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BEYOND THE SILO EFFECT; THE CHALLENGES OF COLLABORATION

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‘New’ and ‘Old’ Professionalism

Women entering the maternity arena in Australia and other Western regimes have suffered incidentally from what is known as the 'silo effect'. This refers to a clash between the training regimes of the 'old' professionalism and the 'new' professionalism. Under the 'old' professionalism, hierarchies were erected between medicine and the so-called semi-professions such as nursing and social work (Tully and Mortlock 2004) resulting in what Degeling et al (1998; 2000) have documented as oppositional modes of decision-making, styles of working, roles and accountabilities. Within the last decade, a ‘new professionalism’ has emerged in many Western regimes, including Canada, NZ, the UK and The Netherlands. (Romanow Report 2002; Street, Gannon and Holt 1991; Victorian Department of Human Services, Australia 2004) depicted by a flatter more egalitarian structure of multidisciplinarity. An example in Australia is the Future Directions in Maternity Care document released in mid 2004 by the Bracks Victorian Labor government. In Australia, the move towards the ‘new professionalism’ can be attributed to a confluence of macro economic factors including the swing away from hospital-based training and towards university-based training for nurses and midwives, the ripple effects of three decades of feminism, the professionalisation of midwifery, the attrition of midwives from the workforce, the rise of health consumerism from the late 1980s and the crippling costs of professional indemnity health insurance for obstetricians leading to a crisis in recruitment.

In Australia, the emergence of new models of midwifery-led care sometimes sit uncomfortably alongside traditional models of service delivery as in the case study reported upon in this paper. The result is a patchwork quilt of different models spawning disparate discourses (including sub-discourses) and disparate identities as midwives and obstetricians negotiate the clash between the old and new professionalism. It should not be surprising therefore to find lingering resentments and frustrations on both sides as well as a genuine welcoming of new skills and working arrangements.

Collaborative care

This paper explores some of the responses of midwives and doctors who work together in a medium-sized public maternity unit in Australia to the possibility of collaborative models of care. This hospital has a range of models of care including team midwifery, a birthing unit (midwifery-only care), birthing suite (conventional obstetric-led care) and other specialty facilities. Caseload is not yet in situ and the prospect of this model in the future is only marginally supported by midwives. Collaboration implies a flat, egalitarian structure as opposed to the vertical authority structure common to conventional midwife/obstetric relations. According to (Evans 1994) collaboration comprises mutual trust; interdependence and mutual accountability. The problem is, however, that especially in times of transition, the
very values that underline and make possible the transition to new relationships are themselves in the process of creation and consolidation. In interviews with twenty-eight midwives and eight obstetricians, I was able to document the fluid identities and social locations of these professionals as they traversed the difficult transitional terrain from the ‘old’ to the ‘new’ professionalism.

**Are obstetricians and midwives prepared to work collaboratively?**

According to one midwife only three out of nine obstetricians were prepared to work collaboratively, that is, in terms of entering into a genuine partnership with midwives and women, seeking their views and advice, discussing potential courses of action and sharing the responsibility among them for all outcomes.

These comments raise several issues. First, what undermines collaboration? That is, what are the respective pressures facing midwives and obstetricians that tax a potentially collaborative approach to maternity care? Second, how can we explain divergences between the professional identities of midwives and obstetricians? Finally, are there any solutions to these professional schisms?

**What undermines collaboration?**

Midwives and doctors expressed a range of factors that undermined collaboration. These included a lack of respect on the part of doctors for the skills of the midwife; a lack of confidence by midwives in their own skills; the charge by obstetricians that midwives were either not skilled enough or lacked skills in their own competence; that midwifery advocacy undermined the credibility of the obstetrician and created an adversarial relationship between the patient and midwife, on the one hand, and the obstetrician, on the other; that doctors over-inflated the degree of advocacy exercised by midwives; that both professional groups distrusted the ‘other’; that doctors pathologised normal birth and that midwives normalised abnormal births; that midwives were inconsistent in their practice (some midwives were prepared to act as autonomous professionals and share some responsibility with obstetricians but others were not prepared for that role and wanted to remain very much in the role of support person); that (according to doctors) only around half of the midwives were prepared to take on full responsibility for decision-making and outcomes; that doctors commonly perceived their patients as legal adversaries in which case their practice necessarily turned into defensive medicine; and that the assignment of full responsibility and accountability for adverse outcomes to the doctor retarded the realisation of collaboration and turned complementarity into a decision-making hierarchy when doctors became involved.

