DISCUSSION

When is collaboration not collaboration? When it’s militarized

Karen Lane*

Deakin University, Faculty of Arts and Education, School History, Heritage and Society, Pidgons Road, Waurn Ponds, Geelong, Victoria 3217, Australia

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Summary In adopting the medical lobby’s preferred definition of collaboration where midwives are legally compelled to seek endorsement for their care plan from an obstetrician, Determination 2010 connotes a form of militarized collaboration and thus negates all that genuine collaboration stands for—equality, mutual trust and reciprocal respect. Using Critical Discourse Analysis, the first half of this paper analyses the submissions from medical, midwifery and consumer peak organisations to the Maternity Services Review and Senate reviews held between 2008 and 2010 showing that Determination 2010 privileges the medical lobby worldview in adopting a vertical definition of collaboration. The second half of the paper responds to the principal assumption of Determination 2010—that midwives do not voluntarily collaborate. It argues by reference to a qualitative inquiry conducted into select caseload maternity units in South Australia, Victoria and New South Wales during 2009–2010 that this presupposition is erroneous. The evidence shows that genuine collaboration is possible without legislative force but it requires a coalition of the willing among senior midwives and obstetricians to institute regular interdisciplinary meetings and clinical reviews and to model respectful behaviour to new entrants.

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Introduction

New reforms in maternity care legislation (the Health Insurance Act 1973 and associated regulations (HIA)) mean that midwives and nurse practitioners (NPs) may be eligible to provide some services that are funded through the Medicare Benefits Schedule (MBS) and prescribe certain medications subsidised under the Pharmaceutical Benefits Scheme (PBS) if they (a) hold appropriate accreditation endorsed by the Nursing and Midwifery Board of Australia (NMBA) and (2) have a collaborative arrangement in place with a medical practitioner(s). If a midwife works in a hospital she will be able to access the Professional Indemnity Insurance provided by the hospital. Although an ostensibly liberal move in expanding market share to allow midwives and nurse practitioners (NPs) to practice in collaboration with doctors, the sting for midwives and NPs is that the National Health (collaborative arrangements for midwives) Determination 2010 embeds several erroneous presuppositions. First, as a...
unilateral requirement directed at midwives only (doctors are under no obligation to collaborate), Determination 2010 ignores the current flotilla of monitoring vehicles that govern professional relationships, including collaboration. Second, the legislation presupposes a medical fraternity that routinely acts collaboratively.

Studies show that collaboration requires certain minimal conditions to flourish, including a strong financial and patient base; competent and confident participants; ground rules that encourage open communication, consensus decision-making and role clarity; and trust and commitment to other professionals and to better patient care. Genuine collaboration fails to flourish under vertical structures. This paper first analyses the submissions from medical, midwifery and consumer peak organisations to the Maternity Services Review and Senate reviews held whose outcomes are crystallized within Determination 2010. The paper identifies a number of contesting discourses around collaboration. The second half of the paper responds to the principal notion informing Determination 2010—that midwives do not and will not collaborate unless a required to do so via legislative decree. Reporting on evidence from a qualitative inquiry into select caseload maternity units in South Australia, Victoria and New South Wales during 2009–2010, the paper further argues that collaboration formed the modus operandi of all caseload units under review at least on the part of midwives although it was common for Visiting Medical Officers to resist collaboration with midwives. Yet ironically Determination 2010 requires midwives to demonstrate their collaborative propensities and, by enshrining a vertical definition of collaboration, negates all that collaboration stands for—equality, mutual trust and reciprocal respect. Its punitive and surveillance overtones are likely to crush an emergent collaborative culture and inflame historical enmities within and between midwifery and obstetric communities. Determination 2010 connotes militarized collaboration.

Background

Midwives have reacted strongly to the government’s proposed amendments to existing health legislation¹ that from November 1, 2010 will require them to enter into a formal collaborative arrangement with an obstetrician or institution. The cautious optimism expressed at the national conference in Adelaide in 2009 towards the Recommendations of the Maternity Services Review² has, in the latter half of 2010, given way to despair, frustration and internal strife. The Report³ had been encouraging in its recommendations for an expanded role for midwives including changes to funding arrangements and support for professional indemnity insurance; “new national cross-professional guidelines” to support ‘collaborative multidisciplinary care’ and ‘advanced midwifery professional requirements’; improved access for rural and Indigenous mothers; and improved and more accessible information for mothers. Although welcome, they were somewhat unsurprising given the in-principle recommendations of the Productivity Commission Inquiry into the Health Workforce⁴ that highlighted the built-in limitations of a professions-based approach to accreditation, education and registration with its follow-on impediments to workforce innovations, cost effectiveness, expanded professional roles and alleviation of workforce shortages in rural areas.

The Productivity Commission recommended a shake-up of the health industry in promoting “cross current professional boundaries” by delegating “less complex tasks to less highly qualified, but more cost-effective, health professionals” (i.e. midwives) with flow-on effects for education, training, accreditation, registration, funding and insurance arrangements. In prioritising consumer preferences and attention to services for Indigenous Australians, the Maternity Services Review merely reiterated the Productivity Commission’s principles but applied them specifically to maternity care. Even at that early stage, the Review Committee anticipated a rocky road ahead declaring at the outset that despite a lack of unanimity within and between some... medical and midwifery professionals on how to deal with risk and consumer preferences... it would be remiss to always use it as an excuse not to change practices based on evidence that supports changes to practice.⁵ Such evidence included two previous discussion papers; one from the Australian Health Ministers Advisory Council⁶ and another from the Department of Health and Ageing,⁷ both of which endorsed a multidisciplinary and collaborative approach to maternity care taking into account the excellent outcomes for midwifery-led models. In that sense, the Maternity Services Review recommendations merely rubber-stamped the idea that a collaborative team approach would best ensure continuity of care, greater choice of models of care and a greater role for midwives supported by interdisciplinairy national guidelines. Yet eighteen months later the recommendations issued by all of the inquiries have failed to materialise. Instead, we have exactly the kinds of arrangements the two major Reviews (Productivity Commission and MSR)¹,² specifically eschewed: a militarized form of collaboration where midwives are now more firmly relegated to subsidiary status than ever before via legislative decree. For AMA President Andrew Pesce, Determination 2010 represented his finest hour; as he said, the greatest achievement in his term of office.⁸ Such strongarm tactics were understood by midwives as more about defending obstetric territory than questioning midwifery competence, yet the remarks were still critiqued as an inappropriate attack on a co-professional under reflexive modernity.

