

STILL SUFFERING FROM THE 'SILO EFFECT': LINGERING CULTURAL BARRIERS TO COLLABORATIVE CARE

SOUFFRANT SANS CESSER DE 'L'EFFET DE SILO': LES BARRIÈRES CULTURELLES AUX SOINS EN COLLABORATION SUBSISTENT ENCORE

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ABSTRACT

This research project sought to draw out the contesting definitions of collaborative care among professional subgroups in maternity services. The paper contrasts medical and social models of knowledge and reports on qualitative evidence from midwives and doctors in Australian hospitals. The evidence indicates that collaborative care is welcomed by both midwives and doctors but that there remains a lingering residue of the 'silo effect' of the 'old' professionalism, characterized by hierarchical relations, divergent philosophies and competing domains. Although a 'new professionalism' has emerged that challenges the old hierarchies and professional dependencies, it too harbours lingering residues of the former dichotomy between midwives and obstetricians. These tensions and enmities will need to be resolved before genuine collaboration may take full effect. The objective is a relationship-focused model of care that transcends professional or woman-focused models. The 'new' professionalism may be expedited through mediation strategies, a version of which is the 'sociological intervention method' discussed in this article.¹

KEY WORDS

'old' and 'new' professionalism, collaborative care, medical and social models of birth, social constructionist models of knowledge

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RÉSUMÉ

Ce projet de recherche tente de faire ressortir les définitions divergentes des soins en collaboration au sein de sous-groupes de professionnels en services de maternité. Ce travail met en contraste les modèles médical et social de la connaissance et rend compte des données qualitatives provenant de sages-femmes et de médecins dans des hôpitaux australiens. Les données démontrent que l'approche collaborative est appréciée par les sages-femmes ainsi que par les médecins, mais que les malaises résiduels de 'l'effet de silo' de 'l'ancien' professionnalisme perdurent. Ceci est caractérisé par des relations hiérarchisées, des philosophies divergentes et des domaines qui se font concurrence. Quoiqu'un 'nouveau professionnalisme' qui défie les vieilles hiérarchies et les dépendances professionnelles ait émergé, ce dernier aussi entretient les malaises résiduels de l'ancienne dichotomie entre les sages-femmes et les obstétriciens. Ces tensions et inimitiés devront être résolues avant qu'une véritable collaboration puisse prendre effet entièrement. L'objectif est un modèle de soins axé sur les relations qui peut transcender les modèles professionnels ou les modèles centrés sur la femme. Le 'nouveau professionnalisme' peut être activé à travers des stratégies de médiations, une telle stratégie serait la 'méthode d'intervention sociologique' qui sera examinée dans cet article.¹

MOTS CLÉS

'l'ancien' et le 'nouveau' professionnalisme, les soins en collaboration, les modèles médical et social de la naissance, les modèles socio-constructionnistes de la connaissance

CET ARTICLE FUT RÉVISÉ PAR SES PAIRS

INTRODUCTION

Women entering the maternity arena in Australia and other western regimes have suffered incidentally from what is known as the 'silo effect'. This refers to a clash between the training regimes of the 'old professionalism' and the 'new professionalism'. Under the 'old professionalism', hierarchies were erected between the so-called semiprofessions such as nursing and social work on the one hand and medicine on the other, resulting in what Degeling et al have documented as oppositional modes of decision-making, styles of working, roles and accountabilities.^{2,3,4} Within the last decade, a 'new professionalism' has emerged in many western regimes, including Canada, New Zealand (NZ), the United Kingdom (UK) and, most recently, Australia.^{5,6,7}

In Australia, the 'new professionalism' has emerged through a range of innovative working configurations such as team midwifery and caseload. These models put the midwife into the picture much more as a primary carer instead of obstetric nurse. Social forces such as a swing from hospital-based to university-based training for nurses and midwives, the ripple effects of three decades of feminism, the professionalization of midwifery, the attrition of midwives from the workforce, the rise of health consumerism from the late 1980s and the crippling costs of professional indemnity health insurance for obstetricians (leading to a crisis in recruitment) have led to this 'new professionalism' in maternity services in Australia, NZ, Canada and Britain.

