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Chapter IX

Consumer Participation and Collaborative Care and Midwifery Practice

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Abstract

Western governments are faced with two main problems in delivering effective health care to populations without sacrificing quality of care and universality of access. The first is no-ceiling costs and the second is avoidable adverse events. A renewed focus on consumer participation and collaborative care has been a partial response to both inspired by trials that demonstrated improved cost-effectiveness, patient outcomes in mortality and morbidity rates, and patient and professional satisfaction (Sandall et al 2001, Dower and O’Neil 1997, Henneman 1995). This paper discusses the results of three interrelated studies: (a) Part 1 - consumer participation (b) Part 2 - midwifery managers’ constructions of collaborative care and (c) Part 3 - obstetric meanings of collaboration. The studies found that consumer participation was not institutionalised substantially at the operational levels that is, in policy setting. Nor was power-sharing significantly evident in restructured models of care that placed obstetricians, midwives and women on an equal footing, that is as partners in collaborative care. A qualitative study of midwifery and obstetric constructions of collaboration found in the minority of cases where it was achieved four pre-requisites – (1) midwifery continuity of care; (2) antenatal care was delivered by midwives; (3) consumers were proactive; and (4) there was a high level of confidence in the skills of the ‘other’. These factors interacted synergistically to produce mutual trust which reinforced the collaborative project. The conclusion was that successful implementation of collaborative care models requires a full complement of
administrative policies, inter-professional commitment to inclusiveness and associated social and cultural changes.

**Introduction: Consumer Participation – The Cure for Adverse Events**

Governments in Western regimes have increasingly encouraged a shift from practitioner-centred to patient-centred services particularly in Northern America, Australia and Northern Europe (Mounjid 2003; O’Connor et al 2003) by insisting that lay people should be appointed to national professional governance, standard-setting and regulatory bodies (Davies 2003) in order to modernise health services and empower patients to make informed choices and actively participate in decisions about their own condition and treatment. To some extent these changes stem from the World Health Organisation’s global health directives (1985; 1986; 1988; and 1992) that epitomise the ‘new public health’ approach to the management of health care and risk. Compatible strategies include ‘health promotion and health education, social marketing, epidemiology, biostatistics, diagnostic screening, immunisation, intersectoral collaboration, ecology, health advocacy and health economics’ (Peterson and Lupton 1996:5).

Consumer participation initiatives may be seen in much the same way as preventive health drives such as the wearing of seat belts and safety helmets, using drugs in moderation (alcohol) or not at all (illicit drugs, cigarettes). Like any public health initiative the idea has been to alleviate two main problems - no-ceiling costs and adverse events – while maintaining high levels of quality of care and universality of access. Similarly, collaborative models of maternity care have been endorsed by professional organizations and accreditation agencies in various Western regimes on the grounds of its demonstrable advantages measured in terms of cost-effectiveness, better patient outcomes in mortality and morbidity rates, and higher rates of patient and professional satisfaction (Sandall et al 2001, Dower and O’Neil 1997, Henneman 1995).

Although commensurate with the spirit of the new social movements of the 1970s in the sense of wresting control away from professionals and empowering consumers to take charge of their own destinies, Peterson and Lupton (1996) critically question whether the ‘new public health’ is more or less like the ‘old public health’. Both are modernist or neo-liberalist. The only difference is that the new public health expresses the increasingly intolerable burdens of welfarism in the age of globalism and loss of control experienced by the nation state. Is it the case that the new public health initiatives are merely guises for continuing state regulation where consumers are offered regulated freedom in pursuit of a market-driven agenda? Some health care researchers since the 1990s have tried to address this question by exploring issues such as communication between professionals (Stevenson et al; Bajramovic et al 2004; the relationship between patient characteristics and health care preferences (Jung et al 2003); or the role of health consumer groups in affecting government policy (Jones et al 2004). There is also the question of whether consumer participation was designed further market imperatives or support a broadly-based social rights agenda (Johnson and Silburn 2000). The national study of Australian maternity units reported in this paper was promoted by similar concerns. It investigated macro and micro initiatives introduced by providers (hospitals) to encourage


maternity consumers to participate in setting policy (such as representation on committees, policy round tables, complaints mechanisms, information brochures) and in health care decision-making at the micro levels (collaborative models of clinical care).

Background: The Problem with Health Care in Australia – The Sticky Issue of Adverse Events

In June 1995, the Commonwealth Minister for Human Services and Health released the preliminary results of the Quality in Australian Health Care (formerly Australian Hospital Care) Study. The study was based on the analysis of over 14,000 admission records from 28 hospitals during 1992. It found that a ‘significant proportion of people admitted to Australian hospitals had suffered adverse events – unintended injuries or complications – as a result of their health care’ (Final Report Taskforce … 1996:1) and that over half were potentially preventable (1996:A9). This Study had in turn arisen from the work of the Review of Professional Indemnity Arrangements for Health Care Professionals set up in 1991 that had reported on the paucity of information relating to adverse patient outcomes, how severe they were and their impact on health services. The only study marginally relevant (The Harvard Study) had been conducted in the USA in 1990. It found that 3.7% of hospital stays had involved an adverse event; that 1% of discharges (or 28%) of adverse events involved negligence and that most resulted in minimal impairment, that is, 57% of patients recovered within one month. However, death occurred in 14% of cases; permanent total disability in 3%; and 4% resulted in permanent impairment with less than 50% disability. The Australian Health Care Study aimed to replicate the Harvard Study, although it did not gather data relating to negligence.

In Australia, shifts towards consumer participation may be seen partly as a logical consequence of attempts to reduce health care costs by reducing the incidence of adverse events (AEs), especially in high-risk specialties such as Surgery, Orthopaedics, Obstetrics and Gynaecology and Internal Medicine (Final Report of the Quality in Health Care Study 1996:1: A9). Follow-up studies of adverse events showed that the majority (81.8%) could be attributed to human error (see Wilson et al 1999 and the Bhasale et al 1998 study of Australian general practice). Cognitive failure, in the form of errors of omission, was evident in 57% of cases. Of all AEs most were judged to be of high preventability and to have caused significant disability (Wilson et al 1999:4). AEs were categorised into four main groups: communication problems (between professionals and between professionals and consumers); procedural problems (failure to check records, machines); clinical problems (of judgement); and external problems (those outside the doctor’s control). AEs are not only costly in human terms but impose exorbitant costs on the health budget. The cost of additional hospital bed-days was estimated to be in excess of $800 million dollars per year and even higher if subsequent admissions and out-of-hospital healthcare expenses are added on (Wilson et al 1999:3). Whilst human error had been regarded as inevitable to some degree, it was widely agreed among practitioners, administrators and politicians that the system need to be made as ‘failsafe’ as possible. That meant including consumers in decision-making via collaborative models of care.
Who Wants Consumer Participation?

Although providers had been urged to institute policies to encourage consumer participation at all levels, a study of Australian providers by Johnson and Silburn (2000) showed that after several years few providers had been able to achieve the consumer participation element of collaborative care at the ‘higher levels’, that is, at the level of decision-making and planning. In order to investigate the level of collaborative care in maternity services, two related surveys were undertaken of 125 providers throughout Australia. These included public and privately-funded hospitals at metropolitan, regional and rural locations.

Part 1 - A Quantitative Study of Consumer Participation

Midwifery managers were the respondents in this leg of the survey carried out between 2002 and 2003. (An interim report may be found at Lane 2003). The results are reported below. Note that the final response rate was 62%.

Q. 1 What is the level of commitment to consumer participation in the hospital's vision, values and other philosophical statements? N = 77

The responses to Question 1 indicated a high to medium commitment by providers to consumer participation.
Q. 2 How much is the hospital committed to participation by users of maternity services?  
N = 77

Low, 8%  
High, 48%  
Medium, 44%

Again, a high level (92%) of providers possessed a high or medium commitment to the idea of consumer participation in maternity services.

