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**Chapter 2**

**THE POLITICS OF RECOGNITION AND RESPECT:**

**COLLABORATION AND CONFLICT**

**WITHIN MATERNITY CARE**

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ABSTRACT

Contemporary health policies in many Western regimes (Australia, Canada, New Zealand, the UK) reflect characteristic neo-liberal strategies of privatization and deregulation of public sector services combined with the tightening of regulations to ensure accountability and visibility of clinical responsibilities. Such tools include the publication of surgical rates and rates of medical intervention and putting into place practice guidelines, codes of ethics, professional competencies, spheres of practice guidelines and referral guidelines. Other financial and professional tools in maternity care include the allocation of provider numbers to midwives, professional indemnity insurance for midwives and the extension of prescribing rights to midwives, all of which increase the real possibility of competition between obstetrics and midwifery in the marketplace and, more to the point, in professional status. In addition, state policies such as collaborative care models to be instituted in public maternity units can be seen as effectively softening the boundaries around the medical professions by enlarging the role of the midwife as the leader maternity carer (LMC).

Using a framework derived from the writings of Fraser, Honneth and other commentators, referred to here as the politics of recognition and respect, this paper will analyse the dynamics in maternity units that attempted to bring greater parity to relationships between midwives and obstetricians in response to government calls for greater collaboration among maternity professionals. First, I will consider the outcomes of early attempts to achieve collaboration within four maternity units in different hospitals in Australia. Second, the paper reports on findings of a further study that
Karen Lane evaluated the professional dynamics within fifteen caseload models across Australia. The results indicate, first, major barriers to collaboration on both sides of the professional divide. Second, the follow-up study shows that collaboration is not just a structural accomplishment but requires the creation of collaborative cultures and that cultures of collaboration comprise numerous dimensions, all of which are pivotal to achieving what Fraser calls ‘parity of participation’ and Honneth calls the recognition and respect. I have called these the ‘ten commandments’ of social change in maternity care.

BACKGROUND: RESPECT AND RECOGNITION

AND THE CASE OF MIDWIFERY AND OBSTETRICS

The subordination of midwifery to obstetrics represents a particular form of oppression; it is a metaphor for the subordination of experiential forms of knowledge and practice, on the one hand, to rationalised technocratic medical knowledge, on the other. Many commentators have documented the historical trajectory of midwifery viz-a-viz obstetrics (for example, Willis 1983; Arney 1982; Leap and Hunter 1983; Oakley 1986). In brief, although midwives led the field in maternity care prior to the eighteenth century, they were undermined with the rise of science and the professionalisation of medicine in the eighteenth and nineteenth centuries. Midwifery was finally eclipsed when medicine was institutionalised within hospitals and gained control over recruitment, training and knowledge production (Foucault 1975, 1977, 1980). All events led to an ever-increasingly popular perception that medicine
and safety were interchangeable where midwifery came a poor second. Only recently in the first decade of the new millennium have many Western neo-liberal regimes, such as those in Australia, Canada, Scotland and the UK, moved towards collaborative, midwifery-led models, such as team midwifery and caseload, primarily to stem rising costs associated with globalization and financial strictures but also to meet the crises in recruitment and retention rates of midwives and obstetricians. More than ever before, these issues loom large for governments creaking under the strains of financial duress.

In Australia, the Victorian Labor Government’s policy document, *Future Directions in Maternity Care* published in 2004, for example, called for the *equal participation* of women, midwives and obstetricians in maternity care as did other government inquiries in the years following leading to significant changes in health care legislation allowing midwives to prescribe certain medications. They were also included under the Medicare benefits schedule and provided with professional indemnity insurance if employed by a hospital. Under this model midwives would take on the care of low-risk women, a role long envisaged by midwifery professional bodies such as the Australian College of Midwives Incorporated (ACMI) and the International College of Midwives (ICM). In response, some Australian maternity units set up experimental arrangements to forge new alliances between the professions, to dispel traditional enmities and to create a respectful dialogue between the professions. Part of the strategy involved upgrading midwifery skills to encourage each midwife to develop both a new identity and renewed confidence commensurate with the

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
status of a (relatively) autonomous professional. Although ostensibly approximating Fraser’s ‘parity of participation’, a study of this initiative (Lane 2005; Lane 2006; Reiger 2008; Reiger and Lane 2009) showed that historical enmities and rivalries continued to block the full realisation of parity among actors, notably obstetricians, midwives and women. Further, the resistance came not exclusively from some obstetricians, as one may expect, but the bulk of midwives. These conflicts and struggles remain under-theorized. Specifically, one of the main barriers to collaborative care was the reluctance of midwives to accept the full implications of their role as primary carer. Despite long struggles by midwifery professional bodies since at least the 1980s in demanding professional autonomy and equal recognition of midwifery skills and knowledge their trademark holistic and experiential skills were always undervalued compared to the rational, scientific and interventionist approach of medicine and obstetrics. The above studies showed that both midwives and obstetricians disputed the boundaries of their traditional and future roles and many vigorously debated the idea that the skills of the ‘other’ were complimentary and/or subordinate. As the literature shows, attempts at collaboration elsewhere have met similar difficulties. The findings of these studies will be elaborated later. First, it is useful to locate the debate between Fraser and Honneth and others in relation to social justice, structural change and social equality as they may be applied to maternity care.

THEORISING SOCIAL JUSTICE: REDISTRIBUTION
The idea that childbirth merits legislative protection was endorsed first by the Declaration of Human Rights (1946) and then more recently by the Millenium Development Goals particularly Goal 3 (Promote gender equality and empower women) Goal 4 (Reduce Infant Mortality) and Goal 5 (Improve Maternal Health) (UN 2000). The problem with these legislative mechanisms is that although they focus attention on global deficits, they fail to specify the remedies so that, for example, individual accounts of gross violations of human rights within Western hospitals continue to be brought to public attention, including what one mother called ‘birth rape’ (‘Birth Rape: Why is This Happening in Our Hospitals? http://shine.yahoo.com/parenting/birth-rape-cultural and symbolic forms of inequality as well as the usual calls for economic redistribution.