Reflexive modernity

By reflexive modernity I mean a situation that emerged from the 1950s onwards whereby the capitalist market and welfare state “freed” people from traditional ties and compulsory relationships (such as monogamous marriage or heterosexuality) because with the security of government transfer payments in times of trial individuals could sustain themselves economically and socially outside of traditional relationships. As it became increasingly evident in the 20th century that science and technology actually created the

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¹ The Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and the related bills—the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009; and the Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009.
problems of modernity (climate change, industrial waste, toxic accidents) rather than solved them, science and the professions were revealed for what they had always been - an arena of constant struggle, competition and contestation rather than a repository of an accumulative, coherent body of knowledge employed in the pursuit of enlightenment and abolition of need and scarcity. The term, ‘second modernity, refers to societies characterised by a pluralization of lifestyles, identities, do-it-yourself biographies and futures; Beck and Beck-Gernsheim that ‘free’ the individual from traditional social ties and roles, but where everyone is thrust into a ‘risk society’; one where risk is ubiquitous but where authority is invested in everyone and no-one. In the social vacuum left by certainty and traditional authority structures, the individual becomes reflexive; constantly examining the past to crystallise lessons for the future and in constructing and re-constructing the self in order to survive. The point is that once the reflexive individual becomes the social norm, policies that force compliance, such as Determination 2010, appear anachronistic and intolerable especially when applied to health care workers, like midwives, whose identity and sphere of practice are grounded in professional autonomy.

Collaboration—what does it mean?

Collaboration has not only become a key resource in the marketplace but it also facilitates the normalisation of childbirth for pregnant women who cross the low to high risk boundaries. It means working in a ‘true partnership’ with others to accomplish a task that no individual can achieve alone. Assertiveness (as opposed to aggression) and trust are key elements. Once present, trust acts in a circular fashion becoming one of the primary consequences but it flounders under vertical structures. Pertaining to the current maternity care system, achieving collaboration would entail a shift from the present hierarchical, competitive model to an egalitarian structure of shared power, mutual respect and a commitment to working cooperatively. Midwives more than obstetricians aspire to the collaborative ideal. According to the American College of Obstetrician/Gynaecologists (ACOG), the doctor is ‘the ultimate authority because of their education and training’ although the contributions of other members, such as midwives, are valued and important to patient outcomes. For the American College of Nurse-Midwives (ACNM), who regard themselves as professional equals, however, collaboration means ‘a process whereby health care professionals jointly manage care’ and share authority. Similar divisions are evident between Australian obstetric and midwifery professional bodies. The problem is that professional training, accreditation and hospital protocols institutionalise hierarchical professional identities and relationships expressed in mannerisms, attitudes, social rituals, skills, knowledge, hospital protocols, clinical decision-making and structures. The upshot is the existence of a range of tensions and anxieties within and between professional sub-groups as a result of entrenched hierarchies and philosophical differences.

Such tensions were abundantly evident in studies of four maternity units in Victoria (across tertiary, metropolitan, regional and rural levels) from 2005 to 2007 confirming the findings in the literature that collaborative care arrangements were difficult to institute. Obstetricians were generally loathe to relinquish control over decision-making; they exercised veto-power over midwifery decision-making; and resented models that demanded collaboration but that left them to shoulder legal accountability. They held little respect for midwives who refused to upgrade their skills. Midwives, on the other hand, resented the lack of respect on the part of doctors for their skills and knowledge; their systematic social exclusion from morning handovers (and the opportunity to discuss clinical matters); the poor communication skills on the part of doctors and registrars; professional arrogance; doctors’ insensitive use of medicalized language; the escalation of fear tactics to achieve patient and midwifery compliance and knee-jerk interventionist tendencies. In summary, except for the dedicated caseload models, reported below, maternity care has been characterised not by collaborative relationships but by unequal relationships and ongoing professional tensions.

Critical Discourse Analysis (CDA) was used to analyse transcripts of evidence given before governmental reviews of maternity care arrangements over the period 2008–2010 and from interviews with thirty maternity professionals (senior obstetricians and senior midwifery managers) from fifteen select caseload units in South Australia, Victoria and New South Wales. N-Vivo7 was used to create categories to compare evidence across sites and professional groups. Ethics clearance was obtained by all host institutions. Interviews typically took 60 min but often longer at the discretion of the participant.

Part I—discourses from government reviews

The idea that collaborative arrangements should govern midwifery and obstetric relationships could have been seen as setting a premium standard of practice to which both professions might aspire for the future. However, obviously at the behest of the medical lobby, Determination 2010 was set up to demand unilateral compliance on the part of midwives only. Thus, although offering putative equality to midwives via their authority to prescribe medicines, receive Medicare provider status and Professional Indemnity Insurance, the government ultimately accepted the vertical definition of collaboration adopted by the medical lobby denying other versions of collaborative practice put forward by midwifery, nursing and consumer bodies. The assumption that only midwives need legislative decree to ensure collaboration seems fallacious since it ignores the panoply of existing protocols, consultation and referral guidelines as well as ethical codes of conduct that successfully govern the day-to-day practices of Australian maternity units. The unilateral requirement assumes either that obstetricians do not need to collaborate or that they routinely do so. In the remainder of this paper I wish to review contrasting ideas of collaborative practice put forward by the medical lobby, by the midwifery lobby and by consumer groups to show that (1) Determination 2010 enshrines the vertical definition adopted by the medical lobby and (2) dismisses the horizontal definition of collaboration coined by midwifery and consumer groups. This confirms a continuing privileged relationship between the state and the medical profession within neo-liberal market economies.
I will also report on the findings of a study of Australian caseload practices to argue that the claim that obstetricians routinely collaborate with midwives is misplaced. Directors of Obstetric Services in many units argued that Visiting Medical Officers refused to collaborate with midwives.

