

Collaborative care

This submission expresses our concerns as social scientists about projected legislative amendments requiring midwives to make ‘collaborative arrangements’ in order to become ‘eligible’ to participate in the ground-breaking step of accessing the MBS and PBS. It is based upon our recent research into professional relationships in Australian maternity care. We have undertaken several studies in Victorian units, including 1 rural, 1 regional and several hospitals (see attached Reiger and Lane 2009) as well as further work on collaboration in Australian innovative models of care (Lane 2009). We also have many years of involvement in consumer-driven efforts to improve options for women in birth, and thus write as mothers too: one of us has experienced the value of well-supported homebirths in Holland and the UK, and the other, excellent collaborative care with a GP and midwives in a small local Victorian maternity unit.

Our central argument is that there is a profound *contradiction* between promoting increased professional midwifery autonomy and women-centred and collaborative maternity care on the one hand, and, on the other, projected legislative amendments which would effectively negate that intent. To insist on ‘collaborative arrangements’ for midwives *alone*, and not for their medical peers, inhibits their legitimate and internationally-recognised autonomy and women’s capacity to choose qualified midwives who work independently in community settings. Collaboration is, by definition, a *two-way process* requiring a fair degree of equality in the professional and personal relationships. It cannot be conceptualised as one partner being *mandated* to ‘collaborate’! Instead collaboration involves working relationships based upon mutual trust, mutual respect, mutual accountability and reciprocity, and can be reduced neither to ‘upward consultation’ or merely to ‘interpersonal communication.’ The projected legislative amendment reinforces the traditional hierarchies of the westernised maternity systems established in the late nineteenth century in which mothers and midwives were unequal ‘partners’. Such power imbalances are offensive and no longer appropriate to providing ‘women- centred’ and high quality maternity care’. In the 21st century, mothers and midwives are more ‘information-savvy’. They now expect involvement in decision-making, and social relationships that are quite different to those underpinning the current system. Our research has shown that this lag requires further *cultural* change across the Australian maternity care sector rather than further regulatory control of midwives. Above all, legislation cannot be allowed to institutionalise inequitable and discriminatory arrangements that will endanger quality and safety in maternity care by provoking ongoing tensions. Our research has clearly demonstrated the entrenched nature of these tensions (Reiger 2001; Reiger and Lane 2009)

Continued barriers to collaboration

Our research findings points to significant barriers to collaborative maternity care in spite of many changes under way in the sector and those recommended by the MSR. Conflicts continue due to philosophical differences between, and even within, the professions, e.g.

- Midwives and obstetricians remain in fundamental disagreement about how to conceptualise birth and the level of risk associated with ‘normal’ birth.
- There exist inter and intra-professional differences in power, financial reward and status. The legacy of earlier organisational and professional cultures

continues to produce resistance to new models and forms of care from both midwifery and obstetrics.

- Obstetrics remains a status-oriented and hierarchical profession with significant internal professional tensions, especially over public-private practice, real and perceived resistance to evidence-based medicine. There is a critique within the profession itself that some colleagues are more oriented to making money than to service and that doctors in the public system are considered as 'second class citizens'
- Doctors now face challenges to their traditional authority by the consumer health movement and by midwives who have increasingly moved towards full professionalism to act as practitioners in their own right rather than as obstetric assistants.
- Obstetricians remain faced with concerns over litigation, insurance costs and lifestyle constraints.
- As a result of the above, both professional groups experience difficulties in recruitment and training of midwives and doctors, especially in rural areas
- Although many units adopting caseload and midwifery models of care refer to the practice referral guidelines, in practice role boundaries are often 'fuzzy' or 'foggy' due to differing interpretations.
- Different professional orientations towards birth have led to mistrust, hasty criticism, 'looking down' on the other and ridicule or generally uncivil behaviour.