Q. 3 To what level are consumers of maternity services involved in a needs assessment?  N = 77

70%  
60%  
50%  
40%  
30%  
20%  
10%  
0%  

Low  
63%  
Medium  
18%  
High  
19%

The overall picture is that over 80% of providers were reasonably committed to involving consumers in determining consumer needs.
Q. 4. Are specific staff delegated with the task of overseeing consumer participation strategies? N = 77

Two-thirds of providers allocated a staff member(s) with specific responsibilities for overseeing consumer participation strategies indicating a considerable commitment to consumer involvement.

Q. 5 Does the hospital have key consumer policies in place for mothers and their families. (Respondents ticked more than one box) N = 77

Most providers had instituted policies on consumer rights and other information although this only complied with ‘lower levels’ of consumer participation (Johnson and Silburn 2000).
**Q. 6 Has the hospital compiled these policies in consultation with consumers? N = 77**

- Yes, 39%
- No, 61%

In constructing policies, 'higher levels' had not been achieved for 61% of providers.

**Q. 8 If maternity consumers currently participate in the hospital's planning and review panels, please specify how. (Respondents ticked more than one box) N = 77**

- Submissions: 16%
- Consumer Councils: 18%
- Representatives on Committees: 35%
- Policy Round tables: 0.50%
- Consumer Representative on special projects: 33%
- Partnership role in planning services: 23%

At the administrative level, however, consumers were more involved in planning and review via committees and special projects indicating consumer participation at the 'higher levels' (Johnson and Silburn 2000).
Most providers used surveys and suggestion boxes to measure consumer satisfaction with maternity services. Encouragingly, around one-third followed up the quantitative data with focus groups and in-depth interviews indicating a commitment by at least one-third of maternity service providers to improving relations with consumers and involving them in their own care.

Most staff remained uneducated regarding consumer participation programs.
Most maternity units did not evaluate their programs.

However, three-quarters of unit managers revealed that consumer feedback (from whatever sources) had resulted in policy changes.

The following questions and responses related to maternity units specifically:
Q. 13a Does the maternity services department wish to have consumers involved in setting policy and reviewing performance? N = 76

- Yes: 84%
- No: 16%

Q. 13b At what level do you currently involve consumers? N = 75

- Low: 31%
- Medium: 60%
- High: 9%

Question 13 parts a. and b. taken together reveal a high commitment to involve consumers but a reduced capacity to actually do so.

Q. 14a Has the maternity services department identified who its consumers are? N = 77

- Yes, 95%
- No, 5%
Q. 14b If yes, how has the department achieved that? (Respondents ticked more than one box) N = 75

- Surveys (quantitative): 61%
- In-Depth Interviews: 43%
- Focus Groups: 31%
- Patient Forums: 21%
- Support Groups: 41%
- Suggestion Boxes: 44%
- Submissions: 17%
- Complaints: 60%

Taken together, Questions 14 a. and 14 b. indicate that a high responsibility to articulate the nature (and presumably needs) of consumers in the service area is operationalised mainly through the complaints mechanism and quantitative surveys. Suggestion boxes, interviews, support groups and focus groups (mainly qualitative methods) were subsidiary methods of identifying consumers.

Q. 15 What types of strategies are used to involve consumers in decision-making about care processes and service improvement within the maternity department? (Respondents ticked more than 1 box) 34% of respondents had no strategies. N = 51

- Submissions: 24%
- Consumer Council: 22%
- Consumers: 43%
- Representation on Policy Round Tables: 4%
- Consumer Representation: 45%
- Planning: 33%

Twenty-six providers had no strategy in place at all to involve consumers at the 'higher levels' of policy decision-making. Of the 51 providers who did answer this question, the most common (45%) included consumers on special projects, that is, ad hoc representation. Of the total sample of 77 providers across the nation, this represents a very modest number of maternity units (30%) who included consumers in policy formation. Consumers were granted
representation on committees in 43% of the 51 providers but again, this represents only 29% of providers in the study who systematically involved consumers in policy decision-making, i.e. the 'high' level.

Nevertheless, nearly 60% of providers regarded relationships with support groups in the community as reasonably effective.

Very few (one-fifth) of respondents published a special report designed for consumers. The majority relied on the Annual Report to convey information about services and outcomes.
Q. 18 Have any policy and/or procedural changes taken place as a result of consumer participation feedback? N = 70

No, 20%
Yes, 80%

The high response rate to this question in the affirmative would suggest that consumer participation had been responsible for significant changes in policy and procedures. Yet the qualitative responses provided in Question 18 b. indicate that 72% of the changes related to modifications of existing practices, such as changes in visiting times, breastfeeding policy and antenatal information. Only three managers reported structural changes to models of care designed specifically to institute a consumer-focus.

Q. 19 What in your view is the ideal model of maternity care? N = 70

Over three-quarters of Australian maternity unit managers reported that the Collaborative model of care (described below) was the ideal model of care to incorporate all health professionals in delivering the best care for women. The three models were described in the questionnaire as:

Participatory: Information gathered from consumers is integrated into choices made available to women.
**Collaborative**: Decision-making is an ongoing process between the woman and her carer, both of whom possess special expertise in childbirth.

**Consultative**: Caret-provider provides information to families about available services.

The Collaborative model is the most inclusive (in consumer participation terms) of the three models. This model conceptualizes the clinical encounter as a dialogic relationship between the woman and the carers. Constant negotiation of procedures between the mother and professional carers (midwives and obstetricians) is necessary because of the unpredictable nature of the process. This model articulates the patient as an active and knowing participant (Rothfield 1995) in an on-going alliance with her carer(s). The Consultative model is a paternalistic, mostly one-way communication model where power accrues mainly to the obstetrician but also the midwife. This model regards the patient as predominantly a passive receiver of information. In the Participatory model, obstetricians and midwives solicit information from consumers but there is a decision-making rigidity over choice of procedures. This model comes close to the liberal, informed consent model of patient care. There are choices available but only within a prescribed range and thus very little opportunity for negotiation outside the set parameters. The parameters would be determined by obstetricians.

Note that this question focussed on respondents’ view of the ideal clinical relationship and was the acid test in the sense that it was designed to uncover a culture of non-participation on the part of maternity health professionals at the most basic level of the system. The clinical level is very sensitive because it is here that consumers may best represent their own idiosyncratic needs. Indeed, it is argued here that this is the only level at which individual consumers needs could be most fully expressed because of the largely idiosyncratic nature of subjectivity and the complex, sometimes contradictory and constantly shifting nature of identity over time (Fraser 1997; Nicholson 1999; Braidotti 1994). It follows that ‘high level’ consumer participation (actual decision-making about care rather than information-gathering or information-dissemination) must be sought in the clinical encounter because only the individual may make on-going decisions about their own care as the need arises.

Yet because this level confronts traditional inequalities between doctor and patient and doctor and midwife that are embedded in professional roles, identities, skills and knowledge (discussed above) and cemented into place by an adversarial legal system in many Western countries, it is the most resilient to change. As the National Resource Centre for Consumer Participation in Health (1999:25-27) noted, the training, skills and knowledge of health service providers and managers are often one of the greatest perceived barriers to effective consumer participation. This is because the biomedical model regards health problems as physical problems internal to the body of the patient. The social context is considered immaterial in the aetiology of disease or pathology which rules out the possibility of consumers being ‘experts’ in their own care. Thus, communication skills are not allocated priority in training programs and there is a fear that encouragement of consumer participation will unduly raise patient expectations, undermine professional autonomy and raise litigation rates. It follows that some practitioners regard consumers as not knowledgeable enough to share in decision-making. As one midwifery manager put it, ‘...they are the mercy of their own education system and prejudices’.
Summary So Far

The quantitative survey of national providers regarding the commitment and practice of consumer participation indicated mixed results. There was a high commitment to consumer involvement at the administrative and maternity unit levels. This was indicated by the institution of policies and by the allocation of specific staff to operationalise them. However, the policies related mainly to gathering information rather than involving consumers in the actual construction of the policies. Only one third of providers, for example, included consumers on committees and special projects (Q.8), the ostensibly ‘higher levels’ articulated by Johnson and Silburn (2000). This bifurcated interest in consumer participation was mirrored in the measurement of consumer satisfaction with services. One-fifth of providers assigned staff to oversee programs or evaluate programs (Q.8 10 and 11). Questions 13-18 tested consumer participation at the ward or unit level. Again, unit managers expressed a strong commitment to consumers being involved in setting policy and reviewing performance but in practice just over two-thirds involved consumers at a medium to high level. Although maternity units reported an almost unanimous identification of their consumers (Q.14a), most used quantitative surveys and complaints mechanisms to do so (Q.14b). Qualitative methods which would yield rich and deeply textured material about consumer needs were utilised less frequently (in-depth interviews (43%) and support groups (41%)). Only around one-third of maternity units surveyed (77 in total) included consumer representatives on committees and on special projects although 57% of maternity units claimed a medium level of effectiveness with consumer groups. Very few providers (one-fifth) published a special report for consumers; most relied on their Annual Report to convey information about consumer services and consumer feedback. Although responses to Q18. suggested a high level (80%) of providers had changed their policies and procedures as a result of consumer input, quantitative responses showed that these amounted to minor modifications of existing practices. Only three managers reported structural changes, for example to models of care, designed to transform power imbalances between professionals and consumers.