**Medical discourses**

Collaboration-by-compulsion was demanded across the board by peak medical organisations, (RACGP (The Royal Australian College of General Practitioners), RANZCOG (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists) and the AMA (The Australian Medical Association)) giving evidence to the Maternity Services Review and other Senate Inquiries into Amendments to the Health Bill. It is important to note that a call for midwives to unilaterally collaborate with doctors was prompted primarily by a fear on the part of the AMA that the proposed amendments would result in professional equivalence between doctors and midwives. It would almost certainly, they argued, threaten patient access, push up rates of mortality and morbidity, fragment services and create duplication and overlap resulting in higher costs for governments and consumers unless the nature of the ‘eligible’ midwife, the midwife indemnity scheme and collaborative care models were ‘clarified’ and enshrined in legislation. In a missive to their members, the AMA\(^9\) heralded the new Determination arguing that mandating a ‘team-based approach’ to collaboration would ensure quality and coherence:

For collaboration to work well, the AMA believes that the arrangement should be well documented and clarified in advance to ensure that every member of the team knows exactly what their role is and how they need to work with each other. This will ensure high quality patient care and minimise the potential for fragmentation of patient care.\(^9\)

The virtue of the existing medical model of care (the doctor/nurse hierarchy) was that it avoided duplication of effort and unnecessary tests or interventions because with the highest level and longest training, a medical practitioner is best placed to accurately diagnose a patient, giving [consideration] to the patient’s needs as a whole.\(^2\) The AMA cited the ubiquity of chronic diseases in post-industrial societies where patient care required the exercise of significant judgement that goes well beyond the application of “technical skills” or predetermined single disease treatment protocols that may conflict with other treatment protocols. Allowing NPs and midwives “to work in isolation of the medical profession” or institute “sham” arrangements that merely ‘give the appearance of collaboration’ would most certainly result in a fragmentation of care leading to exclusion of the patient’s usual doctor, misdiagnosis and missed diagnosis, a fragmented health record, increased risk of adverse outcomes, break-down in communication, the re-emergence of professional silos, recourse to medical expertise at the last minute when things go wrong and increased workloads and costs to the health system. Such risk outcomes went beyond hyperbole, claimed the AMA, because they related to evidence of adverse events stemming from the New Zealand midwifery-led model including a reduction in maternity services to women because GPs no longer provided intrapartum care; a retreat by midwives from the public health system, a disconnection between GPs and the community resulting lower immunisation rates and a sharp rise in postnatal depression. Negative effects also flowed onto anaesthetists and paediatricians who lost clientele, their skill base and the economic viability of their practices resulting in an exodus of the medical workforce.

To avoid the exigencies of the NZ model, the AMA recommended that the inclusion of the ‘allied health services’ could be supported only with appropriate legislation, regulations and guidelines that [hardwire\(^9\)] the role of a medical practitioner and ensured meaningful collaboration between doctors, nurse practitioners and midwives via two mechanisms: (a) RANZCOG’s Criteria for Models of Care and Indications for Referral within and between Models of Care\(^9\) that formalised exactly who was eligible and stipulated details of care including demographic data, care protocols, how communication will take place, methods to assess outcomes, referral arrangements, which pathology tests might be ordered and what arrangements would be put into place when a local doctor was not available. (b) A consultation framework stipulating the range of tests a NP or midwife might order and one that makes provision for an expert advisory panel comprising the AMA, medical colleges, Rural Doctors Association and nursing groups (the latter presumably in a token role).

For GPs,\(^2\) the fear of a new multidisciplinary regime should midwives be granted unmediated access to MBS, PBS and PII was expressed as a fear around ‘fragmentation of care’: any future models, argued The Royal Australian College of General Practitioners (RACGP) must put a premium on teamwork rather than fragmenting care [that would ensue through] creating new silos of care delivery. Not surprisingly, the medical lobby recommended their own guidelines\(^2\) should be adopted by all.

RANZCOG\(^2\) projected their fear of midwifery autonomy and market competition onto the issue of safety. Obstetricians would vacate the field (just as they did in the indemnity crisis) should they be made to work in cooperative care systems [with midwives] that they considered unsafe with dramatic implications for rural GP obstetricians who underpinned the rural workforce. Medical Defence Organisations would be similarly blighted in estimating future premiums by midwife frequent flyers—that is, those making frequent claims on indemnity insurance and those who worked outside an agreed collaborative care framework or the midwife who oversees a bad outcome for a mother or baby.

The Rural Doctors Association of Australia (RDA\(^2\)) found themselves in a dilemma. On the one hand they needed remote area nurses to work autonomously. On the other hand, the RDA, like the AMA and RANZCOG, rejected professional competition on financial, business and efficiency grounds. Rural practices would be balanced on a knife-edge of financial viability should they face competition from new midwifery practitioners; costs would inevitably rise because midwives untrained in medical diagnosis and assessment

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\(^{19}\) The Core Competency Education Framework for Maternity Care Providers developed by the University of Technology Sydney.
would lead to unnecessary referrals to specialists and added costs. Like RANZCOG and the AMA, RDAA forecast a fragmented system unless GPs coordinated care. Midwives and NPs could play a role but only under clear protocols dictated by medical bodies.