Recommended strategies for change in maternity care

We argue that instead of legislative requirements for 'collaboration' good policy should promote arrangements to facilitate *all* midwives and doctors involved in maternity provision belonging to local collaborative networks of care for referral, consultation, and transfer when appropriate, including the real possibility of referral *back* to primary care! Care providers would acknowledge and work within agreed scopes of practice (including the midwifery scope of practice dealing with normal birth and obstetric scope of practice dealing with high risk events). All providers would then be subject to systematic and periodic professional review arrangements; the nature of which should be discussed and implemented by consensus and in consultation with women/families in the area.

All doctors working in obstetrics as well as all midwives would need to demonstrate their professional linkages/consultation processes. Whether in institutional or community settings this could be achieved by health authorities and professional bodies establishing educational meetings on a regular basis including, for example, in-house multidisciplinary reviews (daily and or weekly) and annual inter-professional educational forums, on both normal birth management as well as obstetric emergencies. Professional leadership from the major disciplines (midwifery and obstetrics) would provide the necessary modelling behaviour and encouragement to mediate an entrenched individualistic medical culture and a somewhat tentative midwifery culture. While policy initiatives may lead change, enduring cultural change can only be 'grown' and by becoming embedded in everyday workplace routines. Interdisciplinary training would also need to be supported by state and federal funding in pre-service education and through employing replacement staff for those undergoing training on a regular, cyclical basis. Further strategies include:

- regularly asking for input from other professional points of view into decision-making,
- discussing the question of advocacy and levels of responsibility,
- re-appraising professional spheres of competence especially in light of the practical autonomy required of midwives under caseload,
- encouraging structured and informal dialogue to enhance staff capacity for critical thinking and a sense of hospitals as ‘learning organisations’,
- specific training in essential interpersonal skills through experiential, trust-building workshops,
- identifying key ‘change champions’ in the professions—people with a clear vision for the future to consult widely with staff, testing out and disseminating strategies,
- remedying workplace problems, notably poor communication skills (particularly on the part of consultants and registrars) and the provision of dedicated meeting places for both social meeting and professional dialogue, especially across professional and unit boundaries.

In conclusion, our research evidence supports our argument that without effective *cultural* change processes, efforts to institutionalise professional collaboration in childbirth face certain failure and continued professional name-calling and competition.

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Working together: collaboration between midwives and doctors in public hospitals

Kerreen M Reiger and Karen L Lane

Abstract

While collaborative, multidisciplinary teamwork is widely espoused as the goal of contemporary hospitals, it is hard to achieve. In maternity care especially, professional rivalries and deep-seated philosophical differences over childbirth generate significant tensions. This article draws on qualitative research in several Victorian public maternity units to consider the challenges to inter-professional collaboration. It reports what doctors and midwives looked for in colleagues they liked to work with — the attributes of a “good doctor” or a “good midwife”. Although their ideals did not entirely match, both groups respected skill and hard work and sought mutual trust, respect and accountability. Yet effective working together is limited both by tensions over role boundaries and power and by incivility that is intensified by increasing workloads and a fragmented labour force. The skills and qualities that form the basis of “professional courtesy” need to be recognised as essential to good collaborative practice.

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WORKPLACE CULTURES and professional relationships in contemporary hospitals are in upheaval from several factors: the impact of neo-liberal health reforms requiring increased efficiencies, greater accountability and managerial power;¹ the questioning of doctors’ traditional authority by

Kerreen M Reiger, PhD, Lecturer
School of Social Sciences, La Trobe University, Melbourne, VIC.

Karen L Lane, PhD, Lecturer
School of History, Heritage and Society, Deakin University, Melbourne, VIC.

Correspondence: Associate Professor Kerreen M Reiger, Sociology Program, School of Social Sciences, La Trobe University, Melbourne, VIC 3086.
k.reiger@latrobe.edu.au

What is known about the topic?

Collaboration among health professionals has been identified as an important aspect of care delivery and is widely advocated in contemporary policy frameworks.

What does this paper add?

This paper explores the attitudes of midwives, doctors and managers in relation to collaborative maternity practice.

What are the implications for practitioners?

