

Who Do We Serve? Role Conflict in Ontario Midwifery

by Julie Corey, RM

ABSTRACT

The integration of midwifery into the Ontario health care system has posed challenges to the role of the midwife. The pressure to maintain hospital privileges and the fear of litigation can place midwives in opposition to their role of advocate and support for childbearing women. Additionally, collaborative maternity care models may also create conflicting demands on midwives. Midwives can experience these challenges as role conflict which can have a detrimental effect on midwifery care and lead to work stress and attrition in the profession. Open dialogue, further research, education, consumer involvement and improved interdisciplinary communication are among the strategies that could be used to better understand and address role conflict amongst midwives.

KEY WORDS

midwifery, professional roles, ethical issues

Role conflict has been described as "incongruity of the expectations associated with a role". This may be due to differences in an individual's preparation, training and the role they are asked to fulfill. It may also arise from incompatible expectations within a role or competing/incompatible demands coming from different sources.¹ Role conflict in midwifery may arise from any of these sources. How does this role conflict affect a midwife's ability to be "with woman", while striving to be a contributing member of the larger health care community?

The integral role of consumers in the lobby for midwifery legislation and funding created a mandate for registered midwives to respect the basic elements of care that women were seeking. The partnership between midwives and women that helped form midwifery legislation also contributed to defining the model of practice.

Of the various models of health care relationships, midwifery most resembled a covenant model which

emphasizes mutual commitment and reciprocal obligation.² In addition to being caregivers, many midwives envisioned political action as an integral part of midwifery.

Midwives' interpretation of traditional midwifery, therefore, not only refers to a particular set of knowledge and practices, or model of care, but also stands as political symbol of women's resistance to the medicalization of pregnancy and birth.³

Thus, midwives at the forefront of modern Canadian midwifery were agents of change as well as care providers. Some worried about the effect of legislation on the model of practice, that it would become diluted and no longer meet the needs of the women who helped create it. One pre-legislation publication observed:

Some midwifery advocates do not welcome legalization. Others pursue it with mixed feelings. They foresee the midwife's role co-opted by the system, her philosophy of

care corrupted. Pointing to midwifery systems in Europe and the United States that fall far short of current Canadian ideals, they ask if professional midwives will still be able to respond personally to parents' individual needs. Will responsibility to doctors and hospitals who hire them interfere with the primary alliance to clients? Will formal qualifications replace her current striving for up-to-date skills with "qualified" complacency?⁴

Others felt that for midwifery to remain marginalized was only a disservice to both women and midwives.

We came to believe that it was possible to create a form of regulation that would benefit midwifery. Rather than being a threat to the woman-centred model of care that had evolved outside of the health care system, regulation was a strategy for midwifery's growth and development.⁵

There is some evidence that the client-midwife relationship was perceived differently before and after legislation by both women and midwives.⁶ The pre-legislation relationship was that of peers, akin to friendship, whereas the relationship after legislation is one of service-provider and client. However, women still come to midwives with the expectation that they will be respected as the primary decision maker. A post-legislation book on midwifery in Canada describes a client's view of the informed choice process:

In some cases, midwives may offer choices about care, based on pros and cons from the research. In other cases midwives may recommend a course of action or have practice protocols that guide the care they usually provide, based on the best available evidence. Ultimately, the decision lies with you and will reflect your own values and specific needs.⁷

College of Midwives' Code of Ethics stipulates that midwives should "always act in such a way as to promote and safeguard the well-being of clients, advocating their interests" and "respect clients' right to informed choice".⁸ The standard on the Philosophy of Midwifery Care in Ontario describes this responsibility in more detail:

- Care is continuous, personalized and non-authoritarian. It responds to a woman's social, emotional and cultural as well as physical needs.
- Midwives promote decision-making as a shared responsibility between the woman, her family (as defined by the woman) and her caregivers. The mother is recognized as the primary decision maker.
- Fundamental to midwifery care is the understanding that a woman's caregivers respect and support her so that she may give birth safely, with power and dignity.⁹

What these College documents do not address is how to provide care when there is tension between the described model and other professional demands.

Other forces that influence a midwife's practice include the hospital environment, collaborative maternity care models, and liability concerns. Midwives now find themselves in the interesting position of being a part of the health care system and the institutions they once critiqued.

The Hospital Environment

As an increasing number of midwife-attended births occur in the hospital, women expect midwives to be adept in that setting. Hospitals must ensure that midwives work within their policies. However, midwifery clients still rely on midwives to advocate for them and support their choices and birth plans. Midwives are sometimes constrained in the options they can offer by the hospital rules or working environment. Alternatively, midwives face friction and even discipline if they support a client's choice that does not conform to hospital policy or community standard. For example, a woman may want to decline continuous fetal monitoring or an intravenous line during a more complex labour. If a midwife has discussed the risks and benefits of declining these interventions she will support the woman's informed choice. However, the hospital unit in which she works would expect her to advise the woman to follow hospital protocols. Midwives in the UK have questioned whether hospital integration has interfered with their ability to provide advocacy to women.