In summary, although the threat of professional redundancy and relative economic deprivation for members informed the global concern of medical professionals, the site onto which it was projected was the issue of collaboration interpreted opportunistically as a vertical relationship. Collaboration was defined not as a joint exercise but... who leads in any particular case.22 The view that midwives and other allied health professionals, were looming as doctor substitutes is the key to the medical consciousness and explains why medical bodies urged the enacting of Legislation to enshrine the dominance of medicine... because it was too risky for health professionals [read, midwives] to use their discretion as to when, where and in what circumstances they will collaborate.20

**Midwifery/nursing discourses**

A second major discourse around how to define collaboration emanated from midwifery peak bodies who generally welcomed the amendments on the grounds that prescribing rights, Medicare rebates and professional indemnity insurance expanded women's access to the choice of primary care by midwives in both hospital and community.23 Unlike medical bodies who defined collaboration as a lead carer [the obstetrician] directing lesser others, midwifery associations defined collaboration in terms of a horizontal relationship where midwives worked 'with' not 'for' a doctor. Existing regulatory mechanisms such as protocols, accreditations, standards and regulations currently governing midwifery education, practice and competence5 made legislative decrees redundant.

The nursing/midwifery discourses can be summed up by the following quote from Ms Bryce, Senior Professional Officer of the Australian Nursing Federation (ANF)26 who declared: It is whoever the consumer sees fit to consult in relation to their health care. Although their effectiveness had been denied by the AMA, ACM National Midwifery guidelines for Referral and Consultation proved successful when tested in a randomised controlled trial and all practising midwives complied with the Australian Nursing and Midwives Council's (ANMC) codes of conduct, codes of ethics, competency requirements and continuing professional development requirements. However, the ANF differed in degree from the ACM in advocating Masters level training in addition to clinical experience for midwives and NPs to be considered 'eligible' to practise. Although pushing a tougher line for accreditation, the ANF recommended that qualified midwives should then be permitted to exercise their full scope of practice in prescribing medicines, ordering diagnostics and pathology services and making referrals to other health professionals. The idea of requiring a doctor to 'rubber stamp' a professional decision was grossly inappropriate because trained nurses and midwives knew exactly when to refer on. Similarly, rendering independent midwifery illegal by default through lack of PII (an earlier policy proposal) would drive women underground to 'free birth' at the expense of safety and quality.

The President of the Australian Private Midwives Association (APMA)27 strongly refuted the medical claim that midwives' entry to the field as equivalent players would result in fragmentation. Currently, a woman birthing in any hospital was likely to have up to four midwives and would typically see up to thirty different people throughout her pregnancy. At present, at least while they were legally registered to practice (and there was a move to deregister private midwives by disallowing PII) Independent Midwives worked collaboratively observing national consultation referral guidelines, competency standards, frameworks and codes of conduct and ethics. De-registered midwives, on the other hand, forced underground by lack of PII, and released from codes of practice would leave women without quality and safety guidelines.

By November 2010, the government had made provision for private midwives to take up the offer of MBS and PBS although considerable hurdles remained. Currently, a midwife must either secure a signed collaborative arrangement with a doctor by whom they are employed (very unlikely) or when a doctor refers a patient to the midwife (even more unlikely) or the midwife may be authorised to participate in a collaborative agreement by the medical director or head of obstetrics in a public hospital who may delegate this authority to the obstetrics registrar (much more likely). The collaborative arrangement would apply only to antenatal and postnatal care because no Medicare item number exists for intrapartum midwifery care in the community (homebirth). Collaborative arrangements are not required to cover home birth. Alternatively, the midwife must comply with a lengthy documentation procedure (APMA online Newsletter November 2010). How these processes pan out remains to be seen.

**Consumer discourses**

A third discourse emanating from consumers closely aligned with the midwifery discourses prioritising the right of mothers and families to choice of carer and setting and to decision-making autonomy. Health Consumers of Rural and Remote Australia Inc.28 urged government not to rule against private midwifery and homebirth for rural families. Likewise, Maternity Coalition (MC)19 welcomed reforms to provide safe, high-quality and accessible care through collaborative arrangements. But they opposed what they saw as the disproportionate weight exercised by the medical lobby in determining government policy particularly in light of the AMA's declared aversion to women having direct access to Medicare-funded midwives in private practice. As such, the AMA's hierarchical interpretation of "collaborative arrangements" would certainly result in medical limitations on women's choices and access to a range of options. Homebirth

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3 These included the ICM International definition of a midwife; the ANMC Midwifery Competency Standards; the ANMC Code of Professional Conduct for Midwives and the ANMC Code of Ethics for Midwives. Evidence for continuing competence was also supported by the ACM continuing competence framework as well as MidPlus and Midwifery Practice Review. The Health Professions Boards under State, Territory and Commonwealth Legislation should retain legitimate authority (rather than the Commonwealth Department of Health and Ageing) for regulating practice areas.

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When is collaboration not collaboration? When it's militarized 33
Australia (HBA)\textsuperscript{30} predictably urged the government to endorse a nationally funded homebirth scheme by supporting private homebirth midwifery in line with the UK, NZ, Canada and the Netherlands governments. It was the woman who reserved the right to engage any professional(s) and rightly expects them to collaborate to secure her safety and quality of care.

In summary, contesting discourses on how to define and operationalise collaboration are categorized around medical discourses, midwifery discourses and consumer discourses. Medical bodies argued that midwifery access to MBS, PBS and PII would turn midwives into doctor substitutes and sought qualifying legislation to ensure the subordination of midwives under the ‘eligibility’ clause that required midwives to get a doctor, head of obstetrics or proxy (i.e. the registrar) to ratify their care regime. Failure to put doctors in charge of midwives would jeopardise patient access, push up rates of mortality and morbidity, fragment services and create duplication and overlap resulting in higher costs for governments and consumers. Surety could not be left to midwifery discretion but needed to be enshrined in legislation. Midwives argued that a situation where one professional could limit the practice of another was \textit{totally unprecedented and unacceptable, particularly when there is no guarantee that the… professional given dominance has relevant knowledge or skill to do so}.\textsuperscript{31} Finally, a signed agreement did not constitute collaboration and as a proxy made collaboration \textit{meaningless and unworkable}.\textsuperscript{32} Consumer discourses supported legislative changes regarding midwifery access to PBS, MBS and PII because they facilitated consumer choice of setting, carer and model of care. However, the government’s acceptance of the medical version of “collaborative arrangements”\textsuperscript{33} would certainly result in medical limitations on women’s choices and access to a range of options.