In summary, consumer participation at the administrative and unit levels had been embraced as an ideal objective, but was not achieved in practice. Since the questionnaire permitted little qualitative response, it was decided to follow-up the quantitative data with telephone interviews with midwifery managers to ascertain whether the ideal model of care (the Collaborative model) also remained an ideal but had not been achieved in practice and, if not, what may be the barriers to attaining full collaboration between obstetricians, midwives and consumers.

The Ideal Versus the Practice

It was anticipated that midwives would be more accepting of the idea of a democratic clinical relationship on the grounds that midwifery is defined (by midwives themselves) as a partnership with women. It was anticipated that obstetricians would be less likely to opt for a collaborative model of care on the grounds that obstetrics has been defined as the practice of medical experts grounded in scientific truths in contradistinction to the (perceived) empirical,
non-codified nature of midwifery knowledge of women's bodies and birth (Kent 2000). This was borne out through the study (reported below).

In the quantitative study reported above (N = 77), seven respondents failed to answer the question. Of the remaining 70 respondents, 10% cited all three models as being ideal; 6% chose the Consultative Model; 16% cited the Participatory Model and 78% responded that the Collaborative Model was the ideal model for the clinical relationship i.e. one that conceptualized participation as an on-going partnership with the carer (whether midwife or obstetrician or GP). Embracing the Collaborative model as the ideal model is consistent with the generally supportive response to consumer participation from most providers at the Administrative and Unit/Ward levels (reported above in the quantitative study of providers).

However, the picture is much more complex at the level of actual practice.

The clinical level was further explored via a follow-up qualitative interview with twenty maternity unit managers from a range of providers across Australia regarding the nature of the relationship between the carer(s) and the woman. The interviews were conducted with midwifery Managers of maternity units via telephone lasting around twenty to thirty minutes. According to a sample survey of twenty midwifery managers, all regarded the Collaborative model as the ideal model, but only five maternity units had put the Collaborative Model into practice (including one partially). These providers were varied in size (both large and small) funding source (public and private) and geographical location (metropolitan, regional and city based). Seven managers reported their unit conformed to the Participatory model and eight units conformed to the Consultative model. Overall, the study of the clinical relationship – a site where the idiosyncrasy of consumer needs could be most effectively conveyed to achieve 'higher' levels of consumer participation – again demonstrated a marked contrast between the ideal and the practice. The findings are reported below but it is useful first to elaborate on the concept of collaboration and the outcomes of studies of collaboration in health services.

Part 2 – Collaborative Care

Collaboration means working with others to accomplish a task that no individual can achieve alone. Participants are required to act as interdependent members of a team characterised by mutual trust, respect for the perspective of the other, sharing of responsibility for decisions and outcomes and a commitment to work cooperatively. Assertiveness, as opposed to aggression, is a key element (Keleher 1998:8). At the institutional level, collaboration entails a shift from the hierarchical, competitive model of the current health care system to an egalitarian structure of shared power, mutual respect and equality premised on evidence-based practice (Evans 1994:22). However, successful 'synergistic' practices have been rare. For example, a study in the US (Miller 1997) of 27 midwives and 10 physicians who had worked in over 100 collaborative care practices reported that five factors were crucial in achieving success. There had to be a strong financial and patient base; individual participants needed to be competent and confident in their skills; there needed to be ground rules to encourage open communication, consensus decision-making and role clarity; and participants needed to possess trusting attitudes and a commitment to superior patient care. When all five core elements were present they synergised each other creating a spiral of trusting relationships. In most cases, however, some core factors were absent compromising
the synergy. Leppert’s study (1997: 285-287) identified key factors in collaborative practice as: a commitment to excellence in patient care; professional expertise within a scope of practice; trust and respect of the others’ scope of practice; non-ownership of the patient by any professional group; evidence-based practice; early career training in teamwork; optimal size of teams; primary care as well as specialist care by all professionals; open resolution of disagreements; and inclusion of the family as part of the team. Of critical importance was the commitment by all participants to share and review information and correct distortions. People also needed to have the time to communicate.

The Importance of Trust

One of the foundational factors noted by both Miller (1997) and Leppert (1997) was mutual trust between professionals which, when present, acted in a circular fashion making it one of the primary consequences. However, Miller’s study surmised that trust simply could not flourish under ‘a vertical structure with a predictable pecking order...’ For trust to evolve, a fundamental shift needed to occur from a vertical model of communication to a horizontal, complementary structure that fully nurtured, appreciated and utilised the respective skills of all professionals (Porter 2003:219). The ability of providers to make this shift is compromised at a number of levels. At the institutional level, professional training, accreditation and hospital protocols create and ‘naturalise’ hierarchical relationships that are then expressed at the cultural and social levels in mannerisms, attitudes, social rituals, and medical and nursing/midwifery roles and identities, skills and knowledge (Walby et al 1994). These asymmetrical and often competing professional identities are then affirmed and negotiated through social interactions with a broad range of contacts – medical and nursing faculty staff, interactions with other students, patients, hospital staff, professional mentors and professional superiors.

Clashes of Values

The end result, according to Degeling et al (1998; 2000), is a series of fundamental differences between nurses, doctors and managers related to styles of working and decision-making, perceived roles and professional accountabilities. For example, Degeling et al (1998) found that Australian nurses (clinicians and managers) were more likely than doctors and managers to accept institutional shortcomings as explanations of clinical practice variation while doctors would point to individual factors. Nurses embraced workplace teams and protocols as enhancing rather than reducing their autonomy and they rejected the view that clinical standards were based on self-generated knowledge. On all of these points, clinicians expressed the reverse. That is, doctors saw themselves as autonomous practitioners who relied on self-generated knowledge. They believed that hierarchies were natural and appropriate since their skills and knowledge were superior. Significantly, the studies found differences between nurses and doctors about whether or not it was appropriate for professionals to consult with consumers; nurses did and doctors didn’t. Clinicians regarded calls for greater accountability by government and consumers as assaults on their professional autonomy in much the same way as they did encroachments from complementary medicine. Managers in
Australia and New Zealand also exhibited different values from nurses and practitioners in relation to styles of management (hierarchical versus egalitarian), patient-centred accountability, the importance of accountability compared with clinical autonomy and the need to avoid risk (Degeling et al 1999). Those managers with a medical background also differed from other managers in that they struggled with the mix of professional and managerial roles viz-a-viz their clinical counterparts. 'Lay' managers (those without a medical background) felt themselves to be the target of resentments by medical professionals.

In summary, studies show that the medical arena produces a series of tensions and anxieties among major professional groups, notably around the naturalness or otherwise of professional hierarchies, styles of decision-making, professional autonomy, the merit of consumer participation in decision-making, whether or not they accepted team-based practice and whether or not they attributed knowledge to individual or collective processes. Obviously, the adversarial legal system that allows patients to sue on the grounds of professional negligence is based upon and reinforces medical dominance.