In this quest, both Fraser and Honneth agree that social justice requires more than the Fordist claim of economic redistribution, long the singular objective of labour organisations and the radical Left in the post-war era. Now recognition is just as important in securing moral autonomy particularly under globalizing capitalism with its ‘transcultural contacts, fracturing interpretative schemata, pluralizing value horizons and politicizing identities and differences’ (Fraser and Honneth 2003:1). For Honneth, economic redistribution is a derivative of recognition. For Fraser, on the other hand, redistribution stands on its own just as recognition remains an irreducible category and both are essential in evaluating real situations of inequality. Both theorists are committed to ‘… Critical Theory’s signature goal of accommodating immanence and transcendence simultaneously’ (Fraser 2003:202): Both theorists aim to go beyond neo-liberal orthodoxies that naturalise socially-induced inequalities to engage with the real dilemmas facing people in everyday life (Fraser 2003).
The essence of the debate between the two philosophers stands on their divergent interpretations of what constitutes a normative theory of social justice. Fraser argues that all inequalities must be evaluated in terms of economic aspects of inequality and cultural evaluation aspects and that neither may be ignored in bringing out genuine long-term structural reform. For example, women’s unpaid labour at home, or the emotion work carried out in the public sphere of work (think here of the work of midwives, nurses, teachers, airline stewards, social workers, etc.). Such activities involve economic inequalities and cultural evaluations of women’s work and both contribute to lower levels of remuneration. Honneth would argue, on the other hand, that women are paid less because they are recognised as having lower social worth giving rise to lower economic remuneration: Recognition presupposes economic worth.

For Honneth (2003), who derives the bases of recognition from Hegel’s triumvirate ethical order (the family, civil society and the state) as well as Mead’s idea of the ‘generalized other’, recognition is a master category. Individuals derive social autonomy from three bases – from socialisation (unconditional love), from their legal status (citizenship) and from the world of work (the achievement principle). All rest upon mutual recognition and provide a normative framework of social justice. The different types of moral respect give rise to the distribution of different kinds of goods so that when the spheres of recognition have been honoured the individual will experience the maximum freedom possible to argue for their needs and particular capacities and thus achieve social, political and economic inclusion. For
Honneth, unequal distribution of economic resources is merely one form of misrecognition. To fortify the individual to enter into meaningful political and economic dialogue, one must be resilient and the way to prepare for this is through careful socialisation and protection via the legal system and then by meritocratic institutions. As he says (2003:174):

The justice or well-being of a society is proportionate to its ability to secure conditions of mutual recognition under which personal identity-formation, hence individual self-realization, can proceed adequately.

For Fraser (2003), by contrast, a viable theory of justice must go beyond the sphere of recognition. Although recognition remains central to the reconstruction of Critical Theory in the age of globalization where ‘value horizons are pluralized, fractured and cross-cutting’ (Fraser 2003:198), her perspectival-dualist framework comprising redistribution and recognition are posited as irreducible categories. Dismissing Honneth’s master category of recognition applied to three spheres as ‘a moral psychology of pre-political suffering’ (p. 202) relying simplistically on one single underlying motivation, namely the lack of recognition of one’s identity, Fraser argues that a viable theory of justice would begin with the ‘decentred discourses of social criticism’ (p. 207) pertaining to cultural recognition and economic redistribution, the goal being to achieve ‘participatory parity’ or ‘equal respect for all participants and ensure equal opportunity for achieving social esteem’ (Fraser 2001:29). It is not that recognition applies to culture while redistribution applies to the economic domain, but that there are cultural and economic aspects to any situation of inequality. For example, there are cultural valuations associated with lower rates of pay for work that is traditionally carried out by women for which there is no male equivalent.

Both theorists begin with divergent bases. For Honneth, following Hegel, respect is
nurtured from three nodes – socialisation, the legal domain and the public sphere. His aim is
to fortify the self against the flints and arrows of diverse inequalities that begin in childhood
and then may be exacerbated in the legal/political and then economic domains. Fraser begins
with actual situations of inequality within contemporary marketized societies and pluralised
civil societies that have given rise to ‘a shifting field of cross-cutting status distinctions
…[where] … social actors … participate actively in a dynamic regime of ongoing struggles
for recognition’ (Fraser 2003:57). To be misrecognised, she argues, ‘… is to be denied the
status of a full partner in social interaction, as a consequence of institutionalised patterns of
cultural value that constitute one as comparatively unworthy of respect or esteem (Fraser
2000:113-4). Although Fraser and Honneth (2005) declared divergence from each other, both
agreed that culture may serve as a medium of domination and is pivotal to the quest for social
justice. In my view, which theory commands maximum utility must be answered by reference
to specific issues in specific contexts.
The question here is whether it is possible to achieve parity of participation among two
professionally contesting groups – midwifery and obstetrics - where obstetrics has long held
the upper hand in terms of the institutionalisation of professional privilege and cultural
legitimacy by virtue of their adoption of a medical, positivist view of birth and the female
body? Rawls (1999) would urge parties to intentionally disregard all factors that engender
inequalities such as gender, race, age, status etc. so they can enter into deliberations on an
equal footing. The critique of this position is that the reigning group are unlikely to see their
advantage as unjust but more as a just entitlement on the grounds of superior knowledge, skills and experience in relation to the vulnerable, naïve patient and other para-professionals (Friedson 2001; Welie 2011).

In resolving this kind of dilemma Fraser (2001; 2003) argues that it is not necessary in the quest for equality that all parties share universal values but it is mandatory that they achieve a dialogic relationship, that is, one based on equality plus a unity of purpose. She eschews the ‘identity’ model of recognition as tantamount to imposing a monolithic psychic identity on members inevitably exerting on them a tyrannical pressure to align with the dominant ethos. Rather than pander to dominant power factions that suppress differences within groups, she argues, the idea is to acknowledge the real complexity in people’s lives, the internal heterogeneity within social groups and between them rather than enforce a unified identity (a common strategy among identity theorists, see Walby 1990; Brown 1981). To foster ‘parity of participation’ (or recognition) (Fraser 2001:25), one need not make a moral judgement about the verity of philosophical claims of competing discourses of knowledge, but all parties must meet in a dialogic relationship; one characterised by equality. Claims for recognition thus seek to:

... establish the subordinated party as a full partner in social life, able to interact with others as a peer. They aim, that is, to de-institutionalize patterns of cultural value that impede parity of participation and to replace them with patterns that foster it (Fraser 2001:25).

