

Moving towards trust and cooperation in obstetrics

Two Fellows describe their experiences of the ‘suspicious’ and sometimes ‘antagonistic’ – but crucial – relationship between midwives and obstetricians in Australia.

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In describing the past relationship between obstetricians and midwives in Australia, the words suspicion, mistrust and antagonism spring to mind. Why? It seems difficult to believe given the complementary and co-dependent nature of these two professions. What should be a team approach to the care of pregnant women has often become a battleground. I have observed in my career that there is a distinct cycle to this ‘war’.

When I was a medical student doing my obstetric term, I couldn’t believe how badly treated we were by some of the midwives. This was repeated a few years later, when I was a resident and junior registrar. Predictably, and under the influence of senior medical colleagues, we returned the favour – increasingly so the more senior we became. Over the years as I (hopefully) matured, I realised I had entered a cycle of dislike and resentment which was perpetuated by both sides. Specialists were awful to midwives, who were awful to medical students, who became registrars, who were then awful to midwives and so on, ad infinitum.

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I was certainly an eager participant in this cycle. I remember as a junior registrar when I went to see a patient after she had had a stillbirth. I was bodily blocked at the entrance of the door by the midwife, who told me it was inappropriate for me to go into the room. ‘Inappropriate’ was a word often used at that hospital by midwives towards registrars. I pointed out that as I had diagnosed the stillbirth and performed the induction, it was appropriate for me to go in and offer my condolences. More to the point, the hospital’s own protocols required me to do so. This, however, failed to convince the midwife concerned and the door remained barred to me. I bided my time and several weeks later managed to humiliate the same midwife in front of many colleagues, after she had made an obvious clinical mistake. I had my revenge and as a result, never established any meaningful working relationship with that midwife. I wish now that I had had more maturity and had known how to handle the situation better. From discussions with Sam, it’s clear she had better relationships with midwives as a registrar. I wish I had been as mature and level headed as she was, but I hope I have managed to improve!

Any working relationship between two professions requires effort on both sides. Teamwork without mutual respect and understanding is doomed to fail. Recognition of the skills and knowledge of the other team members is essential.

I am very fortunate to work in a unit where we all get on very well and there is virtually no friction between medical and midwifery staff. This isn’t some sort of spontaneous miracle. All of us work hard at keeping it this way. The key is to remember what we are here for, to respect each other’s abilities and avoid criticism and one-upmanship. It’s interesting when new staff start work in our unit. Coming from units where there is a high level of tension between doctors and midwives, they sometimes seek to establish the usual dysfunctional relationship. The senior midwifery and medical staff are aware of this and have learned to recognise and stop it before it becomes established.

Part of the reason that our unit functions well is that we have defined practitioner roles and responsibilities for patient care, but these are not exclusive of the other discipline. We have broadened the midwifery role by introducing greater responsibility, including team midwifery, outreach midwifery and expanding skills to include duties such as suturing and speculum examinations. I think this has resulted in more career satisfaction for our midwives. We encourage attendances at education meetings and morning handovers, and we have a monthly forum which any staff can attend to express opinions and concerns. In general, the midwives perform all the care for the low-risk patients and we are called when needed. We trust the midwives to have the responsibility for this care and the midwives trust us to give assistance when called upon. In addition, the midwives of our unit are significantly involved in the care of higher-risk pregnancies, a further indication of our trust in them.

It’s interesting that there is some evidence to suggest that there is more patient satisfaction in small, rural obstetric units. Doctors and midwives in rural areas rely heavily on each other and there is no time for grandstanding or hot-headedness. The job is there and it needs to be done, and it is done without individual agendas or forgetting the reason for being there – the woman and her baby. Perhaps the sense that ‘all is well’ in the team looking after her contributes to the woman’s sense of satisfaction with her care.

Of course, I can only write from the perspective of a staff specialist who feels it isn’t his role or responsibility to care for low-risk pregnant women and deliver their babies. If we trust midwives to do this, they will trust us to be there when we are needed. I think it’s sad when good relationships between midwives and obstetricians are threatened by the seemingly entrenched enmity of obstetricians who fear midwives will exclude them, and midwives who think obstetricians aren’t needed. There’s no possible common ground between these extremes.

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