The Transgression of Boundaries in Maternity Care

Walby et al (1994) found that transgression of professional boundaries caused the greatest conflict between nurses and doctors in UK hospitals. In maternity services, Australian-based studies revealed similar findings, that is, profound dissonance among midwives, obstetricians and managers regarding self-identity, roles and boundaries, the realisation of professional skills and ideas about the optimal organisation of maternity care. In Australia, these endemic and ongoing tensions have contributed to a crisis in staff retention rates and inadequate numbers of midwives currently in training for the future (AMAP 2002). A UK study (Hughes et al 2002: 48) similarly highlighted disquiet among midwives about lack of communication between professionals, lack of consultation about new policy initiatives, the intrusion of work into home life, continual pressure to work extra shifts and increasing (sometimes unrealistic) client expectations under holistic, continuity of care models. Many of the tensions may be attributed to hierarchical relations between doctors and midwives, medical versus social theories of birth, differences in skills bases and professional spheres of competence. Of critical importance were the perceived and actual responsibilities for legal liability.

According to Hughes et al (2002), when egalitarian, collaborative care models have been imposed on medical and midwifery professionals, long-established conventions are realigned demanding considerable conceptual shifts on both sides. Consultant obstetricians need to overcome their resistance to sharing power with midwives, while midwives are required to upgrade their skills and assume greater responsibility (Leppert 1997). The difficulty in changing embedded professional values may account for the fact that so few health providers in Australia have moved to collaborative models and explains why so many maternity units are characterised by greater or lesser degrees of hostility between obstetricians and midwives (Lane 2003).

In summary, achieving collaborative relationships on the ‘foundation of shared knowledge and mutual trust .... in an egalitarian or balanced working situation’ (Evans 1994:23) represents a huge conceptual and practical shift in the traditional hierarchical arrangements between doctors and nurses, obstetricians and midwives. Although some
Australian maternity units, especially in the public sector, are increasingly moving towards team midwifery and caseload models of care in attempts to stem rising costs without sacrificing universal access to quality care, there remain considerable obstacles, reported below.

Qualitative Survey Responses

All 20 Maternity Unit Managers who participated in the study believed that the Collaborative Model was ideal because it conceptualised the clinical encounter as a dialogic relationship between the woman and the carer(s). This means that, ideally, In other words, this model of care is relationship-centred. Decisions are the outcome of negotiation between the mother and her carers not just the province of the obstetrician or the midwife. However, only five providers from a total of twenty in the study achieved this in practice (including one who achieved collaboration only partially). Seven managers reported that their maternity unit followed a Participatory model. Eight Midwifery Managers reported that their unit used a Consultative model. Collaborative care was obviously difficult to construct. Those units who did work collaboratively reported four common prerequisites: there were administrative policies that embraced continuity of midwifery care; the consumers were pro-active about participation; doctors and midwives trusted each other; and women were presented with options about their care in the antenatal period. (This usually meant attending a midwife-led antenatal class at the hospital). Collaboration was not tied to size, public or private status or geographical location. Three out of the five collaborative units were located in public hospitals and two were private. The private hospitals were both small suburban units with around twenty maternity beds and around 400 births per year. The three public hospitals were large units with around forty maternity beds and between 2,000-2,500 births per year.

The Collaborative Model of Maternity Services

A unit was defined by midwives as collaborative when all of the following criteria were present. Although not mutually exclusive, when all factors are present they appeared to reinforce each other and act synergistically (Miller 1997). If some factors were present, the synergy was compromised.

(1) Midwives (Like Obstetricians) Are Situated as Primary Carers

The midwife-as- primary-carer factor was regarded as central by the midwifery managers although said to be difficult in units with high numbers of part-time workers, midwives with young children and those who just wanted regular rosters and regular hours. It was achieved through continuity of care models such as caseload or team midwifery. A manager of a large tertiary public hospital explained that collaboration was achieved only in the midwives’ clinic or birth centre. Within the conventional obstetric-led system, the obstetrician informed women of their options (The Consultative Model).
Care [in the birth centre] is collaborative because the woman and midwife discuss her care throughout the pregnancy and the woman is empowered to have input into her care. The other type of care is the consultative model – the woman doesn’t participate as much in her care. The doctor tends to have most of the choice. He lets the woman know what is happening but it is not a collaborative model.

A midwifery manager of a large public teaching hospital explained that they achieved collaboration with two models of care – the team model and the caseload model but that the consultative model remained in situ for women and midwives who preferred traditional obstetric-led care.

We do like to promote a doctor/midwifery team approach to the management of our women here in the unit. That’s all important.

She also explained that there had been pockets of resistance from obstetricians.

But there are a couple of older consultants who just want to get on with things rather than spend time with women and that does cause some dissatisfaction. But I keep communicating with the obstetric head and he says that as long as we enforce this approach with the medical staff and we don’t call them midwifery models [but] maternity models then possibly we will get the medical staff more on side.

Women Receive Antenatal Care from Midwives

The importance of midwifery antenatal care is that women can be taught that there are alternative options. When women receive private obstetric care they are primed to receive and to request intervention typically via strategies for pain management. However, if antenatal care was received from midwives there was a greater chance that low-interventionist techniques could be trialled as a way of managing pain without the slide into the cascade of intervention. Clearly, the midwives saw intervention as inhibiting the on-going participation by women and as handing over responsibility for decision-making to the obstetrician. This should not be surprising given that the midwifery strategy for professionalization has been to claim specialisation in any areas in direct opposition to obstetrics. Thus, midwives have defined themselves as guardians of ‘normal’ childbirth via a special relationship with women built upon a monopoly of tacit, experiential and practical knowledge (Kent 2000:64-7).

... we hope that our new obstetric manager won’t try to push the obstetric intervention line. ... we do try to encourage women to speak out and to be more involved in their pregnancy care and discuss things with the doctor rather than take everything as gospel. We try and encourage them to participate.... You are going to get a certain number of women who believe the doctor knows everything but we are trying to get women to ask and participate in their own health care in general. We are trying to get women to ask about their medication and how it will affect them ... not just take things that the doctor says but to ask questions and be more involved.
The Pro-Active Consumer

Both Miller (1997) and Leppert (1997) stressed the importance of including the family as part of the team. Midwifery managers also stressed the importance of the pro-active consumer who was typically over 35 years, more highly educated and in the middle-to-high income earning bracket. Where women did not meet this demographic, hospitals relied on other methods of inclusion. One large public hospital liaised with a local women’s health liaison group to gauge women’s needs. All midwifery managers were insistent on the importance of women being involved in decision-making about their own care:

I think it is the utmost importance [that women were assertive about wanting to be involved in decision-making] although not all women will come in that way. Many think that we will tell them what to do.

Confidence in the Skills of the ‘Other’ and the Creation of Inter-Professional Trust

Trust was a strong connecting theme (Miller 1997: Leppert 1997: Porter 2003). A major pre-condition for the fostering of trust was the perception by obstetricians that midwives were highly skilled and that the obstetricians could rely on them to ring if they were needed. Many providers, however, allocated their midwifery staff to one of three areas with the result that midwives had become de-skilled in basic midwifery competencies. For those maternity units displaying a high degree of trust, midwives had been rotated between antenatal, labour and postnatal wards to equip them with the requisite range of skills.

We have competition between the midwives because the new graduates want to get into the birthing area but the old ones don’t want to give up their area. But we are changing that culture we have a rotation now that takes the postnatal midwives into the birthing suite for two months for example, every twelve months. And they go on shift every month so that they maintain their skills because midwives left on the ward were losing their skills because they didn’t have the access.

A manager of a large public hospital remarked that low-risk women were automatically assigned to midwifery care.

[The obstetricians] trust the [midwifery] staff and expect them to know [when to call]. But it’s probably the core staff that they trust because when they are around they won’t need to be called for low-risk women.