I argue in this paper that a 'new professionalism', defined by midwives as woman-centredness or a partnership model of care, is certainly displacing the 'old' style of professionalism entailing professional hierarchies and vertical lines of styles of authority and accountabilities.² Indeed, maternity services in Australia are currently running under two contesting models or discourses (including sub-discourses),

leading to considerable strains and anxieties. The genesis of this is located in formative training regimes and professionalization strategies that are realized in everyday exchanges in the birthplace, often to the detriment of women. The caveat with the 'new professionalism' is that it fails to achieve genuine collaboration, defined as mutual trust, interdependence and mutual accountability because, in many respects, it remains defined by the old divisions.⁸

THE MEDICAL MODEL OF ILLNESS AND DISEASE

According to the biomechanical model, disease is an organic condition; psychological or social conditions are ignored on the assumption that the causes of disease or illness can be found within the body or biology.⁹ Sick individuals then report to the doctor who takes on the role of expert to heal the sick body, while the patient becomes a compliant recipient of the doctor's expertise.¹⁰ This usually takes place in a medical setting. The patient becomes the object of the professional medical 'gaze'; there is no reason for the patient to be drawn into more than a formative discussion of the treatment or its causes because the expert possesses knowledge about the body independent of the knowledge conveyed by the patient.

The medical model of care is also termed 'objectivist' because it assumes that there is an objective reality that can be studied, learned and applied to solving problems. An alternative term is 'positivist' because reality is posited rather than constructed.¹¹ The model is inherently expansionary in that it constantly recruits new domains for exclusive jurisdiction. This is what is meant by medicalization, or a situation where ordinary social problems are turned into medical problems and then quarantined as the province of accredited medical practitioners who control the entry, practice and use of equipment and treatment regimes through strategies of professionalization.¹² Examples include homosexuality, alcoholism and childbirth. The

outcome is broad-based medical dominance. Take childbirth as an example. A normal physiological event in the social lives of many women over history in different cultures has been reconceptualized as a dangerous event best undertaken in an acute-care setting under the auspices of specialist obstetricians, who then claim exclusive legal authority over knowledge, the procedures and the women. Their authority is legalized and accredited by the state on the grounds that only they possess the codified knowledge to use special equipment (forceps, scalpels, or drugs) or prescribe potentially dangerous drugs.

THE IDEAL ROLE OF THE MIDWIFE: A SOCIAL MODEL OF HEALTH AND ILLNESS

As a defence against historical colonization of their occupational domain, and in support of their own knowledge about birth, the midwifery strategy of professionalism defined midwifery in contrast to the medical model. Where medicine adopted biological reductionism (where things are broken down into their smallest component parts to seek causal explanation), hierarchical relations (the expert commands obedience and respect for their exclusive knowledge) and an interventionist philosophy (on the grounds that the body is essentially pathological and the expert must restore the body to a healthy equilibrium), midwives marked out a separate terrain by embracing a holistic, non-interventionist, and politically inclusive paradigm.

The midwife looks at the social context for causal explanation. She has faith in the normality of the female body. She believes that most women are able to birth without medical intervention. She incorporates the woman into decision-making. Some called it a 'partnership' model of care.^{13,14,15} It refers to a relationship characterized by communication exchange, trust, reciprocity and integrity.¹⁶

Midwifery became defined as 'guardianship of the normal'. It came to define itself in opposition to precipitous medical intervention.² Midwifery goes well beyond the narrowly codified medical and obstetric knowledge to parallel the World Health Organization (WHO) social model of health, defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.^{17,18} Also unlike conventional medical practice, midwives

recognized that the woman possessed agency or a 'self' (she had physical, psychological, social, cultural, spiritual needs and expectations), which entitled her to be treated as the final authority on how to proceed.¹⁹ For example, according to the Victorian Midwifery Code of Practice, midwifery signifies woman-centred care:

*...working with women throughout the continuum of childbirth, which extends from preconception to early parenting. In the provision of care, which ideally is provided within a continuity of care model, the midwife is cognisant of the woman's physical, psychological, social, cultural, spiritual needs and expectations....The philosophy for this care is woman-centred....*²⁰

THE LEGACIES OF THE 'SILO' EFFECT

Midwifery's 'woman-centredness' embodies what Tully and Mortlock term the 'new professionalism' where the professional and the client together negotiate a desired outcome.² It challenges the 'old professionalism', characterized by a top-down model of knowledge imposed by the doctor on the patient, where knowledge is posited as objective, beyond question and value free.