The announcement of the details of Determination 2010 failed to confirm the worst fears of consumers that medical veto enshrined in legislation would limit their choices by limiting private midwifery practice. Private midwives were permitted to continue to practice, as always without PII, and possibly with access to MBS and PBS depending on the goodwill of hospital obstetrics to validate their care plan. Midwives will need to demonstrate a capacity and willingness to collaborate and doctors will exercise veto power over midwifery practice. So apart from limited prescribing rights and access to Medicare rebates and PII it was business as usual, at least for private midwives. But the idea that midwives will take their place as professional equals by virtue of their access or provider numbers, Medicare rebates and PII was made a nonsense by Determination 2010 which is only logical if one assumes, as the government did, that doctors routinely collaborate and midwives do not. This assumption is refuted by a research study of caseload units which showed the reverse—that midwives routinely collaborated but that many Visiting Medical Officers resisted authentic collaborative practices.

Part II—findings of qualitative study of caseload units: creating collaboration from the ground-up

A recent study of 15 select caseload units across South Australia, Victoria and NSW shows that building collaborative relationships is an organic process; there was no one uniform model but rather a range of successful units whose modus operandi reflected local historical, demographic, social and professional exigencies. Successful collaboration relies on human goodwill and conscious strategies to engage the professionals in mutual dialogue and cross-disciplinary learning. It defies top-down legislative decree because collaboration emanates from ground-up or organic processes although these need to be catalysed by a coalition of ‘change champions’ in the launching phase.

The most successful collaborative units were labelled \textit{Collaborative Reflexive} because a coalition of senior midwives and obstetricians had instituted regular multidisciplinary learning opportunities and senior staff reflexively modelled good collaborative behaviour to more junior staff. They encouraged collaboration and practised knowledge pluralism. \textit{Collaborative Nascent} Units were those where midwives and doctors failed to respect the skills of the other or those where trust was absent or where consultants waited expectantly for midwives to make mistakes fell short of achieving full collaborative partnerships. They were still collaborative but one or other or both groups were less committed to change. In lesser cases of evolution, units were called \textit{Collaborative Provisional} because of a marked degree of antipathy towards the caseload model and tensions between professions. They retained a conventional authority structure and took few steps to move to a flat collaborative model.

\textbf{Discourses from the field}

\textit{Collaborative Reflexive} units represented a horizontal interpretation of collaborative practice on both sides. All units not only observed respective scopes of practice and used clinical pathways and practice guidelines for consultation and referral, but regular multidisciplinary meetings comprising case reviews of decision-making and processes from inception to discharge. These units had substituted a blame and shame culture with a mutual learning culture where attendees, especially midwives, were encouraged to feel confident enough to critically review their own practices aided by midwifery and medical colleagues. According to the Midwifery Manager (Mid11NSW), if something goes wrong we \textit{don’t see it as making a mistake, we look at processes so I think it’s very positive.} Far from being unaccountable, the midwives \textit{get far more scrutinized than someone [working] in fragmented [conventional] care.} Additionally, there were clear rules for transfer between the low risk Midwife Group Practice and a nearby tertiary hospital. If a woman remained low risk she would remain with the Midwife Group Practice caseload team but if she developed a problem under 36 weeks she was automatically transferred to the other caseload team at the tertiary unit. The difference was that at the tertiary unit the midwife would remain with the woman even if they developed a problem whereas at the community unit, the midwife referred the mother onto specialist care if need be. The system worked admirably in large part because ‘midwives working in their scope and practice will be more acceptable by the obstetricians and if obstetricians work within their scope and practice...then it’s beneficial for all — the future — the promotion of midwifery and obstetric services’. The Clinical Director (Ob11NSW) explained that

[30] Australia (HBA) predictably urged the government to endorse a nationally funded homebirth scheme by supporting private homebirth midwifery in line with the UK, NZ, Canada and the Netherlands governments. It was the woman who reserved the right to engage any professional(s) and rightly expects them to collaborate to secure her safety and quality of care.

[31] In summary, contesting discourses on how to define and operationalise collaboration are categorized around medical discourses, midwifery discourses and consumer discourses. Medical bodies argued that midwifery access to MBS, PBS and PII would turn midwives into doctor substitutes and sought qualifying legislation to ensure the subordination of midwives under the ‘eligibility’ clause that required midwives to get a doctor, head of obstetrics or proxy (i.e. the registrar) to ratify their care regime. Failure to put doctors in charge of midwives would jeopardise patient access, push up rates of mortality and morbidity, fragment services and create duplication and overlap resulting in higher costs for governments and consumers. Surety could not be left to midwifery discretion but needed to be enshrined in legislation. Midwives argued that a situation where one professional could limit the practice of another was \textit{totally unprecedented and unacceptable, particularly when there is no guarantee that the… professional given dominance has relevant knowledge or skill to do so}. Finally, a signed agreement did not constitute collaboration and as a proxy made collaboration \textit{meaningless and unworkable}. Consumer discourses supported legislative changes regarding midwifery access to PBS, MBS and PII because they facilitated consumer choice of setting, carer and model of care. However, the government’s acceptance of the medical version of “collaborative arrangements” would certainly result in medical limitations on women’s choices and access to a range of options.