Then it is up to individuals to ‘define for themselves what counts as a good life and to devise for themselves an approach to pursuing it, within limits that ensure a like liberty for others’ (Fraser 2001:27). The assumption here is that ‘value pluralism’, where no group is denied access to democratic forums or social interaction, will ensure just outcomes. In
summary, for Fraser, recognition is framed not in terms of self-realisation (Honneth 2001) or the ability to achieve the good life (Taylor 1992), but in terms of achieving a dialogic relationship (one of equality) with others in the democratic process. Conversely, misrecognition occurs when someone is prevented from participating equally in which case the conditions that impede parity of participation need to be dismantled and replaced. Butler (2004) follows suit arguing that unequal frameworks, discourses and structures should be dismantled to perform other, more democratic ways of being and doing. But how to perform such transformations is the challenge. Fraser argues that structures have to be changed in order to bring about the conditions to encourage dialogic relations. In Australia and Europe (Kateman and Herschderfer 2009) experiments in new collaborative arrangements offered this kind of opportunity to ‘perform’ (Butler 2004) things differently.

‘PARITY OF PARTICIPATION’ AS COLLABORATION: A LITERATURE REVIEW

Under collaborative models midwives, for the first time, may eclipse an obstetric-assistant role to work on a par with obstetric colleagues as different-but-equal partners. Honneth’s paradigm is less applicable in this regard, not because it lacks verity or insight, but because it refers to measures to fortify the individual throughout the life-cycle that would prepare and support their participation in public life whereas this paper reviews the current struggles around the renegotiation of professional boundaries in the shift to midwifery-led, so-called collaborative models of maternity care.
Collaboration is one of the key motifs of neo-liberal governmentality. The problems facing a pluralized, fragmented globalized world are seen to be such that no one disciplinary tradition is adequate on its own to offer solutions. Where in a modernist world of competing professions and hierarchical divisions it was enough to rely on legislative boundaries to ensure ongoing market monopolies (Fournier 2000; Lane 2006) in a neo-liberal, post-bureaucratic, individualized world, new solutions to old and new problems have become urgent. It is within this context that government calls for collaboration between professional groups have occurred. But what does it entail? The question has begun to exercise the minds of researchers. 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). 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). Predictably, given the institutional dominance of science and medicine, the literature shows that 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 a strong financial and patient base; competent and confident individuals; appropriate ground rules to encourage open communication, consensus decision-making and role clarity; trusting attitudes; and a commitment to superior patient care were core elements for success that, when present, synergised each other creating a spiral of trusting relationships. In most cases,
however, missing core factors compromised the synergy. Leppert’s study (1997) reaffirmed the importance of inclusive attitudes and practices, such 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. Critical to the success of collaborative practice was the commitment by all participants to share information and to critically review information and correct distortions. People also needed to have the time to communicate. It is clear, therefore, that collaboration is not just a matter of imposing a structure over participants but must be created by participants themselves if lasting success is to be achieved.

**THE IMPORTANCE OF TRUST / RESPECT**

Fraser supports this argument but poses the preconditions in terms of recognition and reciprocal respect achieved only if a number of political and cultural changes are first instituted. Other studies of collaborative care practices endorsed the importance of changing vertical structures to horizontal structures that ‘…fully nurtured, appreciated and utilised the respective skills of the professional ‘other’” (Miller 1997; Porter 2003:219). This is easier said than done. Many studies of health professional cultures have reported the resilience of professional asymmetries expressed as both economic and cultural hierarchies. Walby et al (1994), for example, noted that professional training, accreditation and hospital protocols
created and ‘naturalised’ hierarchical relationships that came to be expressed at the cultural and social levels in mannerisms, attitudes, social rituals, identities, skills and knowledge. Asymmetrical and often competing professional identities were then affirmed and negotiated through social interactions with a broad range of other contacts – with medical and nursing faculty staff, interactions with other students, patients, hospital staff, professional mentors and professional superiors. They were also imbricated in differential rates of pay and professional statuses. The end result, according to Degeling et al (1998; 2000), has been 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 rejected the view that clinical standards were based on self-generated knowledge. On all of these points, clinicians expressed the reverse. Doctors saw themselves as autonomous practitioners who relied on self-generated knowledge and 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. Similar findings have arisen in relation to studies of maternity services, that is, the existence of marked 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. The recent backlash by the Royal Australian College of Gynaecologists and Obstetricians (RANZCOG) to the prospect of stand-alone midwifery units and Medicare rebates for independent midwifery care as well as access to Professional Indemnity Insurance and the PBS testifies to the on-going resistance to institutionalised equality in Australian maternity care (Lane 2012a; Lane 2012b; Lane 2012c). The chronic nature of these endemic and ongoing tensions partially explains present crises in staff retention rates and inadequate numbers of midwives currently in training for the future (AMAP 2002). In the UK also, Hughes et al (2002) discovered 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 were attributed to the ‘silo effect’ (Lane 2006); a culture of oppositional values produced through the institutional juxtaposition of objectivist knowledge (Rothfield 1995) (rational technical knowledge) versus productivist (Rothfield 1995) or holistic knowledge causing an asymmetry in professional relationships and practices. In effect, the present maternity system in many Western regimes has institutionalised disrespect for midwifery knowledge despite the considerable body of evidence that testifies to its efficacy in producing safe and low-intervention births for the majority of women, whether deemed low or high risk (Homer et al 2001; Rowley 1995).
Placed against that historical background, turning traditional vertical structures into flat, collaborative relationships defined by ‘…shared knowledge and mutual trust … in an egalitarian or balanced working situation’ (Evans 1994:23) would represent a seismic conceptual and practical shift. The following study of the institutionalisation of ‘parity of participation’ shows where Fraser’s framework is useful. Midwives in large numbers both resisted and defended in different ways the structures that oppressed them and, predictably, there were enduring tensions between professional groups. Of even greater interest, however, was the emergence of cross-alliances between midwives and obstetricians indicating that the institutionalisation of participation under collaborative care arrangements had at least partially moved some individuals from their professional ‘silos’ to become professional collaborators.