**Competing discourses of knowledge, childbirth and the body**

We can think of different birth philosophies emanating from different discourses about the knowledge, the body and birth. For example the medical model issues from an objectivist or positivist model (where knowledge is posited as a truth). Adapting this model to birth results in an approach whereby labour and birth will be plotted against a ‘normal’ or generalised time frame applied to all women for first, second and third stages. Tests will be carried out every four hours, including heart rate and pulse and vaginal examinations to assess the rate of dilatation. Any departure from
the ‘norm’ will be treated as a risk and intervention will follow. This is sometimes called the Dublin method of childbirth management. Knowledge is held exclusively by the professional expert and administered to a naïve patient via other lesser professionals. It must be stressed that I am not applying this model exclusively to doctors. Many midwives also perceive birth in this way.

A productivist approach to knowledge and the body, by contrast, assumes that knowledge is created through our interactions with each other. This is why many midwives insist that they job is to ask the woman what she wants; the woman is moved into the category of ‘expert’ with the health professionals. Under this model, the skills primarily demanded of the carer include close observation, listening, empathy and respect for the knowledge of the woman about herself and her baby and the knowledge of how to proceed will be formed out of the dialogue between the carer and the woman. It cannot be known in advance or presupposed by a medical theory that defines all bodies. The performance of women’s bodies will be sensitive to contextual changes, for example, in staff movements, physical location, negative or positive comments, technology, support persons, and power relations in the birthplace. Non-conformity with specified timeframes does not always indicate pathology, but may simply be a result of idiosyncratic difference.

The models may be contrasted quite simply by saying that the productivist model recognises the social context, including the woman’s perceptions thereof, which impinge upon bodily performance. It is an embodied theory of knowledge and power: the material body and its cultural representations are inextricably bound up together (Rothfield 1995; Diprose 1994; Grosz 1994). The medical, objectivist model is the opposite; it sees causation emanating from within the body and exclusive of contextual factors. The evidence above indicates that the models are rather wooden. In practice, both midwives and doctors range across both discourses extracting bits from both and other discourses and stitching the bits together to create their own narrative and worldview. However, we can see evidence of both models in the narratives offered by the participants in the study. To illustrate, the ‘pure’ objectivist model is illustrated in the following comment by an obstetrician:

*It doesn’t matter what the midwife or anyone else does to make the woman feel better, if she is going to have a caesarean section she will have one.*

In other words, the social context would make absolutely no difference to the physiological performance of the body. Yet in the following narrative the carer’s skill (in this case a midwife but could have been an obstetrician) is supreme in maintaining the normalcy of birth. In the second narrative, the midwife worked on changing the woman’s perception of her body and the social context (the relationship between herself and her carer) to expedite a trouble-free and emotionally enhanced outcome:

*A woman came in last week and said she’s had a prostin gel with her first baby. She ended up with a precipitous labour and delivered in under five hours. She had severe nightmares after the birth for months and months, and years, afterwards and said she never wanted to go through that again. She was booked in for her epidural for the second birth. She weight 155 kilos and had terrible back problems. For the last two months of her pregnancy she had used a frame to physically carry herself. I was on a late shift when she was in early labour. The anaesthetist was coming to induce her
but not before 4 cms. My job was not to talk her out of anything. My job was to facilitate what was important to her. Before the labour got really intense I said, ‘You’ll let me know when you want the epidural, won’t you?’ She said she would. I found that out she didn’t know anything about epidurals so I [gave her some information]. I kept saying to her ‘you’re working well here’. I could see that she was a ‘glass-half-empty’ person so I said I wanted to turn it around so that we could be ‘glass-half-full’ people today. And that’s how we worked. That afternoon she gave birth to a baby which was 4.4 kilos. At no time did I say you can’t have an epidural. And at no time did she say, ‘I want that epidural now’.