This study found that effective collaboration among doctors and midwives was limited by tensions over role boundaries, power relationships and incivility that appeared to be related to increasing workload and fragmentation of the workforce. There is a need to address these issues more effectively at policy and education levels to improve future collaborative practice.

the consumer health movement,² and challenges to traditional medical dominance by nurses and midwives. Relationships between staff in maternity hospitals are especially contentious. Since the 1990s, struggles to introduce new models of care, notably midwifery teams and caseload models, have faced deep-seated professional rivalries and conflicts and sometimes foundered. In Australia as in Britain, tensions are widespread across the maternity care sector, but they are played out in specific local contexts.^{3–6} While contemporary state policy initiatives increasingly promote multidisciplinary teamwork and collaboration,^{5,7,8} they can underestimate the difficulty of implementing change in practice, especially in an environment of financial stringencies, increased cultural diversity, staff shortages and increased birth numbers.

Drawing on qualitative research in several Victorian maternity units, this article considers inter-professional collaboration between midwives and doctors, arguing that new forms of working

together are essential to solve pressing staff recruitment and retention problems and to ensure improved care for childbearing women and their babies. Replacing the century-old hierarchical system of professional relationships in maternity care with one more appropriate to the 21st century remains a major challenge.

In recent years, health care has been affected not only by escalating costs, technological change, and administrative restructuring but by intensified calls for professional accountability as consumers demand greater involvement in decisions about their care and choice of caregiver. In Britain, the implications of such developments for the professional work of nurses, midwives and doctors are reported to include increased conflict and uncertainty concerning professional boundaries.⁹⁻¹² Although one panacea would include a more egalitarian professionalism,^{3,10,13} Degeling et al have argued that doctors' individualistic attitudes to their work make them less supportive of teamwork than nursing colleagues and managers.¹ Such underlying tensions have not been widely examined in maternity settings, yet lively public controversies about the appropriate "social design" of birth impact directly on organisational and professional arrangements.^{14,15} As midwives have sought enhanced professional status, the relationship between midwifery and nursing has become contentious and the role boundaries between midwifery and obstetrics increasingly disputed.^{4,16,17} In Australia, tensions are exacerbated by obstetricians' concerns over litigation, insurance costs and lifestyle constraints.¹⁸

The management of maternity care is also made more difficult by acute difficulties of recruitment and retention of both midwives and doctors, especially in rural areas.^{19,20} State policy direction in several Australian states and territories has responded to these developments by promoting multidisciplinary collaboration but also by supporting the establishment of less medicalised models of care and an expanded role for midwives.²¹ Several stand-alone midwifery-staffed birthing units without access to surgical facilities have been established. Significant momentum towards change has been occurring across the

Australian public maternity care system, as evident in the high attendance and discussion at the Australian Resource Centre for Health Innovations (ARCHI) conference, *Improving the quality of maternity services*, in June 2003. That many new arrangements, and birth itself, remain contentious has been evident since the launch of the federal Maternity Services Review in late 2008; articles such as that in *The Australian* 10 January 2009 use recurrent "battlefield" imagery, reporting a "counter-attack" by obstetricians against a "push to give midwives a bigger role".

National policy now echoes current Victorian guidelines which refer, for example, to the "complementary skills of midwives, general practitioners and obstetricians"⁸ and promoting "multidisciplinary learning, respect and trust among these different disciplines". Yet the difficulty of implementing such lofty ideals is often underestimated. Introducing genuinely "collaborative" maternity care involves resources and management of professional egos that have been locked in entrenched conflict for at least a couple of hundred years.^{22,23} Moreover, not only do some doctors resist change, but there are also midwives who prefer to work as what others disparagingly call "obstetric nurses", taking less responsibility and expecting less autonomy than those keen to work in new models of care.¹⁷ These policy and professional developments, within the wider social and political context of "risk society" and of health reforms,²⁴ form the context for the research into professional working relationships reported here. Evidence concerning the attributes desired in colleagues throws useful light on the sources of inter- and intra-professional tensions. Problems of incivility are further exacerbated in public hospital environments in which an increasingly fragmented labour force struggles with intensified work demands.