Proximity was also important. In one public hospital, the doctors trusted midwives because they worked with each other in the hospital and in the obstetricians’ rooms. Consultants had come to respect the skills and competence of the long-term senior midwifery staff in the other large public hospital located in a remote area because the junior staff were mostly transient. The creation of trust had in turn expanded the long-term midwives’ professional autonomy. As Miller (1997) argued, ‘Once present, it [trust] acts in a circular fashion making it one of the primary consequences’. The manager elaborated:
It's a small area and we are very dependent on each other. There are four consultants and the registrars and RMOs turn over every 3-6 months. So they respect what the midwife does because the turnover rate is so high. Because they feel confident that the midwife is capable they then allow us to manage our unit to be more efficient and effective for the women.

In another private hospital, trust had been created through good communication practices. For example, although antenatal care was provided by obstetricians in their rooms the maternity unit kept in touch with women from 28 weeks’ gestation via telephone. This was enough to foster ongoing familiarity and trust between the midwife and obstetrician and between the woman and her carers. But not all obstetricians had been initially positive about collaborative care. As one Unit Manager put it:

I wouldn't say that everyone likes each other, but they do respect the knowledge base of those people and they are very happy to work with it. And that's why the doctors and midwives work well together because the senior midwives are very cluey ladies and they [the obstetricians] are very fortunate to have them because they have that knowledge base. Sometimes when they go to use forceps, the senior midwives will say if you do it this way the baby will flip through and they do. Some of them are willing to share, although some will keep their knowledge to themselves. And the obstetricians are also willing to learn.

Nor were all doctors were prepared to spend time to explain things to women or to hear what women had to say. However, the manager detected shifts in attitude over time towards facilitating consumer needs. In the case of another private hospital located in an affluent Sydney hospital, trust was cited as germane to the efficient provision of care:

Our obstetricians are very good. Our midwives say this or that and within reason they do it for us and they have always done it for us unlike the doctors in the rest of the hospital. The doctors like to tell the mothers what they are doing all the time.

One manager attributed trust to sustained proximity over time and systematic consultation:

We've actually got a wonderful working relationship here. I guess we are unique in a way in that a lot of us have been here for quite some time and we have a very good relationship with our consultants who allow us to be fairly independent with our clients. They consult with us and we consult with them. We work on a one-to-one basis where we have most of the care and they only really come in for delivery. So they trust our judgement and our working with the client. The doctor only comes in if there's something wrong with the delivery. I think we are lucky and unique in that way.

Another manager in a large public, tertiary hospital commented on the importance of the age of the obstetrician as well as proximity:

[Trust is underscored by] recognised experience and probably it depends on the age of the doctors which is ridiculous. The older obstetricians tend to trust people they have known for a long time whereas a lot of the young ones will trust people on the look of their expertise whether they have been working here for ten or two years. When you work
together over a period of time the trust develops but also the [older] midwives have taught the residents and registrars so the trust comes from there.

The Participatory Model

Managers cited various omissions in claiming their unit conformed to a description of the Participatory Model.

Midwives Were Not Regarded as Primary Carers

Lack of continuity of care by a known midwife in the antenatal and postnatal periods represented a serious detractor to achieving a collaborative model because the woman was often not made aware of a full range of options and nor was she encouraged to participate in her own care. For collaboration to be effective, according to midwifery managers, midwives needed to be involved throughout the antenatal, labour and intrapartum periods. This also applied to private patients because the doctor typically attended the woman only in the very final stages of delivery.

Units employing high numbers of part-time midwives found it difficult to institute continuity of care models. As one manager said:

We have no continuity of carer models because with part-time staff we cannot adopt that principle but the midwives do try to follow them through. It is more of a team approach. ... Most of the midwives prefer to know exactly when they are going to have days off in advance because they have their own families to care for and this was the thing that came through with team midwifery – it did have an effect on their families.

Continuity of midwifery care was exclusive to the public sector:

The participatory model is the most effective or realistic for a private hospital because we don’t have a midwifery mode. If they come to a private hospital then the midwives don’t get a say in what happens after that.

Sometimes staffing constraints ruled out continuity of midwifery care. A manager of a small private hospital said:

Queensland team midwifery hasn’t been successful and has fallen through ... we have had to give it a back seat. There is a high degree of staff burnout ... you are asking people to be on call for 24 hours at a time. With staffing the way it is at present with so many part-timers ... it wasn’t practical. Most of the midwives prefer to know exactly when they are going to have days off in advance because they have their own families to care for and this was the thing that came through with team midwifery it did have an effect on their family.
Antenatal Care Was Not Delivered by Midwives

Another Midwifery Manager of a very small maternity unit said:

*We can achieve it [collaboration] to a certain extent in the birthing suite and on the postnatal floor and when we work with the mother/baby unit, but obviously it doesn’t happen antenatally because the women are going to their obstetricians in the community.*

According to a manager of a small, private unit:

*My interpretation of midwifery is that you get out there; you’re doing the clinics, seeing the patients, doing the antenatal care and the deliveries. Now we don’t do that. In terms of making decisions, yes. In terms of looking after the patient antenatally, we don’t.*

Lack of Proactive Consumers

Collaboration was compromised if women lacked the confidence or will to negotiate their own care. In a large public hospital in a remote region, the indigenous women were less vocal about demands except pain relief. Needs were better conveyed if the support person was older because younger supporters were not confident to engage with the midwife or doctor. The indigenous women came into the hospital to have their babies and return home as rapidly as possible. As the manager reported:

*[The Aboriginal women] have special needs. To make the relationship equal, a lot more education would be need to make it work. They just want to have their babies and go home. They don’t want to contribute much more. .... You don’t get a fair picture of their needs because sometimes the support people are younger than the mother. ... they are nervous and frightened. We work towards that goal [collaboration] but it is difficult to find out what they real needs are.*

The white Caucasian women who birthed at the hospital, by contrast, were very expressive and confident about their needs and usually provided staff with a full a birthing plan. In this case, the clinical relationship was categorised as Collaborative but only in the case of the white Anglo-European women.

In another large regional hospital, midwives had carried out surveys to ascertain needs but consumer representation had been hard to achieve, even on special projects. One hospital tried hard to encourage women to participate in decision-making with limited success:

*With our antenatal classes we do try to encourage women to speak out and to be more involved in their pregnancy care and discuss things with the doctor rather than take everything as gospel. We try and encourage them to participate but.. it’s really hard. You are going to get a certain number of women who believe the doctor knows everything. We are trying to get people to be more involved in their health care generally, not just maternity.*

Another manager reported:
We certainly encourage the women to think about what's happening and to make decisions for themselves and to speak up for themselves but in the end it's what the doctor says which in their mind they think, 'I have to listen to what he's telling me'.... We do get some clients who will stick to their beliefs but I guess most of them will conform to the medical model.

**The Consultative Model**

Managers described their units as Consultative when core elements of collaboration were absent. This was usually the case in private hospitals. When policies were determined by obstetricians, the major elements of collaboration – midwives as primary carers, midwives providing education about alternative options leading to proactive consumers and high levels of midwifery skills – were absent. One manager of a small private hospital said:

*We have a medical model of childbirth because this is a private hospital [which] means that the policies are set by the obstetricians and that's pretty well set in concrete. Our intervention rates are fairly high. This is because of the clientele – they are middle-class and want the baby out as soon as possible.*

**Midwives Are Not Employed as Primary Carers**

Another manager of a middle-range private hospital (2,000 births per year) equated the medical model with a culture of high intervention, a low degree of professional input by midwives and thus, a lack of professional equality:

*I think there is quite a degree of trust but I don’t think the midwives necessarily have autonomy. It’s partly the medico-legal situation. Fear of litigation makes everyone interventionist.*

A collaborative culture was attributed to an age factor:

*... fortunately lots of the younger girls are coming in and bringing new ideas and trying to bring in the collaborative model. It does cause a fair bit of stress between staff and the doctors. On the other hand, we have a few new obstetricians who don’t care where the babies are born, in the shower or wherever, they don’t care. ..... They are coming in from bigger hospitals with collaborative models.*

Some midwives were unhappy with lack of professional autonomy:

*Midwives get very unhappy with the way things happen but they can't change it. In a private situation it is very difficult. We have had midwives change to other hospitals because they can’t practice as they like.*

The Consultative Model was a medical model and typically involved higher rates of intervention:
Because a lot of the staff have been here for a long time and have a lot of entitlements they are more loath to leave but a lot of them are unhappy with the way things are practised and ... they have to accept it. It [intervention] doesn’t seem to happen as much at night. If women come in at night they seem to be able to labour more normally. The inductions are more during the day when they are induced in the morning and have the baby at night. If they come into labour naturally during the night they come in and it's a more natural situation.... From a midwifery perspective, if they have a run of normal deliveries they have a much better feeling about achievement like they have been through something with those women and the women and the staff are happier. The more normal deliveries there are the happier the midwives are. I don't know why but that's how they feel.