COLLABORATIVE CARE IN MATERNITY SERVICES:
STUDIES IN POLITICAL RECOGNITION

Studies undertaken (Lane 2006; Lane and Regier 2009) of collaborative care practices in Australia indicated that success had been muted. Midwives remained unconvinced that obstetricians accepted them or their women clients as equal partners. They complained that obstetricians failed to respect their ‘hands on’ approach and ‘emotion work’ (Hochschild 1983) skills. They charged doctors with routinely pathologising normal birth and intervening precipitously thus denying them parity of participation in assessing the woman’s progress via other knowledge and clinical indicators. Although midwives now acted as primary carers (seeing women at their first antenatal visit and supervising them during labour) doctors had retained veto power over decision-making by virtue of seeing women at the booking-in visit and at 41 weeks obstetricians at which times they would decide risk status and then to which
Midwives remained critical about their judgement regarding women’s risk status, about whether and when they should intervene and were often scathing about obstetricians’ lack of communication skills. Midwives complained that doctors rarely acknowledged ordinary courtesies such as greeting women by name or acknowledging the presence of the midwife. Yet despite these complaints, the majority of midwives rejected the role of primary carer under caseload schemes pointing to burn-out, family responsibilities and lack of confidence in their own skills. Thus a final and conclusive step to achieving institutionalisation of parity of participation with obstetricians was thwarted, but this had occurred not at the behest of obstetricians, but by midwives themselves despite a long battle by The Australian College of Midwives to seek independence from obstetrics and overt bitterness from midwives towards obstetric dominance. In other words, the complexity of midwifery identities will variously position each midwife to accept, resist or just remain ambivalent about the causes and forms of their own oppression (Swanson 2005; Weedon 1992).

Obstetricians complained that midwives lacked necessary skills and clinical confidence, they failed to take responsibility in decision-making about procedures and outcomes and hid behind the false security of the hospital’s medical indemnity cover. They felt that midwives colonised patients under the mantle of midwifery advocacy to undermine the obstetrician’s credibility and routinely ‘normalised the abnormal’. For obstetricians, midwives remained a ‘craft group’ rather than a profession and it was somewhat of a travesty that government policies obliged them to reconcile irreconcilable philosophies of care.
In essence, many midwives and obstetricians constructed and reconstructed the barriers that divided them and effectively sabotaged professional parity. Yet some were moved to consider the worldview of the other. Some midwives conceded that a few of their colleagues did ‘normalise the abnormal’ although there was disagreement about how many and the more autonomous-leaning midwives expressed frustration with those that failed to up-skill and take equal responsibility for decision-making and outcomes. Some obstetricians showed signs of becoming more reflexive about intervening too early and were even prepared to criticise colleagues who resisted collaborative arrangements or who failed to respect midwifery skills and knowledge. Having said that, there was nothing like a wholesale movement on either side to inter-disciplinarity or any form of integrative practice that would have qualified as ‘parity of participation’. Indeed, for many on both sides collaboration merely meant, not overlapping spheres of competence in a horizontal institutional structure, but the same old vertical decision-making and skills hierarchy. The point remains, therefore, whether parity of participation would be at all possible in maternity care given its entrenched structures of professional inequality and mutual disrespect?

According to Fraser (2005) transformative mechanisms require strategies that actually enact parity of participation. Caseload is such a model. Instituted in many maternity units across Australia within the last five years, its esprit de corps was to create structures of collaboration based on recognition and respect for the skills and worldview of the other and, in so doing, deliver safer and better services for women. This was no small task. To succeed, midwives would need to fully appreciate the non-commensurate value of their own skills; they would need to see themselves as fully worthy of equal professional status to obstetricians (despite training to see themselves as subordinate) and to take up the challenge of primary
carer in accepting the full legal and clinical implications. Obstetricians would need to re-imagine first, the nature of birth within a more holistic framework where the social context

Karen Lane

impinges upon clinical outcomes and, second, to revalorise midwifery skills. Such a shift would require a seismic change in mindset away from an iconic Enlightenment faith in reason and science towards an appreciation of the embodied advantages of making women feel confident about their abilities and their body to engineer greater ease and safety of birth. This would be akin to overturning the old industrial framework of birth and instituting one that would mesh positivism with holism. In order to do that both Honneth (2003) and Fraser (2003) agree that structural change must occur across political, economic and cultural domains. In Australia, by the mid-2000’s, the conditions for such a transformation began to be put into place.

MARKETISATION, THE ‘AUDIT SOCIETY’
AND THE POST-WELFARE STATE

Post the 1960s and in the wake of globalisation, the audit society (Neave 1988; Power 1999, 2005; Horrocks 2006) heralded a shift towards a new public management (NPM) approach to marketise public sector activity (Christensen and Laegreid 2011; Hood 1991). A modified price mechanism was put into place in conjunction with a system of regulation that appealed to individual incentives as well systems for checking, monitoring and verifying individual performance outcomes. Social justice indicators have not been forgotten but become part of the rhetoric rather than the practice of health care reform. The National Health
and Hospitals Reform commission in Australia (Commonwealth of Australia 2010), for example, earmarked equal access, promotion of social inclusion and reduction of disadvantage as key planks in the delivery of health care by state and federal health bodies. Yet as Young and McGrath (2011) have argued, such apparently liberal and progressive aims were interpreted, not in terms of the WHO framework of health promotion and social justice, but more in line with neo-liberal, economic rationalist, audit culture objectives. For example, in their discourse analysis of current State health department documents in Australia, concepts such as ‘excellence’, ‘quality’ and ‘equal access’ (all potentially social justice criteria) were to be met solely by clinical service provision. In relation to maternity care reform, the complexity of social determinants of outcomes, including the social relations of care, would remain unacknowledged while measures such as percentages of patients subject to reduced waiting times would be evidence of improved outcomes. Evidence of excellence would focus upon maternal and infant morbidity and mortality and rates of patient satisfaction but with little attention to indicators such as quality, access and safety in the context of inter- and intra- professional relationships, consumer/professional relationships, different birth settings and the availability of genuine choice for consumers in carer and setting (McCourt et al 2011).