The research

The above issues were explored in Victoria through several interrelated but distinct qualitative case studies. Following pilot interviews in another four suburban maternity units, research

Site participation			
Hospital	Midwives	Doctors	Managers
City	68	15	6
Region	26	9	3
Rural	8	4	1
Suburban 1	29	5	4
Sub. 2–4	3	3	3

settings included a tertiary metropolitan hospital, a regional unit, a suburban hospital and a small rural unit (Box). The projects were carried out as collaborative projects between the university-based researchers and the hospitals. In all settings, interviews and focus groups with midwives and obstetricians covered similar issues concerning professional identities, inter- and intraprofessional collaboration, and organisational change in the sector as midwifery teams are introduced. In the tertiary and rural settings, research also included observational fieldwork during 2003–05 in some staff meetings, shift handovers and in the public areas of clinics and wards as well as attendance at several inter-professional meetings. In the regional and suburban units, research was largely confined to formal interviews.

Formal semi-structured interviews ranged from 30 to 90 minutes and most were tape-recorded and fully transcribed with transcripts returned to participants for checking and confirmation of what could be cited. This process, along with the fieldwork and informal interactions in several settings, produced a very rich and complex data set that was coded and analysed using NVivo software (QSR International, Melbourne, Vic, 2003). Major categories explored across data sets included organisational and management processes, professional cultures and identities, relationships and emotions. Progress and lengthy final reports were prepared for the main case study sites, and data validated through participants' and organisations' feedback. Although the distinctive historical legacy and contemporary management of each hospital site means that differences between them are important, this

article considers the recurrent patterns of response to questions about inter- and intra-professional working relationships.

Working together: views of collegial relationships

As well as reports of professional tensions, responses to questions about what doctors and midwives “looked for” in colleagues they liked to work with indicated considerable agreement about “ideal” workmates. Although midwifery and obstetric ideals did not entirely match — for example, midwives emphasised trust and respect while obstetricians emphasised accountability — across all sites ideas of trust, respect and accountability indicate a common basis on which to build collaborative practice.

Midwives who are “good to work with”

The personal is political

When asked what were the qualities of the “ideal midwife” some midwives cited personal qualities, others referred specifically to skills needed, and others to a strong midwifery identity or consciousness as practitioners of normal birth. Good midwifery colleagues were professionally supportive, backing each other up and sharing professional knowledge as well as personal support. Others valued a “hard worker”, someone who is “willing to share the load” and able to pick things up quickly or have “peripheral vision’ as to what needs to be done, as well as someone with commonsense and who took initiative:

... I look for someone, I like someone that can work, that can take a bit of initiative. OK, someone that ... is reliable And professional. I sort of get a bit upset with people who are a bit blasé about their job and don't give the service that they should be giving. (Mid 40 City)

I think you have to be flexible, approachable and relatively easy going ... and open to suggestions. (Mid 11 Regional)

Midwives did not appreciate a “panicker”. Some senior midwives in the tertiary hospital

suggested that their preference for working in a particular area was that it seemed more orderly, “hard-working” and team-oriented. Some regional midwives also stressed collegiality:

What makes a good midwifery colleague [is] someone who can see that other ways can be just as good, you don't have to practice all similarly to be right but I mean it has to be safe, someone who can be trusted and someone who respects your practice and someone who will actually care about you, making sure that the workload that you have got is fair, that you are not left in the ward when everyone else is taking off because it is home time and they have all cleared off and left you, not at all worried about what you are dealing with, that's about it, or someone with a bit of humour. (Mid 24 Regional)

Skilling-up and branching out

Variable skill levels emerged as a difficult issue for peers and midwifery managers as well as impacting on relations with doctors. Loss of some traditional skills due the medicalised nature of childbirth had undermined the capacity of the midwifery workforce to respond effectively to the new demands for midwifery professionalism. Several senior midwives disapproved of those who relied on a monitor to oversee women labouring with an epidural while they sat at the desk outside. Extra skills involved in managing “machines and things” sometimes seemed to be at the expense of other core midwifery knowledge. Managers pointed out that midwives' ability to work in all areas across the care continuum varied yet upskilling was sometimes resisted. Not having advanced skills for birth suite work, such as suturing, contributed to the reluctance of some midwives to practise more autonomously, and thus also, to the reluctance of both their colleagues and medical staff to rely on their clinical assessment. Midwives said it was important to acknowledge each others' varying skill levels and to be supportive of each other (that it should be “safe to ask”) rather than have peers merely be critical. One suburban unit introduced Clinical Midwife Consultants in an effort to broaden

midwifery skills and, importantly, to encourage greater confidence and professional autonomy among their largely working-class midwifery workforce. As one CMC explained:

[E]ight months ago [the midwife] would never have challenged what the consultant had said . . . now she comes and talks to me about it, she's already thought it through she's already made up her mind. Three months ago she wouldn't have thought it through . . . and within another three months she won't even be discussing it with me, she'll just ring the consultant and have a discussion directly with him. (Mid 12 Suburban)

The importance of having a strong midwifery professional identity emerged especially in interviews with students, graduate-level midwives, rural team and birth centre midwives: the value of genuine love of their calling — the importance of coming to work for more than the money, and being aware of professional developments, political issues and research.

A good carer

There was widespread consensus among the midwives interviewed that a “good midwife” is skilled at “being with women”, responding to an individual woman's needs and then working in partnership with her. The importance of respect for the birth process and of knowing women, or at least being very open to knowing them, and not judging them is crucial in this understanding. While at one level everyone expects a midwife to be a good “carer”, committed to the woman and her family, not everyone interpreted this the same way. Some tended to emphasise flexibility and other personal qualities. Another midwife said that a good midwife “avoided putting guilt trips on women” such as pushing women too far with regard to breastfeeding. A “good” midwife's commitment to birthing women was focused on listening and on flexibility of the self:

A good midwife should be able to [be] non judgemental, . . . Because we do have different clients from different backgrounds. They

have to be caring, and they need to give the patient emotional support as well as physical support. And that to me is a good midwife. It's not only the physical. (Mid Manager 10 City)

While practising safely, a good midwife therefore had to have the “highly developed skill” of “being able to individualise needs”, and to

respect their wishes because it's their body, it's their process, it's totally theirs it's not ours. We have to disown what we think is ours, we're there to support women and be with women. (Mid 14/3 City)

In these comments, clinical competence was assumed to be only part of the story — the “good midwife” has a firm commitment to supporting physiological birth and distinct personal qualities to facilitate it.

Midwives' views on a “good doctor”

When asked about “the qualities of a good doctor” as a colleague, midwives again mentioned a combination of practical, clinical, organisational, professional and personal qualities. They stressed the importance of doctors being competent, reliable and accessible, that is, coming when needed and doing what was necessary: “One who answers their pager is step one in the right direction” said one midwife and a doctor who “documents effectively” said another.

I've never had a problem with wanting to have a doctor up here and I just need you and they say do you and you say yes and they say fine. I've never had to explain myself in any great detail to get them up here. Which is good. So that's a good working relationship. (Team midwife Rural)

Most importantly, they wanted doctors to trust and respect their expertise as professionals, speaking warmly of times when they felt consulted as equals about a woman's care:

Yeah and we could work together and there was no title of doctor and midwife, we were colleagues, we worked together to help this woman. (Mid 19 Regional)

Doctors who respected midwifery knowledge and solicited their opinions were the most valued and those who negated or ignored midwifery knowledge were strongly criticised.

Midwives were conscious of the importance of the social relationships involved in professional interaction as well as in caregiving. Being “pleasant and helpful” was important, and most significantly, treating women courteously and not dismissing them as merely “public patients”. One midwife in the tertiary unit recalled being impressed by a resident who made the effort to sit down to talk with women, and another, the importance of doctors always introducing themselves, which most, but not all, bothered to do. At the regional unit a midwife expressed frustration at doctors who do not relate well to women:

They walk to the door and put their head out and yell out [the patient's name]. They sit at the desk and the computer's there and the notes are there and they look up and say 'I'm Dr X'. They have a flick through the history and say 'Yes you're 37 weeks.' There's no small talk — how are you today? Did you get a car park? Just to get the woman settled and to settle her nerves . . . She's a woman having a baby. She's not case number 24. She's a human being that needs interaction and support and I don't see that a lot of the time. The younger doctors are better at it. (Mid 25 Regional)

