Integration from Belle’s Story</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Five: Analysis of Stories of Positive Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Introduction</td>
</tr>
<tr>
<td>2.0 Sarah</td>
</tr>
<tr>
<td>2.1 Discussion</td>
</tr>
<tr>
<td>2.2 Initial Analysis and Conceptual Integration from Sarah’s Story</td>
</tr>
<tr>
<td>3.0 Jason</td>
</tr>
<tr>
<td>3.1 Discussion</td>
</tr>
<tr>
<td>3.2 Initial Analysis and Conceptual Integration from Jason’s Story</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Six: Construction and Contextualisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Introduction</td>
</tr>
<tr>
<td>2.0 A Theory of Interprofessional Integrative Power</td>
</tr>
<tr>
<td>3.0 Background to Analysis and Conceptual Integration</td>
</tr>
<tr>
<td>4.0 A Theory of Interprofessional Integrative Power (Negative)</td>
</tr>
<tr>
<td>5.0 A Theory of Interprofessional Integrative Power (Positive)</td>
</tr>
<tr>
<td>5.0 Conclusion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Seven: Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Introduction</td>
</tr>
<tr>
<td>2.0 Recommendations</td>
</tr>
<tr>
<td>2.1 Midwifery and Organisational Administration</td>
</tr>
<tr>
<td>2.2 Recommendations for Midwifery and Organisational Administration</td>
</tr>
<tr>
<td>2.3 Midwifery Practice</td>
</tr>
<tr>
<td>2.3.1 Recommendations for Midwifery Practice</td>
</tr>
<tr>
<td>2.4 Midwifery Education</td>
</tr>
</tbody>
</table>
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.