Yet the audit culture framework of neo-liberalism did bring significant reforms. The old-style professional who was typically complacent about their superior status, class location and cultural authority (Freidson 2001) came under threat mainly because this iconic identity stood for a system of out-dated cultural and economic privilege in the face of much needed budget reforms for nation-states facing the financial strictures of globalization. Whereas state regulation has been the pivotal instrument in guarding market privileges for elite professional
groups (such as obstetricians), including the political power to exclude other groups and to protect their own members, the softening of professional boundaries by instituting alternative models of care opened up the way for other possibilities in the private and public sectors, such as maternity professionals. Such reforms also demanded a new worker identity; no longer dutiful and compliant under bureaucratic structures, the new ideal worker need to be flexible, multi-skilled, reflexive, a team-worker and lifelong learner adding new skills to their repertoire to provide unmet needs (Power 1999; Dent and Whitehead 2002). In hospitals, the new nurse-practitioner professional role emerged to take over some tasks from GPs, just as the case-load midwife emerged to manage the new midwifery-led caseload models in moves tantamount to ‘horizontal substitution’ (Nancarrow and Borthwick 2005). In terms of bringing accountability to the old professional structure, evidence-based medicine instituted a new ‘gold standard’, effectively mediating the medical idiosyncrasy and arbitrary authority of old-style obstetrics with its high rates of avoidable adverse events and increasing costs of health care (Lane 2005). Combined with the new public management approach to public sector management, its overarching discourse of quality, accountability and excellence (Darbyshire 2008) promised a fresh approach to social justice in health because market efficiencies demanded collaboration among equals with different and complementary skills and knowledge (Tully and Mortlock 2004); the ‘new professional’ was not just an industrial relations add-on, but came to be seen as a key factor in production.
In this new mood of collaboration and professional equivalence, recognition in terms of Honneth’s legal status and Fraser’s parity of participation had finally been granted, at least notionally. From 2012, midwives were granted a Provider Number enabling clients to claim medical rebates for their services, they were authorised to prescribe appropriate medicines and, at least for midwives working in hospitals, professional indemnity insurance provided legal cover for midwives and their clients. The political mechanisms were all in place. For those midwives in private practice who stood in direct market competition with private obstetricians, a major detractor to economic, political and legal parity loomed from 2013 onwards with the statutory requirement that private midwives would need to take out professional indemnity insurance. Until then they would be exempt. It was a large and potentially disastrous qualifier because the considerable economic burden would put most community midwives out of practice. The exception was those who were willing to go underground and accept cash-only payment, risk legal implications and leave their clients without insurance cover. The other caveat, and this was a serious detractor to the newly found midwifery ‘parity of participation’ status, neutralised nearly all of the gains from Provider Numbers, prescribing rights and professional indemnity insurance. Determination 2010 required an obstetrician to sign off on all midwifery care plans. In one magnanimous legal fillip, therefore, midwives were cast back to the days of para-professional status, at least legally. It acted to curtail market competition posed by independent midwives but had a neutral effect on hospital midwives working in the public and private sectors. For midwives in the public hospital system where most women would birth their babies, the caseload models offered an experimental opportunity to test the willingness of both professional groups to shift to collaborative structures and develop a new collaborative mindset.
A study of fifteen caseload units in South Australia, Victoria and New South Wales from 2008 – 2010 was undertaken to evaluate this very question. Interviews with thirty maternity professionals (senior obstetricians and senior midwifery managers) yielded transcripts that were coded using N-Vivo7 to create comparative categories across sites and professional groups. Ethics approval was obtained from governing ethics boards. Interviews typically took 60 minutes but often longer at the discretion of the participant. Critical Discourse Analysis (CDA) was used to evaluate the transcripts. Transcripts from professional and consumer groups who gave evidence to major government inquiries into maternity care arrangements held during the same period were cited as background information. The findings indicated a range of interpretations of caseload reflecting local, historical, demographic, social and professional exigencies.

The most successful collaborative units were labelled *Collaborative Reflexive* because a coalition of senior midwives and obstetricians had crystallized key criteria in structural change and instituted these in everyday practices and interactions. Of especial importance, the setting up of regular multidisciplinary learning opportunities brought about a new culture of recognition and respect enacted by senior staff reflexively modelling good collaborative behaviour. In other units where midwives and doctors failed to respect the skills of the other, or where trust was absent, where consultants waited expectantly for midwives to make mistakes and then trumpeted them to colleagues, or where educational, multidisciplinary
reviews were absent fell short of achieving collaborative partnerships. These units have been labelled *Collaborative Nascent*; they may have been partially collaborative but one or other or both groups were less committed to change and the structures that would bring about parity of participation were absent. In lesser cases of evolution, units were called *Collaborative Provisional* due to a marked degree of antipathy towards collaboration, a staunch defence of conventional authority structures, a marked degree of antipathy towards the caseload model and tensions between professions that were unlikely to be resolved in the short term given the degree of mistrust and lack of recognition of the skills and competence of the other.