She went on to say that many consultants are “physically big” and need to “get down on the women's level” to put them at ease. Midwives' views were quite consistent on this: they valued doctors who trusted and respected not only them but the women, who were prepared to listen well, to negotiate and collaborate rather than just dictate how things would happen. Nonetheless, one midwife commented they also expected them to be able to make decisions when necessary: “To be decisive is important in an obstetrician.” (Mid 11 Regional)

Many midwives indicated concern about the individualistic nature of some doctors' style of operating, pointing out that they failed to communicate effectively with each other let alone

midwives and mothers. Desirable professional attributes of doctors also included wanting doctors not to feel *solely* responsible for outcomes, but to share their knowledge and decision-making, not only with midwives but with women and families. Along with this went a strong desire for obstetric staff to understand and respect, hopefully even share, midwives' commitment to normal physiological birth and to work in partnership to achieve it where possible. The difficulty of varying levels of professional investment in birthing was also apparent though. Some obstetricians in the tertiary unit were much more oriented to research into abnormalities, for example, than birth-suite work, and for GPs in the rural area, maternity care was a relatively small part of the load whereas the team midwives were passionate about it. A midwife in the regional unit noted acerbically that she expected doctors "to be interested" but they weren't always, especially juniors:

They are only here because they have to be and they don't really want to do obstetrics. They are not really interested in what's happening. (Mid 15 Regional)

Medical views on "a good midwife"

While doctors seemed not to have given as much thought to the issue of what they sought in inter-professional relationships than had midwives, for whom it was often a "hot topic", in general they wanted midwives to take considerable professional responsibility for managing a labour, as long as they had the clinical skills to do so. Most important, from a medical point of view, was clear communication and being kept informed of potential problems so that the doctor knew when they might be required:

The really good midwives [phone and] will say, look it's Joan here and Mrs So & So has just come in, she is in early labour, her past history is this, this is what she has come in with, everything is OK, the foetal heart is OK. She just tells you everything you need to know, you don't even have to ask a question and likewise you know that the really good ones will let you know when you

are needed, their anxiety about a situation will be clearly communicated, you know, because that's an important thing too. 'Do you want me to come in or do you not want me to come in?' (Con 2 Regional)

A good midwife as a colleague was skilled and could be relied upon to work as part of a team with medical staff. Furthermore, as one VMO at the tertiary unit said, she would be "astute enough and clever enough to know when there's a problem and to raise it" (Con 52 City). Similarly "a competent midwife [is] somebody who knows what she's doing and you know can handle labour well and has a good understanding of it. Ahh, and [is] somebody who calls you early enough", said another staff consultant. (Con 35 City)

A good midwife is somebody who knows the stuff, knows what is happening with the patient, is able to read things, is able to monitor the patient well and is able to tell you at the right time, this is when you need to come in and take a look. Somebody that you can rely on. (Con 8 Regional)

Doctors did not want to be called unnecessarily, and were scathing about midwives who were inept and called too often. Conversely, they wanted to be kept involved and resented midwives who they thought "hung onto" women "too long without consulting". Several said they valued midwives with a "good grasp of what's going on", and who shared their understanding, including the more intuitive dimensions:

You know, if there's a problem I like them to be, to be personally involved ... I like to know if they think someone's sick, a very basic question, but you can read all the blood tests and all the other ultrasounds and anything you like, but I still like to know whether you're worried about someone. I think that ah, that involves a hands-on sort of approach and a wholistic sort of approach, I think that's important. (Con 69 City)

While an emphasis on empowering women and trusting their bodies was not generally evident in medical discourse, some doctors shared mid-

wives' emphasis on a really good midwife being one who was "there with women", demonstrating finely honed skills of supporting her. As one said, "A great midwife is worth her weight in gold. A great midwife I think ... can do the supporting function [that most] doctors are pretty useless at ... hanging in there for hours and you know, really giving encouragement." (Con 42 City)