[32] The announcement of the details of Determination 2010 failed to confirm the worst fears of consumers that medical veto enshrined in legislation would limit their choices by limiting private midwifery practice. Private midwives were permitted to continue to practice, as always without PII, and possibly with access to MBS and PBS depending on the goodwill of hospital obstetrics to validate their care plan. Midwives will need to demonstrate a capacity and willingness to collaborate and doctors will exercise veto power over midwifery practice. So apart from limited prescribing rights and access to Medicare rebates and PII it was business as usual, at least for private midwives. But the idea that midwives will take their place as professional equals by virtue of their access or provider numbers, Medicare rebates and PII was made a nonsense by Determination 2010 which is only logical if one assumes, as the government did, that doctors routinely collaborate and midwives do not. This assumption is refuted by a research study of caseload units which showed the reverse—that midwives routinely collaborated but that many Visiting Medical Officers resisted authentic collaborative practices.

[33] Part II—findings of qualitative study of caseload units: creating collaboration from the ground-up

A recent study of 15 select caseload units across South Australia, Victoria and NSW shows that building collaborative relationships is an organic process; there was no one uniform model but rather a range of successful units whose modus operandi reflected local historical, demographic, social and professional exigencies. Successful collaboration relies on human goodwill and conscious strategies to engage the professionals in mutual dialogue and cross-disciplinary learning. It defies top-down legislative decree because collaboration emanates from ground-up or organic processes although these need to be catalysed by a coalition of ‘change champions’ in the launching phase.

The most successful collaborative units were labelled \textit{Collaborative Reflexive} because a coalition of senior midwives and obstetricians had instituted regular multidisciplinary learning opportunities and senior staff reflexively modelled good collaborative behaviour to more junior staff. They encouraged collaboration and practised knowledge pluralism. \textit{Collaborative Nascent} Units were those where midwives and doctors failed to respect the skills of the other or those where trust was absent or where consultants waited expectantly for midwives to make mistakes fell short of achieving full collaborative partnerships. They were still collaborative but one or other or both groups were less committed to change. In lesser cases of evolution, units were called \textit{Collaborative Provisional} because of a marked degree of antipathy towards the caseload model and tensions between professions. They retained a conventional authority structure and took few steps to move to a flat collaborative model.

\textbf{Discourses from the field}

\textit{Collaborative Reflexive} units represented a horizontal interpretation of collaborative practice on both sides. All units not only observed respective scopes of practice and used clinical pathways and practice guidelines for consultation and referral, but regular multidisciplinary meetings comprising case reviews of decision-making and processes from inception to discharge. These units had substituted a blame and shame culture with a mutual learning culture where attendees, especially midwives, were encouraged to feel confident enough to critically review their own practices aided by midwifery and medical colleagues. According to the Midwifery Manager (Mid11NSW), if something goes wrong we \textit{don’t see it as making a mistake, we look at processes so I think it’s very positive.} Far from being unaccountable, the midwives \textit{get far more scrutinized than someone [working] in fragmented [conventional] care.} Additionally, there were clear rules for transfer between the low risk Midwife Group Practice and a nearby tertiary hospital. If a woman remained low risk she would remain with the Midwife Group Practice caseload team but if she developed a problem under 36 weeks she was automatically transferred to the other caseload team at the tertiary unit. The difference was that at the tertiary unit the midwife would remain with the woman even if they developed a problem whereas at the community unit, the midwife referred the mother onto specialist care if need be. The system worked admirably in large part because ‘midwives working in their scope and practice will be more acceptable by the obstetricians and if obstetricians work within their scope and practice...then it’s beneficial for all — the future — the promotion of midwifery and obstetric services’. The Clinical Director (Ob11NSW) explained that
they no longer talked about to whose clinic did she go. Now we're able to talk about models of care...identifying historical or current risk factors and then the allocation of the model of care. After five years into the collaborative model, a degree of antagonism remained especially when we get obstetric trainees who move from other hospitals and there were still some difficult encounters with the senior medical staff (VMOs), he explained. The interaction with the VMOs was sporadic but with five permanent staff obstetricians there was the luxury of developing a rapport with the midwives to our [mutual] advantage. The other thing that had established a genuine collaborative model was a shared understanding of what normal and normal risk is so that we're all on the same page. There was no room now for individual practitioner variation in terms of how they manage a labour. For example, there was no longer time pressures that everyone should be delivered before the sun goes down that obstetricians had built up over the 1990s. Importantly, the new model had allowed them to review the existing culture and work practices.

In another Collaborative Reflexive caseload unit, the Senior Consultant Obstetrician and Neonatologist (Ob75A) met with the Midwifery Group Practice staff on Mondays and Thursdays so that anyone could bring cases along to the group for discussion. He enunciated an enormous trust in my midwifery colleagues because they were experts in the normal which meant that they could identify quickly anything outside of a low risk category. He trusted implicitly that they would bring their problems to the group. Again, this was a collaborative workplace where the morning handover meeting was multidisciplinary and where the senior director of obstetrics fully endorsed university-educated direct entry midwives who would see caseload as a natural direction, like doctors going into private practice. The crime within the structure of maternity services, he believed, was that midwives were being penalized enormously for the inability to do that final step whereas the obstetrician would collect $5,000 including the Medicare rebate for a private patient.

A unique twist on a collaborative reflexive unit was expressed by a Director of Obstetrics (Ob14NSW) at another major tertiary hospital in an economically deprived, outer region of Sydney who said that he wanted to institute an inverse pyramid model with a role for everyone...within a high risk clinic which involved dedicated midwifery, a social worker, psychologist input and medical input. First there is the specialist obstetrician who sees really sick people, then there are private and public obstetricians, then senior midwives, then independent midwives in the community. For the Midwifery Manager (Mid10NSW) at this site also, the best work as midwives is the preventive work that can be done around some of the high risk groups. This meant the investment of time. Dr X used to question that a little bit but I'd say to him, that's their need—the psychology, the depression, the kids, the lack of support when they go home and the breastfeeding, the fact that they were terrified of having another Caesar. Their collaborative model was a mix of informality within formal guidelines: I just say to Dr X, this is what we’ve decided, are you happy? Obviously you’ve got the protocols to follow. In her view, you need to achieve respect between the disciplines so that people aren’t acting defensively and there can be genuine collaboration. Although some traditional (nursing-oriented) midwives lacked the kind of education and skills that would allow them to advocate for women and feel confident in their field, the multidisciplinary forum had made doctors realise that midwives were very highly skilled and very knowledgeable but also that they questioned care and wanted answers to what they perceived as deficits in any care regime. There had been a synergy of knowledge due in large part to the work of the Clinical Director in modelling collaborative behaviour to the registrars. One university had invited them to provide education for medical students.