Lack of Proactive Consumers

Collaboration required on-going input by consumers as well as midwives and a willingness by obstetricians to engage with both on an equal footing. The manager of a rural hospital maternity unit pointed out the difficulty in achieving collaboration when clients were generally not well-informed and when doctors felt threatened when people were assertive:

[Collaboration] is always difficult to achieve in a health setting because of an unequal balance of power between the medical profession who has the knowledge and the consumer who has little. ... They[obstetricians] do feel threatened by people who are more assertive. To be fair it's not a model they have been familiar with or have had training in.

A manager of a unit in a public teaching hospital reported that doctors varied in their preparedness to draw women into the decision-making process:

We do like to promote a doctor/midwifery team approach to the management of our women here in the unit. That's all important. But there are a couple of older consultants who just want to get on with things rather than spend time with women and that does cause some dissatisfaction. There has been a change in attitudes and obstetricians are aware of consumer needs.

Lack of Antenatal Education by Midwives

The manager of the small rural public unit pointed out that midwives and consumers were obliged to accept the medical, consultative model because the midwives were unable to provide offer options to women in the antenatal period of pregnancy which rendered them powerless to suggest alternative strategies when the woman presented at the hospital in labour:

Alternative models of care have come from the antenatal clinic and if you don't have that you are up against changing the system because the large part comes down to money. And you have to accept that you haven't been the primary carer during the antenatal care so you have to have a pretty good reason to come in at the end and try to change it. ... there is sometimes among midwives the view that all doctors are bad. That's not true.
All doctors aren’t bad. The ones here are good at a professional level and have a great commitment to their clients but they are at the mercy of their own education system and own prejudices. So they work within the parameters they feel comfortable with.

A manager of a unit within a large regional private provider explained that when women do not see a midwife the obstetricians encourage them to have intervention to avoid pain. However, women were not informed of the ‘cascade of intervention’ consequences of a small, initial intervention:

"...Doctors tend to tell women what they think is best for them rather than asking them what they want. ... We might be following their orders rather than giving women other options. ... whereas may be if they were given more choices ... they may have their [own] idea of how they might like their labour to go... I wonder if they [women] are asking for intervention because the doctor suggests it’s a good idea. More people coming into hospital are requesting elective epidurals than there was in the past and there has been a swing away from natural childbirth [towards] the idea that it is really great to have an epidural because you don’t get any pain. But I wonder if they know that if you have an epidural then the instrumental delivery rate and caesarean section rates are much higher."

Lack of Confidence in the Skills of the ‘Other’: The Absence of Trust

Collaboration also demands a high degree of professional skill on the part of midwives via their formative training at university or in the hospital via mandatory roster changes requiring all midwives to work in all areas of care. Without the requisite skills, trust will be absent and collaboration will be impossible to achieve.

"We might get them [caseload or team midwifery models] over the next couple of years but the person has to be confident and competent in a range of areas that they are not now. That must happen over a number of years. At the moment they don’t have the necessary skills and that’s because the existing education system doesn’t produce independent midwives. They need 6-12 months until they feel confident. Perineal suture, vaginal examinations, turning babies – midwives need those skills. The deficit is in antenatal skills. We might have to send people away to get that extra. But team midwifery is better. You need someone who can carry on right through instead of setting up an antenatal clinic and just adding another caregiver. We are working towards that over time. But there will still be issues around professional indemnity insurance. It should be noted that many universities and providers in Australia are now training midwives in a range of necessary skills]."

Conclusions So Far

The findings indicated that for collaborative models to take full effect, the essential ingredients were: continuity of midwifery are; the provision of antenatal education by midwives; pro-active consumers; and confidence in the skills of the ‘other’ creating a synergy between them and a spiral of trust. The interview material demonstrated that the key to achieving collaboration was not just one of putting the right structures into place but of
changing a paternalistic consciousness and a legally-endorsed adversarial relationship between maternity professionals as well as between carer and consumer embedded within hospital protocols, policies and professional boundaries. These inter-professional tensions and anxieties were further clarified during interviews with obstetric staff.

**Part 3 - The Obstetric Response**

Eight obstetricians from a large regional centre who practised in public and private hospitals were interviewed separately for approximately 1 ½ hours\(^1\). Their responses highlighted similar areas raised by midwifery managers. They also produced new concerns relating to professional boundaries, legal pressures and professional adversarialism. Most obstetricians described their relationship with midwives in the public sector as comprising 'overlapping spheres' rather than a hierarchy (Evans 1994).

*I value their [the midwives'] opinions and I like them to feel that they can easily and freely tell me what they are thinking. We really rely on the midwives as the people with the patient for 24 hours a day while they are in labour particularly, to ring us up and say, hey, they've got a gut feeling that something is going wrong or you know, this patient is not coping...*

**Continuity of Midwifery Care - Midwives as Primary Carers**

Genuine collaboration (interdependence, mutual respect and joint responsibility) could only occur in the public sector where there was continuity of midwifery care:

*The days of the doctor being God or being very authoritarian are well and truly passed. I think the midwives, after all they spend eight hours a day up there and often eight hours with that one patient, so they know a lot better I think particularly in the public side ... a much better idea of what they will be happy with as far as treatment [is concerned]. .... Whereas we walk in and we really have never seen that public patient before, we haven't got a clue what their personality is like so the midwives have got a lot to offer us but it needs to come across as, well the communication needs to be on a sensitive level if you like .... where it is seen as equal rather than the midwife almost reversing the role and telling the doctor what to do. On the private side the obstetricians have a bit better understanding of how that particular patient responds.*

In the private sector, the midwife/obstetrician relationship was construed as hierarchical by virtue of the woman's choice of obstetrician as lead carer:

*I have a good working relationship with them [the midwives in the private sector] and I know that they are frustrated sometimes and they would like to do more. But they accept that the woman has chosen an obstetrician as her model of care and probably their employment contracts would expect them to appreciate that they must not undermine that. They need to collaborate with us and not undermine that relationship.*

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\(^1\) The interviews were carried out at the end of 2003 and the beginning of 2004.
When Continuity of Midwifery Care Turns into Adversarialism

A detractor of midwifery autonomy, however, was an element of adversarialism. As primary carer in the public sector, the midwife occupied a prime position to easily undermine obstetric dominance. Obstetricians reported that small number of midwives in the public sector turned collaboration into an adversarial relationship between the midwife and woman on the one hand, and the obstetrician, on the other.

...the relationship between midwives in the public sector and with me, in particular, is extremely difficult .... There are a small number who tend to practice independent midwifery. When they become the patient's advocate set up, maybe not consciously, an adversarial relationship with the obstetrician which is very difficult because there is not that intimate personal relationship with the woman. Because of the lack of continuity of care [between the woman and the obstetrician] there are many, many opportunities for those midwives with that philosophy to undermine what would be considered safe, gold-standard effective care. They advocate for the patient and take on what they perceive she wants but it may not be in her (the woman's) best interest.

... there are a small number who tend to practice independent midwifery under the Health Authority auspices. When they become the patient's advocate they set up may be not consciously an adversarial relationship with the obstetrician which is very difficult. The difficulty comes because there is not that intimate personal relationship with the woman. .... Because of the lack of continuity of care ..there are many many opportunities for those midwives with that philosophy to undermine what would be considered safe gold standard effective care.