Of course in the advent of a serious pathology in around 10% or less of cases the skills of the surgeon would be crucial to the life of the mother and her baby. Yet there is a persistent perception that the quintessential skills of listening, supporting, watching for cues and clues and nurturing the mother through the pregnancy and the birth occupy a lower rung on the skills hierarchy. It seems that when women are assigned to a lower-level risk category, their carers’ skills are similarly assigned. Yet this view of the subordinate status of productivist skills can only be sustained if we regard the body as uninfluenced by the social context, that is, if we hold an objectivist view of the body. The second scenario shows us that the skills of the carer result in considerable savings associated with the high costs of technology, surgery, pharmaceutical use, bed days, and specialist fees. Further, avoidance of technological aids by facilitating an intervention-free birth fosters mother/baby bonding and family relations long into the post-birth phase. Further, these skills are relevant to 90% and more of cases. It is difficult to assign a hierarchy of skills in these cases, yet many midwives and doctors commonly asserted the superiority of rational scientific skills associated with medicine which is reflected in hospital protocols, lines of authority and styles of decision-making, as Degeling et al (1998; 2000) have also observed.

The solution is to achieve a respectful recognition of the complementary skills of the ‘other’. One obstetrician expressed an ideal relationship:

I think our technical knowledge is certainly superior to anybody else... I think midwives would be much more aware of other aspects of the patients’ lives, social situations, how they are coping with what’s happening around them, you know, they are actually much more with the patients and so there is a difference in the obstetrician’s role. .... I would say the obstetricians who are adopting the role of you know, directing, giving orders, expecting them carried out, are being less amenable, less open to feedback and to criticism. They are the ones who are running into the most trouble.

The Win-Win Solution

The objective is to create a new body of knowledge that embraces the non-codified, wholistic, and ‘emotion work’ of the carer (a knowledge that is founded on intersubjective sensitivity and a respect for the dynamic interaction between mind and body) and rational, scientific knowledge brought to technological intervention in ways that are appropriate and necessary. This is easier said than done because, as the foregoing evidence shows and as Foucault (1973) argues, medical dominance is
institutionalised in recruitment, training and clinical practice in hospitals. So how may competing models of knowledge and childbirth be reconciled in a strategic effort to achieve collaborative care?

Successful mediation works on the principle that everyone should win. But that also means everyone has to give something up. According to the evidence, midwives need to vacate the high moral ground as 'guardians of the normal' and to recognise the limits of their respective sphere of practice, that is, when physiological changes indicate a shift from the normal to the abnormal. They also need to upgrade their skills and be prepared to be fully accountable for outcomes. Caseload would facilitate that objective because midwives will need to take full responsibility for women under their care.

For their part, obstetricians need to jettison the burden of sole arbiter and architect of birth outcomes. This will no doubt be difficult in an adversarial legal climate that seeks to apportion blame even for events that may occur outside of the control of anyone e.g. cerebral palsy, and a system that requires practitioners to remain culpable retrospectively for 18 years. Technically, of course, midwives are already responsible for their actions but they do hand over the high-risk cases. Nevertheless, doctors need to relinquish the moral high ground of heroic medicine and systematically construct an ongoing dialogue with midwives and mothers in deciding the modus operandi for every birth. Mothers need to be made aware that they are part of the decision-making circle. Doctors, more than any other party, will benefit from genuine collaboration because it will remove the burden of taking sole responsibility for all outcomes but they need to be supported by a management structure that encourages the wider dissipation of responsibility among all actors.

The Dialogic Relationship: the invocation of Generativity

In creating collaboration models, all parties will benefit from the institutionalisation of a dialogic relationship between obstetricians, midwives and women. A dialogic relationship is one that assumes an open discussion among equals. This would mediate the inevitable tensions that arise between professionals trained in different philosophies that give rise to different perspectives on birth and the body. The attainment of an ontological equality within the dialogue cannot be achieved by requiring one party to capitulate to the worldview of the other. Rather, it may occur only with a respectful acknowledgement of the skills and worldview of the 'other'. This is not meant to cement in a new dualism but to achieve a genuine interdisciplinarity where the appropriate treatment is offered at the appropriate moment. This collaborative model of care would creatively enmesh technical skills and pastoral skills whether they came from obstetrics, midwifery or both. This new partnership may fruitfully be based on the concept and practice of 'Generativity' (Ericson 1963) – the idea that health professionals could transcend narrow professional interests and traditional rivalries in the pursuit of the health and well-being of future generations.

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