The success of a further highly successful collaborative unit in a tertiary hospital was due, in large part, according to the Midwifery Manager (Mid10NSW), to a creative synergy between senior staff specialists and senior midwives in constructing a model of absolute flatness characterised by 'cooperation and cohesiveness' philosophically and culturally (Mid3Vic). In this unit, the model exemplified genuine collaboration—a mutual exchange of professional views within a shared learning model where the obstetricians took the lead from some of the midwives and the midwives took cues from them [the obstetricians]. Further, the Director of Obstetrics had actively intervened to counteract negative VMOs by role-modelling to the registrars, midwives and junior medical officers at daily handover how a genuinely respectful collaborative model is created (Mid10NSW). The outcome was a unit that exemplified the ideal collaborative project—a creative synergy where outcomes not only excelled safety, equity and universality goals but where interdisciplinary exchange created a new knowledge synergy. Everybody gained except perhaps the VMOs who refused to participate.

In another Collaborative Reflexive caseload unit shared care guidelines governed all processes, such as referral patterns, topics of discussion at each visit, and the numbers and scheduling of mandatory visits to medical staff. Although common educational programs had not been institutionalised on a regular basis, an organic type of collaboration occurred by virtue of the long period of time that senior midwives and senior obstetricians had worked together over which time they had developed mutual respect and rapport. The strict requirement that all midwives worked within the guidelines managed the amount of 'angst' that was endemic to midwife/obstetricians (the only clinical relationships in the medical arena where there is 'independence on both sides and interdependence') (Mid3Vic). In this unit, an agreement had been reached to enable both sides to work together which meant that the mavericks on both sides have left the organisation or retired. When disputes occurred, we try now and sit down together. Both midwives and obstetricians recognised that although the ‘three centres guidelines’ provided a framework for decision-making regarding referrals, there inevitably remained a lot of grey area. It’s like enterprise bargaining—give a little bit and this will be our safe practice. Not everything is evidence-based but more what we can agree on—it’s collaboration. It’s not best practice, but safe practice. To make this strategy work, the unit instituted ‘action lines’ and ‘alert lines’. The obstetricians preferred to work to ‘action lines’ because it provided prescriptive direction. However, the midwives rejected the utility of ‘action lines’ in a western context with a large contingent of low-risk cases. Action lines were ‘a thing of the past only fine for WHO if you’re in Zimbabwe or under a tree and you need to get to a hospital before your baby dies. Both
midwives and obstetricians came to observe ‘alert lines’ or markers depicting a transition from low risk to high risk, as a result of which the obstetricians said that they didn’t need to know about the low risk women above the line because they were busy enough managing the public sector (Mid3Vic).

The Collaborative Nascent groups defined relationships as collaborative but still tension-fuelled along the lines of authority and responsibility. We are not all happy families holding hands together, one Midwifery Manager (Mid6SA) put it. We are very clear about what the role of the midwife is — not a pseudo obstetrician and not an obstetric nurse… midwives look after this range of things — anything else they go to a medical model of care. Again, in another unit, midwives collaborated routinely under the auspices of the Australian College of Midwives Consultation and Referral guidelines, [‘…so when a woman oversteps the boundary and becomes high risk there is an automatic referral and consultation with the medical officer (Mid9NSW)]. If there was a complication the woman would see the staff specialists and VMOs or if it was a more general issue beyond midwifery scope of practice the midwives would see the registrars. However, despite common agreement on referral and consultation guidelines, professional relationships were not collegiate. Midwives and VMOs rarely conversed. The Senior Obstetrician expressed the midwife/obstetrician relationship as inherently tension-ridden because of the vast difference in their legal liability for adverse events:…if there’s avoidable factors associated with a midwifery then the perception is that the midwife would be sent for some emergency obstetric training—all’s forgiven. But if it’s an obstetrician and there’s an adverse outcome the perception is that they’re on the front page of the local newspaper. Their whole private practice is ruined and they’re before the courts with a $2m lawsuit. And that is the frustration (Ob13NSW). The unit had instituted a multidisciplinary peer review but they did not celebrate the good births and it was only when something goes wrong” that the doctors scrutinised the midwives’ work (Mid13NSW).

A midwife manager (Mid6SA) in another caseload unit explained how hard she tried to avoid adversarial confrontations and that:…if someone is proposing an intervention it’s not about me and what I believe in—it’s what the woman wants. She took the deliberate pathway of presenting the relevant evidence to all parties. Her strategy was to ‘Always keep that collaborative part; it is what the woman wants in the end’ and that the only way to achieve change was to continually ‘talk and engage’ with people. It was not easy to bring about collaborative cultures because trust and respect lay at the heart of good relationships and this had to be nurtured in a reflexive way through ongoing talks especially in view of endemic tensions between midwifery staff in ‘core’ areas and the midwives in caseload. The nurturing strategy did not extend to formalised inter-professional and regular reviews or common training sessions although some key obstetricians, but not all of them, acknowledged that the midwifery group practice produced positive outcomes and is a useful model to have.