Under the 'new professionalism', knowledge is regarded as socially constructed. The objective is to share professional knowledge in serving the special needs of the client. The 'new professionalism' is gradually displacing the 'old professionalism' in Australian maternity care. For example, many maternity units are now introducing team midwifery and caseload models of care where the midwife is the primary carer in providing continuity of care (and possibly carer) and will only refer problematic cases to the obstetrician or their deputy, the registrar. This is a sharp shift from the traditional model of care in Australia where midwives were trained first as nurses with an add-on speciality in midwifery and where they were treated as maternity nurses rather than independent practitioners. This status was achieved primarily through employment policies where the bulk of midwives were deployed in hospitals on a roster system in either antenatal, delivery suite or postnatal ward and where the outcome was fragmentation, deskilling and loss of professional confidence. For example, in 1999 in Victorian hospitals, it was

estimated that women were given a choice of 18 different of models of care, but only around 5.6% of women saw a midwife as their primary carer.²¹

In the past few years, a number of social forces have coalesced to change that pattern. These include a rise in health consumerism, an irreversible pressure by midwives to claim genuine professional autonomy, a crisis in obstetric retention rates fuelled by crises in funding and professional indemnity insurance and the extrapolation of elements of alternative maternity models from Canada, Britain, the Netherlands, Scotland and New Zealand that posited the midwife as primary carer under the 'new professionalism'.

Unlike Canada or New Zealand, however, Australian midwifery autonomy was never legalized. For example, in many states the legal machinery covering midwifery practice has often been included under nursing legislation and, more recently, midwives were refused professional indemnity cover to work in the community. Only recently and only in two states (the Northern Territory and New South Wales) has professional indemnity insurance been extended by hospitals to cover midwifery practice in the community. This means that the status of the 'new professionalism' in Australia is still tenuous. It can be described as the 'silo effect': a residue of the 'old' professional work habits, communication patterns and professional identities cohabiting uneasily with the new.²² The 'silo effect' is evident within both obstetrics and midwifery.

Degeling et al have chartered the 'silo effect' in nursing and medicine, finding that nurses avoided uncertainty, rejected inequalities of power as natural or necessary, preferred security over autonomy and opted for custom and precedent as bases of decision-making. They supported team-based work process models of management, accepted hospital protocols and preferred opaque methods of accountability.³ Doctors saw inequalities of power as natural and necessary. They rejected formal rules as bases for decision-making, ranked autonomy over accountability and saw little value in a supportive superior. They denied clinical knowledge shortcomings as explanations of clinical variation and opposed organizational transparency to achieve clinical accountability. They supported organizationally opaque approaches to

accountability. These mindsets express and galvanize the 'silo effect', explaining why transgressions of traditional professional boundaries cause much conflict.^{23,24} Many of the tensions may be attributed to hierarchical relations between doctors and midwives, medical versus social theories of birth, differences in skills bases and professional spheres of competence. Of critical importance are the perceived and actual responsibilities for legal liability.

The purpose of the current study was to ascertain whether the 'silo effect' operated within maternity services to prevent midwives and obstetricians working collaboratively to provide optimal care for women.

A qualitative study involving in-depth interviews with 20 Australian midwifery managers, 20 midwives and eight obstetricians employed in a range of providers from 2002 to 2004 revealed issues for both professional groups stemming from the 'silo effect' of professional training regimes. Issues included strategies for care, responsibility for outcomes and professional boundaries.

THE MIDWIFERY PERSPECTIVE

When midwives are not regarded as primary carers

The manager of a small rural public unit pointed out that obstetricians were not 'bad', but they were the logical product of medical and educational prejudices. If obstetricians delivered antenatal care, midwives were rendered powerless to suggest less interventionist options if the woman presented for the first time at the hospital already in labour:

...[if] the woman has been through their antenatal care with the doctor he is going to be their source of authority. We try to operate as midwives independently but because they are private patients...ultimately they [the obstetrician] will make the decision.

Obstetric fear of litigation

A midwifery manager of a middle-range private hospital (2,000 births per year) explained that obstetricians' fear of litigation made it impossible for the midwives at the hospital to work collaboratively with doctors.

...I don't think the midwives necessarily have autonomy. It's partly the medico-legal situation. Fear of litigation makes everyone interventionist.