**THE ‘CHANGE CHAMPIONS’: COLLABORATIVE REFLEXIVE**

In the discussion that follows, I will outline the strategies that were employed to create Collaborative Reflexive units; those that consciously aimed to integrate the skills and practices of midwives and obstetricians. It should be noted that oppositional philosophies often persisted. However, Reflexive Units achieved what Fraser calls ‘parity of participation’ and what Honneth (2003) calls ‘the achievement principle’; both professional groups drew upon a ‘unity of purpose’ (rather than insisting on a unity of identity) to expedite the welfare of women – as they put it - ‘*a keep normal normal, minimise intervention, pro midwifery philosophy*’. All participants were brought into a deliberative decision-making arena consciously created for that very purpose with rules, procedures and protocols for encouraging those below parity to reach parity and for disciplining those that threatened or failed to respect the educational aspirations of the collaborative enterprise. In summary, there were ten ‘commandments’ that gave rise to successful collaborative units:

1. potential anxiety

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The Politics of Recognition and Respect
was quelled by a strict observance of complementary spheres of practice (2) strategies to revalue old professional identities were consciously implemented to spearhead innovations; (3) respectful enculturation was practised regularly among all participants; (4) language was used sensitively to create new realities and identities; respect for the ‘other’ was honoured and practised; (5) new entrants were socialised to the new culture of recognition and respect; (6) change was better orchestrated by those who could assume a culture of detachment; one independent from entrenched interests; (7) transformation was incumbent upon a coalition of ‘change champions’ ideally comprising senior clinicians from all professional groups recruited from public sector units (8) a culture of always-learning replaced an old shame and blame culture; (9) all members possessed political autonomy (10) fortuitous contingency prevailed: a planetary alignment of external (political, economic and cultural) factors aligned with internal factors (organisational structures, professional coalitions, interactional dynamics). These criteria are elaborated below.

A CLARITY OF ROLES AND SPHERES OF PRACTICE

For diverse professionals to work together, especially those who were attempting to overcome traditional hierarchies of knowledge, skills and practice, it was important for all to agree on jurisdictional boundaries - long a source of inter-disciplinary conflict. While clear about spheres of practice, reflexive units differed in how they drew the lines. One, for example, channeled all high and low risk cases through the Midwifery Group Practice on the grounds that continuity of care by a named midwife signaled excellent practice from which all women should benefit. A senior obstetrician heading another unit cited an inverted pyramid as his preferred model: one where the midwives formed the first-line cadre and
channeled only high risk cases to him. For the Midwifery Manager working 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.

Wherever the jurisdictional boundaries were drawn, they were patrolled by a spirit of trust and respect for the skills and professionalism of the ‘other’. The only antagonism occurred when we get obstetric trainees who move from other hospitals and with some VMOs but with five permanent staff obstetricians there was the luxury of developing a rapport with the midwives to our [mutual] advantage where there 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.

A Senior Midwifery Consultant from a further unit explained that the strict requirement that all midwives worked within the guidelines managed the amount of ‘angst’ that was endemic to midwife/obstetricians relations (the only clinical relationships in the medical arena, she explained, where there is independence on both sides and interdependence). Such agreements enabled both sides to work together so 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

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52

Karen Lane
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.

RE-VALUING CULTURAL IDENTITIES

The problem generally in upgrading the cultural identity of midwives to professional parity with obstetricians lies in a history of misrecognition of holism as a viable philosophy underpinning midwifery tacit knowledge. The ability to foster calm, confidence and control allowing the mother to deliver with minimal medical intervention is a much maligned, if not entirely misrecognised, skill by positivist obstetrics. In achieving parity of participation, therefore, strategies needed to first, encourage midwives to acknowledge and respect the pivotal nature of this non-commensurate skill and then to express publicly how they manage to achieve it in practice. In so doing, an upward spiral of trust and confidence would infect the Unit. Collaborative Reflexive units brought midwives into the decision-making arena via active contribution to regular multidisciplinary meetings that reviewed clinical decision-
making from inception to discharge. A culture of hierarchy, denial and competition was abandoned and replaced by a mutual learning culture that had gradually fostered a culture of recognition and respect. Another Senior Consultant Obstetrician enunciated an enormous trust in my midwifery colleagues because [they were] experts in the normal - they could identify quickly anything outside of a low risk category and he trusted implicitly that they would bring their problems to the group.

PRACTISING INTERDISCIPLINARY, RESPECTFUL CULTURES:
THE MORNING HANOVER AND THE REGULAR WEEKLY INTERDISCIPLINARY REVIEW
Cultural values were the main target of change strategies. According to the Professor of Obstetrics in one unit, there had been an increase of 25% of all women going into the Midwifery Group Practice (MGP: the caseload model of care) and also, just as significantly, a general cultural change. Those who always supported the MGP continued to do so, those who are anti have just been marginalized. The major vehicle was an open invitation to the interdisciplinary morning handover where as many as 30-40 attendees discussed current cases and issues arising from them. As the Head of Obstetrics said,

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The Politics of Recognition and Respect
53
… you need a lot of continued input to give [a new idea] some momentum .. so its essential to come in every single day for that handover and be there every time to steer the meeting. If the tone became too accusatory or if the tone was confrontational we [the coalition of senior obstetricians and midwives] tried to temper and moderate it.
Midwives were overtly encouraged to contribute. By disciplining his own, over-reactive personal style (by his own admission) and in consciously modelling a respectful style towards midwives to boost their public persona, the Head of Obstetrics together with senior midwifery staff instituted a culture of pluralism, professional confidence and interdisciplinary respect.

… many of us are naturally hot headed people so we have to consciously think how are we discussing this. For a few months it felt like we were still creating the old environment and then after a few months it was, oh this is how it runs and this is how it works. In tandem, he censored negative jibes from outspoken Visiting Medical Officers (those in private practice who worked at the hospital on certain days) who openly undermined the MGP. For example, a senior registrar typically used language such as ‘You won’t believe what they’ve, [the birth centre] have done’. You have to say, ‘Hang on, let’s get rid of that crap sentence you’ve just said. Just tell us the facts, don’t tell us I cant believe this’. Although it was considered unrealistic to expect contrarians to endorse the MGP, they were disciplined not to undermine midwives or the overarching parity objective.

In Collaborative Nascent units, by contrast, multidisciplinary peer reviews were held but they did not celebrate the good births, according to a senior midwife, and it was only when something goes wrong that the doctors reflected upon the midwives’ work, not so much in a spirit of education but of discipline.

**USING LANGUAGE OF RESPECT AND RECOGNITION**

Interdisciplinary meetings consciously adopted positive language and consciously censored negative discourses. Instead of saying something like *Everyone has a career ending moment and you have just had yours*, the senior staff reflexively espoused positive tone and manner. For example, *I’m interested in what you’re doing here. I have some concerns that*
there is a big risk. A lot of people would not have done that. They might have chosen to do so and so. I think you will find there is strong evidence for intervening a bit earlier and the reason I don’t want you to do that is ….. Often, one feels very strongly that what the person had done was blatantly dangerous but there is no point in saying that. On the contrary, the senior staff and especially the senior midwives took pains to establish a culture of calm, confidence and support towards the other midwives.