More vocal and campaigning groups, such as AIMS [Association for Improvements in the Maternity Services], have been highly critical of the fact that not all women practising as midwives are midwives in the traditional sense; instead they are obstetric nurses whose first allegiance is not to the woman, but to the hospital, to protocol and to the consultant obstetrician.¹⁰

Midwives are pressured to conform to a community standard of practice even when she believes that her client has chosen a reasonable alternative. The hospital environment may detract from the time midwives spend with their clients due to increased amount of paperwork and other logistical tasks.⁶

Collaborative Maternity Care Model

There has been much discussion lately of the pending maternity care crisis. Many communities have been left without maternity care services and more women may be left without care if creative solutions are not found.¹¹

As the profession grows, midwifery could be part of a collaborative care model that involves a combination of health care providers. Each could provide some aspect of care: midwives, family physicians, nurse-practitioners, and obstetricians. These models would require teamwork, compromise and innovation in order to serve women in rural, remote or under-serviced areas. Collaborative models may also contribute to the retention of midwives for whom the demands of being on-call are too onerous.¹² For midwives, this could become an ethical choice between maintaining a certain traditional model of care for a smaller number of women and providing care to a greater number of women in need of providers. There is enthusiasm for projects that propose to make use of midwives' knowledge base, clinical skills and commitment to women in an interdisciplinary model, as described in one project focused on rural and remote communities:

Working together in a more integrated way may enable care providers to provide enhanced service to more women. In addition, it can insure that the responsibility and challenge of providing maternity care in rural areas is shared. This could mean less stress

for rural maternity care providers and a more robust and sustainable maternity care service for rural communities.¹³

This kind of flexibility would allow midwives to work in tandem with other disciplines, fostering respect for midwifery as a valuable profession in its own right.

The point of collaboration is to create synergy from the individual skills offered by different professional groups. Collaboration and partnership are words that are frequently used interchangeably, and reflect the sense of approaching a particular task or concern as equals, with each party respected for what they have to contribute.¹⁴

Midwives will need to decide what compromises can be made while still maintaining a distinct professional identity. If care is shared with a multidisciplinary team, will choice of birth place still be an option for the women in the community? If a team approach is taken, will continuity of care be preserved? If care is based out of a clinic or hospital, will postpartum home visits still be provided?

Liability

In some countries (Australia, United States, United Kingdom, New Zealand) there is evidence of defensive practice in medicine, where clinical decisions are made with a view to minimizing vulnerability to a lawsuit as opposed to the patient's best interests.^{15,16} At the outset of legislated midwifery, many midwives believed, naively perhaps, that they were less likely to be sued than physicians due to the close relationship developed with clients and the informed choice process which places women at the centre of the decision-making process. Midwives now try to practice in such a way that the risk of litigation is reduced. One midwife observed a change in her own demeanor due to liability concerns:

Predicated by medico-legal considerations, I have become aware of yet another discourse, that of the insurance company to which my profession is contracted. When discussing a difficult situation

recently with a client, what was profoundly disturbing was that, along with my authentic behaviour and real caring for the woman, I found myself playing a role influenced by the insurance company and prompted by my colleagues. This role was scripted to protect the insurance company, the midwifery profession, and me, and the model a way of behaving appropriately with the client under these circumstances.⁶

Given the disrupting effect of litigation on a health care professional's personal and professional lives, midwives are also vulnerable to defensive practice. For example, midwives may be reluctant to offer VBAC's at home, or other choices that are outside the accepted community standard.

Consequences

Role conflict must be acknowledged and discussed. A lack of dialogue about this issue could lead to the loss of some important aspects of midwifery care due to pressure from more persuasive groups.

[H]owever much the midwife may want to provide supportive care for normal labour at a home birth, she may be continuously looking over her shoulder fearing criticism. . . . In addition, she knows that criticism is more likely to come for failing to act according to hospital protocols than following her instincts as a midwife.¹⁰

If role conflict is left unexamined it could lead to a discrepancy between what is taught in academic programmes and what is observed by students in clinical placements. Role conflict has been identified as a major source of stress in other professions.¹⁷ This stress could lead to attrition and the profession could lose conscientious and caring midwives.¹⁰

Role conflict needs to be examined for its potential to affect attrition, work-related stress, and ability to provide quality care. If midwives are left with role conflict as an experience of medico-legal vulnerability, betrayal of values or confused loyalties, they will miss out on participating in the evolution of a sustainable and responsive midwifery profession.

Next Steps

Research and open dialogue would be helpful to raise awareness of role conflict. It is also important to involve women so that the voices of women who are seeking midwifery care are heard.

Promoting the role of the midwife as advocate should start in the Midwifery Education Programs and continue as a thread through academic discourse and midwifery research.

Finally, the dialogue about role conflict can move beyond the midwifery profession to a more interdisciplinary forum. Knowledge of the stressors and motivation of our co-workers in other professions helps to build understanding and cooperation. By sharing common experiences we reduce the silo effect of isolated disciplines and work more effectively as a team.

There are many forces that can cause role conflict for midwives, including the hospital environment, liability issues, and proposals to work in collaborative care models that conflict with a midwife's advocacy role, her traditional commitment to be "with woman". Solutions lie both within and outside the profession. Research, education, and dialogue can contribute to a greater awareness of this issue. The involvement of clients/consumers can help shape the role of the midwife so that it remains responsive to women's needs. Both challenges and opportunities lie ahead for Ontario midwives.

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