Part-time staff

Another midwife reported that continuity of care in the public sector was compromised because of large numbers of part-time staff:

We have no continuity of carer models because with part-time staff we cannot adopt that principle...Most of the midwives prefer to know exactly when they are going to have days off in advance because they have their own families to care for and this was the thing that came through with team midwifery – it did have an effect on their families.

A culture of consumer passivity

According to midwives, the dominance of the medical model is partially located in a widespread cultural acceptance that the 'doctor knows best'. One midwifery manager reported:

We certainly encourage the women to think about what's happening and to make decisions for themselves and to speak up for themselves but in the end it's what the doctor says, which in their mind they think, 'I have to listen to what he's telling me'.... We do get some clients who will stick to their beliefs but I guess most of them will conform to the medical model.

According to midwives, some obstetricians felt threatened by anyone they thought may challenge their authority. One midwifery manager reported:

[Collaboration] is always difficult to achieve in a health setting because of an unequal balance of power between the medical profession who has the knowledge and the consumer who has little.... They [obstetricians] do feel threatened by people who are more assertive. To be fair it's not a model they have been familiar with or have had training in.

Many of the midwifery managers believed that obstetricians urged women to request intervention such as epidurals as a form of pain relief. A midwifery manager remarked:

I wonder if they [women] are asking for intervention because the doctor suggests it's a good idea.

This could be an effective marketing strategy to recruit

women with private health insurance via word of mouth. It probably also reflects a deeply held conviction on the part of obstetricians that birth is a dangerous event. For example, one obstetrician reported that research studies of UK and Australian female obstetricians showed that between 14-30% would elect to have a Caesarean section for their own births to avoid future morbidities such as fecal and urinary incontinence.

A culture of subordination among midwives

The 'new professionalism' had not mediated a culture of subordination among some midwives or a continuing culture of autocracy among obstetricians. A junior midwife observed that:

The midwives' Code of Practice actually gives you a very good definition of collaborative practice that each health professional's skills and expertise will be recognized. The midwife does midwifery, the doctor does medicine, and we're all a big happy family. No, it doesn't work like that. In fact, the doctor takes ownership of the whole thing and pushes the midwife aside. I find that happens quite a bit because midwives don't all come from the same place. Some midwives don't want responsibility and some do. To give doctors some credit they don't know who those midwives are that want responsibility and who they could work with in the true collaborative sense. It's going to take a long time to get that point [where all midwives will accept responsibility]. Literally, it is just not there. In the hospital system many midwives see their role as simply handmaiden to the doctor.

Lack of midwifery skills

In smaller rural hospitals the culture of subordination was premised on a lack of midwifery skills. A midwifery manager noted that:

...the midwife has to be confident and competent in a range of areas that they are not now. That must happen over a number of years. At the moment they don't have the necessary skills and that's because the existing education system doesn't produce independent midwives. They need six to 12 months until they feel confident. Perineal suture, vaginal examinations, turning babies—midwives need those skills. The deficit is in antenatal skills. We might have to send people away to get that extra. But team midwifery is better. You need someone who can carry on right through instead of setting up an antenatal clinic and just adding another caregiver. We are working towards that over time. But there will still be issues around professional indemnity insurance.

It should be noted that many universities and providers in Australia are now training midwives through a 'direct entry' system to expect to assume an expanded scope of practice in collaboration with obstetricians. Many providers are also up-skilling a proportion of their midwives to do suturing, fetal scalp monitoring and other skills.

Diluted midwifery responsibility for outcomes

Another midwife with long years of public sector service explained that there was a qualitative difference in the degree to which an adverse outcome would result in personal and professional stigma and financial loss for midwives:

Litigation is a huge issue [for obstetricians], more than it is for midwives. Maybe they have had issues whereas a lot of the midwives haven't actually had to deal with the law. If a few more of them were, we would be working differently.

When 'guardian of the normal' becomes a vehicle for self-interest

Many midwives complained that a few midwives pushed the boundaries of the 'normal' in order to secure a non-interventionist birth even when intervention may have been indicated. A more senior midwife reported that:

I have seen some midwives that do work like that [refuse to refer the woman to the obstetrician] and it is more about them and their egos and what is important to them.

THE OBSTETRIC PERSPECTIVE

'Old' and 'new' cultures

One obstetrician noted differences within the profession that he termed 'old' and 'new' cultures. The description of 'old' cultures resonated with Degeling et al's findings reported above.³

The problem is that we have two lots of practitioners [obstetricians and midwives] who have different philosophies, different beliefs and different levels of responsibility and perceive themselves as having different levels of responsibility. That's a real problem.