SOCIALISATION OF NEW ENTRANTS

Although contrarian senior registrars may have been lost to the culture of transformation, the new young registrars coming into the unit entered a uniquely respectful interdisciplinary culture and were rewarded for similar behaviour. They were also disciplined if they violated the collaborative norms.

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54

Karen Lane

A CULTURE OF DETACHMENT

Those who spearheaded collaborative structures and cultures had often been trained within them, especially if they had trained or worked in the UK. From the beginning of their careers they realised that maternity care divided into hierarchies and they decided to engage with the high-end risk cases, as in in fetal medicine, so that problems were registered as minor departures, rather than a crisis event demanding change from low to high-risk status. They [obstetricians] are so used to seeing absolutely the worst end of stuff – the most complicated awful pregnancies - that minor deviations in pregnancy really don’t worry them so much. It was significant also that these senior obstetricians chose public sector careers rather than
private practice because their outspoken views against their colleagues had little effect on their career trajectories. Private obstetricians are heavily dependent upon market forces and unlikely to endorse parity by a competing professional group such as midwives who demonstrate equivalence in measurable outcomes such as safety and patient satisfaction.

**CHANGE CHAMPIONS**

A key feature of transforming old structures of hierarchy and disrespect to new structures of collaboration and recognition was a coalition of ‘change champions’. As one Director explained, *what has changed has been the development of a strong core of [four] people who share an aim and who come from a very similar ‘keep normal normal, minimise intervention, pro midwifery philosophy’. We have almost developed a sort of separate culture within a culture and it is within that culture that MGP is being promoted and we are disseminating that to the broader culture.*

The ‘old culture’ was sclerotic because it was driven by *history, fear and power.* Obstetric staff had been taught that birth was inherently dangerous and only safe in retrospect; they feared complications, of being sued and being critiqued by their colleagues as having erred in judgement. Finally, *they were the people who were fond of arguing that you never get sued for doing a Caesar, for intervening too early.*

**AN ALWAYS-LEARNING CULTURE**

The successful units were those whose team members, including the most senior clinicians, regarded their own skill set as a work-in-progress. They believed they could always learn from others, including those from another profession, and that the most valuable skill was listening to others. As one senior clinician said, *I don’t claim to be an expert. I am still learning. I think its language and tone and manner – you don’t need to belittle people. I*
try to say things like: *I am interested in what you’re doing here.* Midwives were encouraged to feel confident enough to critically review their own practices aided by midwifery and medical colleagues. According to one Midwifery Manager, if something goes wrong *we 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 *get far more scrutinized than someone [working] in fragmented [conventional] care.*

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The Politics of Recognition and Respect

55

**THE MERIT PRINCIPLE**

Achievement (in the Honneth (2003) sense of recognition for merit) was seen as collaborative and collective. As one senior obstetrician said, *…. There’s two ways of being an obstetrician - you can be the knight in shining armour or you can be quietly in the background. Some like the former – “you were in such an awful mess but I was here and saved the day” – clutched the baby back from the brink. The woman doesn’t know any better and the consultant gets the champagne-chocolates-whisky whatever. Actually you’ve managed it correctly if the woman comes through labour and didn’t realize that you actually did anything. For this clinician, the essence of obstetric professionalism was being positive and supportive; perhaps they may make little suggestions in the background but never with a view to over-inflating one’s singular importance.*

Another 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 was that midwives were being penalized for the inability to do that final*
step whereas the obstetrician would collect $5,000 for the final step including the Medicare rebate for a private patient.

A PLANETARY RE-ALIGNMENT

As one senior obstetric clinician put it, it’s very much a planetary alignment situation here – it’s absolutely astonishing what we are doing – astonishing and exciting to be achieving what we are achieving here, including an 18% caesarean section rate compared with 46% in public women’s units. This clinician referred to both external political factors, internal organisational factors and interactional/professional factors that came together fostered by the foresight, vision and determination by a cabal of senior clinicians from different philosophical backgrounds.

THE OTHER RANKS COLLABORATIVE NASCENT

Such units achieved coherence, not through mutually reinforcing activities designed to create trust, but through recourse to referral and consultation guidelines promulgated by the Australian College of Midwives viz, ‘.. so when a woman oversteps the boundary and becomes high risk there is an automatic referral and consultation with the medical officer, according to a senior midwife. When complications arose it was understood that the woman would see the staff specialists and VMOs or, for a more general issue beyond the midwifery scope of practice, the registrars. The Midwifery Manager said candidly: We are not all happy families holding hands together. 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. Thus the detractors were not that collaboration was absent so much as the lack of recognition and respect based upon the perception of the vast difference in legal liability for adverse events. Such disrespect caused
enduring resentment. As the Director of Obstetrics complained. *if there’s avoidable factors

Karen Lane

associated with a midwife 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. 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.

In these kinds of units, nothing was done to bring the two groups together in a learning,
blame-free facilitative environment of mutual exchange so subterranean hostilities thrived and
tension lines persisted along conventional authority and responsibility dimensions. Tensions
also existed between core midwifery staff (employed in the conventional maternity unit) and
the caseload midwives because the core staff managed the ‘overflow’ from caseload, that is,
those women who needed to stay in longer and be cared for when the caseload midwives were
off duty. Of course, responsible people acted responsibly to mediate the lack of grounded
respect by consciously striving to avoid confrontation in the interests of the welfare of
women. As one midwifery manager reported: .. *if someone is proposing an intervention it’s
not about me and what I believe in – it’s what the woman wants.* Such individuals instituted
interactional ploys to present relevant evidence to all parties to a dispute and to …*always keep
that collaborative part going; it is what the woman wants in the end that matters* by actively
engaging with people in the absence of formalised inter-professional and regular reviews or common training sessions. In this way some, though not all, obstetricians had been won over to the caseload idea even acknowledging that it produced positive outcomes and was a useful model to have.