There was evidence that an increasing level of professional equality was being accepted in some units, especially as new models of care, such as the rural midwifery team working with GPs, became established. At least some doctors thought that midwives should be prepared to stand up for themselves, debate issues and offer opinions, but it was essential that they keep up to date with research evidence and disagree discreetly rather than force a confrontation in public. While consultants expected midwives to make independent professional decisions, more junior doctors in larger units seemed to have not thought much about this. If anything, residents and registrars were more likely to want midwives to let them take the lead and not undermine their decision-making. Most significantly, several obstetricians also spoke with concern about feeling dismissed and distrusted by midwifery colleagues and wanted them not to treat all doctors as equally interventionist, as "the enemy". In commenting on tensions and conflicts, they expressed frustration and sometimes considerable pain at not being trusted by midwives who excluded them from decision-making and birth rooms out of midwifery anxiety to "keep things normal".

What doctors want from medical peers

Themes in doctors' responses emerged in answer to questions about their role models, mentoring and leadership as well as in comments about local working relationships. For those in larger, more complex units, effective leadership and sense of direction were important along with clarity of roles and responsibilities. Medical concerns varied at the case study sites in response to specific

medical management issues in their organisation and their own practice demands, but the general context set by the dominance of private practice in Australian obstetrics shaped their perspectives, as well as pervasive concerns with litigation risks. Both consultants and registrars in a suburban hospital in a working class area expressed their frustration at being seen as less worthy by some colleagues in their profession, and even in the tertiary city unit, senior staff specialists reported resentment at the ways in which obstetricians in private practice assigned them second-class status. Nonetheless, those working largely in birth-suite roles rather than in research were seen as somewhere in between in the informal valuing of obstetric roles. In the regional setting, all obstetricians (bar the registrars) maintained independent private practices but their apparent individualism was overlaid with cooperative arrangements to enable off-duty weekends and to ensure representation at the managerial level at the hospital. They had also negotiated with each other and with midwifery managers to roster themselves into a midwifery/obstetric team one day per week; a strategy that had proved relatively successful in quelling old enmities and in forging a more collaborative spirit among themselves and with midwives. Similarly in the rural unit, the GPs who carried an obstetric load became more collegial in the process of working in new ways with team midwives.

Like midwives, many doctors valued "hard workers" and sharing of the workload. A significant theme in medical discussions of collegiality was that work satisfaction required some continuity in caring for women but also intellectual interest. Some consultants thus placed considerable value on research opportunities and opportunities for advancement. They also stressed the importance of good organisational communication, usually finding their local units lacking in some respects at least, and in larger units, doctors stressed the importance of integrating and preparing junior staff effectively. Along with concern about declining levels of specific skills went some fear that junior medical staff were likely to be less good "all rounders", lacking the capacity to assess

a wide variety of factors, or “see the whole picture” compared with previous generations. Their more fragmented and limited training, greater orientation to relying on technology, and more defensive practice because of rising litigation fears, were seen by some senior doctors as potentially leading to a certain deskilling of professional competence. Obstetrics clearly requires greater personal skills than surgery, and this means being “open to discussions and viewpoints different from theirs”, both those of peers and patients:

I have a lot of respect for people who are willing to sit down and think things through ... And I think that's particularly pertinent for obstetrics, where there are often difficult or controversial decisions to make. And I often say this to some of the junior residents now, there often isn't a right or a wrong decision. And you know, there's that real partnership between you and the patients and their family when you're making a difficult decision. [And this is] incredibly different from surgery [where] we would go to a patient and say, right, you need x, y, z, here is the consent form, sign it, and we'd just go ahead and do the procedure. (RMO 28 City)

As with midwives, personal qualities were therefore valued in colleagues, particularly the capacity to stay calm, to listen and be patient and to be able to think independently. Some doctors mentioned the importance of being “caring”, “kind and respectful to midwives and women” and able to “individualise” care, though these attributes were not articulated as consistently as they were by midwives.