Inadequate midwifery skills

Obstetricians were less likely to trust midwives who lacked self-confidence in their own skills. A senior obstetrician believed that:

There is the person who doesn't trust their own skills and who will call you at the drop of a hat because they basically don't know properly how to analyse the CTG.

When the midwife-as-primary-carer turned into patient's advocate

Obstetricians were particularly scathing about the 'silo effect' when it turned into a contrived adversarialism. Another senior obstetrician argued that:

...the relationship between midwives in the public sector and with me, in particular, is extremely difficult... There are a small number who tend to practice independent midwifery. When they become the patient's advocate they set up, maybe not consciously, an adversarial relationship with the obstetrician, which is very difficult because there is not that intimate personal relationship with the woman. Because of the lack of continuity of care [between the woman and the obstetrician] there are many, many opportunities for those midwives with that philosophy to undermine what would be considered safe, gold-standard effective care... they advocate for the patient and take on what they perceive she wants but it may not be in her (the woman's) best interest.

Obstetricians believed that this kind of advocacy was used to promote narrow professional interests rather than the genuine interests of the woman. The following comments from an obstetrician reveal a common view among doctors of anti-medical sentiment among some midwives:

...but some of the midwifery teaching is anti-doctor and some of it comes from this viewpoint that part of a midwife's role is to be a patient advocate. And that means defending the patient from the medical establishment who only seek to do interventionist things and horrible things to this person who is undergoing a wonderful natural process and it is totally within her control and if she does all the right things will have a wonderful outcome. We find this very difficult to deal with... like a midwife whispering in the ear of a patient... sort of immediately puts us off-side.

Litigious consumers

Most of the obstetricians embraced the 'new professionalism' in welcoming a greater vigilance and questioning of authority from women about their own care. Yet they also mentioned a phenomenon of rising and unrealistic demands that caused obstetricians to take defensive action. A senior obstetrician summed up a common concern about litigation among obstetricians:

...the medicalization of childbirth has been driven I think by safety. I think there are certain safety issues and what makes you choose safety in a big way over patient choice or comfort is that legal thing. You know it really swings the balance of that equation markedly. The generic patient does not realize the price that they are paying for having such an overbearing litigation culture. It is just influencing everything we do and the poor old patient cops it.

A clash of cultures – different identities

Obstetricians believed that their medical training and role as primary carers endowed them with a unique view of the short-term and long-term adverse effects of childbirth. This meant they were prepared to intervene much more than midwives. They saw midwives as reluctant to step across the boundary of ‘natural birth’ to learn to use instruments and technologies, even in emergencies. A senior obstetrician noted that:

...we ran an emergency course for our residents, new registrars and some of the more senior midwives. The midwives were very reluctant to even pick up the forceps to do a forceps delivery because they saw that as something that doctors always did. That was interesting to see.... They were very reluctant to sort of get involved in doing the hands-on practical deliveries whereas doing a normal delivery they feel much more competent at it than the resident may be.

In order to professionalize, midwifery became defined in contrast to obstetrics as the guardianship of ‘natural’ birth. The clash between the ‘old professionalism’ and the ‘new professionalism’ is then played out in training, professional practice and informal cultural and interactional styles with staff, patients and superiors.²⁵ A female obstetrician remarked:

The hard thing is I can be just as firm as the most active management practitioner by saying I'm very much not prepared to sacrifice a baby or a baby's good start in life for a birth process [for the mother to have a ‘natural’ birth]. I guess that's probably where sometimes the midwives come up against me.

Asymmetrical accountability

Related to a greater willingness to intervene than midwives (see above), obstetricians saw midwives as quarantined from the harsh realities of a punitive legal environment, which forced them (obstetricians) to

practice defensively. They felt legal pressures had intensified in more recent times when women demanded the perfect baby. For obstetricians, this difference between legal liability lies at the heart of different professional identities and role boundaries. This obstetrician expressed a common view among colleagues:

The average midwife is only just starting to see how overbearing that legal thing is partly because they are not in private practice the same way as we are. They are practicing under the envelope of this hospital that surrounds them. They have not been, up until now, the ultimate decision-maker. It always falls back to the person who is the end of the line and we are the end of the line. Even if midwives independently practice, we are still the end of the line because they will call us up to get them out of trouble.

