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Difficult birth for power sharing

There is meant to be collaboration between doctors and nurses in maternity care but this is being hindered by unequal and disrespectful cultures and practices, writes Karen Lane.

English is a funny language. Apparently it challenges newcomers because of the pluralist meanings of words and the numerous exceptions to the rule. Such is the nature of the word collaboration especially when applied to maternity care. Many studies in NZ, the US, the UK, Canada and Australia have established that it does indeed exist, that many regimes have instituted guidelines for practitioners, that it characterises a new mood in midwifery/woman/obstetric relations and that it involves a three-way dynamic.

This is itself notable because it replaces the traditional, military-style pecking order of obstetric dominance common to hospital-based care and centralised models of birth. Yet there is little agreement about how to define it and the research evidence about how it plays out in practice in different national and institutional settings.

Let us just make a stand and say that the term collaboration in maternity care insinuates (if not ensures) a more horizontal relationship between contenders; one that is notionally respectful of diversity of world views about the nature of birth, contesting knowledge about the female body and resulting care plans. In short, it epipromises equality, power-sharing upon it. It follows that ownership of one's body is even more formative; it guarantees pregnant women, for example, not only the right to consent before any treatment may be applied but, more importantly, it ensures women the right to dissent (although rarely celebrated in the health arena).

Further, although much less robust, egalitarian individualism conveys the right to choose among a range of alternatives: after all, "free" individuals are only free to the extent that there are genuine alternatives from which to choose. But whether the above paradigm is enacted as a genuinely horizontal (as opposed to a vertical structure with medical opinion at the top) three-way sharing of power amid genuine treatment alternatives depends crucially on policies made at the macro governance level.

Take Australia. For the past decade a shift towards collaborative models of care had been evident and reached an apogee in 2008-2010 when many government-funded inquiries, including one by the Productivity Commission and several senate inquiries as well as the national Maternity Services Review, considered the virtues and outcomes of collaborative models.

In their wake, new reforms in support of midwifery (the midwives the doctor the veto power to either endorse or censor any care plan for any consumer. Such a requirement fundamentally ignored the current flotilla of monitoring vehicles and professional cultures that govern working relationships, including collaboration, among private midwives and midwives working in the public sector. Second, the legislation presupposed a medical fraternity that routinely acts collaboratively. This is incorrect.

Studies have shown that midwives more than obstetricians aspire to the collaborative ideal. According to the American College of Obsterician/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 healthcare professionals jointly manage care" and share authority.

In my own research studies into Australian maternity units, it was evident that similar divisions in interpretations exist. Notably, obstetricians were generally loathe to relinquish control over decision-making; they exercised veto power over midwifery decision-making at crucial milestones in the woman's treatment; and (understandably) resented models that demanded collaboration but who left them on shoulder lead and professional hierarchies and philosophical differences.

Nurses and midwives know only too well how these often subterranean interactional mechanisms ensure social control. Within the context of these kinds of historical enmities, the legalisation of midwifery compliance has the effect of engraining a vertical definition of collaboration, one that has suited doctors, but which negates all that genuine collaboration stands for.

What is to be done? Since the state (the government, in the narrow sense) has instituted a vertical definition of collaboration, it is properly the agent to which a renewed redress needs to be made. But how should midwives and nurses construct that? What are the underlying philosophies that would give authority to such redress?

A human rights discourse based on the idea of equality among citizens is obviously insufficient in that it failed to institute genuine collaboration - one that encouraged equality, mutual trust and reciprocal respect. Although not redundant, it needs to be fortified with other principles. The concept of cosmopolitanism could be useful for renewed political action on the part of nurses and midwives in their claims for workplace rights (for themselves and their patients) and social justice because the frame of reference is not the nation state but standards set by the global community.

Cosmopolitanism (in its more recent manifestation) involves three key elements: egalitarian individualism (self-determination and independence...
epitomises equality, power-sharing and reciprocal respect not just at the interational level (although this is significant) but at the institutional and macro levels.

To be effective, collaborative models must ensure that those who have been less dominant are brought to equivalence and this means for midwives (private and public), for example, that they are guaranteed legislative access to institutional support such as Medicare rebates, provider numbers, the right to prescribe certain pharmaceuticals and professional indemnity insurance.

For women, collaboration demands equality in status in decision-making; indeed, they should take front stage because, in a liberal democracy, individuals and the right to own property are the basic building blocks of rights-based discourses, specifically the idea of the citizen and the right to vote. Kant, like other Enlightenment theorists in the 18th century, postulated the individual as possessing reason and rationality and on this basis authorised citizens to make their own decisions.

Our theory of liberal democracy embracing universal franchise and representative democracy depends on the idea of a freedom of the individual to control their destiny and to participate in the political and social processes that affect them.

In their wake, new reforms in maternity care legislation (the Health Insurance Act 1973 and associated regulations) guaranteed that midwives and nurse practitioners may be eligible to provide some services funded through the Medicare Benefits Schedule and prescribe certain medications subsidised under the Pharmaceutical Benefits Scheme if they (a) hold appropriate accreditation endorsed by the Nursing and Midwifery Board of Australia and (b) have a collaborative arrangement in place with a medical practitioner.

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 to practice in collaboration with doctors, the sting for midwives and nurse practitioners is that the National Health (collaborative arrangements for midwives) Determination 2010 embedded several erroneous presuppositions.

First, it conveyed a unilateral requirement that midwives only (not doctors) are required to demonstrate a willingness to collaborate by giving 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 medicalised language; the escalation of fear tactics to achieve patient and midwifery compliance and knee-jerk interventionist tendencies.

In summary, except for a very few dedicated caseload models, maternity care has been characterised not by collaborative relationships but by unequal relationships and ongoing professional tensions.

A further 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 tend to entrench medical elements: egalitarian individualism (self-determination and independent choice); reciprocal recognition (that equal worth of everyone should be acknowledged by everyone); and impartiality (arriving at common rules and principles that can be universally shared).

The latter is crucial for renewed claims for equality of voice in any health debate involving the powerful medical lobby because it insists that all points of view need to be taken into consideration and that all parties need to accept the outcome as fair and reasonable regardless of social position or institutional status.

We need to extend that to different knowledges (or ontologies and epistemologies) that may exist outside the "magical" evidence-based gold standard of the randomised control trial; the new benchmark being whether any policy defends the ideas of equal dignity, equal respect and protection of needs, all of which need to be interpreted at the local level. The new appeal is to social justice.

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