Conclusion: working together in maternity care

The data concerning what doctors as well as midwives in these Victorian hospitals sought from each other as colleagues can be summed up by drawing attention to the themes of trust, respect and accountability as central to intra- and inter-professional collaboration. In spite of different emphases, some of which reveal significant differ-

ences in professional cultures, what one midwife termed “professional courtesy” emerged as a concern across the case study sites, across levels and professional groups. Work units which were reported to be working well were marked by a greater sense of parity between staff, and by courtesy towards each other as well as by strong commitment to caring for women and babies. Real “team work” involved qualities of sharing, support, civility, mutual trust and respect. At the practical level it meant staff introducing themselves, being helpful and pleasant, getting a drink for everyone not just friends, showing newcomers where equipment was, pulling together as a work team, admitting weakness/mistakes, taking responsibility and initiative, exercising “common sense” and being a team player. While there is much rhetoric about reorganising service delivery around “teams” and multidisciplinary collaboration, the actual operation of workplace groups required quite basic qualities of interpersonal interaction. Common civility, or as one staff member in the tertiary unit insisted, “good manners” meant acknowledging names, being polite in asking for things and not abusive in stressful times, considering others’ needs for a break or bringing in a cup of coffee — in general, expressing care for all fellow workers regardless of their occupational status. Others pointed to the various ingredients that flowed from and reinforced trust and respect for each other: being open and honest, including about skill levels and not knowing some things, awareness not only of how others are feeling but *self-awareness*, especially an ability to acknowledge vulnerability and assert competence.

Midwives tend to have thought more about professional courtesy as they have been the subordinated partner in the medical–midwifery relationship. Their search for more equitable treatment depends, they say, on mutual respect. They feel respected, for example, when a clinical judgement around a vaginal examination is not routinely questioned; they “feel taller” because “respect begets respect” and that flows back to medical staff. A Visiting Medical Officer too emphasised the two-way process, and that the

ability to challenge and to disagree was essential to getting away from the old-style authoritarian doctor. Apart from trust and respect, issues of shared accountability, commitment, communication and confidence, competence and cooperation also emerged in people's stories. The importance of a midwife feeling sufficient self-esteem based on her professional competence to do and communicate competent assessments is basic to effective teamwork with medical staff. Yet more than individual attributes are involved. Medical meetings in which derogatory attitudes were expressed to midwives as a collective — such as jocular exchanges on “taking lavender oil to theatre” conveying dismissal of “natural birth” ideas — had the effect of undermining respect for professional competence. So do midwifery exchanges which generalise and denigrate medical practitioners as a group. It is possible to remain critical of specific clinical practices and of the “biomedical model”, or of holistic philosophies, without publicly impugning the motivations of practitioners. Trust and respect within and between the professions also remains limited by inadequate opportunity for effective inter-professional dialogue in respective training regimes.

Furthermore, organisational cultures in health care include a complex mixture of traditional and new tensions. Earlier hierarchical staff relationships went hand in hand with a traditional public hospital “welfare mentality” that, where it lingers, undermines demands for mutual respect, increased diversity and egalitarianism. Attempts to introduce public sector reform have promoted inter-professional collaboration and boundary realignment,^{25,26} but also generated new sources of discontent and incivility. Professional workers in maternity care now struggle in a difficult contemporary work environment defined by staff shortages, rising birth rates, increased acuity and shorter hospital stays. Yet the resulting intensification of workloads has to be managed by a more fragmented labour force. Under these circumstances, both national and local policies advocating a new collaborative culture present a major challenge, especially in view of the philosophical

differences and tensions in maternity care. The data reported in the article indicate that mutual respect is required not only between individuals but at the professional and organisational levels. “Professional courtesy” should be demanded in meetings as well as in clinical settings. If senior medical and midwifery staff deliberately model working together as a process of critical dialogue, they can establish an alternative, mutually respectful professional culture. The concept and principles of “professional courtesy” need therefore to form the benchmark of routine hospital practices — introduced in undergraduate education, reinforced in later professional development, and embedded in policy formulation processes. Only then will collaborative “working together” become effective.

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Competing interests

The authors declare that they have no competing interests.

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