Another obstetrician reported that:

Our MDA [medical defence association] is saying, from a medico-legal perspective, that for our members to act in order to reduce their risk and therefore hopefully to reduce claims and premiums, that the obstetrician must be in charge of the outcome. So you have yet another layer complicating the relationship between the client, the obstetrician and the midwife.

The win-win solution

The objective is to create a new body of knowledge, one that does not privilege objectivist knowledge (codified, scientific knowledge applied universally to women's bodies) or productivist knowledge (non-codified knowledge constructed in social interaction with the woman) but one that embraces elements of both. This new model would expropriate the technological expertise of the medical model when necessary (according to obstetricians and midwives in approximately less than 10% of all cases), and combine it with the holistic, empirical knowledge of the midwife (a knowledge that is founded on intersubjective sensitivity and respect for the dynamic interaction between mind and body and body and social context).

Enduring changes are more assured when everyone wins a win-win solution but this means that everyone must give up something. Midwives need to vacate the high moral ground of ‘guardians of the normal’ and to recognize the limits of their respective sphere of practice. That is, they must recognize when

physiological changes indicate a shift from the normal to the abnormal (however blurry that boundary may be). Obstetricians need to jettison the burden of sole arbiter and architect of birth outcomes by relinquishing the moral high ground of heroic medicine. They must systematically construct an ongoing dialogue with midwives and mothers in deciding the *modus operandi* for every birth. Mothers need to be included in the decision-making loop of communal responsibility for outcomes.

A useful mediation tool is the 'sociological intervention method' that entails a series of mediation workshops among parties to help them to construct a mutually supportive narrative of complementary skills.²⁶ As with all mediation, the aim is to expose the tensions, not to embed them further. It should allow participants to self-reflexively analyse the worldview of the 'other' in the process of creating overlapping spheres of competence and collaboration. As one obstetrician put it:

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

CONCLUSION

The 'old professionalism' is based on traditional hierarchies and vertical lines of authority leading to a 'silo effect' where midwives and obstetricians were educated according to different paradigms, developed oppositional identities and practiced in competition with each other. A range of social forces conspired to challenge this model in maternity services, leading to a 'new professionalism' defined by a social model of knowledge, woman-centred care and inclusivity.

The evidence from this study shows that there are residual elements of the 'old professionalism' seeping into the 'new professionalism' of both midwifery and obstetrics. Collaboration, defined as mutual trust, interdependence and mutual accountability, cannot be

achieved in a climate of residual resentments, mistrust and rivalries.²⁷ Midwives have charged obstetricians with encouraging private sector women to ask for intervention to avoid pain, thus encouraging the persistence of a passive consumer culture. Midwifery managers believed that many obstetricians practiced 'defensive' medicine to avoid litigation and that 25-50% of midwives (like Canadian midwives) were happy with a minimal scope of practice.^{i,28} A few midwives used consumers as a vehicle for self-interest.

Obstetricians were driven by fear of litigation, public humiliation, professional stigma and damage to their income-earning base. They believed that midwives working in the public sector enjoyed a false freedom under the hospital's legal protection; that continuity of midwifery care was a myth; that midwives often lacked the necessary skills to engender their trust and that many refused to learn new skills (such as instrumental deliveries) on the grounds that this would spoil their pristine midwifery identity as 'guardians of the normal'. They resented a contrived adversarialism on the part of midwives and saw themselves as having a unique long-term view of women's health.

Obviously there remain many tensions within the new models of midwifery-led care around transgressions of traditional boundaries. Yet there is evidence that obstetricians genuinely long to construct harmonious relationships with midwives. It is hard to escape the conclusion that the most fruitful way forward is genuine collaboration that is relationship-focused rather than expert-focused, profession-focused or 'woman-centred' that will transcend both the 'old professionalism' and the 'new professionalism' insofar as they continue to be defined in competition with each other. The way forward will present challenges for all participants.

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AUTHOR BIOGRAPHY

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exceptional birth of her first daughter and an equally wonderful birth for her second.

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FOOTNOTES

¹Of course midwives in Canada and Australia work within very different legal contexts. Canadian midwives are legally independent from obstetricians and work independently in and outside of hospitals. Australian midwives may also work independently outside of hospitals, but they do not have professional indemnity insurance unless they work under the cover of the hospital. This is one of the main reasons that Australian midwives work in hospitals.

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