Where a strong interdisciplinary team was absent, collaboration was open to the vicissitudes of incoming staff, particularly the registrars on short-term rotations or new obstetric staff. Younger obstetricians were less skilled and less trusting of midwifery skills and tended to be anxious that midwives may usurp their roles and authority. By midwives requiring midwives to report progress of labour to both the midwife-in-charge and the consultant some of the tensions were alleviated. Also, a new generation of doctors had been more strongly medical model advocates and had been taught to be wary resulting in a culture of more intensive surveillance and a quicker propensity to intervene than in the past. The midwives realised they had to step back and work with medical stuff on the intervention; that’s just the way things are.

COLLABORATIVE PROVISIONAL

Few units occupied this category, defined by an underlying lack of respect in the model itself. Because the New Zealand model of collaboration was a failure then, by extension, the Australian model would also fail, according to one Director of Obstetrics. Although there were regular midwifery peer reviews, inter-disciplinary reviews were not held in this same unit because the Director was afraid that an obstetrician may turn up and say oh you’re all a pack of idiots. In other words, no internal disciplinary action had been taken to repel destructive elements and to build interdisciplinary respect and trust and there remained a suspicion that the model was bound to fail. In another unit, the local obstetricians and
paediatricians effectively boycotted the new collaborative birthing centre by resolving not to work on-site but to remain at a twinned site to see emergency cases. This was a case of collaboration-at-distance.

Not all units were easy to categorise because technically they shifted from one categorisation to another over time. One Midwifery Manager acknowledged enmities between two midwives and older medical staff resolved somewhat by invoking the Referral and Consultation Guidelines and regular inter-professional forum. Several years later independent evaluations showed positive outcomes – 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 had earned credibility and legitimacy so remaining contrarian medical staff found it harder to legitimise their antipathy. 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. Other units were less committed to caseload because they believed it instituted inequalities for women: the caseload women received a Rolls Royce model while others were assigned to the Toyota model so that one unit had cut down on the number of visits for caseload women. In another unit, although there were regular perinatal mortality and morbidity meetings to discuss management of particular cases, conventional lines of authority and accountability prevailed, the doctor being above and the midwife looking after the
patient, according to the Director of Obstetrics. The scope of practice was strictly observed but it was more a statutory obligation than sense of trust that marked the collaborative enterprise. 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. In this unit, a strict division of labour ensued where the (subordinate) role of the midwife was to prepare the woman for motherhood; the role of the doctor was to direct the care. Essentially, collaboration here became a matter of pastoral care undertaken by midwives and clinical care undertaken by the medical staff. In another unit the Clinical Director (of obstetrics) conceded that midwives be allowed to question decisions made by doctors but there was no sense of clinical equality or collegiality between midwives and obstetricians. In fact, this Director had sought advice from the Crown Solicitor regarding midwifery collaboration to lock midwives into legal compliance. In terms of a genuine philosophical synergy, professionals in this unit had reached a situation of tolerance that fell short of being united: in effect, a case of primitive collaboration. Midwives were expected to earn the respect of obstetricians and were paternalistically granted the right to question but denied the right to decide.

**CONCLUSION**

I have argued that Fraser (2003) and Honneth (2003) offer a fruitful framework to analyse recently changes in maternity care arrangements in Western regimes following globalisation and the shift towards an audit culture in public sector utilities. Old professional privileges have been curtailed under this new economic environment precipitating a shift in professional identities and political allegiances. Some units in the Australian setting shifted to Complimentary Contributor Copy
Karen Lane

caseload programs to capitalise on government calls for collaboration between disciplines. This paper has reported on the outcomes of fifteen such units. A few exploited the historic opportunities resulting in outstanding successes for both midwives and obstetricians and, above all, the women and babies under their care because collaborative teams offered seamless care and thus superior grade quality and safety. Other units continued under more or less conventional structures mainly it seems because of enduring resentments attached to what was held to be the lesser legal burden and professional responsibility of midwives. Little had been done to remedy residual ill-feeling and collaboration was achieved more by default than design. The referral and scope of practice guidelines were invoked as disciplinary mechanisms and people stepped back from fully participating to maintain cordial relations. A guardedness against ‘a parity of participation marked other units because of a belief that midwifery-led models belied a misguided confidence in midwifery skills. Extra legal imprimatur brought midwives into line with the old hierarchies stultifying progress through the invocation of nineteenth century ideas about a conventional division of labour: one where doctors carried the clinical load and midwives nursed women and encouraged them to be mothers.

More specifically, the future looks bright for those units who can enact the ten commandments of change. I have articulated these as (1) observe complementary spheres of practice, not as a disciplinary or threatening mechanism but as a rule of thumb (2) introduce strategies to revalue old professional identities (3) respectfully enculturate all participants to achieve ‘parity of participation’ and recognise professional achievements; (4) use language
sensitively to create new realities and identities (5) socialise new entrants to a culture of 
recognition and respect; (6) assume a culture of detachment; one independent from 
entrenched interests; (7) form a coalition of ‘change champions’ ideally comprising senior 
clinicians from all professional groups recruited from public sector units (8) replace an old 
shame and blame culture with an *always-learning* culture (9) institute political autonomy 
among all participants (10) pray to the gods for fortuitous contingencies - *a planetary 
alignment* of external (political, economic and cultural) factors aligned with internal factors 
(organisational structures, professional coalitions, interactional dynamics).

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Chapter 3

MASS SPECTROMETRY STUDIES
IN CARNITINE HOMEOSTASIS: WHAT
MASS SPECTROMETRY TAUGHT US
ABOUT CARNITINE?

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ABSTRACT

A golden age of carnitine research was three decades ago. Huge number of investigations were published establishing several physiological functions of this molecule and revealing different aspects of carnitine homeostasis in normal and pathological conditions. The methods used for determination of carnitine were then based on the classic or radioenzymatic assays, enabling only the determination of free and total carnitine levels and calculation of the amount of the total carnitine esters without any information of the composition of the acyl groups. Introduction of mass spectrometry made not only the measurement of free carnitine but also the specific and sensitive determination of different carnitine esters possible and thus this tool brought a new