Collaboration occurred at another site but it could be described as a defensive variant. The role of the midwife was exemplified as not stepping on their [obstetricians] toes or taking work away from them. There was…a place for obstetricians and a place for midwives and we should be able to work side by side in the whole scheme of things’ (Mid3Vic). Midwives periodically reported progress of labour to both the midwife in charge and the consultant to avoid professional tensions. It is worth noting that units were not static in their orientation. In this unit where the old service director had left and two new obstetricians had been employed, the dynamics changed because the new obstetricians were not as skilled themselves and they are still building up the knowledge of the midwives and trust (Mid3Vic). Also, there was a new generation of doctors who are more strongly medical model and had been taught to be wary so that there was a greater degree of surveillance and a quicker propensity to intervene than in the past. The midwives realised they had to step back and let them work with that medical stuff on the intervention; that’s just the way things are. But the doctors did not realise that women were more assertive and that the women attracted to the caseload model definitely want a choice and be given information and make their own decisions so…there is conflict around that.

In the Collaborative Provisional Group, one Midwifery Manager (Mid9NSW) acknowledged an initial and marked proclivity towards hostility on the part of two midwives to medical interventions matched by an openly antagonistic group of older medical staff towards the shift to caseload. However, the enmities had been resolved in a practical way by observance of the Referral and Consultation Guidelines. Collaboration was also strengthened when the Director of Obstetrics instituted weekly visits to establish mutual trusting relationships and a regular inter-professional forum; both strategies had been running for several years and independent evaluations had been very positive—low caesarean rates, low analgesia use, a high percentage of normal vaginal births and high consumer evaluations as well as few critical incidents. The caseload program now has some credibility and legitimacy of its own [and it has been] much harder for the medical staff who were opposed to it to verbalise anxiety and to criticise it. This unit had also instituted collaboration between midwives by rotating them between two sites. In terms of midwives pushing the boundaries, the Manager could cite only one midwife. Overwhelmingly, she described happy midwives working in a model that they like.

Another unit, while not strictly working within a caseload system, had instituted what the director of Obstetrics called a collaborative model but it retained a conventional set of power structures: the doctor being above and the midwife looking after the patient. It worked, according to the Director of Obstetrics (Ob4Vic) because obstetricians realised they were totally reliant on them [midwives] telling [obstetricians] what’s going on because [obstetricians] are not there, so we have to work closely together. The midwives observed the protocols and guidelines and were properly trained to call you when there’s a problem. I’d like to think they don’t call you when there’s not really a problem. You are really dependent on the cooperative thing going on. Although there were regular perinatal mortality and morbidity meetings to discuss management of particular cases, conventional lines of authority and accountability prevailed.

The idea that a responsible model of care could only be one with the doctor at the top and where midwives, whose role was mainly to prepare the woman for enlarging her family, complied with legal directions had been instituted at the legal behest of the Crown Solicitor. According to the
Clinical Director (Ob6SA), midwives there were happy with that advice particularly as we have built in their right to question and what avenues they have to pursue should they still be unhappy. This unit followed the ACM criteria for suitability for midwifery care (the most widely accepted document we could find in Australia) but also incorporated a team process in developing protocols for seeking medical care. It was very successful, according to the Director, the result being that their [the midwives’] compliance with the protocols is very high and if there are going to be violations of the protocols that needs to be the result of a good argument being put forward, proper discussion and it being recorded in the notes as to what decision was made. According to the Clinical Director, the consumer is completely the person who makes the decision 100% although if the doctor is really confident that something is not in the woman and baby’s best interests, they have an obligation to push it quite strongly. In terms of a genuine philosophical synergy, professionals in this unit had reached a situation of tolerance which fell short of being united in our perspective. The midwives had to earn the respect of the doctors and midwives had realised that the role of the doctor in the provision of antenatal care was detecting abnormalities rather than preparing a woman psychologically for increasing the size of her family. Under these rather primitive collaborative conditions, where the midwife was unilaterally expected to earn the respect of the obstetrician, the clinical director proudly declared that midwives and obstetricians were working so well together he would like it to expand to double their current capacity.

Who’s collaborating now?

The evidence from fifteen caseload maternity units has indicated that there are different interpretations and practices around collaboration. One of the main problems facing new caseload units was not the lack of cooperation on the part of midwives (as the AMA has consistently advised government reviews) but a marked lack of cooperation on the part of Visiting Medical Officers (VMOs). This allegation was made, not by midwives, but by directors of obstetric services and senior medical staff of the most successful Collaborative Reflexive units. Indeed, such was the potential destructive ness created by errant VMOs (those that looked for and trumpeted any sign of midwifery failing) that some directors of obstetrics felt bound to institute radical, counteractive steps to build collaboration. In the more successful and progressive units, new multidisciplinary handover meetings and regular clinical reviews enabled midwives to present problems, hail their successes and, above all, encouraged both professional teams to learn from each other. This meant, not just advocating inter-professional respect, but enacting respectful practices in rituals of reciprocity that recognised the value of the distinctive knowledge and professional skills of the other. VMOs were noticed more for their absence than their presence but the forums continued, particularly in the Collaborative Reflexive units, not so much in the (forlorn) hope that the VMOs would come around but so that new entrants (registrars especially) could be apprised of the new collaborative ethos of the caseload environment. When senior midwifery and obstetric staff pulled together in a spirit of collaboration defined by genuine respect for the skills and competencies of the other, it was like, as one midwifery manager put it, a planetary alignment: a fortuitous mix of ordinary professionalism and extraordinary vision. These were the ‘change champions’. Their clinical outcomes were reported as exceptional.

Conclusion

The radiant success of many dedicated caseload units in achieving organic collaboration makes a mockery of the idea that midwives must be commanded to collaborate and that obstetricians are models of collaborative virtue, as Determination 2010 presupposes. Midwives already collaborate under their scope of practice guided by a flotilla of professional guidelines. By dint of its punitive and surveillance overtones, legislative decrees such as Determination 2010 are bound to fail because the cultural assumptions underlying the idea of force and compulsion, especially in professional health fields, are anachronistic within a contemporary reflexive modernity. Such forms of militarized collaboration can only inflame historic enmities and achieve the very opposite of their putative objectives.

References

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