Tensions between doctors and midwives are often expressed through different discourses of birth. Obstetricians complained that some midwives insisted on natural childbirth beyond a reasonable level of endurance and safety for the woman and baby.

I think that is the main problem – some midwives wanting to do things very naturally. I mean that is the message that comes across all the time from the college of midwives. They say well, birth is a natural process; it is not a disease and so on. It works fine, as you were saying, for maybe 90% of the population but the other 10% we feel need assistance.

There is a sort of bell curve and obstetricians will only accept up to a certain point. I don't know where the percentile is exactly but obstetricians will say this is no longer gettable whether it is a cost to the baby or a cost to the mother or both. Whereas some of the midwives, it is a very small minority, unfortunately ruin the relationship and the trust with me where they think that last percentage is gettable but it is at a cost and that is when the conflict arises. There are certainly many women that come through to our private practice for their second baby who had had psychologically a very traumatic experience being told that they are doing beautifully ... and 36 hours later, yeah sure, they got their normal vaginal delivery.

.... in some circumstances it is the midwives personal satisfaction that there was no intervention. [They like to see] a long labour, a normal vaginal delivery. .... she sees that as a wonderful experience. But I see the women coming in her saying that most of the time they were screaming for an epidural and they were traumatised. ....they come to me for that one-on-one because they know that we will discuss things.
... a lot of the teachers of midwifery are possibly zealots in the field, like they see medicine as a paternalistic establishment driven by private school-type professionals. That's an anathema to their ideology and viewpoint on things and therefore they teach the people who come through to have a rather negative view of doctors.

It must be painful when you see things done badly... or insensitively... but some of the midwifery teaching is anti-doctor and some of it comes from this viewpoint that part of a midwife's role is to be a patient advocate. And that means defending the patient from the medical establishment who only seek to do interventionist things and horrible things to this person who is undergoing a wonderful natural process and it is totally within her control and if she does all the right things will have a wonderful outcome. We find this very difficult to deal with... like a midwife whispering in the ear of a patient... sort of immediately puts us off-side.

... that patient advocate thing is not the way the real world works and it is not the way the system works best... because we need them and they need us...

Sometimes you feel as though they [midwives] are being an advocate for independent midwifery rather than for that patient..... Yes, sometimes I think their philosophy gets in the way of what is the best thing for the patient.

Confidence in the Skills of the 'Other' – The Creation of Trust

Obstetricians needed to know that the midwife would act as their surrogate; that they would ring them if there was a problem and that the midwives possessed the skills to make an independent assessment of the woman's condition. As Miller's (1997) and Leppert's (1997) studies also revealed, trust in the skills of the 'other' was crucial to achieving the collaborative synergy. Some obstetricians were more prepared to embrace up-skilling of midwives across various sectors because of the expansion of workloads and contracting number of obstetricians, although some obstetricians thought that midwives should remain specialised in one area:

... we get to know who you can trust. ... the really good midwives will say, it's Joan here and Mrs X has just come in, she is in early labour, her past history is this, this is what she has come in with, everything is OK, the foetal heart is OK, she just tells you everything you need to know. You don't even have to ask a question and likewise you know that the really good ones will let you know when you are needed. Their anxiety about a situation will be clearly communicated. There is a person who doesn't trust their own skills and who will call you at the drop of a hat because they basically don't know properly how to analyse the CTG. And then there are some who are just fabulous and they say, I have looked at the trace, I don't like it, this is what's wrong with it, can you come in. You know them personally...this is a person who knows what they are talking about and [I know] I had better get in there pretty quick.

We give our midwives a lot of responsibility and that's probably partly because of the trust and it is also because of the pure workload and so we encourage them to see high-risk patients, for example.
... we [midwives and obstetricians] both offer a vital part of care of pregnant women and birth and something that is often lost is the respect that each group has for one another ... and for the job they do.

A Willingness to Intervene: The Medical Versus Midwifery Model

Obstetricians believed that their medical training and role as primary carers endowed them with a unique view of the short-term and long-term adverse effects of childbirth for which they were ultimately and primarily responsible. This meant they were prepared to intervene much more than midwives to expedite a good result. They saw midwives as reluctant to.step across the boundary of ‘natural birth’ to use instruments and technologies, even in emergencies. In order to professionalise, midwifery became defined in contrast to obstetrics as the guardianship of ‘natural’ birth. These professional differences are then played out in training, professional practice and informal cultural and interactional styles with staff, patients and superiors (Walby et al, 1994).

... we have a unique perspective of the long term effects of childbirth and whilst I would also agree that the midwives have their own unique way of seeing things ... that long-term looking after women gives us a unique perspective to see the whole thing.

... we ran an emergency course for our residents, new registrars and some of the more senior midwives. The midwives were very reluctant to even pick up the forceps to do a forceps delivery because they saw that as something that doctors always did. That was interesting to see.... They were very reluctant to sort of get involved in doing the hands-on practical deliveries whereas doing a normal delivery they feel much more competent at it than the resident may be.

There has to be teamwork effort because the doctors don’t want to be there twenty four hours a day and the midwives don’t want to be doing all the difficult stuff if you like the forceps and the vacuum extractions and the Casesarean sections.

Legal Pressures

Related to a greater willingness to intervene than midwives (see above), obstetricians saw midwives as quarantined from the harsh realities of a punitive legal environment which forced them (obstetricians) to practice defensively. Pressures came from the imminent threat of litigation that would touch all of them directly or indirectly during their professional lives. They were the first and last call for emergencies which put the onus of judgement in their court. They were urged by their medical defence organisations to avoid risks to reduce premiums by taking complete charge of decision-making. It also implied that birth needed to be medicalised (to intervene ‘before things go wrong’). Collaborative care, in the sense, of a genuine partnership was impossible because obstetricians shouldered the burden of responsibility for outcomes. This element comprises the most contentious rift between midwives and obstetricians: one profession is perceived to be legally culpable for the actions of themselves and the ‘other’, especially when women now demanded the perfect baby.
Obstetricians thus tolerated much lower levels of risk and adverse outcomes. This difference lies at the heart of different professional identities:

_I understand entirely where the midwives are coming from when they believe we intervene too much [because their] experience is that most women will eventually deliver vaginally if you leave them alone ... that's the truth of nature. I suppose we have a charge of the responsibility of doing more and more and so... through litigation we are more and more charged with not only having [a good] birth, but a vaginal birth, a baby who is in a very good condition, and a mother who has not got perineal damage through prolonged second stage and bladder and bowel problems in the longer term. Both professions get it wrong because we try in a clumsy way to achieve all those aims and something doesn't come through in the translation._

_I would like to see myself as certainly collaborating both with the patient and with the midwives in terms of decision-making ... but I think the difficulty is that what makes us medicalise things a lot more is the legal aspects of it. It just forces you to think defensively." Midwives are not nearly under the same hammer as we are legally despite what their perceptions are ... partly because they are not in private practice; they are practising under the envelope of this hospital that surrounds them. We are still the end of the line because they will call us up to get them out of trouble._

_Our MDA is saying, from a medico legal perspective, that for our members to act in order to reduce their risk and therefore hopefully to reduce claims and premiums, that the obstetrician must be in charge of the outcome. So you have yet another layer complicating the relationship between the client, the obstetrician and the midwife._

_... the difficulty is that somebody needs to be ultimately responsible and that's where the relationship is inherently going to be a bit uneven in that if we do get involved it is us who carry the can. It doesn't mean we don't ask them what they think; it doesn't mean we stop respecting them._

**Differences between Obstetricians and Midwives about How to Define Collaboration**

_In the pristine definition, collaboration entails interdependence, mutual respect and mutual responsibility for outcomes. For midwives, collaboration follows this definition. Interdependence and mutual respect was also endorsed by obstetricians, but they stopped short of mutual responsibility. Obstetricians defined collaboration as open discussion about how to proceed but where the ultimate decision must made by them. Obviously, they embraced the threat of litigation as their singular burden putting them in the invidious role of final arbiter. At that point, collaboration ceases:__

_... the midwives will often say what do you think about this or that and there is a discussion. I am saying that at the end of the day, at the end of the discussion, the decision really does have to be mine, in consultation with the midwife and the couple. My management has to carry the day otherwise I am not comfortable with what is going on and I don't control the outcome. That is where the problem starts._

_... women have come to me saying the midwife has said stay in the shower for hours because the doctor can't come in and do a vaginal examination. I am not saying we have_
to intervene. Lots and lots of women I look after in private practice have no intervention whatsoever but they are given choices, they are given information. It is about information really, giving the woman the information [but] if she is in the shower for ten hours then she hasn’t got any information so how can she make any appropriate decisions? She is denied that information because there is this perception that nature knows best.

Obstetricians noted differences within the profession that they termed ‘old’ and ‘new’ cultures. The description of ‘old’ cultures resonated with Degeling et al’s (1998) findings that nurses and practitioners in Australia displayed different values and styles of management towards hierarchy, accountability, clinical autonomy and the need to avoid risk.

There are differences [within the system]. Some obstetricians are wedded to the notion of the doctor running things and people doing his bidding. Other people are much more comfortable in the group approach to the patients and being only a part of that group. Most of us fall into the latter category. The obstetricians who are adopting the role of directing, giving orders and expecting them to be carried out are less amenable to feedback and they are the ones who are running into the most trouble. The problem is to do with old-fashioned and new-fashioned cultures.

Proactive Consumers

A proactive consumer culture was sometimes experienced as a culture of unrealistic demands:

... we have come through to a society now that expects the perfect labour, the perfect pregnancy, the perfect labour and the perfect outcome and if it is less than perfect then questions are asked. So there is this lack of appreciation. [It is] fantastic if it goes very well and naturally, but that can’t be for all women. And if we are going down that path we have to accept that cost of two generations ago.

Conclusions

Part I of the qualitative study of consumer participation indicated that consumer participation in Australia remains at the ‘low levels’ (of information dissemination) articulated by Johnson and Silburn (2000). To be fully effective, consumer participation needs to be addressed at the macro legal, administrative and educational levels. At the clinical level, midwifery managers believed that collaborative care was the best model of care for women but only a small minority of maternity units had actually instituted collaborative models. The qualitative part of the study reported in Part 2 demonstrated that, according to unit managers, collaboration required a combination of institutional, inter-disciplinary and interactive factors – continuity of midwifery care models; antenatal education delivered by midwives; pro-active consumers; and confidence in the skills of the ‘other’. All factors intertwined to create a synergy of trusting relationships. These preconditions endorsed Miller’s (1997) and Leppert’s (1997) findings that successful collaboration was premised on a strong financial and patient base; that individual participants needed to be competent and confident in their skills; there
needed to be ground rules to encourage open communication, consensus decision-making, role clarity, trust and commitment to superior patient care. For midwifery managers, collaboration was often undermined by either the absence of policies ensuring continuity of midwifery care (and thus enabling women to be educated in a range of choices around childbirth); by the lack of will by women to enter into a partnership relation with carers; and by the lack of power-sharing on the part of obstetricians leading to a lack of trust and respect for midwives by obstetricians. However in the minority of cases reported where collaboration had been achieved (where the foregoing criteria had been achieved in full) midwifery managers reported optimal conditions for staff and women. It appears that collaboration occurs not just because of the inclusion of some factors and not others, but is the outcome of the inter-actional effects of core elements. Collaboration is a synergy.

In Part 3 of the study, it was reported that obstetricians unanimously embraced the concept of collaboration and stressed the importance of good relations with midwives. They appreciated the wholistic approach of midwifery especially in caring for public sector patients whom they met typically for the first time in labour (‘...we need them [midwives] and they need us...’). At the same time, they resented the (small number of) midwives who used their proximity to women in the public sector to launch their own campaign against obstetric intervention in the interests of midwifery independence rather than patient care. Often this kind of advocacy really pertain to sectional professional goals rather than the welfare of the woman. Much of the animosity between obstetricians and midwives appeared to rest on differences regarding what was reasonable and safe. Like midwives, most obstetricians regarded most births (around 90%) as ‘normal’ and low-risk. However, they stressed that their practice was specifically concerned with the 10% of births that were not trouble-free and in these cases their skills and training were undisputedly paramount. Their singular legal responsibility for outcomes (as they saw it) was underpinned by the mammoth professional indemnity fees imposed in recent years in response to exorbitant court rulings, the daily fear of actually being sued or watching their colleagues sued for malpractice or negligence (even if all of these cases did not go to court) and by professional training and practice. They described their practice as ‘defensive’ and attributed medicalization (meaning intervention) to onerous legal burdens to prove they had not been negligent. They did not believe that birth was necessarily a ‘natural and wonderful thing if women were left alone to get on with it’ because this often caused women unnecessarily long and painful births. They chastised midwives who on principle refused to refer women to obstetric care because the midwives defined a good birth as intervention-free. They believed that collaboration was built on trust and trust was premised on high-level skills and independent judgement. However, competence and independence should not extend to adversarialism whereby some midwives stigmatised the obstetrician under the guise of being an advocate for the woman.

In summary, collaboration is defined by mutual trust, mutual respect, and mutual accountability for outcomes (this includes the patient). In Australia, under present legal conditions (where adverse outcomes are judged by the courts against negligence claims), collaboration for midwives, obstetricians and patients remains an ideal, but for different reasons. For midwives, mutual accountability is a legal given but few have wished to achieve, or have been permitted to achieve, the necessary skills or continuity of care practices that would characterise autonomous professionalism or independent judgement. This must be a challenge for policymakers in the future. Many thought obstetricians intervened routinely particularly those in private practice often by ‘setting women up’ to request intervention.
Midwifery as a practice as well as a profession was defined in relation to 'natural' birth and thus against 'un-natural' intervention by obstetricians. They believed the panacea was continuity of midwifery care throughout the whole maternity episode so that consumer participation could be fostered from the beginning.

For obstetricians, mutual respect and mutual trust were effortlessly bestowed upon midwives for their wholistic skills in knowing the woman, especially in the public sector where the midwife is as much the primary carer as the obstetricians. However, for some obstetricians collaboration could only remain an ideal because of their perception that legal accountability for outcomes rested solely on their shoulders. There is some resonance to this perception because even though midwives remain equally legally accountable for any outcomes, their professional indemnity costs (fees and any court expenses) are met by the hospital. For these obstetricians, collaboration was a signifier for obstetric-led care with strong support by midwives in the obstetrician's absence and always according to his tutelage. This is where most hostility is likely to occur and where genuine collaborative effort is needed to achieve satisfactory outcomes at all levels – safety, security and satisfaction. Ultimately, it will hinge on the ability of midwives and obstetricians to suspend inter-professional rivalry and overcome the rigidity of professional boundaries reported in much of the literature. To this end, obstetricians would like midwives to garner the skills necessary to act as autonomous professionals and to relinquish the high moral ground of 'guardians of the normal' (Kent 2000). Midwives would like obstetricians to re-imagine the nature of true partnership in both the public and private sectors. Independence of mind and judgement are not easily switched on and off. It is reasonable to expect respect but this must be extended to respect for professional differences. Ultimately, final decisions must be arbitrated by the consumer which moves all professionals out of the litigation trap.

Unfortunately, the problem is not resolved at that point because the woman in pregnancy and childbirth is not the rational, self-interested individual of neo-liberal theory. Women are at their most vulnerable in childbirth especially within labour and are thus susceptible to power imbalances conveyed through various discourses that may conceal the interests of the bearer (Foucault 1980). Thus, the critique of the 'new public health' movement - that it mouthed the platitudes of democracy and social rights but actually drew consumers into the wider net of surveillance to promote professional self-interests and market efficiencies - is aptly put. The solution is not to withdraw from the social rights agenda of the collaborative project or to fall into the structural functionalist trap of insisting on harmony and stability. It is to enter into collaboration with the understanding that social differences emanate from the unique social location of all subjects. It is important that these differences are not stymied by professional hierarchies. They need to be recognised, nurtured and negotiated in the interests of the consumer.

References


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